The future of the opioid epidemic:

Opioid overdose deaths: 10 projected scenarios.

Current trajectory

2016

Calls for Collective Approach

- “We need an all-hands-on-deck-approach that says... all of us are working together in order to address this problem.”
  - President Barack Obama, National Rx Drug Abuse and Heroin Summit, 2016

- “The epidemic will worsen in the absence of coordinated and collaborative community-wide approaches.”
  - Institute for Healthcare Improvement, 2016: *Addressing the Opioid Crisis in the United States*

California Opioid Safety Coalitions

[Tackling an Epidemic: An Assessment of the California Opioid Safety Coalition Network

Greater Reductions in Opioid Prescribing in Coalition Counties

Preliminary Outcomes: Safe Prescribing

COSN Accelerator Program Components

1. Impact coaches for performance improvement
2. Templates, tools, and resources
3. Interactive webinars & peer exchange
4. Public website
5. Communications, policy advocacy, and sustainability planning support
6. Site visits and regional workshops/convenings
7. VISTA volunteers to help provide infrastructure support to coalitions
California Opioid Safety Network
Accelerator Program -- Critical dates

- RFP release 10/16
- Informational webinar 10/18 4-5pm
- Applications due 11/27 5pm
- Team selections announced 12/4
- VISTA matching process 12/4 – 1/5
- Accelerator program launch February 2018

Fire impacted coalitions should contact Leadership Center to be considered on case-by-case basis for timeline adjustments as necessary.

Community Based Prevention Action Team
Data Collection and Monitoring Action Team
Intervention, Treatment and Recovery Action Team
Prescribers and Pharmacists Action Team
Law Enforcement Action Team
Steering Committee: Coordination, Messaging, Policy

Backbone Support: HHS
The Life of a Pill: Policy Opportunities

Local Policy Change Examples
Recipe for Local Policy Change

- Frame the problem
  - Data
- Potential yield of policy change?
- Feasibility?
  - Political, financial
- Develop a call to action
  - Target stakeholders
- Recruit champions
  - Key executive sponsor
- Propose policy solution
- Advocate publicly
- Celebrate champions

Call to Action for Policymakers:

Fill in the blank with an unacceptable truth:

“Did you know that in our community

___________________________________________?

We’re coming together to fix this, and we need your support.”
Call to Action: DA Letter

“Did you know that opioid prescriptions more than doubled in Marin since 2005– and so have related ER visits, overdoses and arrests?

But doctor’s don’t always know what happens with the medicines they prescribe…

We’re coming together to fix this, and we need your support.”

DA Letter to Prescribers

**Re: Defendant’s name; Marin County Superior Court Case No. *A

Dear Physician’s Name:

It has come to our attention that * is currently, or was recently a patient of yours.

On *, 201X, a criminal complaint was filed against *, alleging violations of Section * of the * Code, occurring on *. A copy of the Complaint is attached hereto for your reference.

This information is being provided as the result of a partnership between the Marin County District Attorney’s Office, Marin Health & Human Services, and Partnership HealthPlan of California. The goal of this partnership is to share information with physicians regarding unlawful prescription drug diversion and misuse, enabling physicians to make informed treatment decisions.

Please do not hesitate to contact our office if you have any questions.

Very truly yours,

EDWARD S. BERBERIAN
DISTRICT ATTORNEY
Call to Action: Drug Take-back Ordinance

“Did you know that one in five Marin teens have taken prescription painkillers that aren’t prescribed to them?

Most of these are coming from our medicine cabinets…

We’re coming together to fix this, and we need your support.”
Medication Take-back Bin

Take-back policy timeline

- January 2015: Supervisor Rice and RxSafe Marin recommended a county-wide ordinance to address drug disposal problem
- March 2015: Ordinance is drafted to mirror other Counties’ ordinances
- July 2015: Proposed ordinance unanimous by BOS
- September 2015: Safe Drug Disposal Ordinance became effective
- March 2017: Stewardship plan approved
- August 2017: Takeback bins in place and operational
CA Pharma-funded Rx Drug Take-back Programs

**Alameda County** Ordinance passed July 2012
Federal Appeals Ct (Sept 2014) Supreme Court (May 2015)

**San Francisco City & County** (March 2015)

**San Mateo County** (May 2015)

**Santa Clara County** (May 2015)

**Marin County** (Sept 2015)

**Santa Cruz County** (December 2015)

**Santa Barbara County** (June 2016)

**Contra Costa County** (December 2016)

**Sonoma County** (Adoption intended Fall 2017)
Reducing the Burden

- Marin County, 2012-2016
  - Opioid Prescriptions: 30% Decrease
  - Pounds of Safely Disposed Medications: 15% Increase
  - 11th graders reporting using pain killer recreationally:
    - Decrease from 17 to 11 percent
Call to Action: Naloxone

“Did you know that more people in Marin die from opioid overdoses than from car crashes, or from breast cancer—

And there’s a medicine that can reverse overdoses in seconds...

We’re coming together to fix this, and we need your support.”

Increasing Naloxone Availability

prescribers

schools

other community settings

Naloxone

pharmacies

first responders

jails

SAFE MARIN
61 opioid overdoses were reversed with naloxone by Emergency Medical Services (911) in Marin County in 2016.

- Police Officer Training:
  - Intra-nasal administration of Naloxone
  - In person and video training
  - Pre and post test

- County provides kits

- January- August 2017
  - 11 of 12 Police Jurisdictions
  - Officers trained and carrying naloxone
Two weeks after being trained…

ON-GOING CHALLENGES

How do we make sure that individuals addicted to opioids are identified and linked to appropriate services?

As opioid use for chronic pain decreases, what non-opioid supports are available for chronic pain?

How can we ensure that Marin County residents are informed partners in decisions about prescription drugs?
Thank You

Stay connected!

www.RxSafeMarin.org
Facebook.com/RxSafeMarin
RxSafeMarin@gmail.com
San Diego County
Prescription Drug Abuse Task Force: Collaboration on a Common Game Plan

November 8, 2017
Cindy M. Cipriani, PDATF Co-chair
Opiate Summit
www.SanDiegoRxAbuseTaskForce.org
http://www.facebook.com/SanDiegoRxAbuseTaskForce

Death Only the Tip of the Iceberg

- Death represents a portion of disease, addiction and related problems
- PDATF Convened a Process to Establish Additional Indicators
  - Recruited epidemiologist, evaluators, subject matter experts
  - Identify stable, reliable and available measures
Three Long Term Objectives
Another Strategy for Long Term Impact: Working with Prescribers & Dispensers

One San Diego Vision for Safe Prescribing
www.sandiegosafeprescribing.org

- One Provider, One Pharmacist
- Use CURES
- Medication Agreement
- No Opioid + Benzodiazepines
- Honor ED Guidelines

2013 Safe Pain Medicine Guidelines for ER Depts.
**Medi-Cal Prescribing Guidelines**

### Prescription Drug Abuse

Prescription Drug Abuse is a leading cause of unintended death in San Diego County. The following are recommendations for health plans and providers to take to promote safe prescribing.

For more information, visit [www.sandiegosafeprescribing.org](http://www.sandiegosafeprescribing.org)

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**Two Parts of Game Plan**

- Prevention Education conducted by partners: HOPE2Gether, Chasing the Dragon and other 2-time events
- Prevention providers
- News and social media coverage

---

**Increase Perception of Harm**

- Media to inform & destigmatize
- PDATF partners include traditional treatment and MAT programs
Naloxone Distribution

San Diego Sheriff’s Department’s pilot program conducted in Santee in July 2014.
First in state to outfit every patrol car with Naloxone
44+ resuscitations
County and Fentanyl Working Group working with interested police departments to facilitate access

Another Piece: Reduce Access with Proper Disposal

Two-Pronged Strategy

1) Take Back Events
   Partnered with the DEA
   • Record amounts
   • Annually +40 sites in county

2) Rx Collection Box Program
   • County Ord 2010
   • All Sheriff stations & County Admin Bldg
   • Local Police Stations

More than 30,000 lbs. a year collected
Data Driven

Who’s Prescribing Where?

Added CURES rates for painkillers, anti-anxiety and stimulants to Report Card
Digging into Opiate Dashboard Data

Overdose Rates

Prescribing Trends
Treatment Trends (including MAT)

CA Dept. of Public Health: Grant Award

- $52,500 for activities to reduce opioid overdose; June 2017 through February 2019 (21 mos.)
- Three main project areas, focused in East Region
  - Inventory and promote MAT
  - Promote distribution of Naloxone via law enforcement policy and media
  - Conduct academic detailing with high risk providers and pharmacies (10 each)
Managing Change
- Loss of key personnel: ME, DEA lead, County champion
  - Robust Executive Committee ensures experienced, committed leaders will step into vacuum

Coalition Governance
- Formal Chair/Vice Chair and voting structure
- Standing committees drill down into key areas
  - Executive Committee
  - Medical Task Force
  - Pharmacy Committee
  - Safe Disposal Committee

Challenges with Policy Advocacy
- Some members cannot engage in advocacy
- Voting process can allow task force engagement despite member limitations
Localizing a national epidemic
James Wilson

- What seemed to be the problem?
- Experienced a high amount of deaths in Plumas County due to overdose.
- Looked into the death data...
- Public Health was well-positioned to respond.
We needed something more. We needed an ongoing effort.

California HealthCare Foundation to the Rescue!
With the RFP came county data

- Plumas County had the highest rate of deaths related to prescription opiate overdoses in the state. (2009-13)
- This problem was more than county-specific. It affected our neighboring counties as well.
- We would have more resources if we worked together.
- If we were to form a coalition, it made sense to make it a regional one.

Our Region

Although each county has its own unique challenges, there are enough similarities to make it worthwhile to work together. Plus, none of us really have the capacity to take this on alone.
Officially formed in January, 2016!

With the highest rate in the state of overdose deaths related to prescription opioids, coming up with a call for action was easy... and well received.

Action Teams!

Safe Prescribing

Naloxone

MAT
Safe Prescribing Goal:
Reduce amount prescribed by 15%

<table>
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<tr>
<th>Opioid Rx's per 1k Residents, 2015</th>
<th>Opioid overdoses per 1k Residents, 2014</th>
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<tbody>
<tr>
<td>California—619</td>
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<td>Lassen—1,113</td>
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<tr>
<td>Sierra—783</td>
<td>Sierra—n/a</td>
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</table>

Posters! Guidelines! Education!!!
Next step, increase # of Docs who are X-waived

The image on the right is a map of our region, with the locations of X-waived physicians in 2015 pinpointed with flags.

To do that...

- We visited treatment clinics...
- Identified X-Waived physicians to act as mentors to our region's doctors...
- And identified people ready for treatment.
- Reviewed policies and procedures and adapted them to the region...
- Collected forms from other clinics (SO many forms!...
TODAY...

Treatment programs were developed in Modoc, Lassen, and Plumas Counties! Still a definite need to increase access, but the region now has six more x-waived doctors than it had before!

Different ways we expanded access to naloxone.

We talked to pharmacists about keeping naloxone on hand. In California, there’s also a protocol that allows pharmacists to provide naloxone to potentially at-risk recipients, without a prescription from a doctor.

We worked with NorCal EMS to develop policies, procedures, and a training mechanism that now allows Emergency Responders in the region, like police and firefighters, to carry naloxone.

We also encouraged doctors to co-prescribe naloxone with opioids, and provided information on naloxone to the general public to create smarter patients.
We really wanted to get naloxone in the hands of those that need it most, so we started a community distribution program.

Policies and Procedures

Distribution Locations

Standing Orders

Each kit includes...

- Two doses of 4 mg naloxone nasal spray,
- Info on how to recognize an overdose and instructions on how to administer naloxone,
- A prescription card with referrals to addiction treatment services and HIV and Hep C testing,
- And rescue breathing apparatus.
Since September, 2016...

All 4 COALITION COUNTIES STARTED DISTRIBUTING NALOXONE

413 DOSES OF NALOXONE HAVE BEEN DISTRIBUTED DIRECTLY TO PEOPLE AT RISK

12 RECORDED INSTANCES OF NALOXONE FROM THE PROGRAM BEING USED TO REVERSE AN OVERDOSE AND SAVE A LIFE!

Public Awareness

Ads! Newspapers! Radio! TV!

The result is a well-informed community.
2016 (A great year!)

- Since the Northern Sierra Opioid Safety Coalition formed...
- Prescribing rates went down in all four counties
- Access to MAT went from 0 to 6 x-waived docs, in three counties
- The naloxone we handed out reversed 12 overdoses (Just that we know of!)
- In three of our counties, Plumas, Sierra, and Modoc, 0 deaths due to prescription opioid overdose.

Looking to the future...

- Primary Prevention
- Safe Drug Disposal
- Academic Detailing
- Clean Syringe Access
- More Harm Reduction Strategies
- Maintain the programs already started
Restructured Action Teams

Prevention

Harm Reduction

Thank you!
(and a big thanks to CHCF, CDPH, CMSP, and DHCS for funding us and making this possible!)

Questions? Comments?
What would it take to get to zero overdose deaths in California?

Kelly Pfeifer, MD
kpfeifer@chcf.org
California Summit, November 2017
Parts of California are harder hit than Ohio

Lake, 27
Tuolumne, 28
Plumas, 31

California Death Rates: All Opioid Overdoses

Source: California Health Care Fdn
Source: California Opioid Overdose Surveillance Dashboard: https://pdop.shinyapps.io/ODdash_v1/
Kaiser Family Foundation
What we can learn from another epidemic

AIDS deaths, United States, 1981-2007

Fewer deaths

Purchasers
(Medi-Cal, Covered CA, CalPERS)

Local coalitions

Policy makers

Technology

Health Plans

Providers

California Health Care
California Partnerships: Coalitions

California Opioid Safety Coalitions Network

California Partnerships: Hub and Spoke

Opioid Treatment Program

- Primary Care Setting
- Mental Health Services
- Residential Services
- Medical Home
- Pain Management Clinic
- SUD Clinic
Preliminary outcomes for CHCF coalition counties

Less Opioid Prescribing

- Q4 2015 Opioid Prescribing Rate
- With CHCF Coalition Support: 0%
- Without CHCF Coalition Support: -7%
- Q4 2016 Opioid Prescribing Rate
- With CHCF Coalition Support: -10%
- Without CHCF Coalition Support: -12%

More Addiction Treatment

- Q4 2015 Buprenorphine Prescribing Rate
- With CHCF Coalition Support: 0%
- Without CHCF Coalition Support: 11%
- Q4 2016 Buprenorphine Prescribing Rate
- With CHCF Coalition Support: 20%
- Without CHCF Coalition Support: 11%
Summary

*Hard problems need systems solutions.*

**PREVENT:** Fewer prescriptions, lower doses, shorter durations

**MANAGE:** Identify patients at risk, taper to safer treatments

**TREAT:** Streamline access to MAT

**STOP:** Stop the deaths – streamline access to naloxone

---

52 weeks, 52 faces
Obituaries narrate lives lost to the opioid epidemic

*Source: David Armstrong, STAT*
OPIOID SAFETY IN MEDI-CAL

JULIA LOGAN, MD, MPH
CHIEF QUALITY OFFICER
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
NOVEMBER 8, 2017

DHCS VISION

Preserve and improve the overall health and well-being of all Californians
MEDI-CAL MATTERS

Medi-Cal Covers Nearly 13.5 Million Californians

Nearly 1 in 3 Californians have Medi-Cal coverage

OPIOIDS AND MEDICAID

- Nearly 12% of adults covered by Medicaid have a substance use disorder, including opioid use disorder.
- Medicaid beneficiaries are prescribed painkillers at higher rates than non-Medicaid patients and have a higher risk of overdose.
- 15% of Medicaid enrollees had at least one prescription opioid claim during 2012.

MEDI-CAL HELPS TREAT ADDICTION

- More than 3,000,000 Californians struggle with alcohol and drug abuse.
- More than 1 in 3 Californians seeking help for an emotional/mental healthy problem or use of alcohol/drug have Medi-Cal coverage.
DHCS LEVELS OF PREVENTION

PRIMARY
• Decrease new starts

SECONDARY
• Support safe prescribing practices

TERTIARY
• Streamline access to MAT

DHCS/STATE

Managed Care Plan
Narcotic Treatment Centers

Member

Providers
Partners

Community
How wonderful it is that nobody need wait a single moment before starting to improve the world.

Anne Frank
Alameda County’s Safe Drug Disposal Ordinance

PROGRESS REPORT

BILL POLLOCK
PROGRAM MANAGER
ALAMEDA COUNTY HHW PROGRAM
BILL.POLLOCK@AC.GOV.ORG

The old way
USGS Groundwater & Landfill Leachate Studies

- Active Pharmaceutical Ingredients (API's) and other household Personal Care Products (PCP's) found in Ground and Surface water
  - Some of which are drinking water sources
- Landfill leachate studies - API's and PCP's found in landfill leachate
- Hormone analogs in water supply may be active in the parts per billion or parts per trillion range
- Wastewater treatment plants are not designed to remove API's and PCP's
- Very expensive to retrofit plants

Societal effects

- Skyrocketing rates of prescription drug abuse in teen-agers and young adults - Pharm Parties
- Rising rates of accidental overdose in senior citizens

**Abusers' Sources of Prescription Painkillers**

- 55% Obtained free from friend or relative
- 7.1% Other source
- 4.4% Obtained from drug dealer or stranger
- 4.8% Took from friend or relative without asking
- 11.4% Bought from friend or relative
- 17.3% Prescribed by a doctor

Centers for Disease Control and Prevention
2003 CIWMB sponsored SB966 Model Collection program

- Encourages local collection programs
- Creates Model Program guidelines
- DEA rules at this time don’t allow non law enforcement programs to “knowingly” collect controlled substances
- Many jurisdictions create local programs - all publically funded
- In Alameda County 5 local wastewater agencies create individual programs
- Supervisor Nate Miley’s Senior AOD group recruits 5 sites in central County
- Provides a framework for coordinating local agencies
- Resulting network of sites (31) is poorly funded and not well distributed
- 1 DEA compliant Controlled Substances site at the Sheriff’s HQ

Brief History of Alameda’s ordinance

- Promoted by Supervisor Nate Miley to address inadequately funded programs
- July 2012 Ordinance passes Alameda County BOS unanimously
- December 2012 Industry Responds – with lawsuit in Federal Court
- Alleged violation of dormant Commerce Clause issue – novel interpretation
- Sept 2013 – We win!
- Dec 2013 – Lawsuit redux – the appeal
- August 2014 – We win again! - 3 Judge panel unanimous decision
- Dec 2014 - Pharma industry files Writ of Certiorari with US Supreme Court
- Petition Denied!!! – No more lawsuits – for now
DEA Rulemaking – Makes it easier and harder to collect drugs

- Legalizes collection of Controlled Substances at DEA registrant locations
  - Pharmacies & Hospitals with on-site (in- or out-patient) pharmacies
  - LTC Facilities in conjunction w/pharmacies
  - Law Enforcement sites & Drug Treatment program sites also
- Commingled drugs are presumed to contain Controlled Substances
- For existing programs, new DEA rules change the standard from -
  - “not knowingly collecting” to “no inadvertent collection” of CS
  - Older program with non-conforming sites are problems
- Requires Registered Haulers to handle transportation
  - UPS/USPS/Common Carrier transport is OK
  - Non-registrant Med-waste Haulers can’t continue servicing kiosks
  - DOT issues for transportation

Implementation/Performance

- Ambitious goals of approved Stewardship Plan
  - Plan Goals 1st year -12 one-day takeback events + up to 20 Kiosks at LEA
  - 1st event within 30 days
  - 100 kiosk sites at Hospitals LEA’s and Pharmacies over 3 years
- Actual performance
  - Year 1 - 1 takeback event
  - Year 2 - 15 + takeback events and 10 kiosks installed
  - Year 3 - 30 kiosks, total, installed through October 2017
One day events 2016

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Current Med Project Kiosk locations

Does not include non Med Project locations (3+)
Now is a great time to pass ordinances

- 9 West Coast Counties have Producer pays Ordinances
  - Alameda, Marin, San Francisco, San Mateo, Santa Clara, Santa Cruz, Santa Barbara - King & Snohomish in WA - More on the way
  - Marin, San Francisco San Mateo, Santa Clara coordinated efforts as a group
  - San Luis Obispo County - Preexisting ordinance mandates pharmacy participation - retailers pay costs - includes Sharps collection
  - Santa Cruz County - Mandatory pharmacy participation, Producers pay - includes Sharps
  - Alameda County - Passed separate Sharps ordinance in 2015
- Good model ordinances exist
- Compliance work is largely done
- Consider a joint sharps/drugs ordinance

Remaining issues

- California Board of Pharmacy rulemaking
  - Additional level of recordkeeping beyond DEA
  - May give pharmacists an "out" to escape mandatory ordinances
- Prefilled syringes/Sharps, Aerosols, Inhalers
  - Can’t go in Kiosk but are still Covered Drugs
  - Sharps can be captured by Sharps ordinance
- Biggest remaining issue - Retail Chain/HMO pharmacy participation
  - About 238 eligible pharmacy/hospital sites in the Alameda County
  - Walgreens & CVS “Big News” hosting kiosks in stores
  - Walgreens - 2 out of 37 stores in county; CVS - propose 1 out of 40
Lessons learned

- Political champion(s) required
- Good ordinance models exist - build on earlier ordinances
- Multijurisdictional approach is better, share the work!
- Get to know potential kiosk hosts
- Expect delays due to contracting
- Consider a more prescriptive ordinance
- Outreach is critical - message must be repeated and delivered using multiple paths

- Don’t be first!
Getting to Zero Overdose Deaths Together: Statewide Initiatives Panel

• CDPH Problem Overview & Current Initiative
• DHCS Initiatives
• DOJ CURES
• California Health Care Foundation
California’s Opioid Burden - 2016

https://pdop.shinyapps.io/ODdash_v1/
Progress to Date

Statewide Opioid Safety (SOS) Workgroup

Background
- 2013: CDC declared prescription drug misuse a nationwide epidemic
- 2014: Association of State and Territorial Health Officials (ASTHO) national challenge to decrease prescription drug overdose deaths 15 percent by the end of 2015
- The Prescription Opioid Misuse and Overdose Prevention Workgroup was convened in Spring 2014 to meet the challenge by CDPH and its state partners
- Renamed - Statewide Opioid Safety (SOS) Workgroup

Current Statewide Efforts

Statewide Multi-Prong Approach

- Convening Statewide Opioid Safety Workgroup
- Safe Prescribing Policies & Practices
- Building Local Community Capacity
- Access to Medication Assisted Treatment
- Naloxone Distribution
- Public Education
- Data Informed
Questions?

Safe and Active Communities, CDPH
PDOP@cdph.ca.gov
“PDMPs continue to be among the most promising state-level interventions to improve opioid prescribing, inform clinical practice, and protect patients at risk.”

https://www.cdc.gov/drugoverdose/pdmp/index.html
Centers for Disease Control and Prevention
CURES stores and reports Schedule II, III, and IV prescription dispensation data reported by dispensers to DOJ.

Pharmacies and dispensers are required to report dispensations of Schedules II through IV controlled substances to DOJ at least weekly.

CURES data reflects dispensing information exactly as it is reported to DOJ. The pharmacy or direct dispenser creates and owns the prescription record submitted to DOJ. DOJ is a custodian (and not editor) of these aggregated prescription records.
The California Triplicate Prescription Program (TPP) was created, capturing Schedule II prescription information.

CURES was initiated, operating in parallel with the TPP’s Automated Triplicate Prescription System (ATPS) to evaluate the comparative efficiencies between the two systems.

TPP/ATPS decommissioned after Senate Bill 151 eliminated the triplicate prescription requirement for Schedule II controlled substances, making CURES permanent. Schedule III controlled substance prescription reporting became required.

PDMP was introduced as a searchable, client-facing component of CURES.

The Bureau of Narcotic Enforcement dissolved and CURES de-funded.

Automated Registration
California clinical users are provided a fully automated registration process.

Delegation Authority
Prescribers and dispensers can easily assign delegates who can initiate CURES 2.0 patient inquiries on their behalf.

Compact Flagging
Prescribers can easily notate their patients with treatment exclusivity compacts, forewarning other providers that additional prescribing to these patients can be potentially counter-productive to their existing treatment regimen.

Peer-to-Peer Communication
Prescribers and dispensers can instigate alert messages to fellow doctors and pharmacists about mutual patients of concern.
CURES 2.0 Features

Patient Safety Alerts/Messaging

Prescribers are alerted daily with information regarding their patients who reach various prescribing thresholds.

- Rx Recipients Who are Currently Prescribed More than 90 Morphine Milligram Equivalency Per Day
- Rx Recipients Who Have Obtained Prescriptions from 6 or More Prescribers or 6 or More Pharmacies During Last 6 Months
- Rx Recipients Who Are Currently Prescribed More than 40 Milligrams Methadone Daily
- Rx Recipients Who Are Currently Prescribed Opioids More Than 90 Consecutive Days
- Rx Recipients Who Are Currently Prescribed Both Benzodiazepines and Opioids

De-duplication

Approximately 165K new Rx records are added to the CURES 2.0 data base daily. With this new data, the analytics engine must re-resolve patient, prescriber, and dispenser entities across the 1TB database every night.

Once the data is de-duplicated nightly, the analytics engine identifies the resolved person entity's current prescriptions based on date filled and number of days supply.

The resolved person entity's current prescription medicinal therapy levels are calculated and compared against pre-established thresholds. Therapy levels exceeding those thresholds trigger Patient Safety Alerts to current prescribers.

The de-duplicated data also contributes to the quarterly and annual systematic production of 58 county and one statewide de-identified data sets for use by public health officers and researchers.
Access to CURES:

To assist health care practitioners in their efforts to ensure appropriate prescribing, ordering, administering, furnishing, and dispensing of controlled substances, law enforcement and regulatory agencies in their efforts to control the diversion and resultant abuse of Schedule II, Schedule III, and Schedule IV controlled substances, and for statistical analysis, education, and research, the Department of Justice shall maintain the Controlled Substance Utilization Review and Evaluation System (CURES)…

California Health & Safety Code section § 11165(a)

SB 809
Requires prescribers and pharmacists to apply for CURES access by 07/01/2016, or upon licensure, whichever occurs later.

SB 482
Mandatory use of CURES becomes effective “…six months after the Department of Justice certifies that the CURES database is ready for statewide use and that the department has adequate staff…”

California Health & Safety Code section § 11165.4 (e)
(6) If the CURES database is not operational, as determined by the department, or when it cannot be accessed by a health care practitioner because of a temporary technological or electrical failure. A health care practitioner who does not consult the CURES database under subparagraph (A) shall document the reason he or she did not consult the database in the patient’s medical record.

(ii) If a health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance is not required, pursuant to an exemption described in subdivision (c), to consult the CURES database the first time he or she prescribes, orders, administers, or furnishes a Schedule II, Schedule III, or Schedule IV controlled substance to a patient and has not previously prescribed a controlled substance to the patient.

(B) For purposes of this paragraph, “first time” means the initial occurrence in which a health care practitioner, in his or her role as a health care practitioner, intends to prescribe, order, administer, or furnish a Schedule II, Schedule III, or Schedule IV controlled substance to a patient or the quantity of the controlled substance does not exceed a nonrefillable five-day supply of the controlled substance to be used in accordance with directions for use.

(1) If a health care practitioner prescribes, orders, or furnishes a controlled substance to be administered to a patient while the patient is admitted to any of the following facilities or during an emergency transfer between any of the following facilities for use while on facility premises:

(A) A licensed clinic, as described in Chapter 1 (commencing with Section 1200) of Division 2.

(B) A health facility, as described in Chapter 2 (commencing with Section 1250) of Division 2.

(C) A health facility, as described in Chapter 3 (commencing with Section 1255) of Division 2.

(D) A county medical facility, as described in Chapter 2.5 (commencing with Section 1440) of Division 2.

(E) A place of practice, as defined in Section 1658 of the Business and Professions Code.

(2) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient currently receiving hospice care, as defined in Section 1339.40.

(3) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient who is not reasonably expected to survive a period of 90 days.

(B) A health care practitioner who does not consult the CURES database under subparagraph (A) shall, without undue delay, seek to correct any cause of the temporary technological or electrical failure that is reasonably within his or her control.

(1) If a health care practitioner prescribes, orders, or furnishes a controlled substance in an emergency department of a general acute care hospital and the quantity of the controlled substance does not exceed a nonrefillable five-day supply of the controlled substance to be used in accordance with directions for use.
California Health & Safety Code section § 11165.4

(1) If a health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance shall consult the CURES database to review a patient’s controlled substance history before subsequently prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient and at least once every four months thereafter if the substance remains part of the treatment of the patient.

(2) If the CURES database is not operational, as determined by the department, or when it cannot be accessed by a health care practitioner because of a temporary technological or electrical failure, a health care practitioner shall, without undue delay, seek to correct any cause of the temporary technological or electrical failure that is reasonably within the control of the health care practitioner.

(3) If consultation of the CURES database would, as determined by the health care practitioner, result in a patient’s inability to obtain a prescription in a timely manner and thereby adversely impact the treatment of the patient.

(4) If a health care practitioner fails to consult the CURES database the first time he or she prescribes, orders, administers, or furnishes a Schedule II, Schedule III, or Schedule IV controlled substance to the patient and has not previously consulted the CURES database for the patient.

(5) If all of the following circumstances are satisfied:

(A) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to be administered to a patient while the patient is admitted to any of the following facilities or during an emergency transfer between any of the following facilities for use while on facility premises:

(i) A licensed clinic, as described in Chapter 1 (commencing with Section 1200) of Division 2.

(ii) An outpatient setting, as described in Chapter 1.3 (commencing with Section 1248) of Division 2.

(iii) A health facility, as described in Chapter 2 (commencing with Section 1250) of Division 2.

(iv) A county medical facility, as described in Chapter 2.5 (commencing with Section 1440) of Division 2.

(B) A health care practitioner who does not consult the CURES database under subparagraph (A) shall document the reason he or she did not consult the database in the patient’s medical record.

(C) The duty to consult the CURES database, as described in subdivision (a), does not apply to a health care practitioner in any of the following circumstances:

(i) If the CURES database is not operational, as determined by the department, or when it cannot be accessed by a health care practitioner because of a temporary technological or electrical failure.

(ii) If consultation of the CURES database would, as determined by the health care practitioner, result in a patient’s inability to obtain a prescription in a timely manner and thereby adversely impact the treatment of the patient.

(iii) If a health care practitioner prescribes, orders, administers, or furnishes a Schedule II, Schedule III, or Schedule IV controlled substance to the patient and has not previously consulted the CURES database for the patient.

(6) If the CURES database is not operational, as determined by the department, or when it cannot be accessed by a health care practitioner because of a temporary technological or electrical failure that is reasonably within the control of the health care practitioner, or when it cannot be accessed by a health care practitioner due to a temporary technological or electrical failure that is not reasonably within the control of the health care practitioner, or when the CURES database is not operational, as determined by the department, or when it cannot be accessed by a health care practitioner due to a temporary technological or electrical failure that is not reasonably within the control of the health care practitioner.

(7) If the CURES database cannot be accessed because of technological limitations that are not reasonably within the control of a health care practitioner.

(8) If consultation of the CURES database would, as determined by the health care practitioner, result in a patient’s inability to obtain a prescription in a timely manner and thereby adversely impact the treatment of the patient.

(9) If a health care practitioner fails to consult the CURES database the first time he or she prescribes, orders, administers, or furnishes a Schedule II, Schedule III, or Schedule IV controlled substance to the patient and at least once every four months thereafter if the substance remains part of the treatment of the patient.

(AB 40)

On October 9, 2017, Assembly Bill 40 passed providing authority for DOJ to make CURES data available to authorized users via a health information technology system, provided the entity operating the health information technology system can certify they meet technical and security requirements and have a MOU with DOJ. DOJ must make CURES data available via integration no later than October 1, 2018.
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thank you!