

The background of the cover is a painting of the Louisiana State Capitol building, a tall, classical-style structure with a prominent central tower. In the foreground, there is a large field of American flags. The sky is blue with white clouds. The text is overlaid on the right side and bottom of the image.

LOUISIANA COMMISSION ON
PREVENTING OPIOID ABUSE

CREATED BY HCR 113
OF THE 2016 REGULAR SESSION

Louisiana Commission on Preventing Opioid
Abuse

**The Opioid Epidemic:
Evidence Based Strategies
Legislative Report**

THE OPIOID EPIDEMIC:
EVIDENCE-BASED STRATEGIES
LEGISLATIVE REPORT
April 2017

STATE OF LOUISIANA COMMISSION ON PREVENTING OPIOID ABUSE
CREATED BY HCR 113 (2016 REGULAR SESSION)

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EXECUTIVE SUMMARY

Deaths in the United States related to opioid drug use have been on the rise since 1999 resulting in more deaths in 2014 than any year on record. It is estimated that the rate of opioid overdose deaths has quadrupled in this same time span accounting for 165,000 deaths.¹ It is noteworthy that this rise in related overdose deaths over recent decades has been in close parallel with an increase in prescribing opioids for pain.² The recent trend of opioid overdose-related deaths has resulted in the Centers for Disease Control and Prevention (CDC) describing the current opioid crisis as an “epidemic.”³ Further, the CDC has identified prescription drug abuse and overdoses as one of the top 5 health threats of 2014.⁴

In response to the opioid epidemic in Louisiana, Representative LeBas and Senators Mills and Thompson, in the 2016 Regular Legislative Session, introduced House Concurrent Resolution No. 113 to establish the Louisiana Commission on Preventing Opioid Abuse (“Commission”). The charge of the Commission was to “study and make recommendations regarding both short-term and long-term measures that can be taken to tackle prescription opioid and heroin abuse and addiction in Louisiana.” The members of the committee included a diverse group of policy makers, administrators, treatment providers, and other stakeholders who understand opioid dependency, Medication Assisted Treatments (MAT), and the needs of both consumers and practitioners. Specifically, the members of the Commission made suggestions regarding (8) topical areas to include:

1. Identification and evaluation of the causes of opioid abuse in Louisiana.
2. Evaluation of the responsible use of opioid medications, to include an assessment of the feasibility and desirability of a statewide adoption of the

¹ Centers for Disease Control and Prevention, National Centers for Health Statistics. Multiple Cause of Death 1999 – 2015 on CDC WONDER Online

² Manchikanti et al., 2012 Opioid Epidemic in the United States, <http://www.painphysicianjournal.com/linkout?issn=1533-3159&vol=15&page=ES9>

³ Centers for Disease Control and Prevention, Understanding the Epidemic, <https://www.cdc.gov/drugoverdose/epidemic/>

⁴ CNN, 5 Health Challenges for 2014, <http://globalpublicsquare.blogs.cnn.com/2013/12/18/5-health-challenges-for-2014/>

recent "Guidelines for Prescribing Opioids for Chronic Pain" promulgated by the Centers for Disease Control and Prevention on March 18, 2016.

3. Evaluation and recommendation of reasonable alternatives of medical treatment to mitigate the overutilization of opioid medications, including but not limited to integrated mental and physical therapy health services.
4. Recommendations regarding policies and procedures for more effective interagency, intergovernmental, and medical provider communication, cooperation, data sharing, and collaboration with other states, the federal government, and local partners, including nonprofit agencies, hospitals, healthcare and medical services providers, and academia to reduce opioid abuse.
5. Evaluation and recommendation of policies and procedures for improved access and more effective opioid abuse treatment and prenatal care for pregnant women with substance abuse problems, including but not limited to clarifying current services available for these women, increasing the number of providers properly trained to provide care to this group, and effective ways to achieve treatment over incarceration.
6. Evaluation of medical professional training needs and the efficacy of educational materials and public education as an outreach strategy to raise public awareness about the dangers of misuse and abuse of opioid drugs.
7. Assessment of alternatives to incarceration and medical treatment of opioid-addicted individuals suffering from severe substance abuse disorders.
8. Recommendations for any appropriate changes to relevant legislation, administrative rules, or pharmaceutical prescribing to mitigate opioid abuse.

The following Commission Report to the legislature encapsulates the committee's work and the suggestions for each of the topics above. Topic 8, recommendations regarding "appropriate changes to relevant legislation, administrative rules, or pharmaceutical use to mitigate opioid abuse" works to

summarize each of the topical areas to provide the Legislature with actionable suggestions. This committee recommends that the Legislature review possible legislation, administrative rules, and policy changes as listed below:

1. Prescriber licensing boards should adopt the CDC guidelines for primary care physicians which focus on the first twelve weeks of therapy.
2. Prescriber licensing boards should adopt and adapt, to the extent possible, language from La. Admin. C. 46:6915 et seq. that provides guidance on Medications Used in the Treatment of Non-Cancer Related Chronic or Intractable Pain.
3. Prescriber licensing boards should require primary care physicians to obtain continuing education regarding the CDC Guidelines. Continuing education providers should collaborate with academia for curriculum development; professional associations should offer learning opportunities.
4. Prescriber licensing boards should encourage the use of the Prescription Monitoring Program (PMP) and should consider mandatory registration of their licensees to access the program data.
5. Establish an Opioid Collaborative group, similar to the PMP Advisory Council, for ongoing efforts on this topic.
6. Increase funding to therapeutic specialty courts to reduce incarceration and the associated costs.
7. Develop alternative funding strategies for judicial programs that leverage federal funds (i.e., Medicaid, Medicare, etc.).
8. Facilitate the access of therapeutic specialty court program personnel to the state PMP database.

CHAPTER I: Overview of the Opioid Epidemic: Causes and Consequences

2016 HCR 113 REQUEST:

Identify and evaluate the causes of opioid abuse in Louisiana

Overview of Addiction

Opioids are psychoactive substances derived from the opium poppy or their synthetic analogs.⁵ Addiction to opioids is a global problem that is estimated to affect between 26.4 million and 36 million people worldwide.⁶ Those addicted to opioids can roughly be divided into two categories - those that abuse prescription drugs (non-medical uses) and those that abuse heroin. Of those addicted in the United States, 2.1 million are addicted to prescription drugs whereas another 517,000 are addicted to heroin.⁷

Addiction is defined as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences.⁸ Addiction is considered a brain disease because drugs change brain structures and the way that these structures work.⁹ These brain changes, caused by drugs, can be long-lasting and ultimately change the way people behave.¹⁰

Initially, people are drawn to drugs for many of the same reasons. Drugs can be used to feel better, relax or sleep, wake up, mitigate pain, or simply change one's moods. For many, taking mood altering or enhancing substances is a daily event. For example, many workers greet the day with a cup of coffee. Coffee contains the stimulant caffeine that promotes alertness and focus. The extent of reliance on these substances largely depends on the addictive properties of the

⁵ World Health Organization, http://www.who.int/substance_abuse/information-sheet/en/

⁶ UNODC, World Drug Report 2012. <http://www.unodc.org/unodc/en/data-and-analysis/WDR-2012.html>

⁷ Substance Abuse and Mental Health Services Administration, Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-46, HHS Publication No. (SMA) 13-4795. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.

⁸ Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5, 2013).

⁹ National Institute of Drug Abuse, https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/soa_2014.pdf

¹⁰ *Id.*

drug, the frequency of use, and the physical and psychological factors that influence our sensitivity to the addictive effects.

Not all drugs are created equal. Some drugs are more addictive than others. As one might imagine, caffeine is considered to have mild addictive properties that may cause minor physical and mental discomfort when use is stopped. In contrast, opioid drugs are considered some of the most addictive drugs with the greatest potential for harm.

Over time, opioid drugs, of sufficient dosage and frequency, can change brain structures and create addictive behaviors. When brain structure become altered, to some extent, the addicted person loses control of the ability to make good choices. Instead, choices are made that support drug seeking.

Of significant importance to opioid addiction are the extreme physical withdrawals that occur when use stops and the tolerance that can be developed. Persons who are addicted to opioids try to avoid painful withdrawals through continued use. This ongoing cycle can create tolerance where addicted persons need more of the substance to produce desired effects. Changes in tolerance can create a dangerous situation where amounts used move closer towards lethal doses.

Addiction and Risk Factors for Overdose

People addicted to opioids are at heightened risk for opioid overdose.¹¹ The incidence of fatal opioid overdose among opioid dependent persons is 0.65% per year.¹² As one might imagine, the incidence of non-fatal overdose is much more common.¹³

There are factors that strongly influence opioid overdose risks. One such factor is that of reduced tolerance following a stay in a controlled environment where the addicted person has discontinued use (i.e., hospitalization, incarceration, rehabilitation).¹⁴ It is during this period of weakened tolerance that addicted persons may misjudge the amounts of opioids that can be safely used.

¹¹ World Health Organization, http://www.who.int/substance_abuse/information-sheet/en/

¹² *Id.*

¹³ *Id.*

¹⁴ *Id.*

Personal risk factors include a history of substance use disorders, male gender, older age, mental health conditions and lower socioeconomic status.¹⁵ Other significant risk factors may include: combining other sedating drugs/benzodiazepines with opioid use, high prescribed dosages (over 100mg of morphine or equivalent daily), I.V. injection of heroin, health complications, and living with a family member that possesses opioid prescriptions.¹⁶

Scope of the Problem: National Overview of Opioid Epidemic

Deaths in the United States related to opioid drug use have been on the rise since 1999 resulting in more deaths in 2014 than any year on record. It is estimated that the rate of opioid overdose deaths has quadrupled in this same time span accounting for 165,000 deaths.¹⁷ It is noteworthy that this rise in related overdose deaths over recent decades has been in close parallel with an increase in prescribing opioids for pain.¹⁸ Natural and semisynthetic opioids, which include the most commonly prescribed opioid pain relievers, oxycodone, and hydrocodone, are involved in more overdose deaths than any other opioid type.¹⁹

The increase in opioid prescribing behavior began in the late 1990's with an increased awareness of the need for the treatment of pain. Before this time, opioids were used, almost exclusively, to treat cancer pain. The recognition of the need to address pain disorders resulted in pain being declared the "fifth vital sign." In turn, patient advocacy groups and pain specialist lobbied state medical boards and state legislatures to lift prohibitions against opioid use for non-cancer pain. These efforts had the effect of relaxing regulation of opioids for non-cancer pain; thus the use of opioids for chronic pain became widespread. Even today, the debate rages over the efficacy of opioids to treat chronic pain conditions.

¹⁵ *Id.*

¹⁶ *Id.*

¹⁷ Centers for Disease Control and Prevention, National Centers for Health Statistics. Multiple Cause of Death 1999 – 2015 on CDC WONDER Online

¹⁸ Manchikanti et al., 2012 Opioid Epidemic in the United States, <http://www.painphysicianjournal.com/linkout?issn=1533-3159&vol=15&page=ES9>

¹⁹ Centers for Disease Control and Prevention, <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6450a3.htm> ; Kaiser Family Foundation, Opioid Overdose Deaths by Type of Opioid, <https://kff.org/other/state-indicator/opioid-overdose-deaths-by-type-of-opioid/>

Arguably, the attention given to pain disorders has resulted in a greater market availability of prescription opioids. This increase of supply has attached unintended consequence of fueling opioid addictions. Both prescribed users and illicit users of diverted drugs are at heightened risk of addiction due to the increased prevalence of opioid medications. If opioids are used in sufficient quantity over a prolonged period, users will become both physically and psychologically dependent. It is all too common for someone who suffers from chronic pain to become addicted to opioids, or else, have medications diverted to others for non-medical (recreational) purposes. The addictive properties of these substances create a situation where those addicted will continuously attempt to increase doses related to drug tolerance and substitute illicit substances if prescriptions become unavailable. The addictive cycle can push opioid dependent persons towards all available forms of opioids – to include illicit forms (heroin). This might suggest that enforcement issues that work to reduce the availability of opioids for nonmedical issues encourage dependent opioid users to switch to more accessible illicit sources such as heroin.

Coinciding with the growth in frequency of opioid prescription is an increasing rate of overdose. The average age-adjusted rate for overdose deaths in the U.S. is 15.6 (per 100,000), the majority of which are related to opioid drug use.²⁰ In 2014 alone, the related overdose deaths in the U.S. have increased by 6.5%. Moreover, opioid overdoses, have been increasing steadily over the last 15 years.²¹ This increase has been true for both males and females across the same time span.²² Even more astonishing than the precipitous rise in medical use opioid-related deaths of the last decade is the more recent rise in heroin deaths. Heroin overdoses have increased steadily since 2010 having tripled in this brief time-span. Overwhelmingly, males have been responsible for this trend.

²⁰ Centers for Disease Control and Prevention, *supra*.

²¹ Centers for Disease Control and Prevention, Multiple Cause of Death 1999 – 2014, *supra*

²² *Id.*

Scope of the Problem: Louisiana Overview

Population Description

The population of Louisiana is approximately 4.5 million.²³ Of those 4.5 million persons, over one-quarter surround the Baton Rouge/ New Orleans metropolitan areas. The other three-quarters of the state live in mostly rural areas.²⁴ As one might expect, it is anticipated that the most pronounced consequences of opioid dependence are found in metropolitan and suburban areas. Although these areas have more concentrated opioid problems, they are also the benefactors of the most treatment resources. Conversely, although rural areas have less pronounced opioid problems overall (e.g., overdose rates), these areas also have few resources to provide opioid dependent persons. One of Louisiana's significant health challenges is to provide healthcare services to underserved rural populations.

Opioid abuse substantially affects both the quality and cost of healthcare in Louisiana. It has been estimated that opioid abuse costs Louisianans \$296 million dollars per year in healthcare costs.²⁵ Moreover, Louisiana ranks 50 of 50 states in the United Health Care Foundation's report, *America's Health Rankings 2015*. This poor ranking for healthcare has been consistently low since 2009. Louisiana has relatively higher rates of heart disease, HIV, and drug-related mortalities as compared to the rest of the nation. It is noteworthy that two of the three primary drivers of poor health, drug related mortalities and HIV infections, are directly influenced by the opioid epidemic.

Overdose Deaths

There are two ways to understand the prevalence of opioid overdose deaths: (1) through the use of general CDC overdose data, and (2) through the use of opioid specific CDC data. General data provide the total number of deaths within a given area that are suspected to be the result of overdoses caused by any number of drugs or medications. Opioid specific drug data, a subset of general

²³ Kaiser Family Foundation, <http://kff.org/health-reform/fact-sheet/the-louisiana-health-care-landscape/>

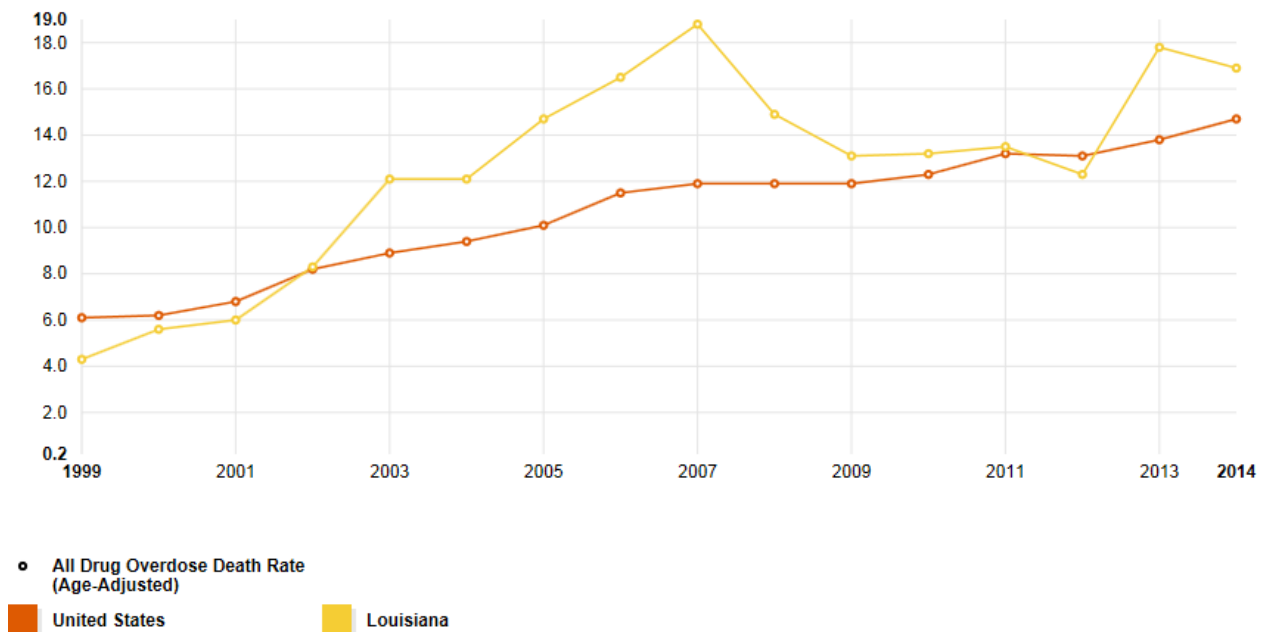
²⁴ *Id.*

²⁵ Matrix Global Advisors, LLC (2014) Health Care Costs from Opioid Abuse: A State by State Analysis. Retrieved from: http://drugfree.org/wp-content/uploads/2015/Matrix_Opioidabuse_040415.pdf

overdose estimates, provides the number of deaths in each area that are thought to be a result of opioid drugs. General data is useful because it is known that opioids are responsible for 60% of all general overdose deaths.²⁶ Given that opioids are known to contribute to general overdose deaths significantly, total overdose rates provides insight to the severity of an area’s opioid problem. Ironically, although more specific to opioids, opioid specific data may underrepresent the severity of an area’s opioid problem. This is because of the tendency to underreport opioid specific data. This underreporting of opioid specific causes of death is related to weaknesses in how data is collected and reported to the CDC.

General Overdose Data

Like much of the nation, overdose deaths in Louisiana have steadily increased since 1999.²⁷ Unlike the rest of the nation, Louisiana posted a brief period between 2007 and 2012 that saw a decrease in overdose deaths; however, it should be noted that overdose rates experienced in this window were still almost three times as high as rates experienced in a decade earlier.²⁸



²⁶ Centers for Disease Control and Prevention, Understanding the Epidemic, <https://www.cdc.gov/drugoverdose/epidemic/>

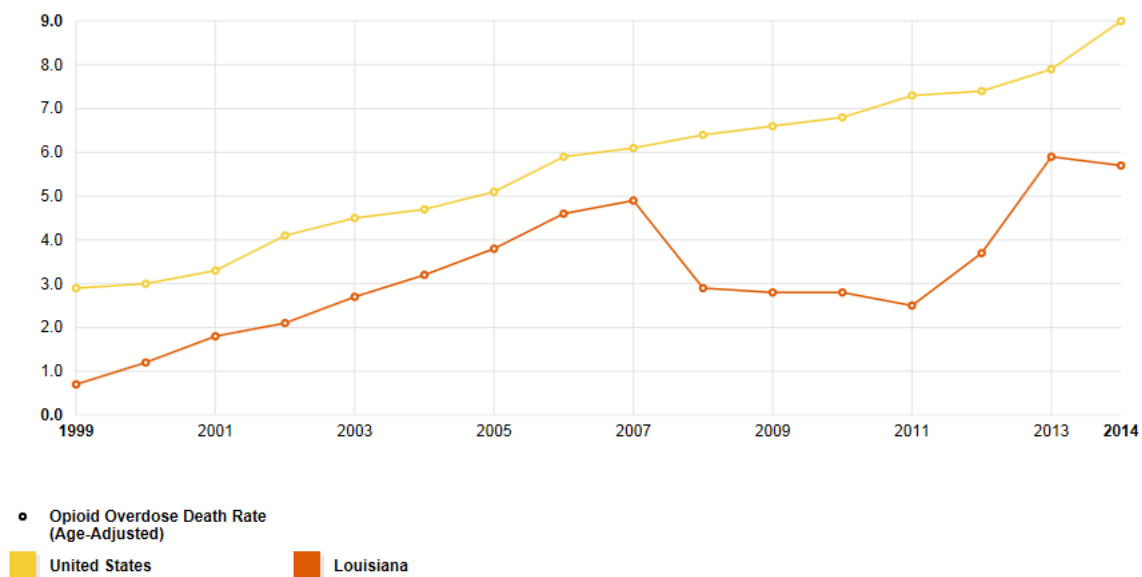
²⁷ Centers for Disease Control and Prevention, Multiple Causes of Death 1999 – 2015, supra.

²⁸ *Id.*

Further, the age-adjusted rates per 100,000 have consistently been higher than national averages in all recent years except brief departures in 2011 and 2012. For comparison, Louisiana posted an age-adjusted overdose rate that was 13% higher than the national average in 2014 (17.6 and 15.6 respectively).²⁹ It is noteworthy that males outnumber females in the rate of opioid overdose 71% to 29% respectively.³⁰ Moreover, whites outnumber all other racial and ethnic groups making up 84% of all opioid overdoses.³¹ African Americans represented the second highest population of opioid overdoses in Louisiana representing 12% of the total.

As a rule, suburban populations surrounding larger metropolitan areas had the highest age-adjusted rates of general overdoses. In 2015, Livingston, Washington, Plaquemines, Terrebonne, Orleans, and St. Tammany Parishes (respectively) led the state with overdose rates that were at least 50% higher than the state average. Possible reasons for the higher overdose rates may include demographics and a greater availability of opioids.

Opioid Specific Data



As compared to the national average, opioid specific rates present a

²⁹ *Id.*

³⁰ Kaiser Family Foundation, <http://kff.org/other/state-indicator/opioid-overdose-deaths-by-gender/?currentTimeframe=0&selectedRows=%7B%22nested%22:%7B%22louisiana%22:%7B%7D%7D%7D>

³¹ Kaiser Family Foundation, <http://kff.org/other/state-indicator/opioid-overdose-deaths-by-raceethnicity/?currentTimeframe=0&selectedRows=%7B%22nested%22:%7B%22louisiana%22:%7B%7D%7D%7D>

completely different picture of the opioid crisis in Louisiana. National averages have consistently outpaced state averages from 1999-2014. Moreover, from 2007 to 2011, Louisiana experienced a precipitous decrease in opioid-related deaths. It is noteworthy, the general overdose deaths also decreased during the same period suggesting that, to some degree, the opioid epidemic lessened intensity in those years.

The bulk of all recorded **opioid overdose deaths** occurred in the parishes surrounding Orleans Parish. Specifically, St. Tammany Parish experiences close to 50 opioid overdoses a year at a rate that is six times that of the state average (20.96 to 3.54 per 100,000).³² Similarly, Jefferson Parish has over 55 opioid overdoses a year at a rate four times higher than the state average (12.85 to 3.54 per 100,000).³³ Washington and St. Bernard Parishes, though having significantly less population, still maintain high rates of opioid overdoses. Washington Parish experienced 27 deaths since 2010; whereas, St. Bernard Parish recorded 13 deaths in the same timeframe.

Of rural parishes, there extends a swath of reported **opioid overdose deaths** that spreads from Bienville Parish, through Winn into Grant Parish. Between these three Parishes, 17 deaths have been recorded in the last five years.³⁴ More importantly, this pattern has been consistent over the last decade with over 40 recorded opioid deaths. This area maintains an average opioid overdose rate per 100,000 that is near twice that of the rest of the state.

Prescribing Behavior

Louisiana is one of the top states related to painkiller prescription frequency. It has been estimated that, on average, Louisiana physicians write 108 to 122 prescriptions per 100 persons per year.^{35,36} Only six states average more prescriptions a year (i.e., Mississippi, Alabama, West Virginia, Oklahoma, Tennessee, Kentucky).³⁷ High rates of painkiller prescribing behavior result in

³² *Id.*

³³ *Id.*

³⁴ *Id.*

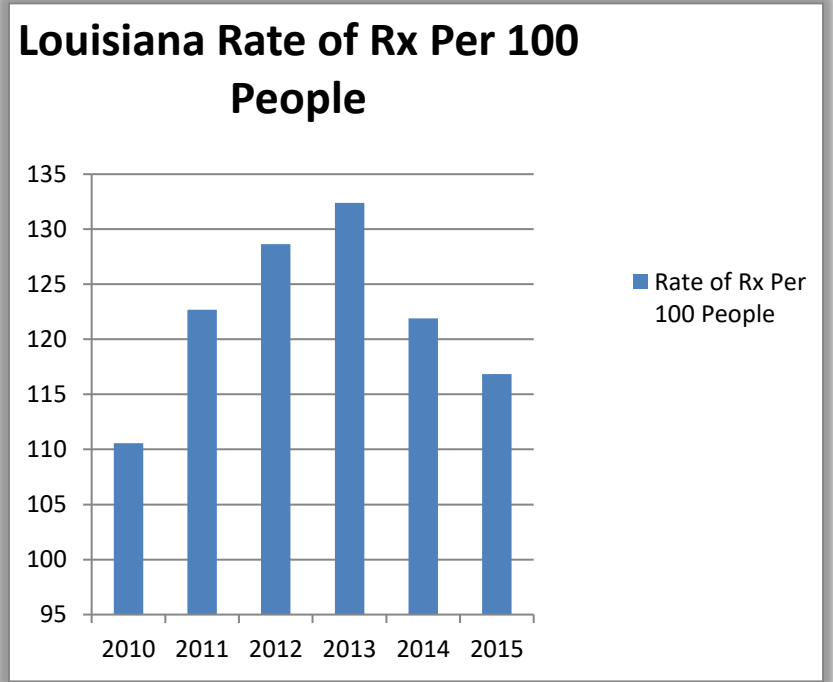
³⁵ IMS Health, Vector One: National, Years 1991-1996, Data Extracted 201. IMS Health, National Prescription Audit, Years 1997-2013, Data Extracted 2014.

³⁶ Louisiana PMP, Data Extracted 2016 and compared to U.S. Census Data

³⁷ *Id.*

concomitant overdose deaths. It has been estimated that for every 6,750 prescriptions written, there will be one predicted overdose death.³⁸

The Louisiana Pharmacy Board monitors prescription behavior through the Prescription Monitoring Program (PMP). Act 676 of the 2006 Louisiana Legislature authorized the Louisiana Board of Pharmacy to develop, implement and operate an electronic system for the monitoring of controlled substances and other drugs of concern dispensed in the state or dispensed to an address within the state. The goal of the program is to improve the state's ability to identify and inhibit the diversion of controlled substances and other drugs of concern in an efficient and cost-effective manner and in a manner that shall not impede the appropriate utilization of these drugs for legitimate medical purposes.³⁹



Per prescription data available through this system, Louisiana has consistently ranked as a top opioid prescribing state. Most states prescribe fewer than 88 narcotic prescriptions per 100 persons. Over the last six years, since the PMP began monitoring narcotic prescribing behavior, Louisiana has averaged 122 prescriptions per 100 persons. This rate is 39% percent higher than the national average (87.44).

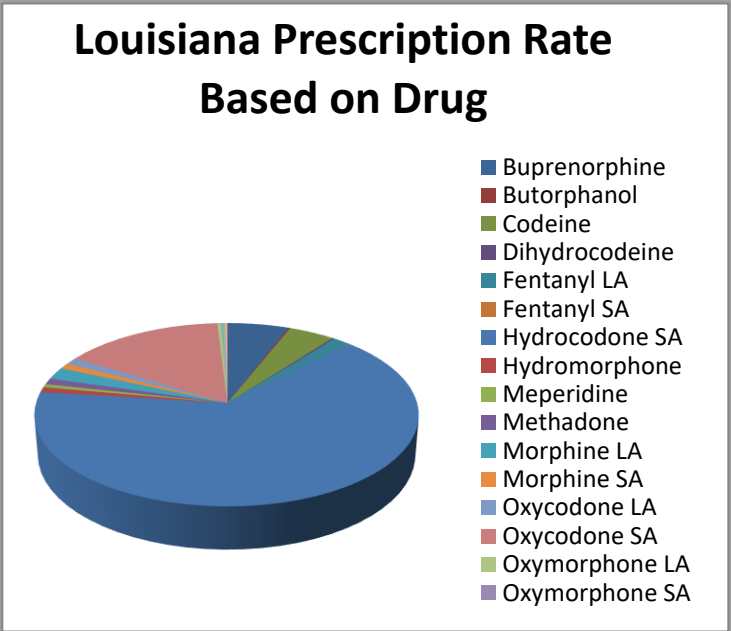
Medicare data also suggest that Louisiana has higher than average prescribing patterns. According to the Centers for Medicare and Medicaid Services (CMS), Louisiana prescribes opioids at a claims rate slightly higher than

³⁸ Regression analysis performed by LDH (Michelle Barnett) using CDC and IMS data.

³⁹ Louisiana Prescription Monitoring Board (PMP), <http://www.labp.com/index.cfm?md=pagebuilder&tmp=home&pid=5&pnid=0&nid=7>

the national average (5.74% to 5.32% respectively).⁴⁰ In the most recent CMS data, Louisiana had 19,136 Part D prescribers that billed for 1,973,051 opioid specific claims. It is noteworthy that fewer than 500 of the 19,136 prescribers account for most opioid prescriptions in the state.⁴¹ Practice types common to this subset of prescribers include anesthesiology, orthopedic medicine, pain management, and physical medicine/ rehabilitation.⁴² Moreover, the general trend for Medicare opioid prescribing behavior is that it is concentrated around metropolitan areas. Parishes with noticeably higher prescription claim averages as compared to state and national averages included: Cameron (17.56%), St. Charles (9.57%), St. John (8.94%), Red River (8.02%), and Bossier (7.13%).

In 2013, the Public Behavior Surveillance System (PBSS) study validated both PMP and Medicare prescription findings and provided unique insights into national and state prescribing behaviors. The PBSS is a public health surveillance system, funded by the CDC, which allows public health officials to quantify misuse of prescribed controlled substances. Starting in 2012, the PBSS began collecting data in eight states to include California, Delaware, Florida, Louisiana, Maine, Ohio, and West Virginia. These states were estimated to represent one-fourth of the U.S. population.⁴³ The first and only report compiled by the PBSS noted the following findings:⁴⁴



- In all eight states, opioid analgesics are prescribed twice as often as stimulants and benzodiazepines.

⁴⁰ Centers for Medicare and Medicaid Services (CMS), Medicare Part D Opioid Mapping Tool, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/OpioidMap.html>

⁴¹ *Id.*

⁴² *Id.*

⁴³ Paulozzi et al., Controlled Substance Prescribing Patterns — Prescription Behavior Surveillance System, Eight States, 2013 <http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6409a1.htm> PBSS

⁴⁴ *Id.*

-
- Rates of prescribing peaked for the 55-64 years age group coinciding with chronic pain conditions.
 - Louisiana ranked 1st out of participant states for opioid prescribing (1.02 prescriptions per resident).
 - Louisiana's #1 rank was mostly related to high rates of short-acting hydrocodone prescribing (3.8 times greater than Delaware). SA hydrocodone accounted for 65% of Louisiana opioid prescriptions.
 - Women experienced higher prescribing rates than men.
 - 10% of prescribers account for 50% - 60% of all opioid prescribing.
 - Legislation related to pain clinic regulation was associated with declines in opioid prescribing rates.
 - Persons prescribed opioids were also commonly prescribed benzodiazepine sedatives despite their additive depressant effects.

Scope of the Problem: Treatment and Use

There are various data sets that can be used to measure this expansion of consumers that are addicted to opioids including, substance abuse treatment episodes, and state and national use surveys. One such data set that provides insight into the treatment of opioid addiction in Louisiana is the Substance Abuse and Mental Health Services Administration's (SAMHSA) Treatment Episode Data Set (TEDS). TEDS provides information on the demographic and substance abuse characteristics of the 1.8 million annual admissions to treatment for abuse of alcohol and drugs in facilities that report to individual State administrative data systems. TEDS is an admission-based system, and TEDS admissions do not represent individuals. Thus, for example, an individual admitted to treatment twice within a calendar year would be counted as two admissions.⁴⁵

TEDS does not include all admissions to substance abuse treatment. It includes admissions to facilities that are licensed or certified by the State substance abuse agency to provide substance abuse treatment (or are administratively tracked for other reasons). In general, facilities reporting TEDS data are those that receive State alcohol and drug agency funds (including Federal Block Grant funds) for the provision of alcohol and drug treatment services. As

⁴⁵ Centers for Behavioral Health Statistics and Quality, Treatment Episode Data Set, <http://www.dasis.samhsa.gov/webt/quicklink/LA15.htm>

such, it should be understood that this data can only be used for a limited interpretation of the substance abuse needs of Louisiana.

In 2015, Louisiana substance abuse facilities treated 1,033 persons for heroin use disorders and 978 persons for all other opioids (nonmedical uses).⁴⁶ Combined, heroin and other opioids amounted to 24.2% of all facility admissions. The age groups most represented for opioid treatment were the 26-30 and the 31-35 ages groups whose numbers composed roughly 50% of all admissions.⁴⁷ Overwhelmingly, whites were more likely to seek treatment for opioid addictions noting that this group represented 72.1% of the total heroin admissions and 84.8% of “other opioid” admissions.⁴⁸ Men consistently had a higher representation in both groups noting that men made up 66.5% of heroin admissions and 53.5% of “other opioids” admissions.⁴⁹ African Americans represented 24.4% of heroin admissions and 13.8% of other opioid drug admissions.⁵⁰ Hispanics represented 3.6% of all heroin and 1.3% of all opioid admissions.⁵¹

TEDS data confirms previously known disparities in the delivery of healthcare in Louisiana.⁵² As it relates to TEDS, Louisiana has seen a pronounced decrease in the number of persons admitted for heroin and opioid disorders between the years of 2014-2015 (40.94% and 24.7% respectively). This is astonishing given the fact that all indicators suggest that Louisiana has a worsening opioid problem. One would anticipate if treatment were readily available, that opioid-related admissions would increase with a worsening problem. Instead, the data suggests that treatment availability/use has decreased during the height of the epidemic. Disproportionately, this loss of treatment availability/use has impacted women and African American minorities.⁵³

⁴⁶ *Id.*

⁴⁷ *Id.*

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² Kaiser Family Foundation (2016). Louisiana Fact Sheet. Retrieved from:

<http://kff.org/health-reform/fact-sheet/the-louisiana-health-care-landscape/>

⁵³ Centers for Behavioral Health Statistics and Quality, Treatment Episode Data Set,

https://www.samhsa.gov/data/sites/default/files/2014_Treatment_Episode_Data_Set_State_Admissions_9_15_16.pdf ; Centers for Behavioral Health Statistics and Quality, Treatment Episode Data Set,

<http://www.dasis.samhsa.gov/webt/quicklink/LA15.htm>

Another SAMHSA data set that provides insight into the severity of opioid addiction problems in Louisiana is the National Survey on Drug Use and Health (NSDUH). The NSDUH is an annual nationwide survey involving interviews with approximately 70,000 randomly selected individuals aged 12 and older. The Substance Abuse and Mental Health Services Administration (SAMHSA), which funds NSDUH, is an agency of the U.S. Department of Health and Human Services (DHHS). Supervision of the project comes from SAMHSA's Center for Behavioral Health Statistics and Quality (CBHSQ).⁵⁴

Data from the NSDUH provides national and state-level estimates on the use of tobacco products, alcohol, illicit drugs (including non-medical use of prescription drugs) and mental health in the United States. In keeping with past studies, these data continue to provide the drug prevention, treatment, and research communities with current, relevant information on the status of the nation's drug usage.

In relation to opioid abuse and dependence, estimates provided through the NSDUH survey may provide some insight to the severity of illicit opioid use in Louisiana. Specifically, there are four questionnaire responses that may be used to glean information about Louisiana's opioid usage as compared to national estimates. These items include:

- *Illicit drug use other than marijuana in the past month*
- *Nonmedical use of pain relievers in the past year*
- *Illicit drug dependence or abuse in the past year*
- *Illicit drug use in the last year*

As compared to national counterparts, Louisiana residents were more likely to have used *illicit drugs in the past month* (3.3% to 3.65% respectively).⁵⁵ Although this category does not specify opioids, one might assume that Louisiana residents, in general, may be more at risk to use “harder” substances like heroin. This trend towards “harder drugs” is further validated by Louisiana's use of *nonmedical pain relievers in the last year* (4.69% to 4.06%).⁵⁶ This category would suggest that Louisianans, on average, misuse prescriptions at rates higher than

⁵⁴Substance Abuse and Mental Health Administration, National Survey on Drug Use and Health, <http://www.samhsa.gov/data/sites/default/files/1/1/NSDUHsaeLouisiana2014.pdf>

⁵⁵ *Id.*

⁵⁶ *Id.*

the national average. Moreover, Louisiana residents were more likely to report illicit drug dependence or abuse than national cohorts (2.95% as compared to 2.64%).⁵⁷

Finally, the Caring Communities Youth Survey (CCYS) provides information about opioid drug initiation among young people in Louisiana. CCYS is designed to assess students' involvement in a specific set of problem behaviors, as well as their exposure to a set of scientifically validated risk and protective factors. The risk and protective factors have been shown to influence the likelihood of academic success, school dropout, substance abuse, violence, and delinquency among youth. For example, children who live in disorganized, crime-ridden neighborhoods are more likely to become involved in crime and drug use than children who live in safe neighborhoods.

The survey is administered every two years to Louisiana students in grades 6, 8, 10 and 12. More than 92,605 Louisiana students participated in the 2014 CCYS survey, and the results of the 2014 survey are now available. You can view the state report or reports for each of the parish school systems in Louisiana.⁵⁸

Of relevance to understanding the trends in opioid use are questions surrounding both prescription drugs and prescription narcotics use. Specifically, there are four questions that are part of the CCYS related to opioid use and abuse that include:

- *On how many occasions have you used heroin or other opioids in your lifetime?*
- *On how many occasions have you used heroin or other opioids in the last 30 days?*
- *On how many occasions have you used narcotic drugs (such as OxyContin, methadone, morphine, codeine, Demerol, Vicodin, Percocet) without a doctor telling you to take them in your lifetime?*
- *On how many occasions have you used narcotic drugs (such as OxyContin, methadone, morphine, codeine, Demerol, Vicodin, Percocet) without a doctor telling you to take them in the last 30 days?*

⁵⁷ *Id.*

⁵⁸ Caring Communities Youth Survey, <https://picardCenters.louisiana.edu/research-areas/quality-life/caring-communities-youth-survey-ccys>

The current opioid use trends for all grade classifications is decreasing for both 30 days and lifetime use. Moreover, when comparing heroin use for 8th, 10th, and 12th graders to national levels (through the Monitoring the Future national study), 8th and 10th graders were below national averages and 12th graders were representative of national norms. One could conclude from this data that children are initiating opioid use at later ages, and therefore there may not be as significant of a problem with these drugs as experienced in the past.

Treatment Providers

Substance abuse treatment providers have been going through a change in basic assumptions for many years regarding the treatment of opioid addiction. Traditional substance abuse therapy has been built on the institutionalization of 12-step practices and “drug-free” treatment.⁵⁹ More recently, Medication Assisted Treatments (MAT) have been shown to be the “most effective of all available treatments for opioid addictions.”⁶⁰ Traditional providers have been slow to adopt MAT treatments, despite the evidence of effectiveness, because of longstanding beliefs about addiction treatment. This has created a fracture in the Louisiana delivery system where opioid addiction is being treated by both traditional providers and MAT providers.

Currently, there are three medications approved by the FDA for the treatment of opioid addictions to include buprenorphine/naloxone (Suboxone), injectable naltrexone (Vivitrol), and methadone. Methadone is the most regulated of these being governed by 42 CFR 8 *et seq.* and RS 40:2159 *et seq.* As consistent with 42 CFR 8 *et seq.*, methadone treatment can only occur in clinic settings. Suboxone can be administered by any physician that possess a waiver to dispense buprenorphine. To acquire a waiver, the physician must attend an (8) hour buprenorphine training course. Once the waiver is obtained, the trained physician can administer buprenorphine in an office setting. Lastly, Vivitrol can be provided by any licensed prescriber in an office setting.

⁵⁹ Roman, Abraham, and Knudsen (2011)

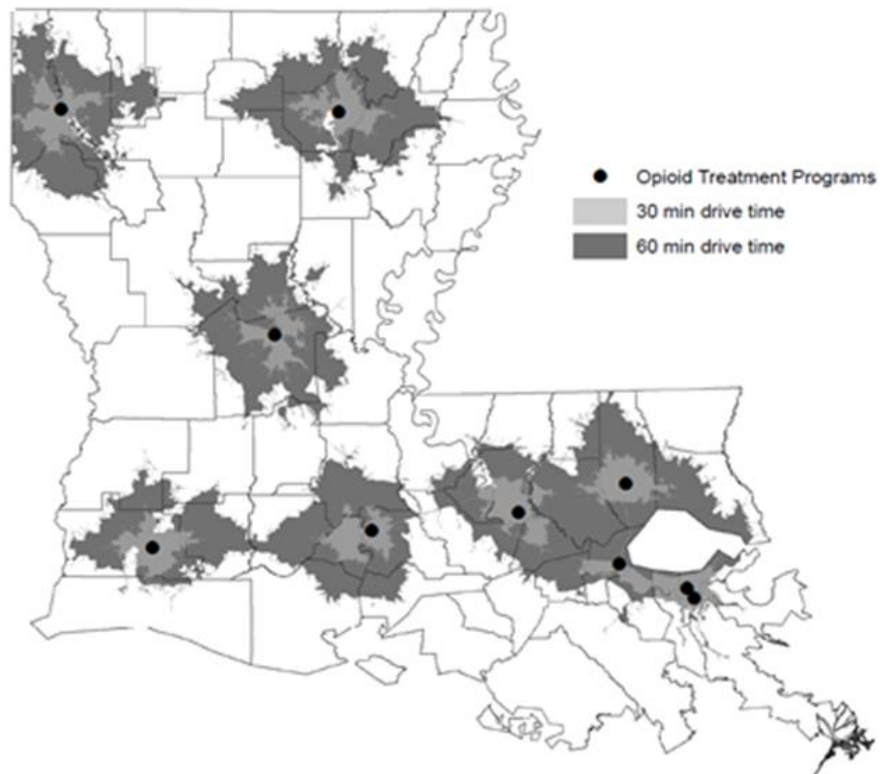
⁶⁰ National Institute of Health (1997), Consensus Development Conference Statement, *Effective Medical Treatment for Opioid Addiction*.

Methadone/Providers

Methadone is an opioid drug used to treat pain or as a medication for maintenance therapy/detoxification for those that suffer from opioid dependence. Methadone works by lessening the painful symptoms of opioid withdrawal and blocks the euphoric effects of opioid drugs such as heroin, morphine, and codeine, as well as semi-synthetic opioids like oxycodone and hydrocodone.⁶¹ Methadone is offered in pill, liquid, and wafer forms and is taken once a day. Pain relief from a dose of methadone lasts about four to eight hours.⁶² Methadone is effective in higher doses, particularly for heroin users, helping them stay in treatment programs longer.⁶³ As with all medications used in medication-assisted treatment (MAT), methadone is to be prescribed as part of a comprehensive treatment plan that includes counseling and participation in social support programs.⁶⁴

Currently, there are (10) licensed methadone providers in Louisiana. These clinics are in the metropolitan areas of the state to include:

- Shreveport
- Monroe
- Alexandria
- Lake Charles
- Breaux Bridge
- Baton Rouge
- New Orleans
- Laplace
- Hammond
- Gretna



⁶¹ Substance Abuse and Mental Health Administration, *Methadone*, <https://samhsa.gov/medication-assisted-treatment/treatment/methadone>

⁶² *Id.*

⁶³ *Id.*

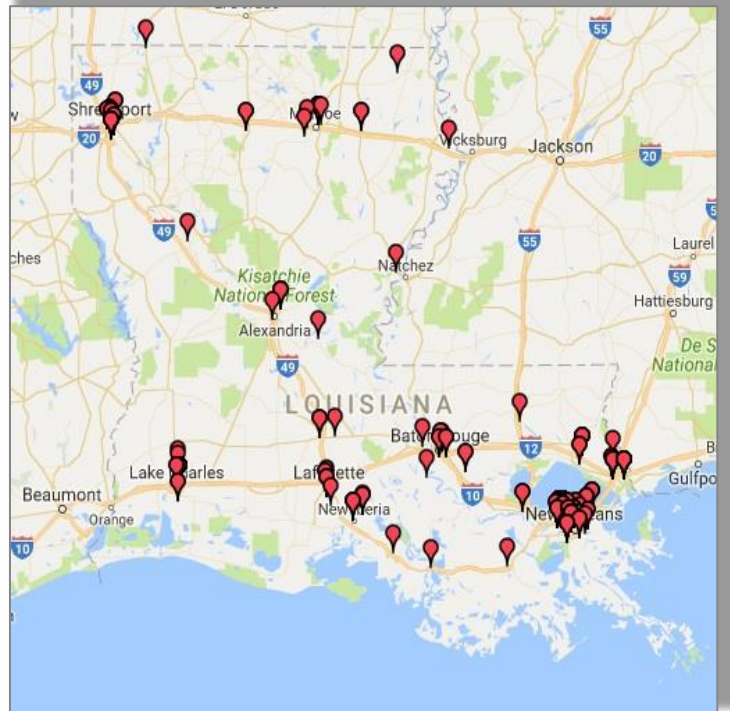
⁶⁴ *Id.*

In addition to methadone treatment, these designated facilities provide all FDA-approved MAT. These providers accept insurances (if the insurance provides coverage) for various services and accept most other forms of payment. It is anticipated that most methadone clients pay for service through cash transactions. It is noteworthy that insurance coverage for methadone is believed to be limited for most.

Access to Methadone Maintenance Treatment (MMT) is limited for various reasons. First, there are geographical barriers related to the number of methadone facilities (See map above). As such, the population that is within a 30 or 60-minute drive to an OTP is limited. Specifically, 48% of Louisiana's population lives within a 30-minute drive to an OTP, while 72% live within a 60-minute drive. Another reason access to MMT is limited is due to health coverage. Medicaid provides recipients opioid treatment services through Suboxone and traditional addiction services. Methadone is only offered through the Medicaid formulary for the treatment of chronic pain conditions. However, there is a current effort to add Methadone for the treatment of OUD to the Medicaid formulary. It is anticipated that this change will go into effect in 1-2 years.

Buprenorphine/Providers

The arrival of buprenorphine represented a significant health services delivery innovation. FDA approved Subutex® (buprenorphine) and Suboxone® tablets (buprenorphine/naloxone formulation) in October 2002, making them the first medications to be eligible for prescribing under the Drug Addiction Treatment Act of 2000. Subutex contains only buprenorphine hydrochloride. This formulation was developed as the initial product. The second medication, Suboxone, contains naloxone to guard against misuse (by initiating withdrawal if the formulation is injected). Subutex and Suboxone are less tightly controlled



than methadone because they have a lower potential for abuse and are less dangerous in an overdose. As patients progress in their therapy, their doctor may write a prescription for a take-home supply of the medication. To date, of the nearly 872,615 potential providers registered with the Drug Enforcement Administration (DEA), 25,021 registered physicians are authorized to prescribe these two medications. The development of buprenorphine and its authorized use in physicians' offices gives opioid-addicted patients more medical options and extends the reach of addiction medication to remote populations.⁶⁵

There are currently 209 Suboxone providers statewide. As is described through the geo-map, the largest concentration of prescribers are located in the New Orleans-Metro area. As one might expect, rural areas of the state have less representation.⁶⁶

⁶⁵ National Institute on Drug Abuse, America's Addiction to Opioids: Heroin and Prescription Drug Abuse, <https://www.drugabuse.gov/about-nida/legislative-activities/testimony-to-congress/2016/americas-addiction-to-opioids-heroin-prescription-drug-abuse>

⁶⁶ Substance Abuse and Mental Health Administration, Buprenorphine Treatment Physician Locator, http://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator?field_bup_physician_us_state_value=LA

CHAPTER II: Strategies for Adopting the *Guidelines for Prescribing Opioids for Chronic Pain*

2016 HCR 113 REQUEST:

Evaluate the responsible use of opioid medications, including the adoption of “Guidelines for Prescribing Opioids for Chronic Pain (March 2016 from CDC).”

RECOMMENDATIONS:

- 2-1. Prescriber licensing boards should adopt the CDC guidelines for primary care physicians which focus on the first twelve weeks of therapy.
- 2-2. Prescriber licensing boards should adopt and adapt, to the extent possible, language from La. Admin. C. 46:6915 et seq. that provides guidance on Medications Used in the Treatment of Non-Cancer Related Chronic or Intractable Pain.
- 2-3. A roster of addiction medicine and pain management specialists should be developed, and consultation with these professionals should be encouraged for prescribers that have clients enrolled in long-term opioid therapy; this roster should be advertised to the prescriber community.
- 2-4. Prevention education is encouraged to inform the public about addiction, the risks of taking opioid medications, and viable alternatives for the treatment of pain. The focus and implementation methods of these educational strategies should include:
 - (a) Medical students should be educated by the professional medical programs in which they are enrolled
 - (b) Licensing boards should educate prescribers.
 - (c) The public should be educated through a series of public service announcements.

CHAPTER III: Alternatives to Opioid Medications

2016 HCR 113 REQUEST:

Evaluate and recommend reasonable alternatives of medical treatment to mitigate the overutilization of opioid medications, including integrated mental and physical therapy health services.

RECOMMENDATIONS:

- 3-1. For new patients, opioid prescriptions should be considered after non-opioid alternatives have been attempted. Current patients that are enrolled in opioid therapies should be informed of non-opioid alternative therapies.
- 3-2. When a patient is enrolled in long-term opioid treatment, referrals should be made to psychotherapy when the prescriber can not provide evidence-based cognitive behavioral therapy.
- 3-3. Physical therapy health services (i.e., physical therapy, occupational therapy, and chiropractic care) should be recommended as one of the primary opioid alternative treatments for managing chronic pain issues.
- 3-4. Prescribers should receive training on Medication Assisted Treatments (MAT). Encourage specialized training and utilization of Medication Assisted Treatments (MAT) that include methadone, Buprenorphine, and naltrexone.
- 3-5. Prescribers should be educated on how to utilize Prescription Monitoring Program (PMP) data. This training should focus on recognizing and reporting drug misuse, abuse, and addiction.
- 3-6. Eliminate prior authorizations for medications used to treat addictions; this rule should apply to new prescriptions and post-detoxification prescriptions.

CHAPTER IV: Communication, Cooperation and Data Sharing

2016 HCR 113 REQUEST:

Recommend policies and procedures for more effective interagency, intergovernmental, and medical provider communication, cooperation, data sharing, and collaboration with other states, the federal government, and local partners (non-profit agencies, hospitals, health care and medical service providers, and academia) to reduce opioid use.

RECOMMENDATIONS:

4-1. Prescriber licensing boards should require primary care physicians to obtain continuing education regarding the CDC Guidelines. Continuing education should be provided in collaboration with academia for curriculum and professional associations for learning opportunities.

4-2. Prescriber licensing boards should encourage the use of the PMP and should consider mandatory registration of their licensees to access the program data.

4-3. Establish an Opioid Collaborative group, similar to the PMP Advisory Council, for ongoing efforts on this topic.

4-4. A list of MAT providers should be created. This list should be distributed to primary care providers.

4-5. Community lists of secure prescription drop box locations should be created. These lists should be publicized to increase community awareness and utilization.

CHAPTER V: Improving Access for Pregnant Women

2016 HCR 113 REQUEST:

Evaluate and recommend policies and procedures for improved access and more effective opioid abuse treatment and prenatal care for pregnant women with substance abuse problems, including but not limited to clarifying current services available for those women, increasing the number of providers properly trained to provide care to this group, and effective ways to achieve treatment over incarceration.

RECOMMENDATIONS:

5-1. Incorporate universal verbal preventive screenings for pregnancy intention and substance use into routine care.

- a. Encourage all providers and clinics that participate in the care of women of reproductive age who are prescribed opioids during the course of treatment, or that are using medication-assisted treatment (MAT) for dependence or addiction, to utilize a simple verbal screening tool for pregnancy intention and/or offer pregnancy testing at all visits.
- a. Encourage all obstetric providers to use a validated universal screening tool for substance use during routine prenatal care, such as the Screening, Brief Intervention, and Referral to Treatment (SBIRT) or 4 P's Plus tools, to prevent the practice of screening or toxicological testing upon suspicion and without informed consent.
- b. Implement structured protocols for verbal substance use screening at birth and during pregnancy at birthing facilities to eliminate discrimination when screening mothers on suspicion of drug use.

5-2. Develop structured protocols at birthing facilities and pediatric care settings to identify and treat neonatal abstinence syndrome (NAS) using validated tools such as the Finnegan Neonatal Abstinence Scoring Tool (FNAST).

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- 5-3. Develop a comprehensive guide of best practices for opioid prescribers that addresses the needs of women of child-bearing age and vulnerable populations, such as pregnant women.
- 5-4. Develop a comprehensive evidence-based guide of best practices for obstetric providers that addresses prenatal care and treatment needs of opioid dependent and addicted pregnant women.
- 5-5. Develop a preferred network of physicians and other advanced care providers who are experienced in obstetrical care and the management of opioid dependence and MAT for public and private managed care organizations.
- 5-6. Post rosters of providers in conspicuous areas in opioid maintenance clinics who are experienced in the care of women whose babies are at risk of NAS and provide a list of those providers to primary care physicians to assure appropriate referrals can be made.
- 5-7. Obtain authorization from the federal Drug Enforcement Administration (DEA) for state birthing facilities to allow birthing hospitals at least 72 hours or longer to transition pregnant women to medication assisted therapy.
- 5-8. Conduct a study to determine if the 2014 changes to Louisiana's Prescription Monitoring Program have had an impact. (This program requires that prescribers issuing opioid prescriptions for non-cancer related chronic pain review a patient's Prescription Monitoring Program record prior to issuing the initial prescription)
- 5-9. Make the public aware of the effects of substance use prior to and during pregnancy.
- 5-10. Support and include voluntary evidence-based home visitation programs in the coordination of care of families with substance use disorder. These programs provide comprehensive management for families struggling with NAS and/or substance use disorder.
- 5-11. Expand evidence-based home visitation programs and home-based mental health services, especially those servicing vulnerable populations such as

substance-dependent and substance addicted pregnant women and mothers, and pregnant women and mothers who are in treatment for substance use disorder.

5-12. Government and private healthcare payors should provide adequate reimbursement for care and care coordination services associated with high-risk pregnancies.

5-13. The committee recommends Healthcare payors, including Medicaid, expand MAT treatment coverage to include Methadone.

5-14. Enforce existing mental health parity laws regarding insurance reimbursement for behavioral health services, including substance use disorder treatment.

5-15. Implement a coordinated care model at treatment centers that tailor SUD treatment to the needs of pregnant and parenting women (for example, co-locate prenatal care and/or establish relationships with understanding providers that can provide on-site childcare options and social workers well-trained and knowledgeable about the needs, social services, and support options required for pregnant families struggling with SUD and addiction).

5-16. Implement a medical home model into the primary care setting for infants with NAS.

5-17. Develop peer-to-peer support networks for persons in opioid treatment programs, including pregnant women.

5-18. Provide improved and updated training for providers and state agencies that care for NAS-affected families to reflect evidence-based best practices.

5-19. Incorporate information about pregnant women, addiction, and NAS into academic curricula for medical students and residents, as well as in continuing education for licensed practitioners.

5-20. Assess and ensure adequate physical capacity and appropriate treatment availability for pregnant women within the current substance use disorder treatment system.

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- a. Review and research referral pathways within and across state and local systems to ensure access to follow-up care for families.
 - b. Conduct additional research to identify the personal, social, and structural influences that increase the risk of NAS.

5-21. Assess the feasibility of implementing a NAS surveillance system that utilizes de-identified data to drive interventions at the state and local level.

5-22. Perform a systematic environmental scan to identify existing local level practices and innovative models that effectively coordinate care and support throughout pregnancy and early childhood.

5-23. Conduct further study to identify and provide culturally competent interventions for prenatal substance exposure and resultant conditions.

- a. Develop a more extensive workforce that is well trained to respond to the needs of this special population.
- b. Collaborate with local community-based organizations when developing toolkits and training materials to ensure those products are culturally appropriate, relevant, and helpful.

5-24. Follow recommendations from the American College of Obstetricians and Gynecologists, the American Public Health Association, the National Perinatal Association, and the American Society on Addiction Medicine, and March of Dimes against punitive policies and practices regarding prenatal substance abuse, create a workgroup to strengthen practices with regard to infants and families impacted by substance abuse, while remaining in compliance with Section 106(b)(2)(B)(iii) of the Child Abuse Prevention and Treatment Act.

CHAPTER VI: Prescriber Training Needs

2016 HCR 113 REQUEST:

Evaluate medical professional training needs and the efficacy of educational materials and public education as an outreach strategy to raise public awareness about the dangers of misuse and abuse of opioid drugs.

RECOMMENDATIONS:

6-1. Provide medical students and all licensed medical prescribers education on the following topics:

CDC based best practice guidelines on

- Prescribing opioids for chronic non-cancer related pain;
- The use of opioids after acute injury or surgery;
- The use of opioids in special patient populations, e.g., pregnant women, pediatrics, elderly.
- Alternatives to opioids;
- When to initiate treatment for addiction; and
- Proper prescribing of Buprenorphine.

6-2. Education planners should take note of the *Providers' Clinical Support System* (PCSS-O) initiative, funded by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and administered by the American Academy of Addiction Psychiatry. The PCSS-O project maintains an inventory of more than 100 online modules and webinars on topics related to pain, opioids, and addiction, as well as a support network.

6-3. Establish evidence-based treatment requirement for residential treatment programs to embrace the use of Medication Assisted Treatment (MAT).

6-4. Implement public education and awareness programs on the availability of naloxone in the state.

6-5. Petition the federal Food and Drug Administration (FDA) to change the classification of naloxone nasal spray from prescription-only to over-the-counter.

6-6. Expand commitment to the funding of substance abuse prevention and treatment services.

CHAPTER VII: Alternatives to Incarceration

2016 HCR 113 REQUEST:

Assess alternatives to incarceration and medical treatment of opioid addicted individuals suffering from severe substance abuse disorders.

RECOMMENDATIONS:

7-1. Increase funding and expand the Louisiana Drug Court Program administered by the Louisiana Supreme Court.

7-2. Increase funding to therapeutic specialty courts to reduce incarceration and the associated costs.

7-3. Develop alternative funding strategies for judicial programs that leverage federal funds (i.e., Medicaid, Medicare, etc.)

7-4. Facilitate the access of therapeutic specialty court program personnel to the state PMP database.

7-5. The criminal justice system should better utilize community treatment providers to work with substance abusing offender populations. This is particularly relevant for offender clients that are not eligible for diversion, drug courts, specialty courts, or other programs.

CHAPTER VIII: Recommendations

2016 HCR 113 REQUEST:

Recommend any appropriate changes to relevant legislation, administrative rules, or pharmaceutical use to mitigate opioid abuse.

Overview of Strategies:

Trust for America's Health - *Prescription Drug Abuse: Strategies to Stop the Epidemic* (2013), is one of the most frequently cited sources regarding opioid policy considerations.⁶⁷ In this report, there are ten mitigation strategies designed to curb the prescription drug epidemic to include:⁶⁸

1. Development of prescription drug monitoring programs (PDMP)
2. Mandatory use of PDMP
3. Creation of doctor shopping laws
4. Support of substance abuse services
5. Prescriber education
6. Creation of Good Samaritan laws
7. Support of Naloxone Use
8. Requirement of physical exams or a bonafide physician relationship before prescribing medications
9. Requiring identification before purchasing controlled substances
10. Development of pharmacy lock-in programs

At the time of the publication (2013), Louisiana had implemented six of the ten recommendations to include establishing a PDMP program,⁶⁹ requiring utilization of the PDMP by physicians,⁷⁰ having created doctor shopping laws,⁷¹ requiring

⁶⁷ Trust for America's Health, *Prescription Drug Abuse: Strategies to Stop the Epidemic 2013*, Retrieved from <http://healthyamericas.org/assets/files/TFAH2013RxDrugAbuseRpt16.pdf>

⁶⁸ *Id.*

⁶⁹ R.S. 40:1004

⁷⁰ R.S. 40:978 (F)

⁷¹ R.S. 40:971 *et seq.*

physical exams and bonafide patient-physician relationships,⁷² requiring identification prior to dispensing a controlled substance,⁷³ and establishing a Medicaid lock-in program.⁷⁴ In the past four years, Louisiana moved closer to meeting the recommended guidelines having established support of substance abuse services through the expansion of Medicaid,⁷⁵ has implemented Good Samaritan Laws,^{76,77} and has created rescue drug laws to assist in counteracting overdoses.^{78,79} It is noteworthy that the only remaining recommendation that Louisiana has not implemented is the requirement of prescriber education. This suggests that Louisiana has made great strides towards implementing safeguards that can assist in the reduction of opioid misuse. Moreover, many of the recommendations provided in this section attempt to address this final recommendation.

Proposed Laws and Rules

2-1. Prescriber licensing boards should adopt the CDC guidelines for primary care physicians which focus on the first twelve weeks of therapy.

2-2. Prescriber licensing boards should adopt and adapt, to the extent possible, language from La. Admin. C. 46:6915 et seq. that provides guidance on Medications Used in the Treatment of Non-Cancer Related Chronic or Intractable Pain.

4-1. Prescriber licensing boards should require primary care physicians to obtain continuing education regarding the CDC Guidelines. Continuing education providers should collaborate with academia for curriculum development; professional associations should offer learning opportunities.

⁷² LA. Admin. C. 46: 6921

⁷³ R.S. 40:971 (E)

⁷⁴ Information available at http://www.lamedicaid.com/provweb1/about_medicaid/lock-in.htm

⁷⁵ JBE 16-01

⁷⁶ R.S. 14:403.10

⁷⁷ See Appendix A for a complete list of Louisiana opioid legislation

⁷⁸ R.S. 40:978.2

⁷⁹ LDH Standing Order, available at <http://new.dhh.louisiana.gov/assets/docs/Behavioral Health/Opioids/Naloxonestandingorder.pdf>

4-2. Prescriber licensing boards should encourage the use of the PMP and should consider mandatory registration of their licensees to access the program data.

4-3. Establish an Opioid Collaborative group, similar to the PMP Advisory Council, for ongoing efforts on this topic.

7-4. Facilitate the access of therapeutic specialty court program personnel to the state PMP database.

Proposed Budgetary Items

7-2. Increase funding to therapeutic specialty courts to reduce incarceration and the associated costs.

7-3 Develop alternative funding strategies for judicial programs that leverage federal funds (i.e., Medicaid, Medicare, etc.).

References

- Alpass, L. (2004). Chiropractic management of 'intractable' chronic whiplash syndrome. *Clinical Chiropractic*, 7(1), 16-23.
- Barnett, M. L., Olenski, A. R., & Jena, A. B. (2017). Opioid-prescribing patterns of emergency physicians and risk of long-term use. *New England Journal of Medicine*, 376(7), 663-673.
- Carabello, L., Clum, G., Meeker, W. (2016). A safer strategy than opioids. foundation for chiropractic progress.
- Centers for Behavioral Health Statistics and Quality. (2016). Treatment Episode Data Set (TEDS): 2002–2015. National Admissions to Substance Abuse Treatment Services. BHSIS Series S-71, HHS Publication No.(SMA) 14-4850.
- Centers for Disease Control and Prevention, National Center for Health Statistics (2016). Multiple Cause of Death 1999 – 2015 on CDC WONDER Online
- Centers for Medicare and Medicaid Services (CMS) (2016). Medicare Part D Opioid Mapping Tool, Retrieved from: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/OpioidMap.html>
- CNN (2014). 5 Health Challenges for 2014, Retrieved from: <http://globalpublicsquare.blogs.cnn.com/2013/12/18/5-health-challenges-for-2014/>
- Commonwealth of Massachusetts (2015). Recommendations of the governor's opioid working group. Boston, Massachusetts.
- Commonwealth of Massachusetts (2015). Action plan to address the opioid epidemic in the Commonwealth. Boston, Massachusetts.
- Dowell, D., Haegerich, T. M., & Chou, R. (2016). CDC guideline for prescribing opioids for chronic pain—the United States, 2016. *Jama*, 315(15), 1624-1645.

Federation of State Medical Boards (2013). Model policy on the use of opioid analgesics in the treatment of chronic pain. Washington, D.C.

IMS Health (2014). National Prescription Audit, Years 1997-2013, Data Extracted 2014.

Jamison et al., (2015). Symposium on pain medicine, "opioid analgesics" Mayo Clinic Proceedings; 90(7): 957-968.

Kaiser Family Foundation (2016). Louisiana Fact Sheet. Retrieved from: <http://kff.org/health-reform/fact-sheet/the-louisiana-health-care-landscape/>

Laxmaiah Manchikanti, M. D., Standiford Helm, I. I., MA, J. W. J., Ph.D., V. P., MSc, J. S. G., & DO, P. (2012). Opioid epidemic in the United States. Pain Physician, 15, 2150-1149.

Manchikanti, L., Abdi, S., Atluri, S., Balog, C. C., Benyamin, R. M., Boswell, M. V., & Burton, A. W. (2012). American Society of Interventional Pain Physicians (ASIPP) guidelines for responsible opioid prescribing in chronic non-cancer pain: Part I--evidence assessment. Pain Physician, 15(3 Suppl), S1-65.

Maumus, M. (2016). Solving America's prescription epidemic. Unpublished paper.

Massachusetts Department of Public Health (2014). Findings of the opioid task force and department of public health recommendations on priorities for investments in prevention, intervention, treatment and recovery. Boston, Massachusetts.

McClusky, P. (2016). Game changers: four innovative ideas for fixing the opioid crisis. Globe Magazine.

National Governors Association (2016). A compact to fight opioid addiction. Washington, D.C.

Paulozzi, L. J., Strickler, G. K., Kreiner, P. W., & Koris, C. M. (2015). Controlled Substance Prescribing Patterns — Prescription Behavior Surveillance System, Eight States, 2013. Retrieved from: <http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6409a1.htm> PBSS

Roman, P. M., Abraham, A. J., & Knudsen, H. K. (2011). Using medication-assisted treatment for substance use disorders: Evidence of barriers and facilitators of implementation. *Addictive Behaviors*, 36(6), 584-589.

Substance Abuse and Mental Health Services Administration (2013). Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-46, HHS Publication No. (SMA) 13-4795. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.

State of Louisiana (2016). Prevention, screening, and treatment of neonatal abstinence syndrome: response to House Concurrent Resolution No. 162. Baton Rouge, Louisiana. *Report to the Legislature*.

Wilkey, A., Gregory, M., Byfield, D., & McCarthy, P. W. (2008). A comparison between chiropractic management and pain clinic management for chronic low- back pain in a national health service outpatient clinic. *The Journal of Alternative and Complementary Medicine*, 14(5), 465-473.

Wisconsin Department of Safety and Professional Services (2016). Wisconsin Medical Examining Board Opioid Prescribing Guideline. Madison, Wisconsin.

World Health Organization. (2012). World Drug Report. New York: United Nations Offices on Drugs and Crime (UNODC).

World Health Organization (2016). Information sheet on opioid overdose. Retrieved from: http://www.who.int/substance_abuse/information-sheet/en/

Volkow, N. D. (2014). America's addiction to opioids: Heroin and prescription drug abuse. Senate Caucus on International Narcotics Control. Washington, DC.
New Hampshire Board of Medicine Opioid Rules adopted 11/2/2016.

APPENDIX A: Louisiana opioid-related legislation

LEGISLATION	DATE ENACTED
<p>ACT 676 Prescription Monitoring Program (Johns)</p> <p>Creates an electronic system for the monitoring of controlled substances and other drugs of concern dispensed in the state or dispensed to an address within the state in order to improve the state's ability to identify and inhibit the diversion of controlled substances and drugs in an efficient and cost-effective manner and in a manner that shall not impede the appropriate utilization of these drugs for legitimate medical purposes.</p>	<p>Regular Session, 2006</p>
<p>ACT 110 Prescription Monitoring Program delegates (LeBas)</p> <p>The Louisiana Prescription Monitoring Program (PMP) can now utilize a "delegate" to assist in retrieving PMP patient reports. A "delegate" is defined in regulation as a person authorized by a prescriber or dispenser which is also an authorized user to access and retrieve program data for the purpose of assisting the prescriber or dispenser, and for whose actions the authorizing prescriber or dispenser retains accountability.</p>	<p>Regular Session, 2013</p>
<p>ACT 392 Good Samaritan (Broome & Dorsey-Colomb)</p> <p>Offers immunity from possession charges to persons when 911 is called, and there is illegal drugs or paraphernalia on location. First responders may administer opioid antagonists without prescription to an individual exhibiting signs of overdose.</p>	<p>Regular Session, 2014</p>
<p>ACT 472 Prescription Monitoring Program (Johns and Thompson)</p> <p>Mandates the reporting of prescription monitoring information; to provide for dispenser (Pharmacist) reporting within twenty-four hours.</p>	<p>Regular Session, 2014</p>
<p>ACT 865 Prescription Monitoring Program (Heitmeier)</p> <p>Limited dispensing of certain controlled substances; Mandates PMP access for Schedule II narcotics for patients' treatment of non-cancer related chronic or intractable pain.</p>	<p>Regular Session, 2014</p>
<p>ACT 192 Opioid Antagonist Administration (Moreno)</p> <p>Authorizes a licensed medical practitioner to prescribe or dispense Naloxone without having examined the individual to whom it may be administered. Limits civil and criminal liability for persons who receive or administer opioid antagonist to a person believed to be undergoing an opioid-related drug overdose.</p>	<p>Regular Session, 2015</p>
<p>ACT 370 Naloxone (Moreno and Willmott)</p> <p>Authorizes storage and dispensing of opioid antagonists; authorizes any person to possess an opioid antagonist. Limitation of liability relative to Naloxone prescription, dispensing and administration by a third party.</p>	<p>Regular Session, 2016</p>