Opioid Action Plan

Opioid Overdose Epidemic Response Report ◊ September 2017

ARIZONA DEPARTMENT OF HEALTH SERVICES

azhealth.gov/opioid

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EXECUTIVE SUMMARY

In 2016, more than two Arizonans died each day due to opioid-related causes, with a tripling in the number of deaths due to heroin since 2012. On June 5, 2017, Governor Doug Ducey issued his first public health emergency declaration, which called for a statewide effort to reduce opioid deaths in Arizona. An Enhanced Surveillance Advisory following the declaration resulted in 280 suspected opioid deaths and 2,361 suspected overdoses reported since June 15th. The public health emergency declaration directed the Arizona Department of Health Services to submit a report of the accomplished activities and identify recommendations for combating the opioid epidemic in Arizona. This report, in response to the emergency declaration, is intended to be an action plan that will serve as a catalyst to reducing deaths from opioids in Arizona.

Goals to address the opioid epidemic:

- Increase patient and public awareness and prevent opioid use disorder
- Improve prescribing and dispensing practices
- Reduce illicit acquisition and diversion of opioids
- Improve access to treatment
- Reduce opioid deaths

Recommendations, created through multiple meetings with partner agencies, impacted stakeholders, Goal Council 3 subgroups, and policy makers, to address the above goals include:

1. Enacting legislation that impacts opioid deaths by addressing identified barriers;
2. Creating a free, statewide consultative call line resource for prescribers seeking advice about prescribing opioids and caring for patients with opioid use disorder;
3. Requiring Arizona medical education programs to incorporate evidence-based pain management and substance-use disorder treatment into their curriculum;
4. Engaging the federal government to address necessary federal-level changes;
5. Establishing a regulatory board workgroup to identify prescribing trends and enforcement issues;
6. Encouraging law enforcement agencies to expand the Angel Initiative and other existing diversion programs and assist the DEA with filling local vacancies on the Tactical Diversion Squad;
7. Increasing access to naloxone for high risk individuals released from correctional facilities;
8. Pulling together experts into task forces to address identified barriers by:
    - Identifying specific improvements to enhance the Arizona Controlled Substance Prescription Monitoring Program;
    - Identifying, utilizing, and building upon Arizona's existing peer recovery support services;
    - Providing recommendations regarding insurance parity and standardization of substance abuse treatment and chronic pain management across the state; and
    - Identifying and implementing school-based prevention curriculum, expanding after school opportunities and identifying resource needs.

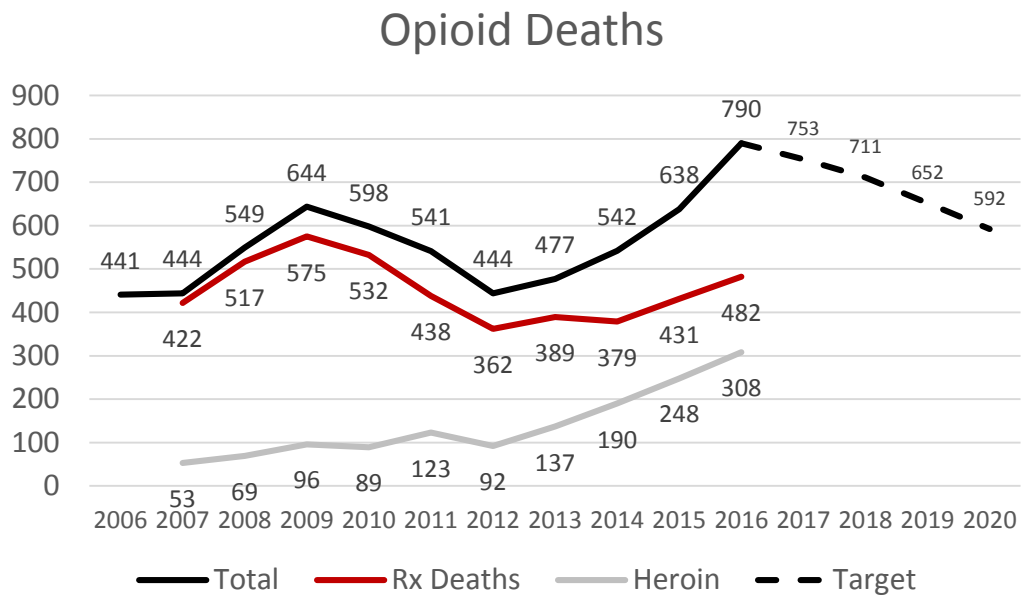
How to use this Report

- **Strategic Plan**: serves as the dashboard for the action plan, with major accomplishments and primary data, and identifies the main recommendations along with the performance measures to ensure the recommendations are accomplished
- **Recommendation Brief**: provides greater detail into each recommendation, including data to support the recommendation, proposal, action plan for implementation and the agencies responsible
- **Scorecard**: measures monthly progress on the implementation of each action item and displays data to measure whether the goal is being reached

Arizona's Opioid Epidemic

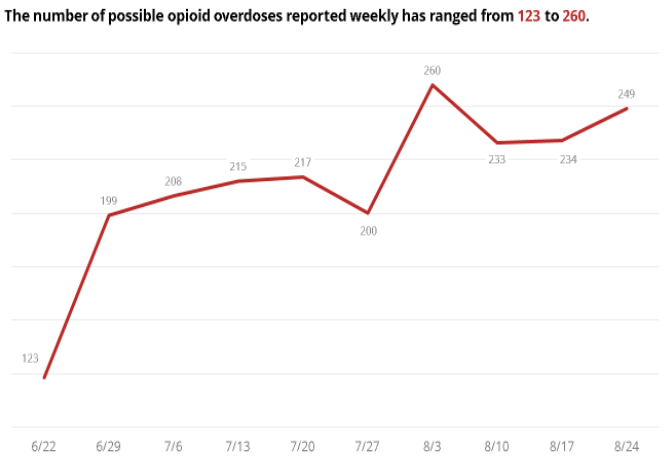
ADHS Emergency Response

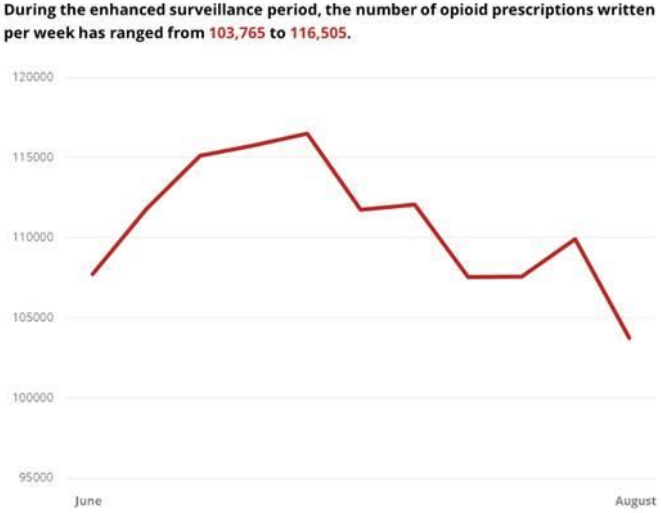
Goal	2-year	5-year
↓ the # of opioid deaths	10%	25%
(Base: 638)	(711)	(592)

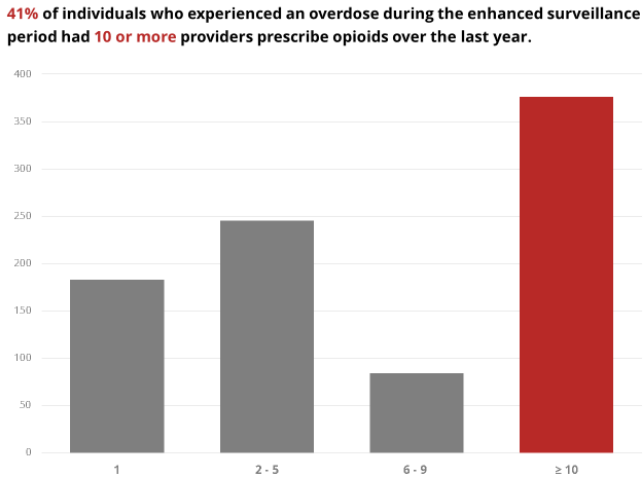


Activity Updates:

- Initiated Enhanced Surveillance to receive real time data
- Developed and implemented emergency rules for opioid prescribing and treatment in health care institutions
- Trained almost 1,000 law enforcement officers to carry and administer naloxone
- Purchased nearly 4,000 naloxone kits for law enforcement agencies
- Purchasing Arizona Opioid Prescribing Guidelines







Recommendations

Goals	Recommendations	Performance Measures
Reduce Opioid Deaths	Enact legislation that impacts opioid deaths by reducing illicit acquisition and diversion of opioids, promoting safe prescribing and dispensing, decreasing the risk of opioid use disorder, and improving access to treatment	• By June 2018, complete 100% of action items in Legislative Action Plan • Legislation is passed that contains 100% of high impact priorities
Improve Prescribing and Dispensing Practices	Establish a Regulatory Board work group to identify prescribing trends and discuss enforcement issues	• By December 2017, complete 100% of the action items in the Regulatory Board Action Plan
	Establish a task force to identify specific improvements that should be made to enhance the Arizona Controlled Substances Prescription Monitoring Programs (CSPMP)	• Percent of prescribers who prescribe controlled substances and have "Lookups" in the CSPMP • By September 2018, complete 100% of the action items in the CSPMP Improvement Action Plan
Reduce Illicit Acquisition and Diversion of Opioids	Meet with leaders of law enforcement and first responder agencies to expand Angel Initiative and other OUD diversion programs and assist the DEA with filling vacancies in the DEA Tactical Diversion Squad	• By November 2017, complete 100% of items in Law Enforcement Action Plan • Number of law enforcement precincts participating in the Angel Initiative • Percent of vacancies on the DEA Tactical Diversion Squad
Improve Access to Treatment	Require all undergraduate and graduate medical education programs to incorporate evidence-based pain management and substance-use disorder treatment into their curriculum	• By September 2018, complete 100% of action items in the Medical School Curriculum Action Plan • By October 2017, 75% of programs have been approached to discuss curriculum proposal
	Create a call-in line resource to provide consultation to prescribers seeking advice about prescribing opioids and caring for patients with opioid use disorder	By April 2018, complete 100% of the action items in the Call Service Action Plan
	Establish through executive order a work group to identify, utilize, and build upon Arizona's existing peer recovery support services	By June 2018, complete 100% of the action items in the Peer Support Action Plan
	Convene an Insurance Parity Task Force to research and provide recommendations regarding parity and standardization across the state	By June 2018, complete 100% of action items in the Insurance Parity Action Plan
	Engage the federal government outlining necessary federal changes to assist Arizona with our response to the opioid epidemic	By November 2017, complete 100% of items in Federal Barrier Action Plan
	Increase access to naloxone and Vivitrol for individuals leaving state and county correctional institutions and increase access to MAT therapy for individuals with opioid-use disorder while incarcerated	By February 2018, complete 100% of actions items in the Correctional Facilities Action Plan
Prevent Opioid Use Disorder/ Increase Patient Awareness	Utilize Public Service Announcements to educate patients, providers and the public regarding opioid use and naloxone	By June 2018, complete 100% of action items in the Public Service Announcement Action Plan
	Create a youth prevention task force to identify and implement evidence based, emerging and best practice substance abuse prevention/early identification curriculum, expand after-school opportunities, and identify resource needs.	By June 2018, complete 100% of the action items in the Youth Prevention Action Plan

EMERGENCY OPERATIONS ACTIVITIES

The Arizona Department of Health Services (ADHS) released the 2016 Arizona Opioid Report on June 1, 2017. This report revealed that in 2016, 790 Arizonans died from opioid overdoses – more than two people per day. Arizona has experienced an alarming increase in opioid deaths of 74 percent since 2012. In the past decade, 5,932 Arizonans died from opioid-induced causes with death rates starting to rise in the late teens and peaking at ages 45-54. This data highlighted a need for action. On June 5, 2017, Governor Doug Ducey declared a public health emergency to address the increase in opioid deaths in Arizona.

Health Emergency Operations Center

The ADHS team immediately sprang into action and activated the Health Emergency Operations Center (HEOC) within hours of the Governor's emergency declaration. More than 75 agency staff across ADHS responded to the Governor's calls to action. As part of the declared state of emergency, ADHS was given the responsibility to:

- Provide consultation to the Governor on identifying and recommending elements for Enhanced Surveillance Advisory
- Initiate emergency rule-making for opioid prescribing and treatment within health care institutions
- Develop guidelines to educate providers on responsible prescribing practices
- Provide training to local law enforcement agencies on proper protocols for carrying, handling, and administering naloxone in overdose situations
- Provide a report to the Governor on findings and recommendations by September 5, 2017

Enhanced Surveillance Advisory

With consultation from ADHS, Governor Ducey issued an executive order on June 15, 2017 to require the reporting of opioid-related data, allowing state health officials to receive information within 24-hours of specific events. This was a first step toward understanding the current opioid burden in Arizona and building recommendations to better target prevention and intervention. These reporting requirements greatly increased the Department's ability to asses and apply timely interventions in comparison with traditional data sources, which are 6 to 18 months delayed. The specific health conditions required in the enhanced surveillance advisory included suspected opioid overdoses, suspected opioid deaths, naloxone doses administered in response to either condition, naloxone doses dispensed, and neonatal abstinence syndrome.

To facilitate collection of data, the agency's secure web-based surveillance systems, Medical Electronic Disease Surveillance Intelligence System (MEDSIS) and Arizona Prehospital Information & EMS Registry System (AZ-PIERS), were utilized for designated reporters to electronically submit mandatory surveillance data. These systems were quickly modified to accommodate data submitted from 165 unique MEDISIS reporters and 129 AZ-PIERS reporters. ADHS coordinated a series of three webinars that trained a total of 171 healthcare, EMS, and law enforcement reporters. Arizona State Public Health Laboratory established the capability to receive the voluntary submission of blood specimens of suspected opioid overdoses for screening of various opioids and other substances as of June 31, 2017.

Treatment Capacity Survey

In order to ascertain the current capacity and occupancy for substance abuse treatment in the state, ADHS requested the completion of an anonymous behavioral health, substance abuse treatment, and healthcare facilities survey. The survey was disseminated through the Regional Behavioral Health Authority system. Survey data was used to get a better understanding of the distribution of services

across the state, understand the utilization and availability of treatment, and better target future resources for treatment capacity in Arizona. Overall, the data collected demonstrated that there are not an adequate number of treatment services available in the state. It was also noted that when seeking care, many individuals may be turned away or placed on waiting lists.

Emergency Rule Making

As directed in the emergency declaration, the Department rapidly initiated emergency rule-making for opioid prescribing and treatment practices in licensed health care institutions. Rules were completed in coordination with Arizona's Attorney General's Office and approved by the Secretary of State for immediate implementation on June 28, 2017. These emergency rules focus on health and safety; provide regulatory consistency for all health care institutions; establish, document, and implement policies and procedures for prescribing, ordering, or administering opioids as part of treatment; include specific processes related to opioids in a health care institution's quality management program, and require notification to the Department of a death of a patient from an opioid overdose. To support the agency's stakeholders and partners, a series of four webinars on the emergency rules were held, training a total of 458 attendees. After the emergency rule implementation, the Department initiated the regular rule making process, which includes opportunities for stakeholder input on the final rules.

ADHS has also drafted and submitted emergency opioid-related reporting rules to the Attorney General's Office. These rules would require continued reporting of suspected opioid deaths, suspected opioid overdoses, naloxone doses administered in response to a suspected opioid overdose, naloxone doses dispensed, and neonatal abstinence syndrome cases. Ongoing reporting requirements will allow sustainable and continued collection of timely data throughout Arizona to better target prevention.

Opioid Prescribing Guidelines

In order to develop guidelines to educate providers on responsible prescribing practices, ADHS is utilizing the Arizona Prescription Drug Misuse & Abuse Initiative Healthcare Advisory Team to assist in updating Arizona's Opioid Prescribing Guidelines. This resource is intended to assist clinical decision-making that reflects the available evidence and local data, in order to keep Arizonans healthy and safe. The updated guidelines aim to reduce overreliance on opioid therapy and make safety a priority in managing acute and chronic pain. Promoting responsible prescribing practices is a key strategy to reduce prescription drug misuse and abuse and prevent future overdoses in our state. The updated draft was posted on www.azhealth.gov/opioidprescribing on September 5, 2017. A final version is slated for completion by December 2017.

Expanding Access to Naloxone

ADHS identified a need to train local law enforcement agencies on proper protocols for carrying, handling, and administering naloxone in overdose situations, in order to positively impact the opioid epidemic through rapid treatment of encountered suspected overdoses. A total of 983 law enforcement officers were educated through four training events held throughout the state from June to July 2017. ADHS is coordinating future requests for law enforcement training with the Arizona Peace Officer Standards and Training Board (AZ-POST).

ADHS secured funding for naloxone for law enforcement agencies whose staff have completed opioid overdose recognition and treatment training consistent with ADHS or AZ-POST standards. The order form for free naloxone for law enforcement agencies is posted on the azhealth.gov/opioid website. To

date, 3,929 naloxone kits have been ordered for 44 law enforcement agencies. The agency has also provided technical assistance to 34 law enforcement agencies to develop individual naloxone programs.

In order to support increased use of naloxone to save lives in Arizona, ADHS Director Dr. Cara Christ signed standing orders that allow pharmacists to dispense naloxone to any individual in the state and allow ancillary law enforcement, correctional officers, and EMS to use naloxone for suspected opioid overdoses. A naloxone pamphlet was developed in both English and Spanish to assist in public education of opioid safety and naloxone use.

Goal Council 3: Opioid Breakthrough Project

With Director Cara Christ as the lead of the Governor's Goal Council 3 on Healthy People, Places and Resources, the ADHS team assisted Director Christ in launching several subgroups to recommend actions that will reduce opioid deaths. On June 26, partners from across the state convened to learn more about the opioid emergency and the work of the Goal Council on Healthy People, Places, and Resources.

Participants were asked to join one of more subgroups to help define problems, set goals, and determine what actions would be most impactful to prevent and reduce opioid deaths. Subgroups worked together in July and August to identify recommendations and convened again on August 23 to share draft recommendations. Approximately 200 committed Arizonans volunteered their time to contribute ideas and prioritize recommendations that shape much of the content of the recommendations in this report. The Goal Council 3 subgroups for the Opioid Breakthrough Project will continue to meet over the next year to work on implementing improvement ideas and measure progress moving forward.

Communication and Resources

ADHS has developed several mechanisms to allow for partner interaction and information distribution. One such mechanism is the development of a dedicated webpage, azhealth.gov/opioid. This webpage organizes resources and allows stakeholders to quickly access up-to-date opioid-related information. Within these webpages the Department has posted numerous unique resources covering various topics including FAQs, reporting-related case definitions, publicly released data, setting-specific guidance and resources, and a recently released 50 State Review on Opioid Related Policy. A centralized email, azopioid@azdhs.gov, and digital interface within the opioid webpage allow for direct stakeholder communication for concerns and interest in partnering with the Department.

ADHS recently formed a drug overdose mortality review team, per §A.R.S. 36-198, to develop a data collection system regarding drug overdoses, conduct an annual analysis relating to drug overdose fatalities, develop standards and protocols, provide training and technical assistance to local overdose review teams, and develop investigation protocols for law enforcement and the medical community.

ADHS is also launching a new approach adopting chronic pain as a public health issue. In follow-up to a chronic pain summit held in May, ADHS developed a dedicated webpage, azhealth.gov/chronicpainmanagement, to increase public awareness and utilization of safe, effective approaches to managing chronic pain. With an emphasis on promoting non-pharmacological therapies that are proven to ease pain and increase function, ADHS aims to help Arizonans with chronic pain resume daily activities and maximize their quality of life.

During the period of the emergency declaration, ADHS also applied for and received additional grant funding to support interventions to reduce opioid deaths. The Centers for Disease Control & Prevention awarded ADHS over $1.2 million in supplemental funding for the existing Prescription Drug Overdose Grant - Prescription for States program. The funds will be used to expand community-level interventions through county health departments, support the new Drug Overdose Mortality Review Program and Naloxone Distribution Program, and expand public awareness campaigns about opioids and launch new messaging about chronic pain. ADHS awaits notice of grant funding from additional applications.

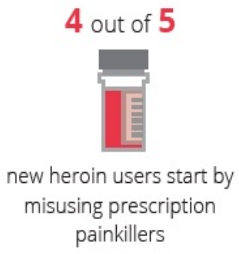
Conclusion

To date, agency staff have dedicated over 7,000 hours in order to initiate and complete activities to assist in combating the identified opioid crisis during the emergency declaration period.

RECOMMENDATION BRIEF: OPIOID LEGISLATION

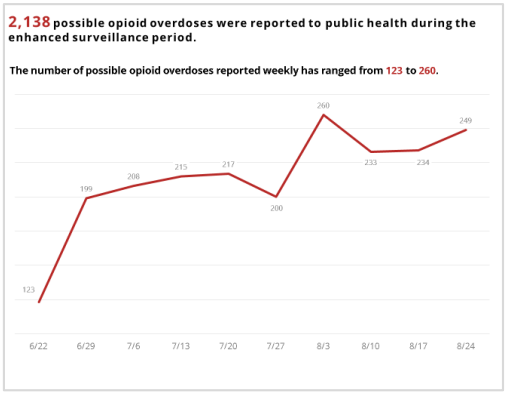
Recommendation: Enact legislation that impacts opioid deaths by reducing illicit acquisition and diversion of opioids, promoting safe prescribing and dispensing, decreasing the risk of opioid use disorder, and improving access to treatment.

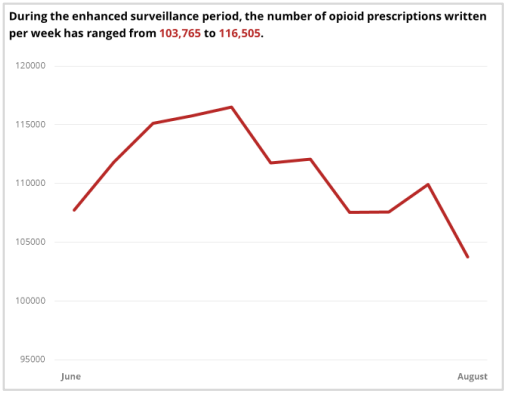
Identified gap: Throughout the response, ADHS met with stakeholders, partners, policy makers and Goal Council members. Gaps were identified in major areas: prescribing requirements, dispensing requirements, enforcement abilities, health and safety issues, regulation, physician education on opioid prescribing and treatment of opioid use disorder, patient awareness of the dangers of opioids and risk of opioid use disorder, and access to treatment and pain management options.

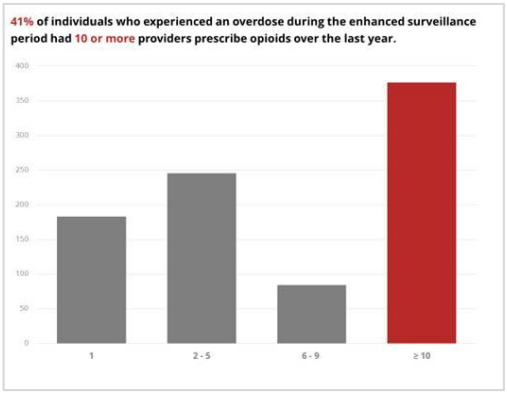


A dose of 50 morphine milligram equivalents (MME) or more per day **doubles** the risk of opioid overdose death, compared to 20 MME or less per day. At 90 MME or more, the risk of death increases **10 times**. Even at low doses, taking an opioid for more than 3 months increases the risk of addiction by **15 times**[1]. According to the Centers for Disease Control and Prevention (CDC), for a prescription for acute pain, **three days or less** is often enough, and more than seven days is rarely needed. The probability of long-term opioid use increases most sharply in the first days of therapy, particularly after 5 days or 1 month of opioid prescription[2].

Trends in Arizona: Arizona continues to see deaths and overdoses due to opioids, both prescription and illicit forms.







[1] Guy GP Jr., Zhang K, Bohm MK, et al. Vital Signs: Changes in Opioid Prescribing in the United States. 2006-2015 MMWRR Morb Mortl Wkly Rep 2017;66:697-704. DOI: https://www.cdc.gov/mmwr/volumes/66/wr/mm6626a4.htm?s_cid=mm6626a4_w

[2] Shah A, Hayes CJ, Martin BC. Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use - United States, 2006-2015. MMWR Morb Mortl Wkly Rep 2017;265-269. DOI: https://www.cdc.gov/mmwr/volumes/66/wr/mm6610a1.htm

RECOMMENDATION BRIEF: OPIOID LEGISLATION

Proposal: Submit a legislative package to comprehensively address the identified problems through the following legislative solutions (bolded solutions are considered high impact):

Category	Problem	Legislative Solution
Prescribing Requirements	Arizonans are being prescribed too many pills	**Impose a 5 day limit on all first fills for opioid naïve patients for all payers**
	Arizonans are being prescribed high doses of opioids	Require a limit (and tapering down) of doses to less than 90 MME. (Taper down would occur over years, exemptions for specific situations would be made in statute)
	Paper prescriptions are easily forged, leading to fraudulent prescriptions	Require e-prescribing for Schedule II controlled substance medications
Promote Safe Prescribing and Dispensing	Arizonans may not understand the dangers of opioids	**Require different labeling and packaging for opioids ("red caps")**
	Private physicians can dispense opioids with little oversight	Eliminate dispensing of controlled substances by prescribers
	Pharmacists do not have to check the CSPMP prior to dispensing	Require pharmacists to check the CSPMP prior to dispensing an opioid or benzodiazepine
	Clinicians lack adequate education on the dangers of opioid prescribing and pain management options	Require at least 3 hours of opioid-related CME for all professions that prescribe/dispense opioids
	Arizona can't adequately analyze opioid/substance abuse treatment data from payers due to lack of transparency	Establish an all payers claim database
	There are no specific regulations for pain management clinics	**Regulate pain management clinics to prohibit "pill mill" activities**
	Prescribers are exempted from checking the CSPMP if they write a prescription for 10 days or less.	Change exemption to match the 5 day fill limit; exempt for prescriptions of 5 days or less.
	Law enforcement agencies have difficulty enforcing illegal prescribing or dispensing	Change law enforcement authority to ensure clear enforcement capabilities
	Hospice providers cannot properly dispose of unused opioids of former patients	Establish authority for hospice providers to properly dispose of opioids to prevent diversion
Decrease the Risk of Opioid Use Disorder	Alternative pain treatments are not being considered and referrals to substance abuse treatment services take too long; opioids are faster to prescribe	Eliminate or decrease the amount of time a prior authorization can take
	Pill mills and opioid dispensing are not highly regulated	Establish enforcement mechanisms for pill mills and illegal opioid dispensing
Improve Access to Treatment	Too many Arizonans are not receiving timely medical care for overdose for fear of prosecution	**Enact a good Samaritan law to allow bystanders to call 911 for a potential opioid overdose**
	Continuity of care for individuals receiving MAT treatment is not fluid	Require licensed behavioral health residential facilities and recovery homes to develop policies and procedures that allow individuals on MAT to continue to receive care in their facilities

RECOMMENDATION BRIEF: OPIOID LEGISLATION

Agencies Impacted:

- Arizona Department of Health Services
- Arizona Board of Pharmacy
- Professional Regulatory Boards
- Law Enforcement Agencies

Alternative Method: None

Agency Responsible:

- Arizona Department of Health Services

Legislative Action Plan/Timeline:

- By September 15, 2017: Work with legislative council
- By October 31, 2017: Identify a bill sponsors
- By November 30, 2017: Work with stakeholders to gather feedback/ideas
- By December 31, 2017: Develop draft legislation
- By June 2018: Work bills through the legislative process

Performance Metrics

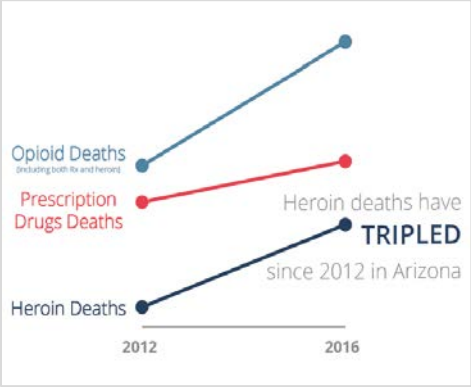
1. By June 30, 2018, complete 100% of the action items in the Legislative Action Plan
2. By June 30, 2018, legislation is passed that contains 100% of high impact priorities

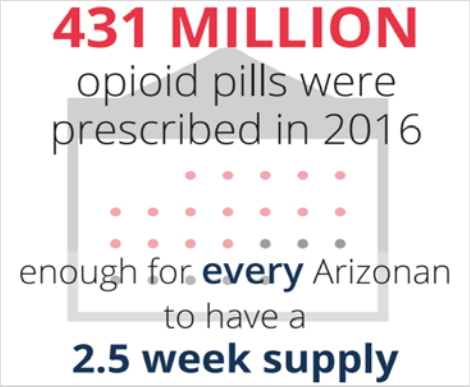
RECOMMENDATION BRIEF: FEDERAL BARRIERS

Recommendation: Engage the federal government to discuss the necessary federal changes to assist Arizona with our response to the opioid epidemic.

Identified gap: There are many federal barriers to Arizona effectively serving our citizens who are impacted by opioid use disorder (OUD). Changing certain federal requirements would expand access to care and treatment, improve prescriber education, confirm requirements for health care facilities align with current efforts to reduce opioid use, address illegal trafficking and distribution of opioids, and ensure health and safety of Arizonans treated at federal facilities by requiring our federal partners to share data.

Trends in Arizona: Arizona continues to see increasing deaths and overdoses due to prescription and illegal opioids, without a change in prescribing habits. According to a treatment capacity survey of inpatient and outpatient substance abuse treatment facilities conducted by the Arizona Department of Health Services, over 1,200 individuals who presented for treatment within the last three months were unable to receive services. Of those facilities with a waitlist (12%), 500 individuals are on their waitlists, with the majority waiting for inpatient beds. In addition, Arizona is impacted by the Institutes of Mental Disease (IMD) exclusion. Approximately 24 facilities have been excluded from Medicaid reimbursement for patients requiring inpatient stays longer than 15 days. This significantly impacts access to care for Arizonans seeking mental health or substance abuse treatment.





RECOMMENDATION BRIEF: FEDERAL BARRIERS

Proposal: Engage the federal government to discuss the necessary federal changes to assist Arizona with our response to the opioid epidemic.

Goal	Problem	Change Requested
Increase access to care and treatment	Substance abuse treatment facilities that are considered Institutes of Mental Disease (IMD) are excluded from reimbursement if the treatment requires an inpatient stay longer than 15 days	Remove the IMD exclusion to allow facilities to receive reimbursement for substance abuse treatment
	Lack of substance abuse treatment in correctional facilities	Allow Medicaid to pay for substance abuse treatment in correctional facilities
Improve prescriber education	Lack of prescriber education on substance abuse screening treatment, pain management and risks of opioids	Require accreditation organizations of medical/nursing/dental schools ensure standards are implemented into the curriculum on MAT, SBIRT, naloxone, and pain management education
	Lack of education regarding responsible opioid prescribing	Amend the Controlled Substances Act to require all Drug Enforcement Administration registrants to take a course in proper pain treatment and responsible opioid prescribing.
Confirm requirements for health care facilities align with current efforts to reduce opioid use	The Centers for Medicare and Medicaid Services (CMS) Hospital Consumer Assessment of Healthcare Providers and Systems (HCHAP) score has been removed from the reimbursement formula but is still utilized in provider ratings	Remove the pain satisfaction score completely from the CMS HCHAP score
	CMS and accreditation organizations have pain management conditions/standards that may not be in alignment with efforts to reduce inappropriate use of opioids	Require CMS and accreditation organizations (i.e. The Joint Commission) that accredit and certify health care organizations re-examine pain management conditions and standards to ensure alignment with efforts to reduce opioid use
	Federal health care facilities do not meet the same requirements as other health care facilities	Require federal health care facilities to maintain state licensure
Address illegal trafficking and distribution of opioids	As a border state, Arizona is a point of entry for opioids	Provide funding and resources to border states to assist law enforcement in preventing illegal supply and distribution of opioids.
Improve opioid data to ensure health and safety of at risk populations	Title 42 Code of Federal Regulations, Chapter I, Subchapter A, Part 2 prohibits facilities from sharing substance use disorder data.	Remove CFR 42 Part 2 reporting restriction, and require facilities to meet HIPAA requirements
	Federal entities are not required to input controlled substances into states' prescription drug monitoring programs, increasing the chances for overprescribing and dispensing	Require federal entities (i.e. Veterans Administration and Indian Health Services) to input dispensing data into states' prescription drug monitoring programs
	Federal entities are not required to report required data to local and state authorities, resulting in lack of data for the at-risk populations they serve	Require federal entities (i.e. Veterans Administration and Indian Health Services) to submit required reporting to state and local public health authorities

RECOMMENDATION BRIEF: FEDERAL BARRIERS

Agencies Impacted:

- Arizona Department of Health Services
- Arizona Health Care Cost Containment System
- Arizona Department of Corrections
- Arizona State Board of Pharmacy

Alternative Method: None

Agency Responsible:

- Arizona Department of Health Services

Federal Barrier Action Plan/Timeline:

- By September 30, 2017: Identify talking points
- By October 15, 2017: Incorporate Governor's feedback
- By October 28, 2017: Develop communication plan
- By October 30, 2017: Implement communication plan

Performance Metrics

1. By November 1, 2017, complete 100% of the action items in the Federal Barrier Action Plan

RECOMMENDATION BRIEF: YOUTH PREVENTION

Recommendation: Create a Youth Prevention Task Force to identify and recommend evidence-based, emerging, and best practice substance abuse prevention/early identification curriculum to be included in all Arizona schools.

Identified Gap: Preventing early use of drugs or alcohol can significantly reduce the risk of developing addiction later in life. Within the school setting, the majority of schools across the U.S. require instruction on substance abuse prevention. The Centers for Disease Control and Prevention (CDC) conducted the National School Health Policies and Practices Study in 2014 and found that among the schools surveyed, 50.0 percent of elementary schools, 66.7 percent of middle schools and 86.9 percent of high schools require students receive instruction on alcohol or other drug use prevention[1].

In Arizona, statute permits, but doesn't require, the instruction on the harmful effects of narcotic drugs, marijuana, date rape drugs, and other dangerous drugs in grades 4-12. The statute also allows instruction to include the harmful effects of drugs on a human fetus in grades 6-12. Currently, federal Substance Abuse Block Grant funds are utilized by the Governor's Office of Youth, Faith and Family to implement school-based programs targeting middle and high school youth.

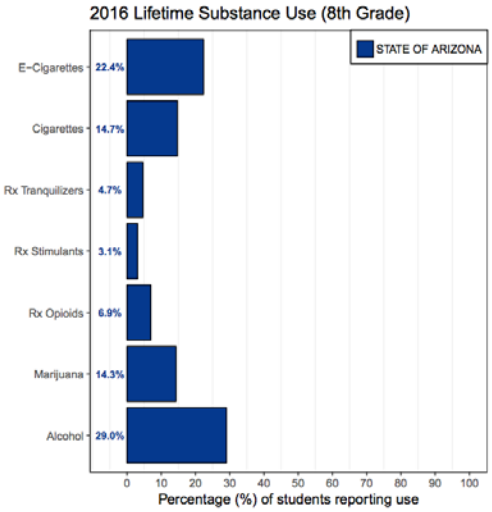
Additional prevention programming is funded through sources such as the Substance Abuse and Mental Health Services Administration's (SAMHSA) Partnership for Success grant, CDC Prescription for States grant, the federal Drug Free Communities grant, and the Arizona Parent's Commission on Drug Education and Prevention. These grants are implemented by a variety of community-based coalitions, non-profits, and county health departments. Arizona has opportunity to expand evidence-based primary prevention programming to reach more children and youth in a coordinated manner. Identification of additional resources is necessary to fully scale programming to impact future substance misuse.

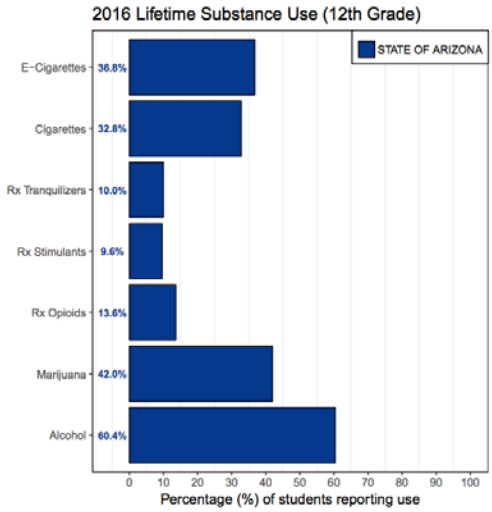
It has been very well documented the positive, protective effect early education intervention programs can have in providing students with information they can use to make good choices in general, and with respect to alcohol and drugs specifically[2]. Longitudinal research has demonstrated that there are individual, family, school and community risk and protective factors that influence an individual's likelihood to use drugs and/or alcohol. Risk and protective factors have implications for the types of policies and prevention programs that are likely to be effective in differing age, ethnic and socio-economic demographics. Prevention interventions are often classified into three categories: universal, selective and indicated depending on the risk of substance use with which the target population presents. While more research is needed to determine the most effective mix of these interventions, communities are encouraged to provide multiple levels of prevention programs.

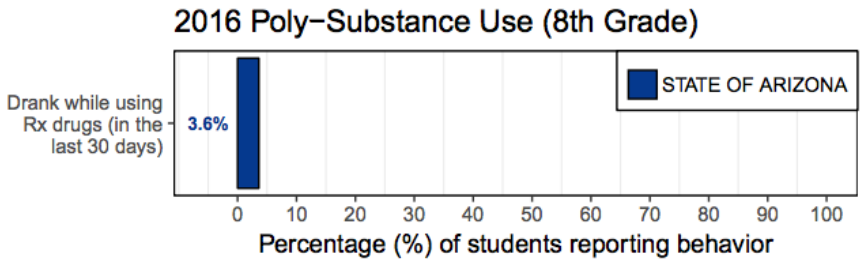
To support these efforts, SAMHSA compiled a compendium of over 132 interventions specific to providing children and youth with substance use disorder prevention and substance use disorder treatment education[3]. In 2016, the U.S. Surgeon General released *Facing Addiction In America*, in which 600 programs were reviewed and the top 42 prevention programs were categorized based on the target population's age[4].

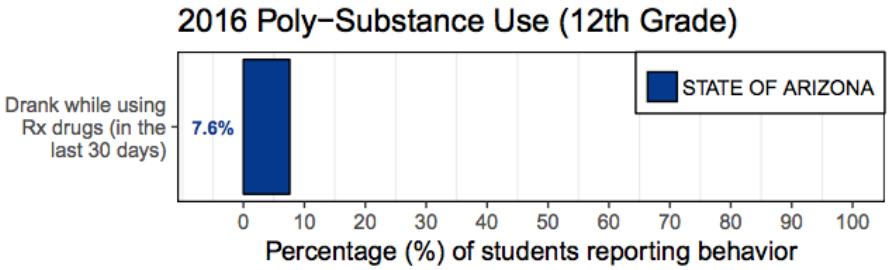
[1] https://www.cdc.gov/healthyyouth/data/shpps/pdf/shpps-508-final_101315.pdf
[2] National Academies Press. (2009). *Adolescent Health Services: Missing Opportunities*. Washington, DC: Author.
[3] https://www.samhsa.gov/nrepp
[4] https://addiction.surgeongeneral.gov/surgeon-generals-report.pdf

Trends in Arizona: The Arizona Youth Survey 2016 conducted by the Arizona Criminal Justice Commission indicated that 5% of Arizona 8th graders used prescription opioids in the 30 days preceding the survey. That percentage increases to 7.8% by 12th grade. Additionally alarming, 7.6% of 12th graders admitted to drinking alcohol while using prescription drugs in the preceding 30 days.









RECOMMENDATION BRIEF: YOUTH PREVENTION

Proposal: Create a Youth Prevention Task Force by executive order to identify and recommend:

- Evidence-based, emerging and best practice substance abuse prevention/early identification curriculum to be implemented in all Arizona schools
- Expanded after-school opportunities for youth from 3-6 P.M. to engage in prevention-based activities
- Potential resource needs
- Available funding opportunities

Recommend the Task Force review all relevant and meaningful early education substance abuse prevention/early identification and substance abuse treatment intervention resources in order to identify and recommend which ones will be most effective in preventing and reducing substance use among Arizona's school-age youth including those provided in the Arizona Substance Abuse Taskforce Report (2016)[5].

Agencies Impacted

- Governor's Office of Youth, Faith, and Family
- Arizona Department of Education
- Arizona schools
- Arizona Health Care Cost Containment System
- Arizona Department of Health Services
- Community coalitions and non-profits

Alternative Method: Task the Goal Council 3 Youth Prevention subgroup with fulfilling this recommendation.

Agency Responsible

- Governor's Office of Youth, Faith, and Family

Youth Prevention Action Plan/Timeline

- By October 1, 2017: Task Force Members identified/Task Force formed
- By November 1, 2017: Executive Order issued
- By December 1, 2017: First Task Force Meeting Held
- By June 30, 2018: Recommendations issued

Performance Metrics

1. By June 30, 2018, implement 100% of the action items in the Youth Prevention Action Plan
2. Number and percent of elementary, middle, and high schools implementing substance abuse interventions

[5] http://substanceabuse.az.gov/sites/default/files/files/substance_abuse_task_force_final_0.pdf

RECOMMENDATION BRIEF: LAW ENFORCEMENT

Recommendation: Meet with and encourage leaders of law enforcement and first responder agencies to:

- Expand the Arizona Angel Initiative to divert substance use disorder (SUD)/opioid use disorder (OUD) patients to substance abuse treatment as opposed to jail
- Identify additional opportunities for SUD/OUD diversion programs in Arizona
- Assist the DEA Tactical Diversion Squad to fill vacant local positions on the task force

Identified gap: Law enforcement plays a large role in the response to the opioid epidemic. Two major functions include working with those impacted by opioid use disorder to seek treatment and reducing the illicit supply of opioids.

Some law enforcement agencies nationally have implemented programs that attempt to reduce obstacles to accessing treatment, including through "deflection", in which police serve as a point of contact for individuals seeking treatment. In Arizona, one such program exists, the Angel Initiative, a partnership with the Governor's Office of Youth, Faith, and Family (GOYFF) and the Phoenix Police Department's Maryvale-Estrella Precinct, which allows citizens to walk into a police precinct, turn in their drugs and request treatment without fear of prosecution. Angels are also able to help parents secure safe placement for their children while they are in treatment in lieu of placing their children in the foster care system. Currently, in Arizona, this program is only operational in Maryvale.

Other law enforcement agencies around the country have developed diversion programs for individuals with SUD. These programs typically engage individuals after they have had involuntary contact with police officers. The program may be offered pre-arrest or post-arrest. Police diversion programs offer community-based treatment, case management, housing, and job attainment services.

The Drug Enforcement Agency maintains tactical diversion squads (TDS) which combine DEA resources with those of federal, state and local law enforcement agencies in an innovative effort to investigate, disrupt and dismantle those suspected of violating the Controlled Substances Act or other relevant federal, state or local statutes pertaining to the diversion of licit pharmaceutical controlled substances or listed chemicals.

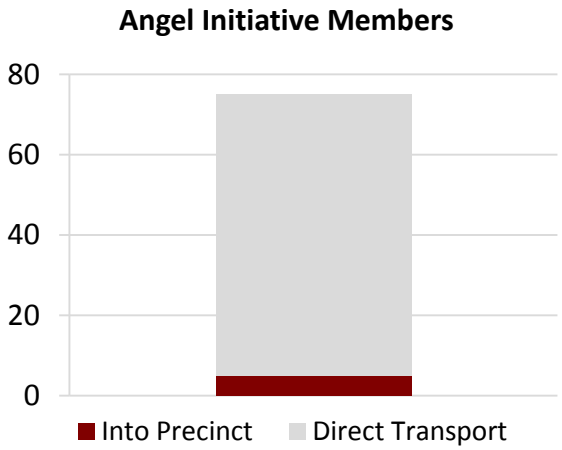
The TDS units:

- Allow for the unification of separate and sometimes disparate federal, state, and local information, authorities, and enforcement programs
- Help coordinate with various judicial districts to maximize the effectiveness of multiple investigations and prosecutions of those involved in the diversion of controlled substances or listed chemicals
- Support traditional Diversion Groups when law enforcement authority is required (i.e., making arrests, purchase of evidence, payment of information, conducting surveillance, executing a search warrant)

The TDS in Arizona has vacancies that need to be filled by local law enforcement in order for the TDS to be able to assist in preventing illegal supply and diversion activities.

RECOMMENDATION BRIEF: LAW ENFORCEMENT

Trends in Arizona: Approximately 75 individuals in Arizona have participated in the Angel Initiative.



Proposal: Meet with and encourage leaders of law enforcement and first responder agencies to:

- Expand the Arizona Angel Initiative to divert substance use disorder (SUD)/opioid use disorder (OUD) patients to substance abuse treatment as opposed to jail
- Identify additional opportunities for SUD/OUD diversion programs in Arizona and Increase the number of non-traditional intake sites individuals with SUD/OUD can access (ie. Safe Stations a fire department based program, additional law enforcement agencies) using the existing 211 hotline to link to treatment services/resources
- Identify barriers to participating with the DEA Tactical Diversion Squad to assist with filling vacant local positions on the task force

Agencies Impacted:

- Governor's Office of Youth, Faith, and Family
- Arizona Department of Homeland Security
- Arizona Department of Health Services

Alternative Method: Agency staff can meet with leadership of Arizona law enforcement agencies to encourage participation in the Angel program, identify other diversion programs and resources, and recruit local members for the DEA TDS.

Agencies Responsible:

- Arizona Department of Homeland Security
- Governor's Office of Youth, Faith, and Family

Law Enforcement Action Plan/Timeline:

- By September 30, 2017: Schedule a meeting for Governor Ducey to meet with leadership from local, county, and state law enforcement agencies
- By November 1, 2017: Governor Ducey hosts meeting to discuss the importance of:
    - Identifying and supporting local SUD/OUD diversion programs
    - Identifying additional sites for expanding the Angel Program
    - Assisting DEA with filling vacancies on TDS
    - Identifying next steps

Performance Metrics

1. By November 1, 2017, implement 100% of the action items in the Law Enforcement Action Plan
2. Number of law enforcement precincts participating in the Angel Initiative
3. Number of individuals with SUD/OUD enrolled in substance abuse treatment through the Angel Initiative
4. Percent of vacancies on the DEA Tactical Diversion Squad

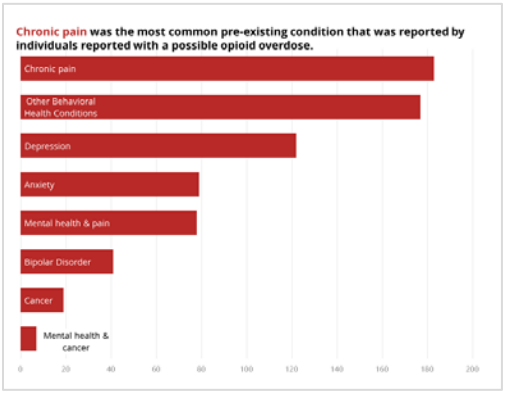
RECOMMENDATION BRIEF: MEDICAL EDUCATION CURRICULUM

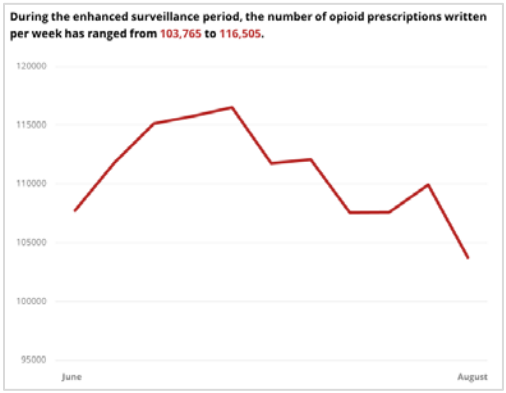
Recommendation: Require all undergraduate and graduate medical education programs[1] to incorporate evidence-based pain management and substance-use disorder treatment[2] into their curriculum.

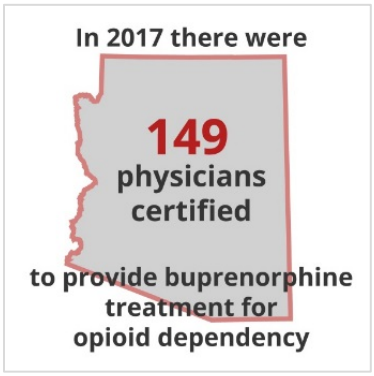
Identified gap: Through stakeholder discussion and agency-based research, educational gaps have been identified in prescriber education on evidence-based pain management and substance-use disorder treatment. No state has required undergraduate or graduate medical programs to incorporate evidence-based pain management or substance-use disorder treatment into their curriculum. The 2017 President's Commission *Interim Report*[3] recommended increasing medical education training in opioid prescribing and substance-use disorders.

Trends in Arizona:

- Arizona prescribers are using too many opioids, enough to provide every Arizonan with a 7-day supply.
- Arizona has fewer than 150 physicians eligible to provide buprenorphine treatment for opioid dependency.[4]
- Despite the FDA black box warning, opioids and benzodiazepines continue to be prescribed in combination in Arizona, with 43% of individuals reported to have overdosed prescribed these medications in combination.







[1] Including medical schools, veterinary schools, dental schools and graduate programs (e.g. residencies).
[2] Including opioid-prescribing practices, medication assisted treatment, Screening-Brief Intervention-Referral to Treatment approaches (SBIRT) and naloxone use.
[3] From the Commission *Interim Report* (2017), www.whitehouse.gov/sites/whitehouse.gov/files/ondcp/commission-interim-report.pdf
[4] Substance Abuse and Mental Health Services Administration, 2017

RECOMMENDATION BRIEF: MEDICAL EDUCATION CURRICULUM

Proposal: Educating the future medical professionals of Arizona on evidence-based pain management and substance-use disorder treatment may contribute to reducing the stigma of substance use disorders, reducing the opioid epidemic in Arizona, and increasing the number of physicians certified to treat opioid-dependency.

An undergraduate and graduate medical education curriculum would include but not be limited to:

- Evidence-based pain management
- Diagnosis and management of substance-use disorders
- Educational requirements to prescribe medication-assisted treatment
- Pharmaceutical interactions of commonly prescribed substances and medications
- Pharmaceutical influence on physician prescribing

Agencies Impacted:

- Arizona Department of Health Services
- Arizona Board of Regents

Alternative Methods:

- Issue an executive order to require all undergraduate or graduate medical education programs to incorporate evidence-based pain management into their curriculum.
- Form an educational workgroup made of academic deans to develop model curriculum for optional use by undergraduate and graduate medical education programs.

Agency Responsible:

- Arizona Department of Health Services

Medical School Curriculum Action Plan/Timeline:

- By October 31, 2017: Acquire curriculum contacts at every undergraduate and graduate medical education program in Arizona
- By November 30, 2017: Create an academic MD/DO/NP/DVM/DDS workgroup to develop curriculum basics
- By January 15, 2018: Host first meeting of academic workgroup
- By March 30, 2018: Present curriculum basics to undergraduate and graduate medical education programs
- By September 2018: Incorporate evidence-based pain management and substance-use disorder treatment into all undergraduate and graduate medical education programs

Performance Metrics

1. By September 2018, implement 100% of the action items in the Medical School Curriculum Action Plan
2. By October 31, 2017, 75% of programs have been approached to discuss curriculum proposal
3. By September 30, 2018, 75% of programs approached will include evidence-based pain management and substance-abuse disorder treatment in their 2018-19 academic year

RECOMMENDATION BRIEF: INSURANCE PARITY

Recommendation: Convene an Insurance Parity Task Force by executive order to identify recommendations to ensure prevention of opioid use disorder, adequate access to care for substance abuse and chronic pain management, and decreased barriers to care are available across all Arizona health insurance plans.

Identified gap: Coverage of treatment for substance abuse and pain management is not standardized and is impeding patient access to care that could help people manage their chronic pain without opioids and improve access to treatment for people with opioid use disorder. Issues of coverage were identified in several of the Goal Council 3 subgroups.

The Centers for Disease Control and Prevention *Chronic Pain Guidelines* and National Safety Council recommendations[1] highlight and underscore the need to utilize non-opioid pharmacologic therapies to treat chronic pain. The Department of Health & Human Services' National Pain Strategy (NPS)[2] states that "evidence suggests that wide variations in clinical practice, inadequate tailoring of pain therapies to individuals, and reliance on relatively ineffective and potentially high risk treatments such as inappropriate prescribing of opioid analgesics, or certain surgical interventions, not only contribute to poor quality care for people with pain, but also increase health care costs." The NPS "supports the development of a system of patient-centered integrated pain management practices based on a biopsychosocial model of care that enables providers and patients to access the full spectrum of pain treatment options."

The White House Commission on Combating Drug Addiction and the Opioid Crisis identified gaps in access to treatment for individuals with opioid use disorder in their recommendations to the President[3]:

> *"The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) prohibits health insurance plans that cover behavioral health from imposing benefit limitations on mental health or SUD treatment that are less favorable than limitations imposed on medical or surgical benefits. Benefit limitations can be quantitative, such as visit limits, or non-quantitative, such as pre-authorization requirements. But not providing real parity is already illegal. The Commission urges you to direct the Secretary of Labor to enforce this law aggressively and to penalize the violators.*
>
> *The Commission heard from numerous organizations, including ASAM and the American Academy of Addiction Psychiatry, about the need to systematically monitor and enforce MHPAEA with a standardized tool, and actual penalties for non-compliance, to ensure parity in the coverage of mental health and addiction treatment services. The Labor Secretary, with appropriate direction from you, is the person to do this.*
>
> *At this point, the largest outstanding issue is treatment limits. Patients seeking addiction treatment, including MAT, are often subjected to dangerous fail-first protocols, a limited provider network, frequent prior authorization requirements, and claim denials without a transparent process. The Commission applauds SAMHSA's work with multidisciplinary teams from states to improve parity enforcement and public education. However, we need robust enforcement of the parity law by the state and federal agencies responsible for implementing the law. Regulators should be required to levy penalties against health plans that violate MHPAEA, and information about parity violations should be made available to the public."*

[1] National Safety Council. (2016) Prescription Nation 2016: Addressing America's Drug Epidemic.
[2] U.S. Department of Health and Human Services. (2016) National Pain Strategy.
[3] From the Commission *Interim Report* (2017), www.whitehouse.gov/sites/whitehouse.gov/files/ondcp/commission-interim-report.pdf

RECOMMENDATION BRIEF: INSURANCE PARITY

Trends in Arizona: Arizona, like other states, has a variety of payer sources including Medicaid, Medicare, commercial plans, employer plans, Veterans Administration (VA), Indian Health Services (IHS), Arizona Department of Corrections, and county Correctional Health plans. There are currently 23 active health care service organizations registered with the Arizona Department of Insurance, which doesn't include the federal payers like the VA, IHS, or correctional payers. Every payer operates differently, which creates confusion and unnecessary barriers.

In a Morrison-Cronkite News poll conducted in March 2017, 29% of the 800 adults surveyed said they had experienced ongoing pain for more than three months at some point during the past 12 months. Prescription pain relievers were used by about 36% of these respondents.

Proposal: Convene an Insurance Parity Task Force to research and provide recommendations regarding parity and standardization across the state. This task force should include at least one representative from each of the payer sources to ensure that the recommendations address concerns across the whole system. The Arizona Health Care Cost Containment System (AHCCCS) offers a wide range of behavioral health and substance abuse treatment services. Using their plan as a standard baseline for parity and treatment criteria is an ideal starting point for discussions of the task force.

Goal	Problem	Recommendation
Increase access to care and treatment	Health insurance plans have a wide range of covered services	Enhance parity for substance abuse treatment and chronic pain management across all payers sources and demographics
	Lack of reimbursement for providers for specific services: informed consent, conducting drug screenings, reviewing records, substance abuse screening	Identify opportunities to incentivize providers for screening and educating patients regarding substance abuse and opioid use disorder
	No standardized criteria to determine appropriate placement for substance abuse treatment	Recommend standardized medical necessity criteria for placement in treatment
	No substance abuse treatment requirements for children under 18	Identify standard substance abuse treatment requirements for children under 18
	Not all plans cover Medication Assisted Therapy (MAT), including psychosocial treatment	Incentivize plans to pay for MAT, including psychosocial treatment
Improve pain management	Opioids are covered by health plans and are easier to access for chronic pain than some non-opioid treatments	Develop and implement value-based incentives to incentivize implementation of pain management strategies that improve outcomes
	Pain management is usually not coordinated among all providers that should be involved in treatment	Incentivize use of interdisciplinary pain management programs (bio-medical and bio-social) to establish a team-based approach to pain management
Reduce barriers	Prior authorizations and fail first protocols are barriers to appropriate substance abuse treatment	Prohibit fail-first protocols and prior authorization requirements to address the issue of treatment limits
	There are no standard criteria for providers to determine what level of care a patient's health plan will provide	Establish and use standard criteria across all payer sources to determine the appropriate level of care

RECOMMENDATION BRIEF: INSURANCE PARITY

Agencies Impacted:

- Arizona Health Care Cost Containment System
- Arizona Department of Health Services
- Arizona Department of Insurance

Alternative Method: The distinct payer sources could independently review their policies and procedures. This would not address the inconsistencies across the system.

Agency Responsible:

- Arizona Department of Health Services

Insurance Parity Action Plan/Timeline:

- By September 30, 2017: Issue an Executive Order to create the task force
- By October 15, 2017: Identify task force members
- By November 30, 2017: Hold the first meeting
- By May 30, 2018: Compile information and finalize recommendations
- By June 30, 2018: Submit a report to the Governor

Performance Metrics

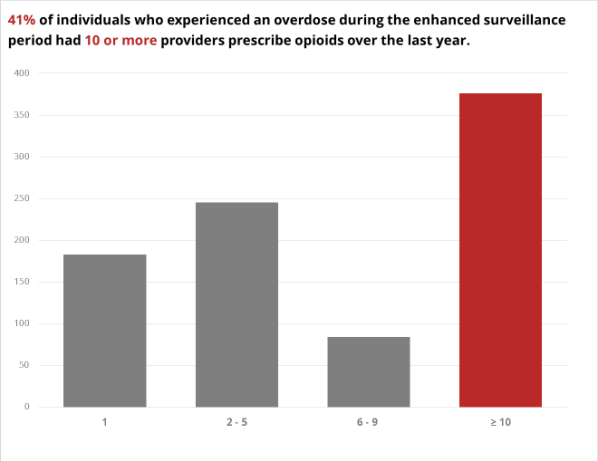
1. By June 30, 2018, implement 100% of the action items in the Insurance Parity Action Plan

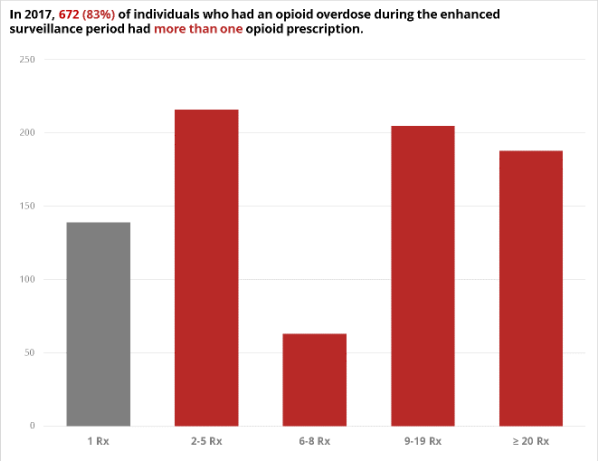
RECOMMENDATION BRIEF: REGULATORY BOARDS

Recommendation: Establish a Regulatory Board work group to identify prescribing trends and discuss enforcement issues.

Identified gap: Currently, there is no mechanism for Arizona's regulatory boards to identify illegal prescribing trends or dispensing activity among their regulated providers. The Arizona Board of Pharmacy is prohibited from sharing prescribing data with entities that have not been identified by statute.

Trends in Arizona: In the first six months of 2017, Arizona prescribers wrote 2,850,535 opioid prescriptions for 227,029,510 opioid pills. This was enough for every Arizonan, regardless of age, to have more than a week supply of opioid pills.





Proposal: Establish, through executive order, a Regulatory Board work group consisting of representatives from the each of the following entities:

- Arizona Regulatory Boards that regulate prescribers,
- Arizona State Board of Pharmacy,
- Drug Enforcement Agency, and
- Attorney General's Office

The work group will be required to meet on a regular basis to identify prescribing trends and discuss enforcement issues regarding their regulated communities.

RECOMMENDATION BRIEF: REGULATORY BOARDS

Agencies Impacted:

- Arizona Department of Health Services
- Arizona State Board of Pharmacy
- Arizona Medical Board
- Arizona Osteopathic Board
- Arizona Naturopathic Board
- Arizona Homeopathic Board
- Arizona Dental Board
- Arizona Board of Nursing
- Attorney General's Office
- Drug Enforcement Administration

Alternative Method: Each regulatory board could arrange to meet on its own with the DEA and Attorney General's office.

Agency Responsible:

- Arizona Department of Health Services

Regulatory Board Action Plan/Timeline:

- By October 1, 2017: Executive Order issued
- By November 1, 2017: Regulatory Board Work Group Members Identified
- By December 31, 2017: First Work Group Meeting Held
- By June 30, 2018: Initial Work Group plan of action drafted

Performance Metrics

1. By December 31, 2017, implement 100% (3 of 3) of the action items in the Regulatory Board Action Plan:
    - Executive Order forming the Workgroup,
    - Task Force formed
    - First meeting held
2. By end of FY18, 100% (3 of 3) of workgroup meetings will be held:
    - FY18 Q2 meeting
    - FY18 Q3 meeting
    - FY18 Q4 meeting

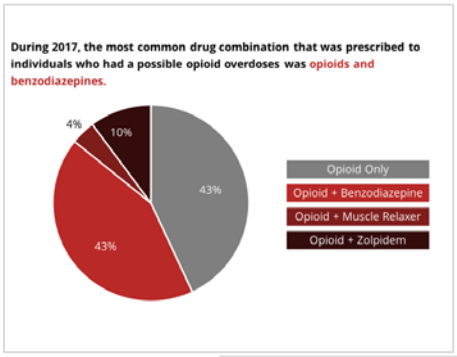
RECOMMENDATION BRIEF: CALL SERVICE

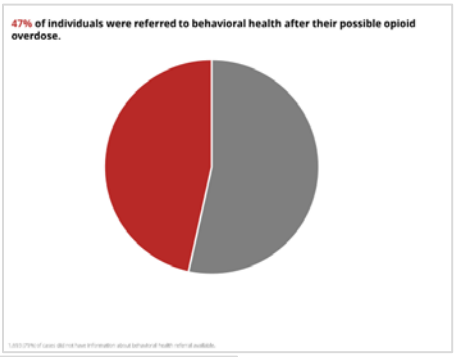
Recommendation: Require the Arizona Department of Health Services to develop a call service that provides 24/7 consultation to prescribers seeking clinical guidance for complicated patients taking opioids or with opioid-use disorder, and 24/7 referral services to patients seeking treatment for opioid use disorder.

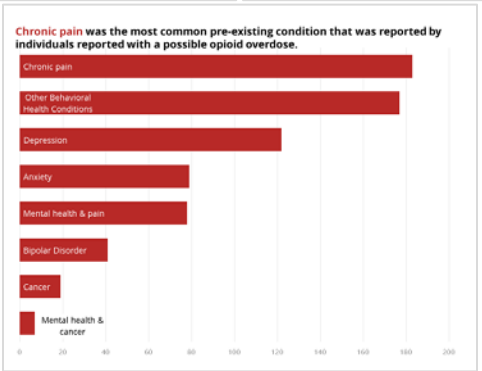
Identified gap: No 24/7 statewide service exists in Arizona to provide evidence-based and expert recommendations to clinicians, nor to conduct warm transfers to referral sources and individual, patient-based follow up. These gaps in consistent and comprehensive resources and consultation services for patients and clinicians related to opioid prescribing and opioid-use disorder have been identified by Goal Council 3 subgroups. While resources exist within specific communities, they are often fragmented, and focus on crisis response or general behavioral health. Rural communities, in particular, may not have access to specialists in their local communities. Having a statewide resource would help clinicians implement best practice guidelines, such as the Arizona Opioid Prescribing Guidelines.

One national model for clinician consultation on opioid use and management exists on a Monday through Friday basis – the Clinical Consultation Center – operated out for the University of California, San Francisco (UCSF). A similar model operates seven days a week in Alberta, Canada for primary care physicians and nurse practitioners exclusively for consultation regarding patients with opioid dependency. Smaller, more targeted services operate in other U.S. states including Kentucky (Operation UNITE – regional, business hours service for patients seeking resources for drug addiction) and New Mexico (Project ECHO – telemedicine-based provider training and treatment capacity for substance use disorder in rural areas), but these are neither comprehensive nor statewide.

Trends in Arizona:
The average opioid dose prescribed in the last year, per individual who overdosed between June 15, 2017 and August 10, 2017 was 96 morphine milligram equivalents, an amount nationally recognized as being associated with increased risk of overdose and adverse outcomes.







RECOMMENDATION BRIEF: CALL SERVICE

Proposal: In order to improve prescribing practices, appropriate patient referral, and treatment for opioid use disorder, the Arizona Department of Health Services should develop a call service that provides 24/7 opioid-related resources for clinicians and patients. The service should include a central repository of available network capacity and a website of current opioid use disorder treatment providers as identified by the Arizona Health Care Cost Containment System and the Governor's Office of Youth, Faith, and Family.

The call service should include the following elements for clinicians:

- Real-time consultation to prescribers seeking advice about prescribing opioids, pain management options, managing high-risk patients, reducing opioid dosing (weaning), and opioid use
- Guidance on caring for patients with opioid use disorder and appropriate referrals for patient support and treatment services
- Identification, assessment, and referral for patients presenting with opioid overdose or opioid use disorder

The call service should include the following elements for patients:

- Emergency resources and referrals for individuals seeking treatment for opioid use disorder
- Warm transfer to behavioral health services or substance abuse/medication assisted treatment with patient follow-up after handoff

Agencies Impacted:

- Arizona Department of Health Services
- Arizona Health Care Cost Containment System
- Governor's Office of Youth, Faith, and Family

Alternative Method:

- Arizona clinicians can be directed to the UCSF Clinician Consultation Center for business hour clinician-to-clinician consultation on substance use evaluation and management.
- Primary care teams associated with a HRSA-funded health center can opt to participate in Opioid ECHO, a free training program in opioid addiction treatment. This only reaches a limited number of providers and is a training program, not specific guidance or consultation.
- Patients seeking emergency resources or referrals can call existing resources like Community Information and Referral, Crisis Response Network, or Poison Control. These entities vary in their capacity to provide comprehensive, statewide referrals or information and to provide warm hand offs or patient follow up.
- Providers or patients can visit the federal Substance Abuse and Mental Health Services Administration (SAMHSA) website to find medication-assisted treatment providers in a given location. This website is not specific to Arizona and not easy to navigate for those unfamiliar with the topic area.

Agency Responsible: Arizona Department of Health Services

Action Plan/Timeline:

- By October 31, 2017: Identify an entity or entities appropriately staffed to support a 24/7 call service for clinicians and patients
- By December 31, 2017: Establish a contract with the identified entity or entities
- By January 31, 2018: Document protocols, guidelines, reference documents, and primary points of contact for use by the contracted entity or entities
- By January 31, 2018: Establish evaluation metrics and data collection tools for use by the contracted entity or entities in reporting back to the Department
- By February 28, 2018: Launch the call service
- By March 31, 2018: Promote the call service through statewide professional associations and licensing boards
- By March 31, 2018: Update substanceabuse.az.gov to reflect current Arizona opioid use disorder treatment providers, including those listed through SAMHSA.

Performance Metrics

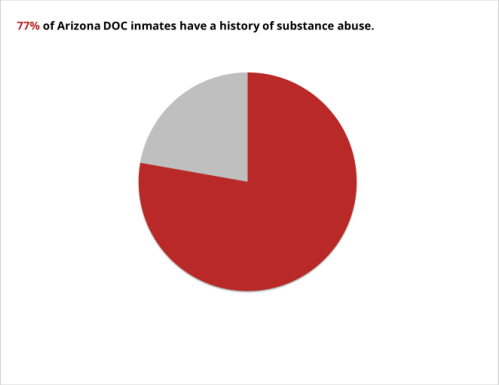
1. By April 2018, implement 100% of the action items in the Call Service Action Plan
2. Number of calls triaged though call service

RECOMMENDATION BRIEF: CORRECTIONAL FACILITIES

Recommendation: Upon release from state and county correctional facilities, provide Vivitrol and naloxone to individuals at high risk for overdose or death. Additionally, if the federal government allows Medicaid to provide substance abuse treatment in correctional facilities, implement medication-assisted treatment (MAT) programs in state and county correctional facilities to address opioid use disorder (OUD).

Identified gap: Many individuals who are incarcerated in state or county correctional facilities have opioid use disorder. Upon release, these individuals may return to their addiction with little transitional support. Additionally, individuals who are incarcerated have limited options for treatment of OUD because of federal restrictions. Studies have shown that among former prisoners, a high rate of death has been documented in the early post-release period, particularly from drug-related causes[1]. Women were at an increased risk for overdose and opioid related deaths.

Trends in Arizona: In July 2017, the Arizona Department of Corrections (ADOC) census was 42,184 inmates[2]. Seventy-seven percent (n=32,482) of inmates assessed at intake have significant substance abuse histories. Only 732 (2.2%) of those inmates with a history of substance abuse are enrolled in addiction treatment.



Proposal: Increase access to Vivitrol and naloxone for individuals exiting state and county correctional institutions and increase access to MAT therapy for individuals with OUD while incarcerated.

Goal	Problem	Solution
Increase access to naloxone	Individuals leaving correctional facilities with high risk of overdose and death do not have immediate access to naloxone or Vivitrol	State and county correctional facilities should implement a risk-based program to provide naloxone and Vivitrol to high risk individuals.
Increase MAT services	Individuals who are in state or county correctional institutions do not have access to MAT treatment programs	If Medicaid will pay for services for individuals who are incarcerated, implement MAT programs in state and county correctional facilities.

[1] Binswanger IA, Blatchford PJ, Mueller SR, Stern MF. Mortality After Prison Release: Opioid Overdose and Other Causes of Death, Risk Factors, and Time Trends From 1999 to 2009. Annals of Internal Medicine. 2013;159(9): 592-600.

[2] https://corrections.az.gov/sites/default/files/REPORTS/CAG/2017/cagjul17_081017.pdf

RECOMMENDATION BRIEF: CORRECTIONAL FACILITIES

Agencies Impacted:

- Arizona Department of Corrections
- Arizona Health Care Cost Containment System (AHCCCS)
- County-based jails

Alternative Method: Initiate an awareness campaign prior to release for high risk individuals, by providing inmates with opioid overdose prevention materials in correctional facilities that include information on how to identify and respond to an opioid overdose, instructions for information on drug treatment options and a Substance Abuse and Mental Health Services Administration (SAMHSA) toolkit for patients and family members.

Agency Responsible:

- Arizona Department of Health Services

Correctional Facilities Action Plan/Timeline:

Increase access to naloxone

- By October 1, 2017: Meet with Goal Council 4 Recidivism Breakthrough Project to discuss employment center involvement for Vivitrol and naloxone projects
- By November 1, 2017: Survey county jails to determine best practice and current availability of Vivitrol and naloxone to those being released
- By December 1, 2017: Identify potential funding sources for Vivitrol and naloxone
- By February 1, 2018: Distribute best practices and funding sources to counties for consideration

Increase MAT services

- If Medicaid allows for coverage of MAT services of people currently incarcerated, ADHS will work with AHCCCS to establish a work plan

Performance Metrics:

1. By February 1, 2018, implement 100% of the action items in the Correctional Facilities Action Plan

RECOMMENDATION BRIEF: CONTINUITY OF CARE

Recommendation: Establish through executive order a work group to identify, utilize, and build upon Arizona's existing peer recovery support services.

Identified gap:
Individuals face a range of obstacles preventing them from entering or gaining access to substance abuse treatment, including lack of knowledge regarding access to services; shame and stigma; denial of substance use disorder or substance misuse; costs and lack of insurance/Medicaid; transportation; treatment waiting lists; and prior negative treatment experiences.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA):

> *"Peer support services are delivered by individuals who have common life experiences with the people they are serving. People with mental and/or substance use disorders have a unique capacity to help each other based on a shared affiliation and a deep understanding of this experience. In self-help and mutual support, people offer this support, strength, and hope to their peers, which allows for personal growth, wellness promotion, and recovery.*
>
> *Research has shown that peer support facilitates recovery and reduces health care costs. Peers also provide assistance that promotes a sense of belonging within the community. The ability to contribute to and enjoy one's community is key to recovery and well-being. Another critical component that peers provide is the development of self-efficacy through role modeling and assisting peers with ongoing recovery through mastery of experiences and finding meaning, purpose, and social connections in their lives."*

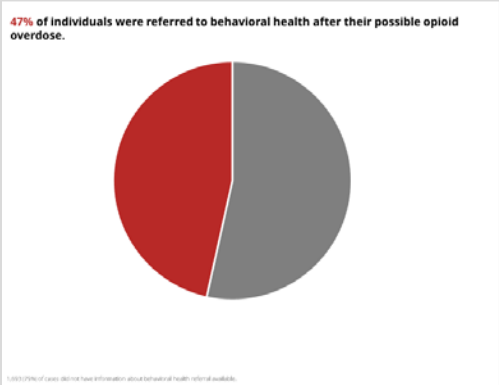
Peer recovery support services help prevent relapse and promote sustained recovery from mental and/or substance use disorders (SUD), and examples can include: peer mentoring or coaching, peer recovery resource connecting, recovery group facilitation, and building community/social networks. Street-based reach-in programs allow peers to provide harm reduction and referral to recovery support services to others suffering from substance use disorder or opioid use disorder. Recovery support services may include medication-assisted treatment (MAT), housing resources and care coordination. Peer recovery support services are services that are designed and delivered by people who, themselves, have experienced both substance use disorder and recovery. These services can include peer counseling, career counseling, and support groups.

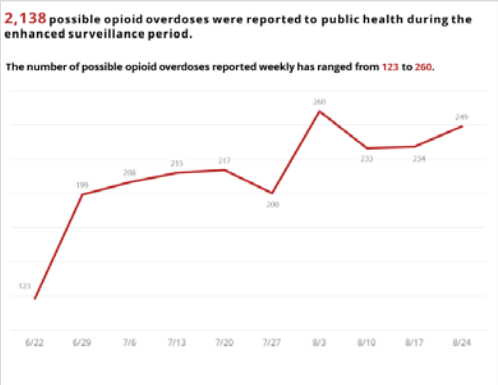
Currently, there is no program in Arizona that connects people who have been admitted to emergency rooms for an opioid-related overdose with trained peer recovery coaches. These recovery coaches could play an important role in helping people avoid another overdose and encouraging them to seek treatment.

Arizona does not have a first responder model for opioid-related support, although the state does have Community Integrated Paramedicine programs that operate in two primary business models. In one model, emergency medical services (EMS) agencies partner with hospitals to reduce the frequency with which patients are re-admitted to hospitals. In the second, EMS agencies cultivate social service referrals to reduce the frequency that individuals access emergency departments for non-emergency events. These models could serve a role in first responder non-fatal overdose scene response. The Arizona Health Care Cost Containment System (AHCCCS) reimburses agencies that are recognized in the ADHS Treat and Refer program.

RECOMMENDATION BRIEF: CONTINUITY OF CARE

Trends in Arizona: Fourteen percent of individuals with a possible opioid overdose during the enhanced surveillance were previously hospitalized in 2016 with an opioid-related cause. Of those hospitalized with an opioid related cause, 9% resulted in a fatal overdose during the enhanced surveillance period. In a retrospective study of Arizona death data from 2005-2015 matched with Hospital Discharge Data, 33% of deaths had a prior hospitalization, with an average of almost three visits prior to death (range 1-33). Admissions/emergency room visits for opioid overdoses provide an opportunity to introduce peer supports, provide naloxone, and offer a referral to a behavioral health treatment provider.





Proposal: Establish through executive order a work group to identify current existing peer support programs, develop a communication plan to providers about existing programs, and build upon those existing resources to establish statewide peer support programs for all payers that can facilitate linkages to substance abuse treatment through warm handoffs and street-based reach-in programs.

The work group would be made up of representatives from the Arizona Department of Health Services (ADHS), AHCCCS, and each of the Regional Behavioral Health Authorities and would be directed to:

- Develop a resource guide of existing peer support services in Arizona
- Develop a communications plan to increase awareness and promote utilization of peer-based services to health care facilities and providers
- Identify resource needs to establish statewide peer support programs to:
    - increase availability to ensure a warm hand off to a substance abuse facility
    - implement reach-in programs by peers in hotspot areas to provide ancillary needs (water, blankets, etc) and navigation to medical and substance abuse treatment, and
    - Include peer supports as part of the first responder non-fatal overdose scene response
- Identify and recommend pilot projects that serve:
    - Hospitals: Implement a program based on Rhode Island's AnchorED that connects people who have been admitted to emergency rooms for an opioid-related overdose with trained peer recovery coaches as included in the ADHS Draft Hospital Discharge Planning Guidelines: Preventing Overdose from a Hospital Setting. AHCCCS and ADHS should work together to provide resources and technical assistance to expand approaches that improve connections with treatment following an opioid-related emergency department visit or hospitalization.
    - First Responders: Explore expansion of the Treat and Refer program to include post-discharge follow-up and readiness to help individuals with SUD receive recovery treatment.
    - Work with the substance abuse coalitions to on-board peer recovery coaches.

Agencies Impacted:

- Arizona Department of Health Services
- Arizona Health Care Cost Containment System

Alternative Method: Work groups can be established without executive order to identify existing resources, develop a communications plan, identify necessary resources to establish statewide peer support programs, and plan and recommend pilot projects to serve specific communities.

Agency Responsible:

- Arizona Department of Health Services
- Arizona Health Care Cost Containment System

Peer Support Action Plan/Timeline:

- By September 30, 2017: Identify work group members
- By October 31, 2017: Issue Executive Order
- By December 31, 2017: Draft resource guide of existing peer support resources
- By March 31, 2018: Develop communications plan
- By April 30, 2018: Identify additional resource needs
- By June 30, 2018: Work group provides recommendations for pilot projects

Performance Metrics:

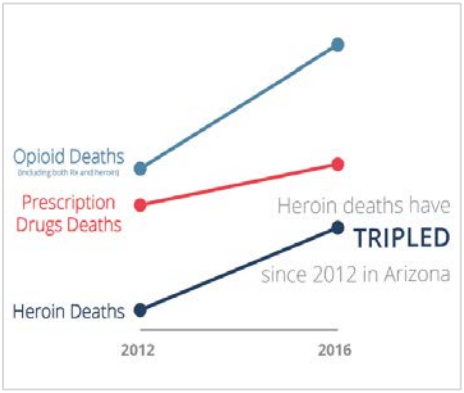
1. By June 30, 2018, implement 100% of the action items in the Peer Support Action Plan

RECOMMENDATION BRIEF: EDUCATE THE PUBLIC

Recommendation: Utilize public service announcements to educate patients, providers and the public regarding opioid use and naloxone.

Identified gap: In Arizona, very few social marketing or public campaigns have been developed to raise awareness of the problem of opioid overdoses. The Governor's Office of Youth, Faith, and Family had limited funding to air one public service announcement about prescription drug abuse in early 2017[1]. Several Goal Council 3 Opioid Breakthrough subgroups identified the need for increased public awareness and education about opioid use, as well as shifting perceptions about pain management. Arizona has opportunity in the next year to shine a spotlight on the opioid epidemic. The Governor's Office of Youth, Faith, and Family is currently developing seven public service announcements to raise awareness about: naloxone; what is an opioid; dangers of poly-drug use; and opioid addiction. The Centers for Disease Control and Prevention is also releasing a new public awareness campaign about prescription opioids and materials should be available for states to use by the end of September.

Trends in Arizona: During 2016, nearly 800 people died of an opioid overdose in Arizona, and heroin deaths have tripled since 2012. In a Morrison-Cronkite News Poll conducted in March 2017, 41.8% of the 800 adults surveyed said they knew someone who has been addicted to prescription painkillers.



Proposal: A public education campaign is a critical component to providing education and action steps to the public that can help prevent overdoses. The use of public service announcements to bring awareness to the problem can have a positive impact on engaging the public to be more proactive about seeking information and taking prevention steps. Engaging different forms of media can bring immediate attention to the issue because of the ability to disseminate information rapidly to a wide audience.

New public service announcements and special public events can increase visibility and awareness of the importance of addressing the opioid crisis. The Governor's Office of Youth, Faith, and Family is leading the development of new Public Service Announcements about the opioid epidemic in Arizona. The Arizona Department of Health Service is assisting with this development and has opportunity to leverage CDC resources to enhance the overall campaign.

[1] www.RethinkRxabuse.org

RECOMMENDATION BRIEF: EDUCATE THE PUBLIC

Agencies Impacted:

- Governor's Office of Youth, Faith, and Family
- Arizona Department of Health Services

Alternative Method: None

Agency Responsible:

- Governor's Office Communications Team

Public Service Announcement Action Plan/Timeline:

- October 1, 2017: Identify specific messages for future PSAs
- October 15, 2017: Develop messaging
- November 30, 2017: Confirm specific methods of dissemination
- June 30, 2018: Public service announcements and events occur

Performance Metrics:

1. By June 30, 2018, implement 100% of the action items in the Public Service Announcement Action Plan

RECOMMENDATION BRIEF: CSPMP IMPROVEMENTS

Recommendation: Establish a task force of healthcare professionals, licensing boards, Board of Pharmacy, Arizona Department of Health Services, and law enforcement agencies to identify specific improvements that should be made to enhance the Arizona Controlled Substances Prescription Monitoring Program (CSPMP). Considerations should include but are not limited to:

- Potential need for grant funding and/or technical assistance to assist health care providers to link their electronic health records to the CSPMP
- Additions to CSPMP to flag patients at higher risk of overdose
- Additions to CSPMP to flag patients who exhibit drug diverting behaviors
- Addition of veterinarians to reporting into and checking the CSPMP
- Assessment of exemptions from mandate to check the CSPMP
- Improvement to prescriber report cards
- Use of CSPMP as a public health surveillance tool

Identified gap: Despite evidence showing the effectiveness of Prescription Drug Monitoring Programs (PDMPs) in reducing prescription drug-related death and injury[1], PDMPs remain underutilized, leaving states unable to reap the full benefits of this system. A national survey conducted in 2014 found that while 72% of primary care physicians were aware of their state's PDMP system, only 53% of those surveyed reported using it, with the two main barriers to use being that it was too time consuming, and lacked ease of access[2].

Electronic Health Records:
While several states have enacted legislation requiring the use of the state PDMP system by prescribers, the integration of PDMPs with Electronic Health Records (EHR) and Health Information Exchange (HIE) systems has been identified as a best practice for increasing PDMP utilization by minimizing technical challenges and making access to prescribing information more readily available to healthcare professionals.

Currently, about 1,500 prescribers have linkages with the CSPMP. Input from the medical community indicates that health care providers are experiencing barriers to making the linkage a reality, but further exploration of the issues is required to understand potential resolutions.

Utility
Arizona arguably has one of the best PDMPs in the country, and report cards issued to prescribers have been recognized nationally as a best practice. Continued refinements and enhancements will improve the user experience and provide better aggregate data from which targeted interventions could be identified. Several ideas for improvements have been identified by partners, but Arizona lacks a systematic plan for prioritizing and operationalizing the ideas for improvement.

[1] Patrick SW, Fry CE, Jones TF, Buntin MB. Implementation of Prescription Drug Monitoring Programs Associated with Reductions in Opioid-Related Death Rates. Health Affairs. 2016;35(7): 1324-1332.
[2] Rutkow L, Turner L, Lucas E, Hwang C, Alexander GC. Most Primary Care Physicians Are Aware of Prescription Drug Monitoring Programs, But Many Find the Data Difficult to Access. Health Affairs. 2015;34(3): 484-492.

Exemptions:
While Arizona's mandate to check the CSPMP goes into effect October 16, 2017, several exemptions exist in current statute. Some of these include situations in which:

- A medical practitioner will administer the controlled substance.
- The patient is receiving the controlled substance during the course of inpatient or residential treatment in a hospital, nursing care facility, assisted living facility, correctional facility or mental health facility.
- The medical practitioner is prescribing the controlled substance to the patient for no more than a ten-day period for an invasive medical or dental procedure or a medical or dental procedure that results in acute pain to the patient.
- The medical practitioner is prescribing the controlled substance to the patient for no more than a ten-day period for a patient who has suffered an acute injury or a medical or dental disease process that is diagnosed in an emergency department setting and that results in acute pain to the patient. An acute injury or medical disease process does not include back pain.
- The medical practitioner is prescribing no more than a five-day prescription and has reviewed the program's central database tracking system for that patient within the last thirty days, and the system shows that no other prescriber has prescribed a controlled substance in the preceding thirty-day period.

In addition, the statute provides little enforcement authority. A medical practitioner acting in good faith, or the medical practitioner's employer, is not subject to liability or disciplinary action arising solely from either:

- Requesting or receiving, or failing to request or receive, prescription monitoring data from the program's central database tracking system
- Acting or failing to act on the basis of the prescription monitoring data provided by the program's central database tracking system

Trends in Arizona:

- Of the 21,501 prescribers with filled controlled substances prescriptions, less than one-quarter (24.7%) of them checked the CSPMP prior to prescribing in July 2017. This has increased from 17.7% in September 2015.
- On August 17, 2017, the Arizona Board of Pharmacy successfully integrated the CSPMP with Health Current, the state's HIE. At least 1,600 prescribers have electronic health records connecting to the CSPMP, with an additional 935 who have signed up with terms and conditions and will be able to link soon.

Proposal: Issue an executive order to put in place a time-limited task force of healthcare professionals, licensing boards, Board of Pharmacy, Arizona Department of Health Services, Health Current, and law enforcement agencies to identify specific improvements that should be made to enhance the Arizona Controlled Substances Prescription Monitoring Programs. The task force would be directed to develop an implementation plan by November 30, 2017 with actionable items, resources needed, and a responsible agency identified.

Agencies Impacted:

- Arizona State Board of Pharmacy
- Arizona Department of Health Services

Alternative Method: Utilize the existing CSPMP taskforce set forth by Arizona Revised Statute 36-2603 to make specific improvement recommendations by November 30, 2017. This taskforce meets annually.

Agency Responsible:

- Arizona State Board of Pharmacy

CSPMP Improvement Action Plan/Timeline:

- By September 30, 2017: Identify task force members
- By September 30, 2017: Issue Executive Order
- By November 30, 2017: Task force will identify specific improvements to the CSPMP
- By February 28, 2018: Board of Pharmacy begins implementing improvements

Performance Metrics:

1. By March 2018, implement 100% of the action items in the CSPMP Improvement Action Plan
2. Percent of prescribers who prescribe controlled substances and have "Lookups" in the CSPMP

Appendix A
Opioid Action Plan Scorecard

Fiscal Year 2018 Opioid Epidemic Breakthrough Project Performance Bowling Chart - Goal Council 3

Last Updated: September 5, 2017

Performance Metric Title	Custom Field	JOP	YTD		July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June
Breakthrough Metrics																
		6/1/17	Target	708	59	59	59	59	59	59	59	59	59	59	59	59
Number of Opioid Deaths		790	Actual	45	45											
Operational / Sustainment Metrics																
		7/31/17	Target	1572	131	131	131	131	131	131	131	131	131	131	131	131
Number of Suspected Opioid Deaths		989	Actual	131	131											
		7/31/17	Target	11868	989	989	989	989	989	989	989	989	989	989	989	989
Number of Opioid Overdoses		989	Actual	989	989											
		7/31/17	Target	756	63	63	63	63	63	63	63	63	63	63	63	63
Number of Neonatal Abstinence Syndrome Cases		63	Actual	63	63											
		7/31/17	Target	7872	656	656	656	656	656	656	656	656	656	656	656	656
Number of Naloxone Doses Administered		656	Actual	656	656											
		7/31/17	Target	10620	885	885	885	885	885	885	885	885	885	885	885	885
Number of Naloxone Doses Dispensed		885	Actual	885	885											
		7/31/17	Target	7889	2258	1671	429	425	425	425	425	425	425	425	278	278
Number of Naloxone Kits Ordered		2258	Actual	2258	2258											
		8/10/17	Target	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%
Percent of Opioid Overdoses by 10 or More Prescribers		50%	Actual	41%	41%											
		7/31/17	Target	4,200,000	350,000	350,000	350,000	350,000	350,000	350,000	350,000	350,000	350,000	350,000	350,000	350,000
Number of Opioid Prescriptions		349,546	Actual	349,546	349,546											
		8/13/17	Target	62	62	62	62	62	62	62	62	62	62	62	62	62
Average Morphine Milligram Equivalents (MME) Prescribed		62	Actual	62	62											
Number of Opioid Legislative Action Plan Action Items Implemented		9/15/17	Target	5	0	0	1	1	1	1	0	0	0	0	0	1
On Time		0	Actual	0	0											
		9/15/17	Target	100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	100%
Percent of High Impact Priorities that are Passed Legislatively		0	Actual	0%	0%											
Number of Federal Barrier Action Plan Action Items Implemented		9/15/17	Target	4	0	0	1	3	0	0	0	0	0	0	0	0
On Time		0	Actual	0	0											
Number of Youth Prevention Action Plan Action Items Implemented		9/15/17	Target	4	0	0	0	1	1	1	0	0	0	0	0	1
On Time		0	Actual	0	0											
Number of Schools Implementing Substance Abuse Intervention		3/14/17	Target	70	60	60	60	60	60	60	60	70	70	70	70	70
Programs		60	Actual	60	60											
Number of Law Enforcement Action Plan Action Items Implemented		9/15/17	Target	2	0	0	1	0	1	0	0	0	0	0	0	0
On Time		0	Actual	0	0											
Number of Local Law Enforcement Agencies Participating in the		3/14/17	Target	5	1	1	2	2	2	3	3	3	4	4	4	5
Angel Program		1	Actual	1	1											
		3/14/17	Target	100	75	75	80	80	85	85	90	90	95	95	100	100
Number of Individuals Enrolled in the Angel Initiative		75	Actual	75	75											
		9/15/17	Target	50%	0%	0%	0%	0%	0%	0%	0%	25%	25%	25%	25%	50%
Percent of Local DEA Tactical Diversion Squad Vacancies Filled		0	Actual	0%	0%											
Number of Medical School Curriculum Action Plan Action Items		9/15/17	Target	4	0	0	0	1	1	0	1	0	1	0	0	0
Implemented On Time		0	Actual	0	0											
		9/15/17	Target	75%	0%	0%	0%	75%	75%	75%	75%	75%	75%	75%	75%	75%
Percent of Medical Education Programs Approached		0%	Actual	0%	0%											
Number of Insurance Parity Action Plan Action Items Implemented		9/15/17	Target	5	0	0	1	1	1	0	0	0	0	0	1	1
On Time		0	Actual	0	0											
Number of Regulatory Board Action Plan Action Items Implemented		9/15/17	Target	4	0	0	0	1	1	1	0	0	1	0	0	0
On Time		0	Actual	0	0											
		9/15/17	Target	100%	0%	0%	0%	0%	0%	33%	33%	33%	66%	66%	66%	100%
Percent of Regulatory Board Work Group Meetings Held		0	Actual	0%	0%											
Number of Call Service Action Plan Action Items Implemented On		9/15/17	Target	7	0	0	0	1	0	1	2	1	2	0	0	0
Time		0	Actual	0	0											
		9/15/17	Target	150	0	0	0	0	0	0	0	0	0	25	25	25
Number of Calls Triaged Through Call Service		0	Actual	0	0											
Number of Correctional Facilities Action Plan Action Items		9/15/17	Target	4	0	0	0	1	1	1	0	1	0	0	0	0

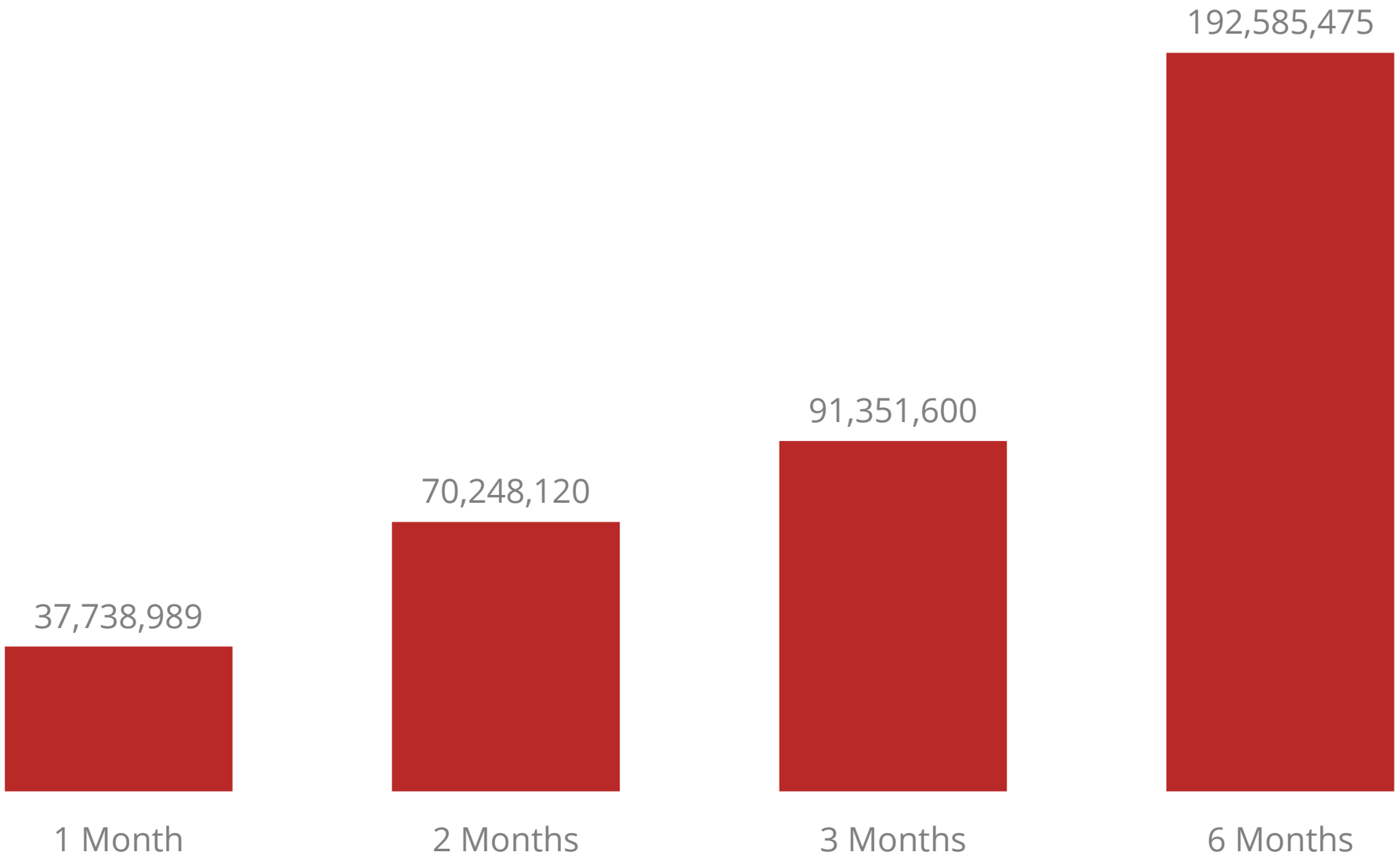
Implemented On Time		0	Actual	0	0											
Number of Peer Support Action Plan Action Items Implemented On		9/15/17	Target	6	0	0	1	1	0	1	0	0	1	1	0	1
Time		0	Actual	0	0											
Number of Public Service Announcement Action Plan Action Items		9/15/17	Target	4	0	0	0	2	1	0	0	0	0	0	0	1
Implemented On Time		0	Actual	0	0											
		9/15/17	Target	4	0	0	2	0	1	0	0	1	0	0	0	0
Number of CSPMP Action Plan Action Items Implemented On Time		0	Actual	0	0											
Percent of Prescribers who Prescribe Controlled Substances and		7/31/17	Target	60%	24%	27%	30%	34%	37%	40%	44%	47%	50%	54%	57%	60%
Have "Lookups" in the CSPMP		24.7%	Actual	24.7%	24.7%											

Appendix B
Opioid Data Summary

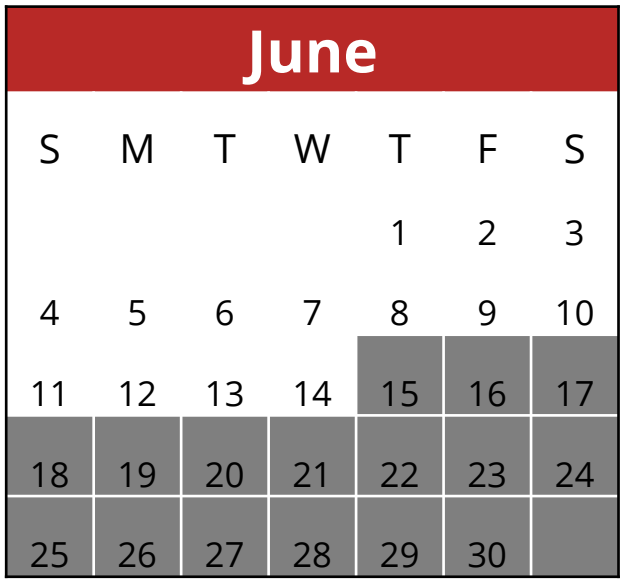
Data Summary

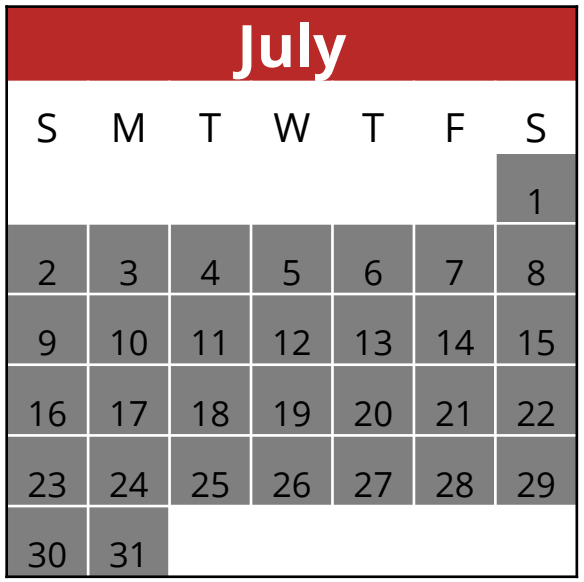
Over the last 6 months, there were a total of 2,850,535 opioid prescriptions written in Arizona which totals to 227,029,510 opioid pills. This is an average of 33 opioid pills per Arizonan.

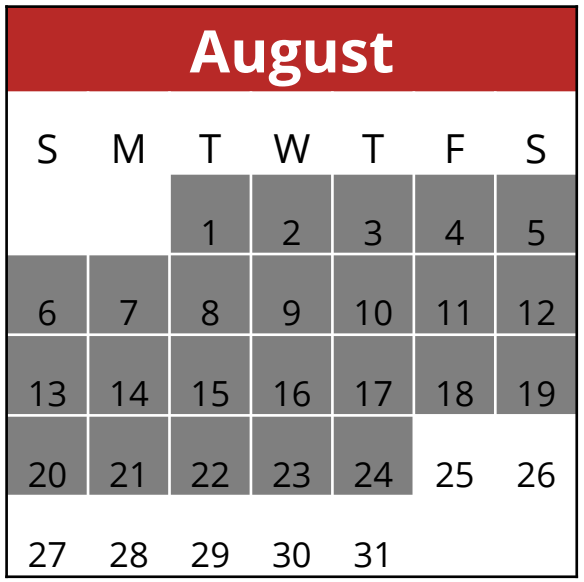
The number of opioid pills that were prescribed in Arizona over the past 1 month, 2 months, 3 months and 6 months.



Enhanced Surveillance Period:

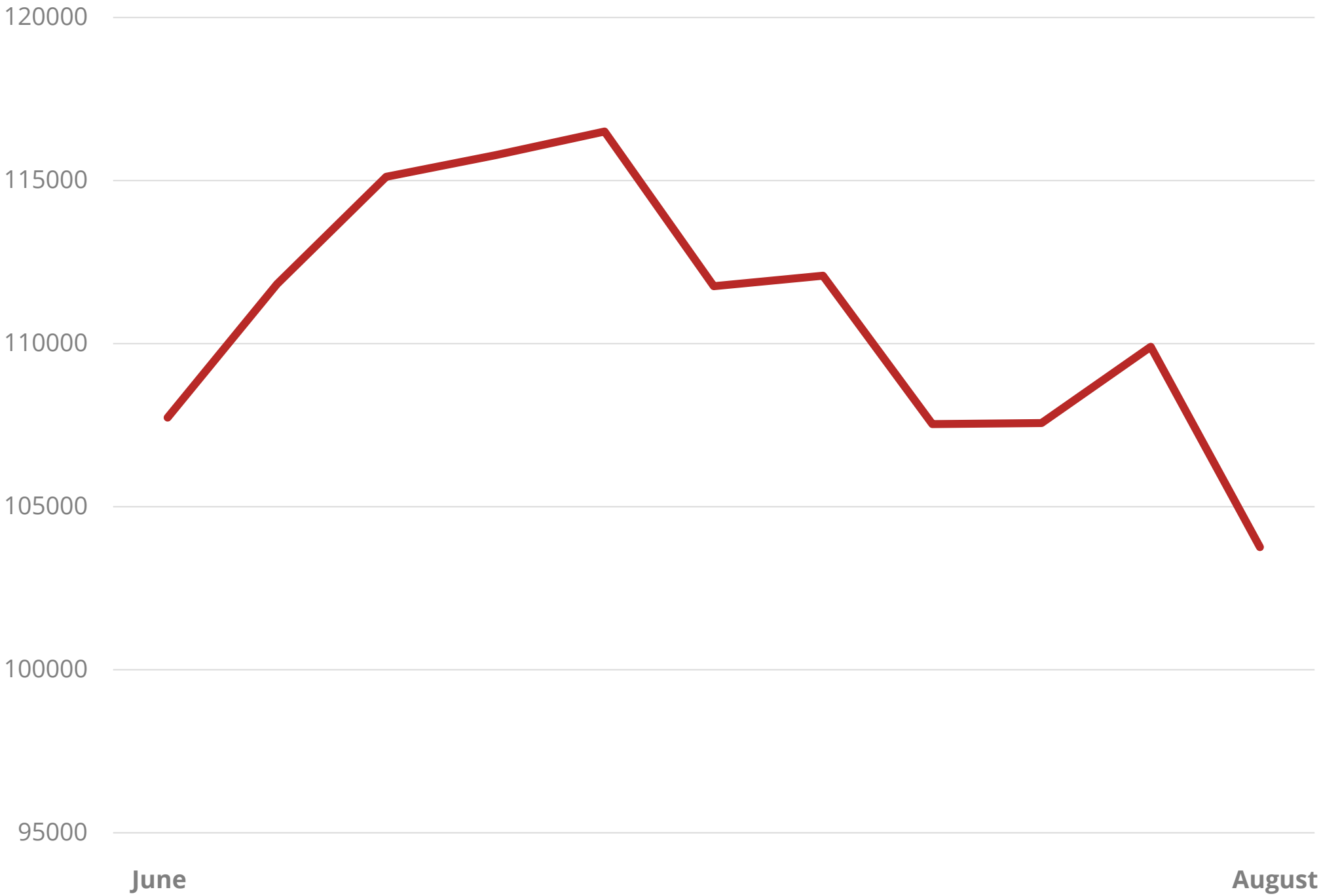






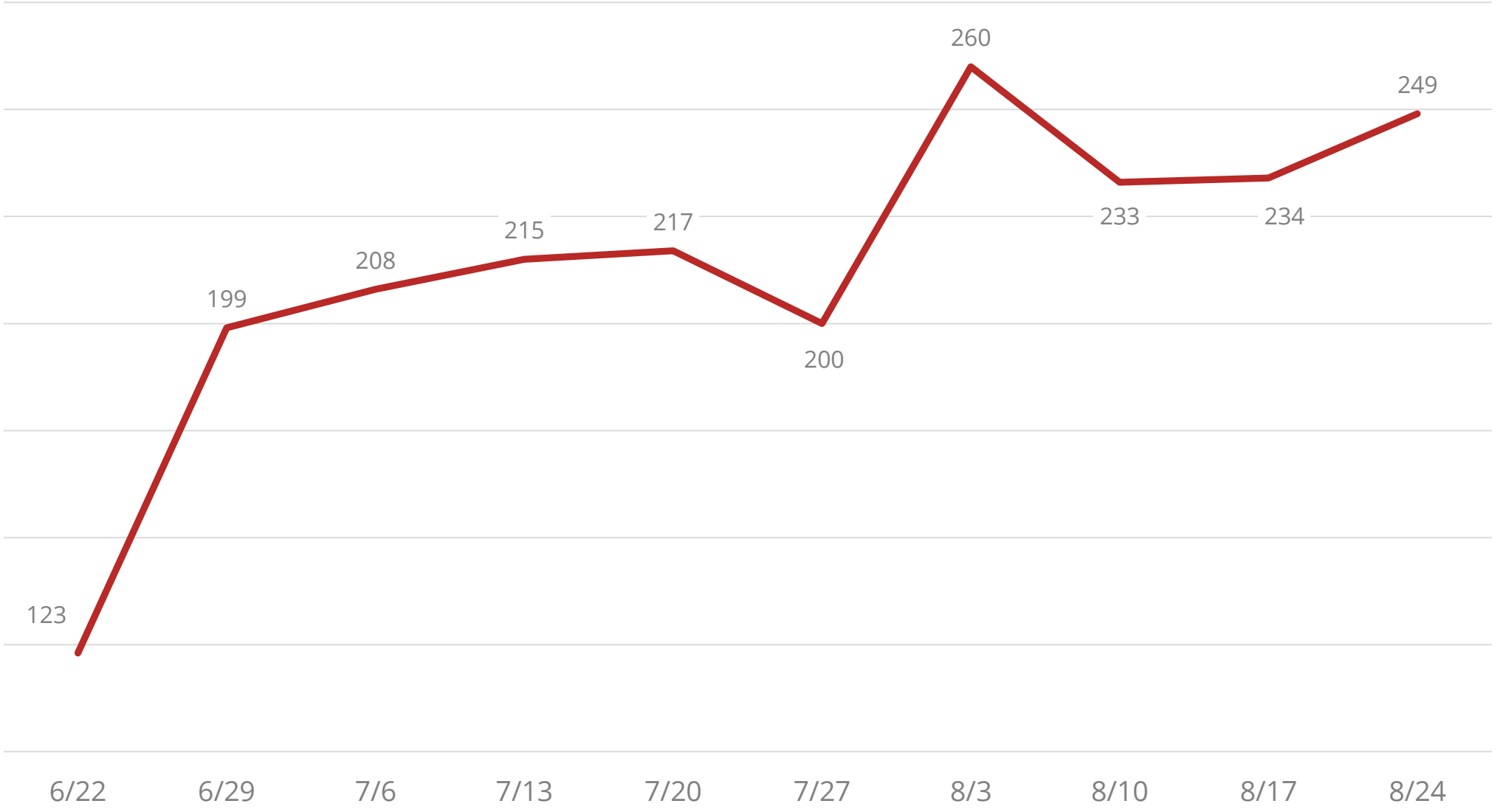
Opioid Overdoses and Deaths

During the enhanced surveillance period, the number of opioid prescriptions written per week has ranged from 103,765 to 116,505.

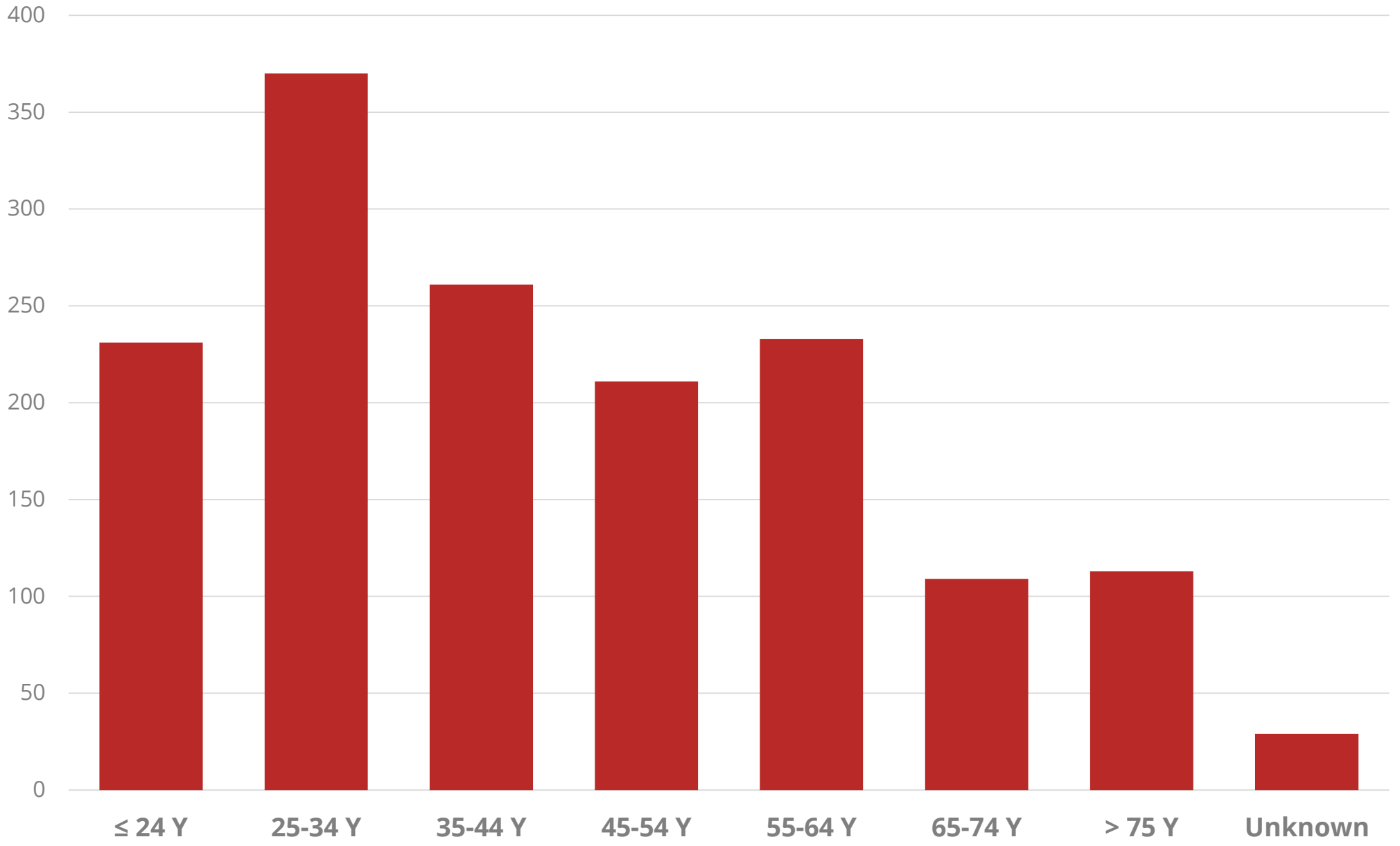


2,138 possible opioid overdoses were reported to public health during the enhanced surveillance period.

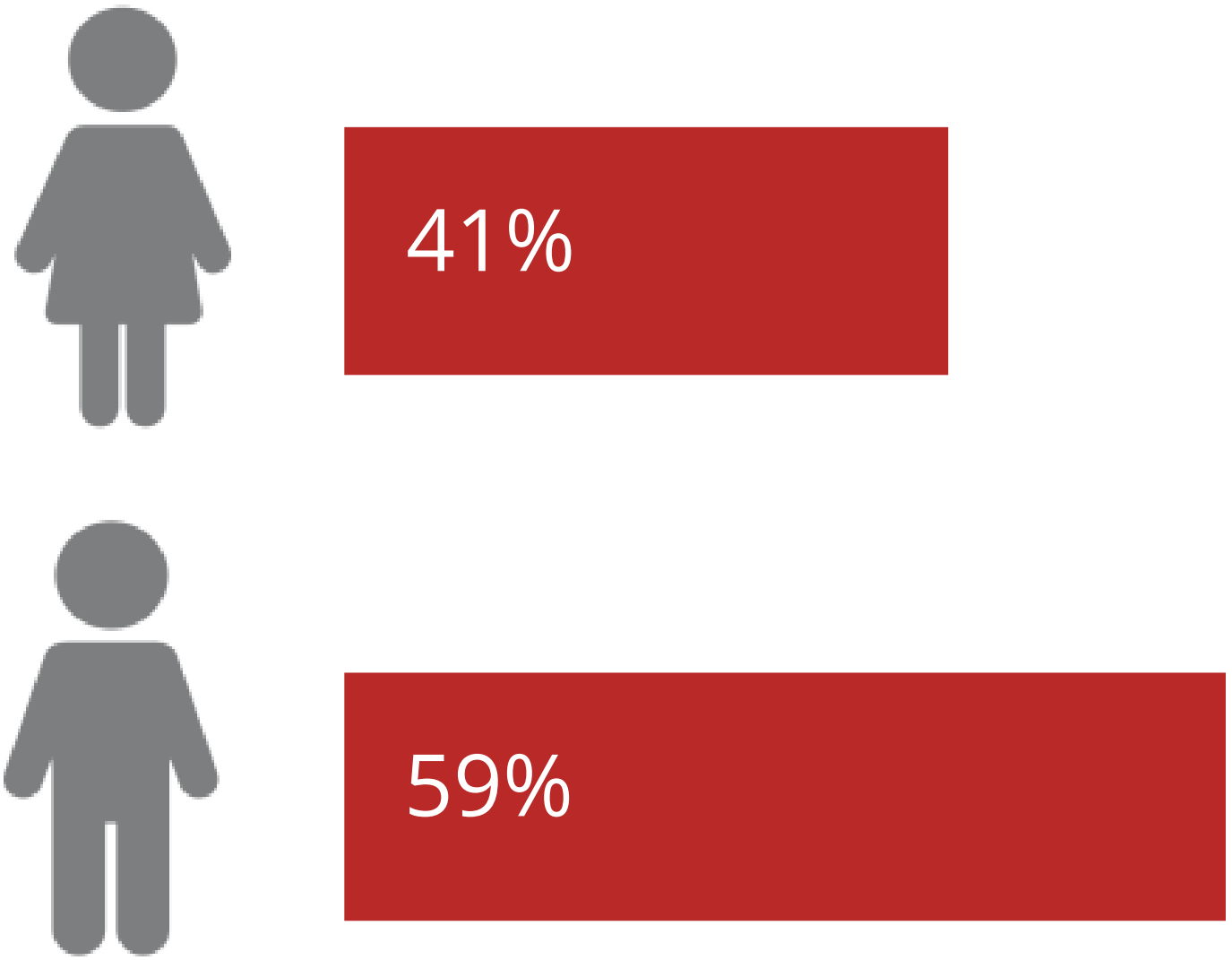
The number of possible opioid overdoses reported weekly has ranged from 123 to 260.



The majority of possible opioid overdoses reported during the enhanced surveillance period were in the 25 – 34 age group.

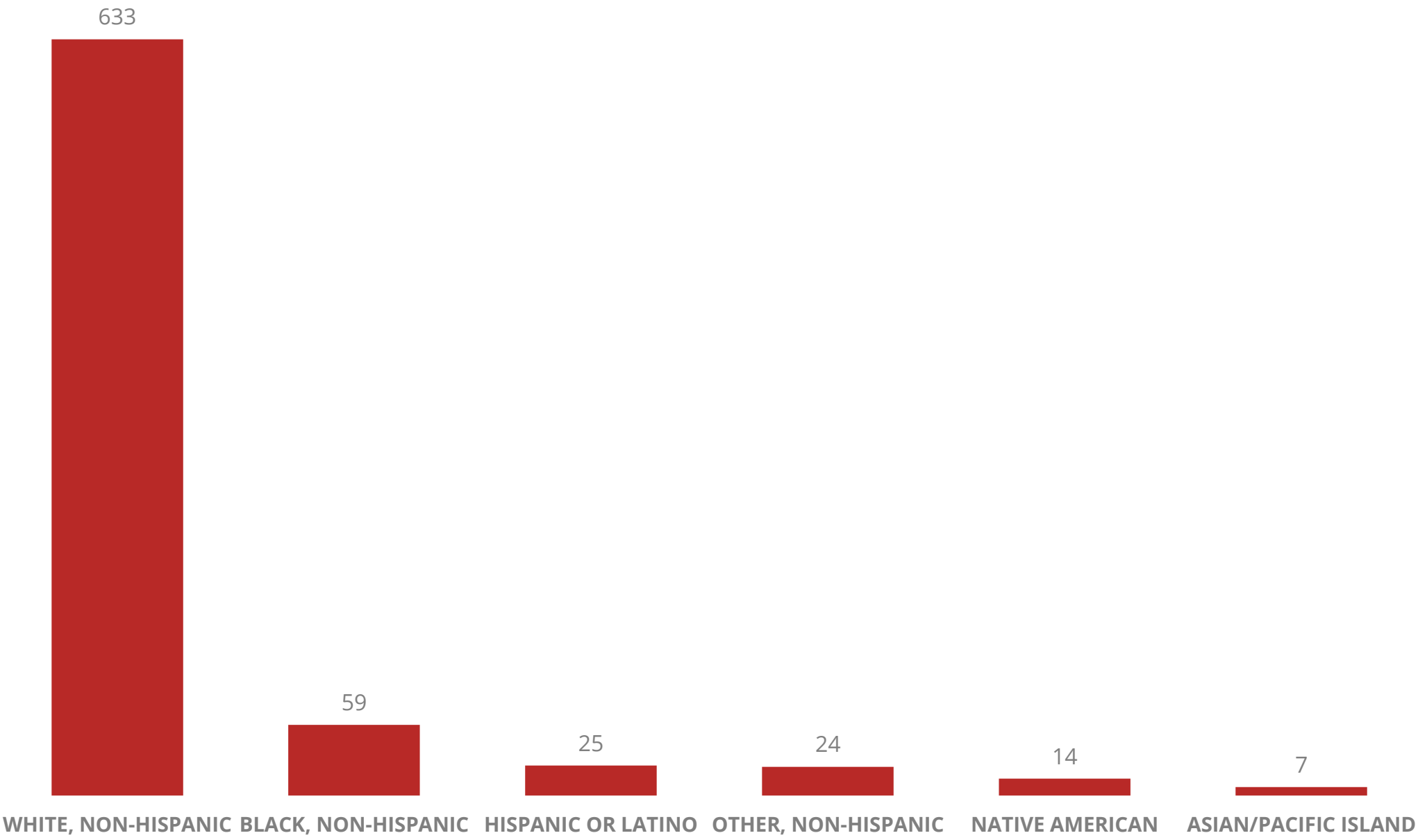


The majority of possible opioid overdoses reported during the enhanced surveillance period were male.

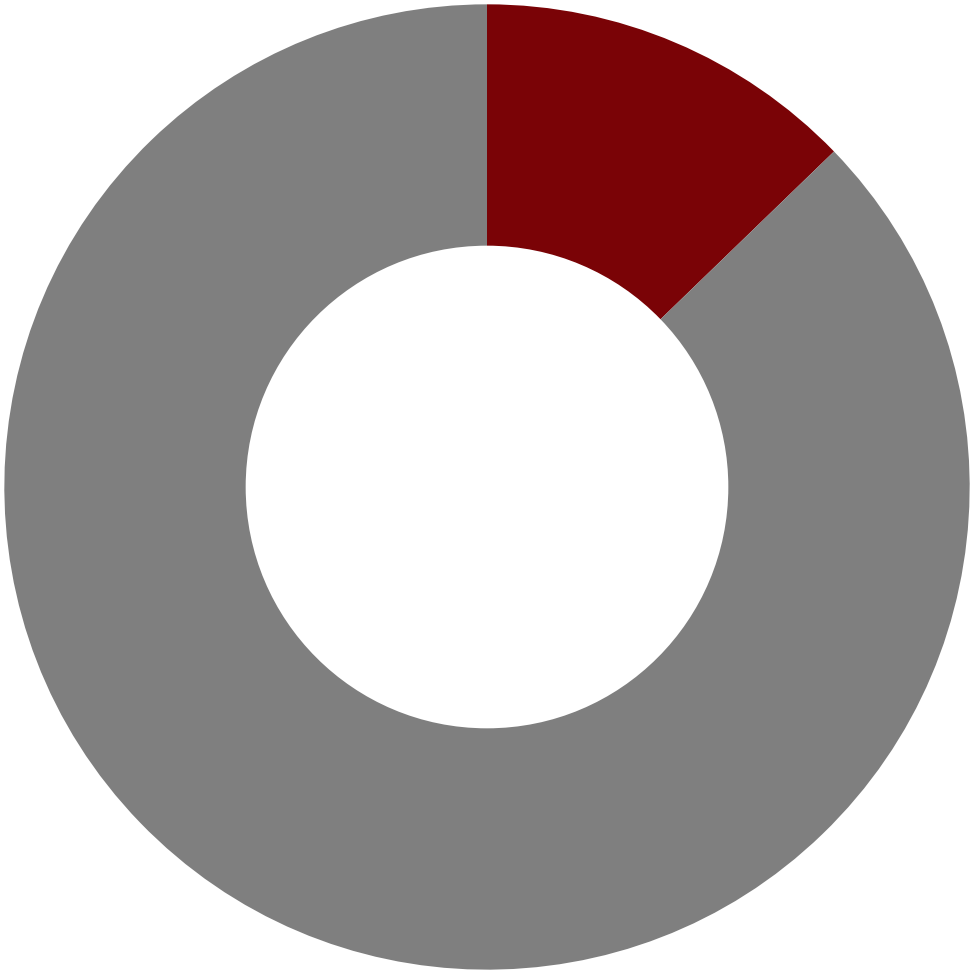


The majority of possible opioid overdoses reported during the enhanced surveillance period were white, non-Hispanic.

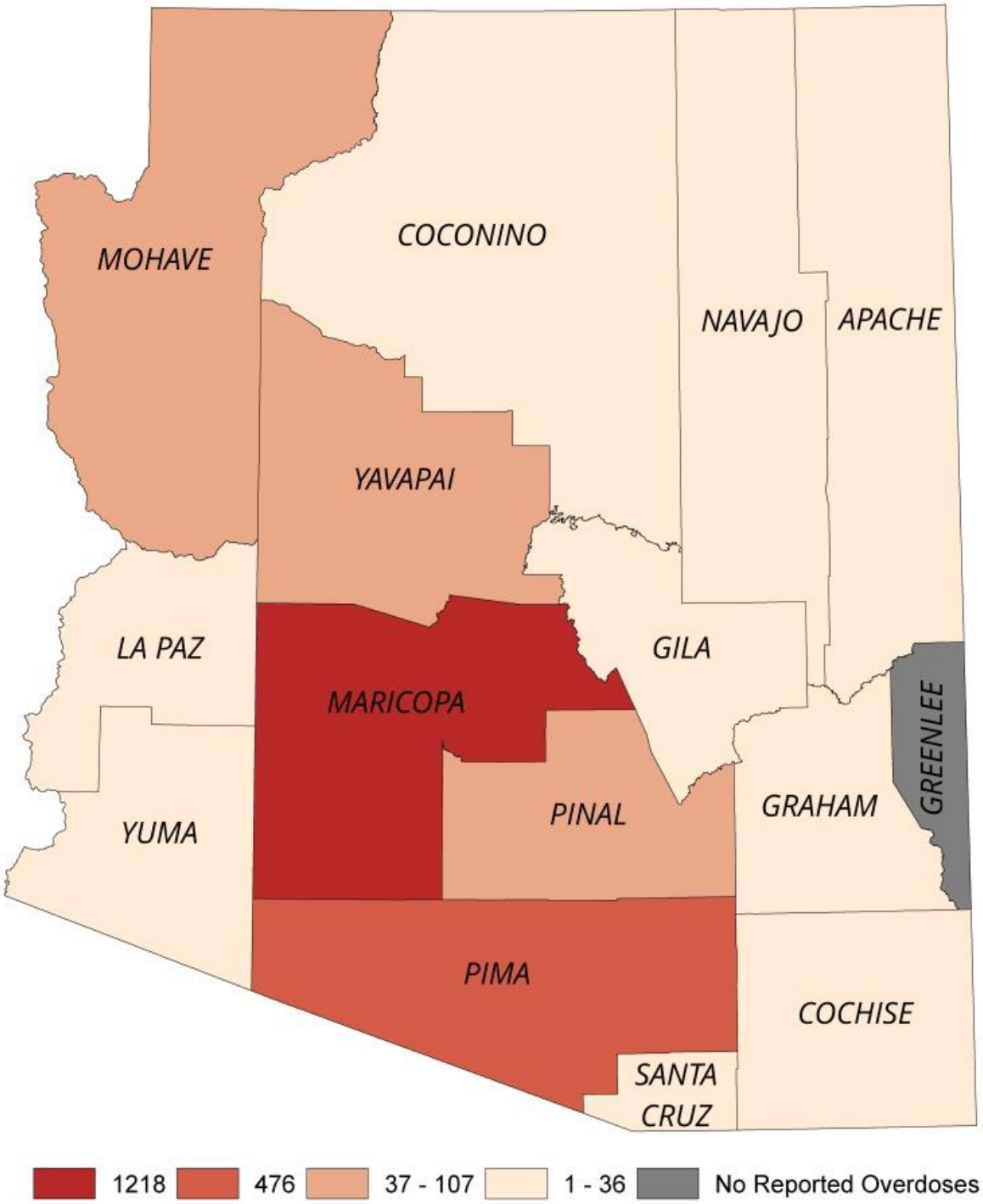
1,189 (61%) of cases did not have information about race/ethnicity available.



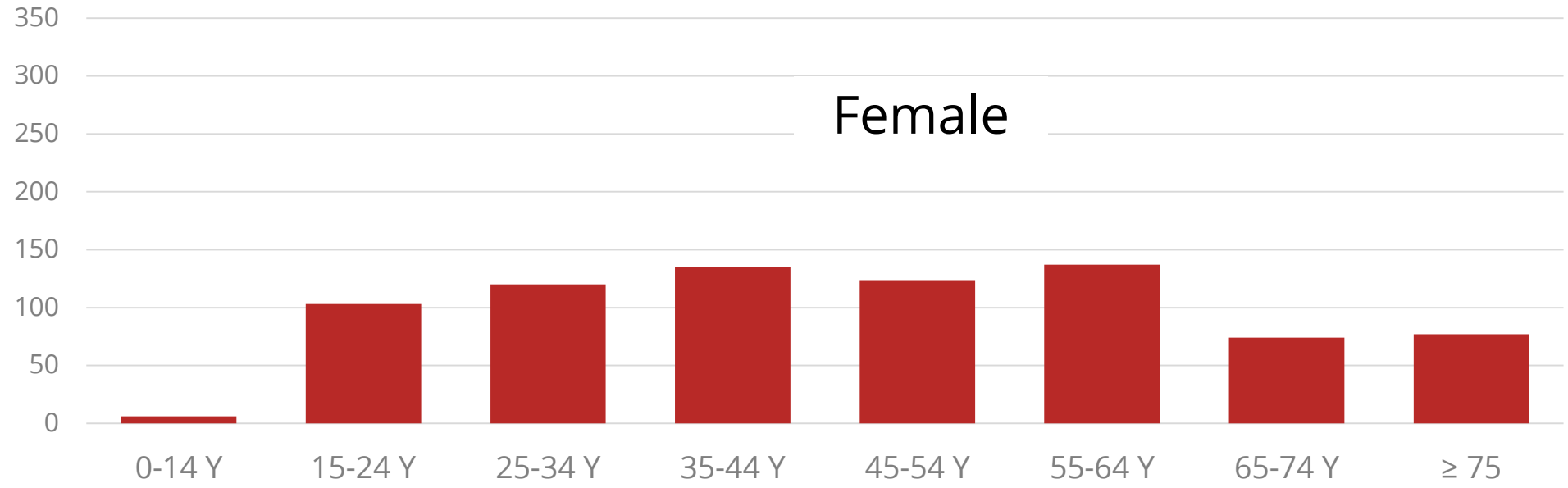
13% of the possible opioid overdoses reported during the enhanced surveillance were fatal.

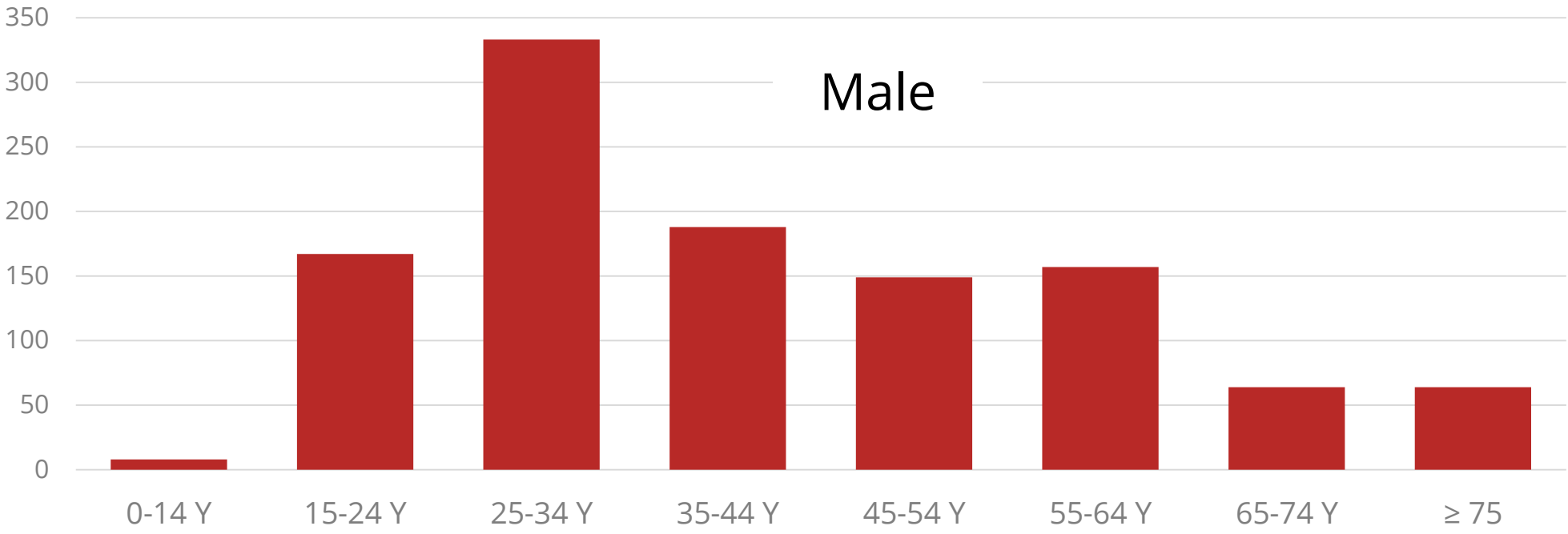


Possible opioid overdoses were reported in 14 out of the 15 counties during the enhanced surveillance period.

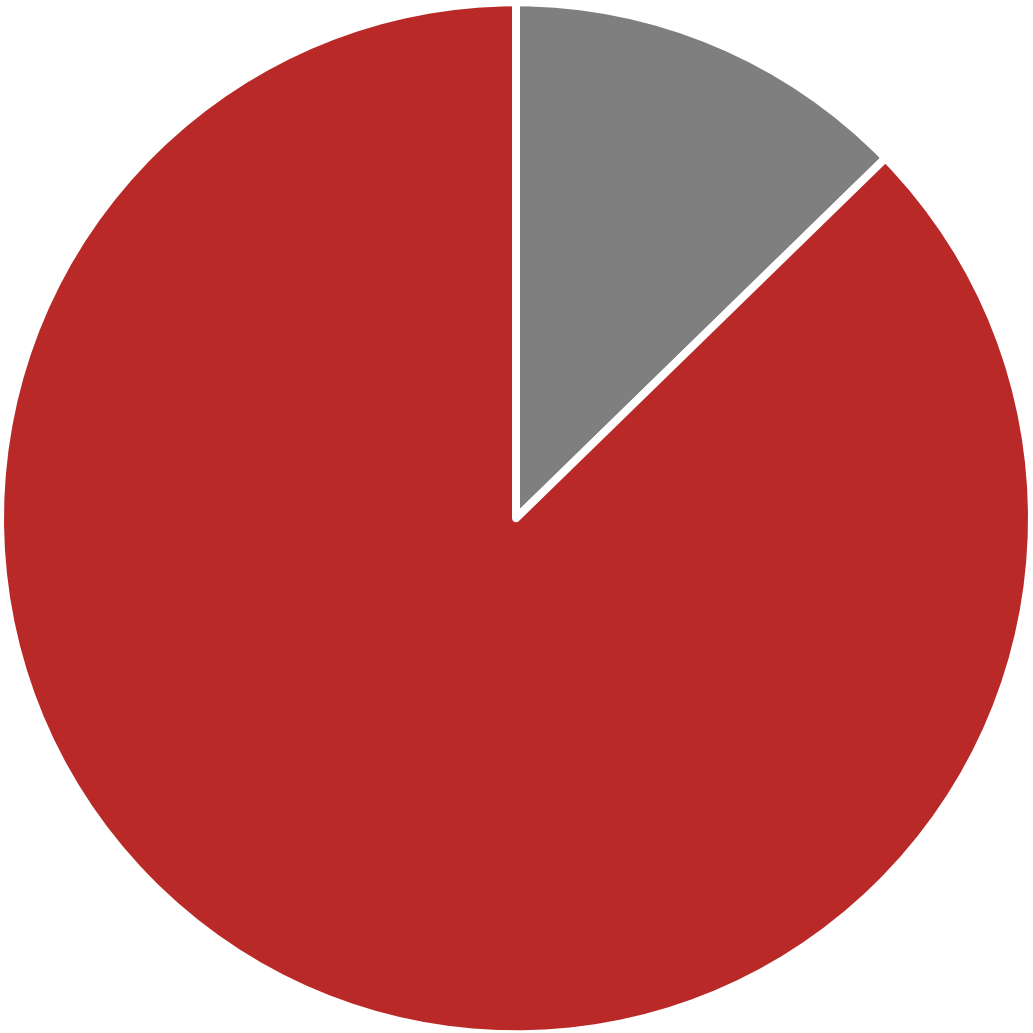


More males than females had a possible opioid overdose. The most overdoses were reported in males in the 25 – 34 year old age group.

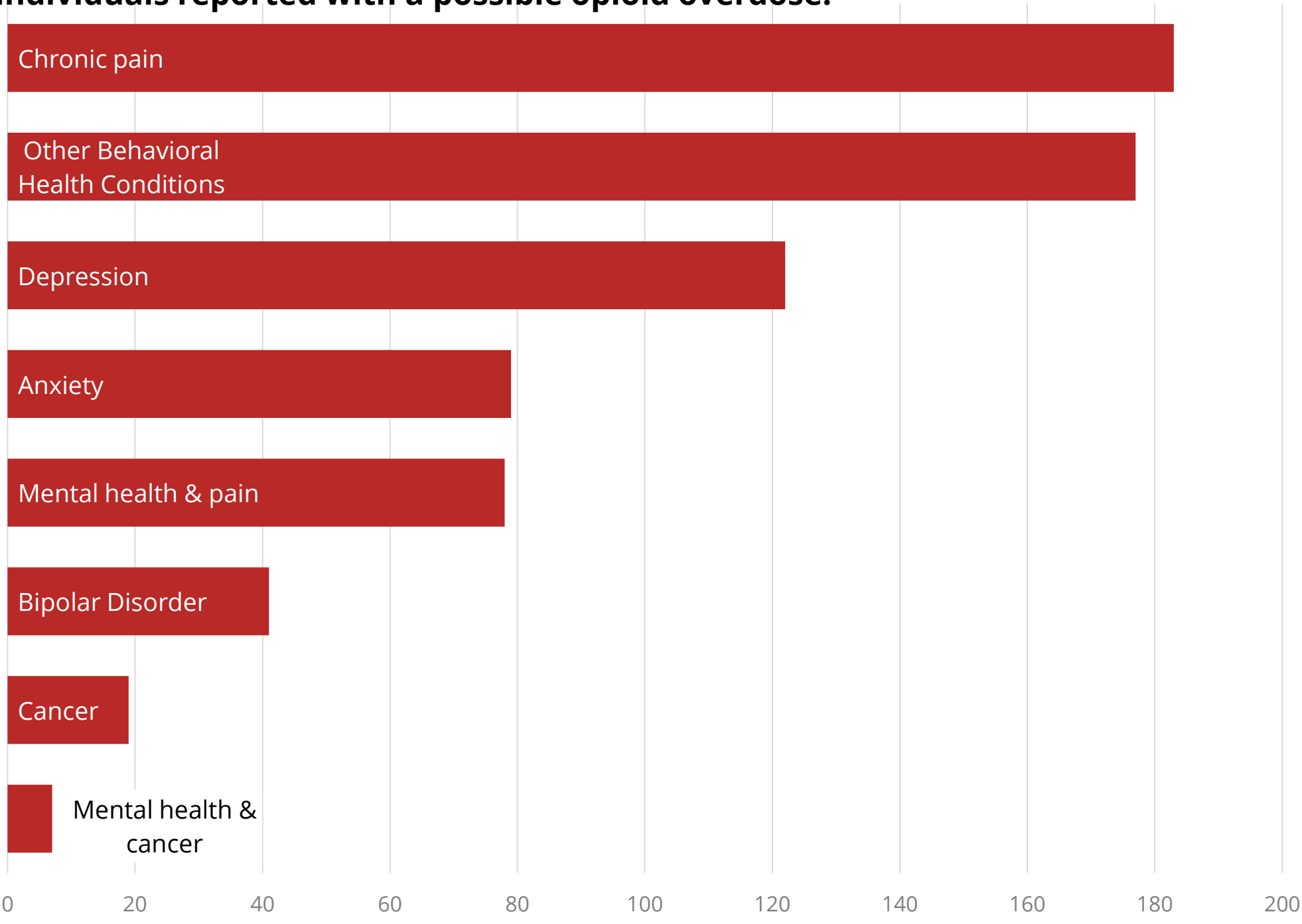




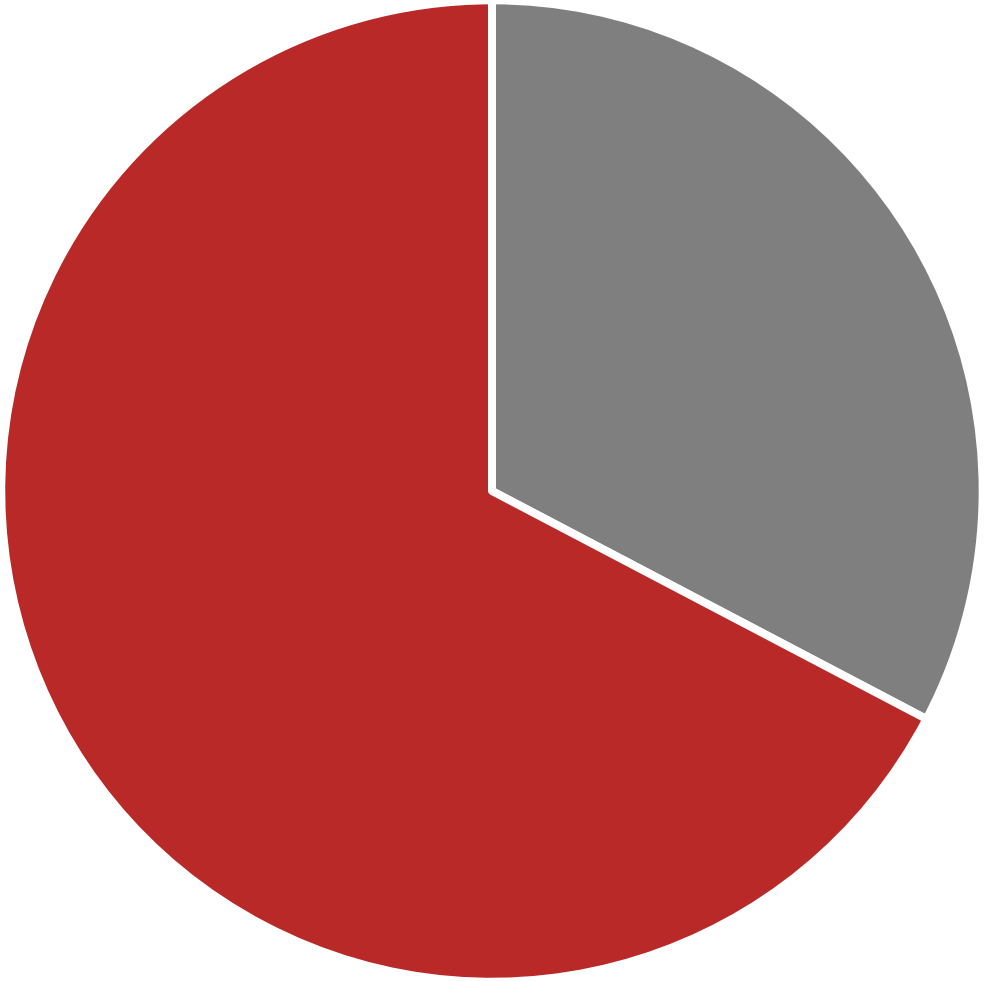
87% of possible opioid overdoses reported during the enhanced surveillance period had at least one pre-existing condition.



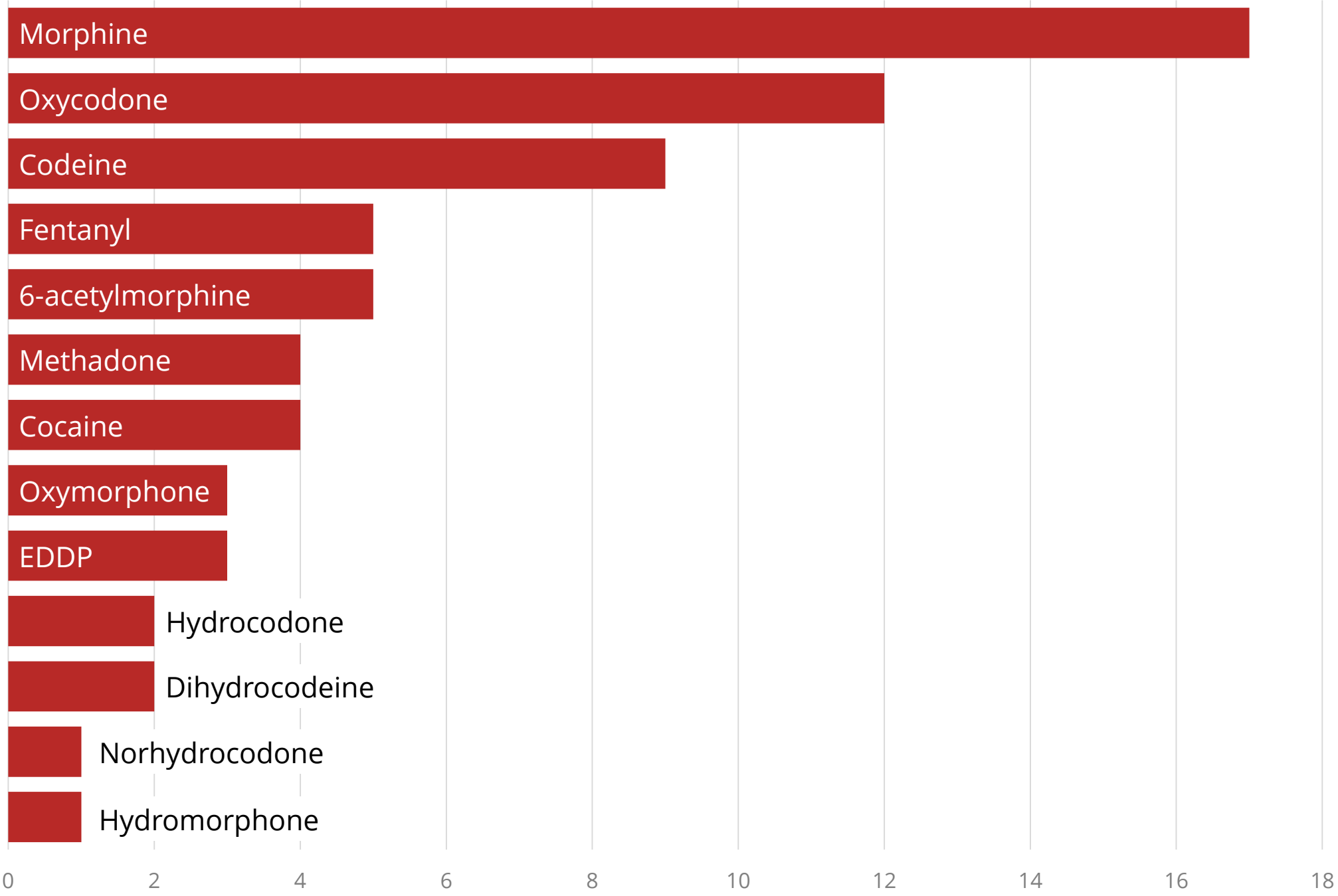
Chronic pain was the most common pre-existing condition that was reported by individuals reported with a possible opioid overdose.



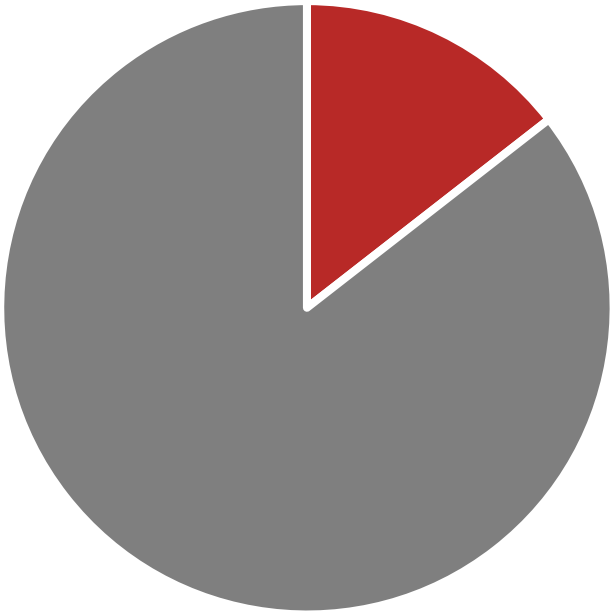
67% of the 52 blood specimens tested at the Arizona State Public Health Laboratory had at least one substance detected.



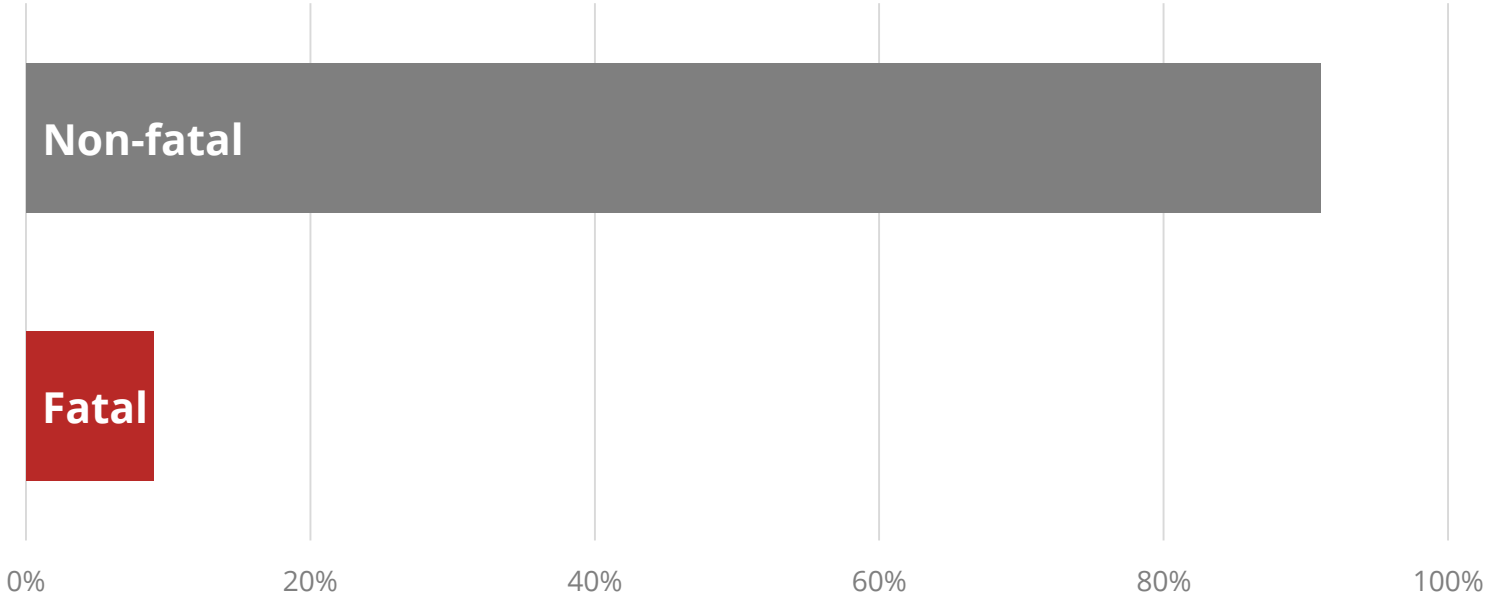
Morphine was the most common substance detected in the blood specimens tested.



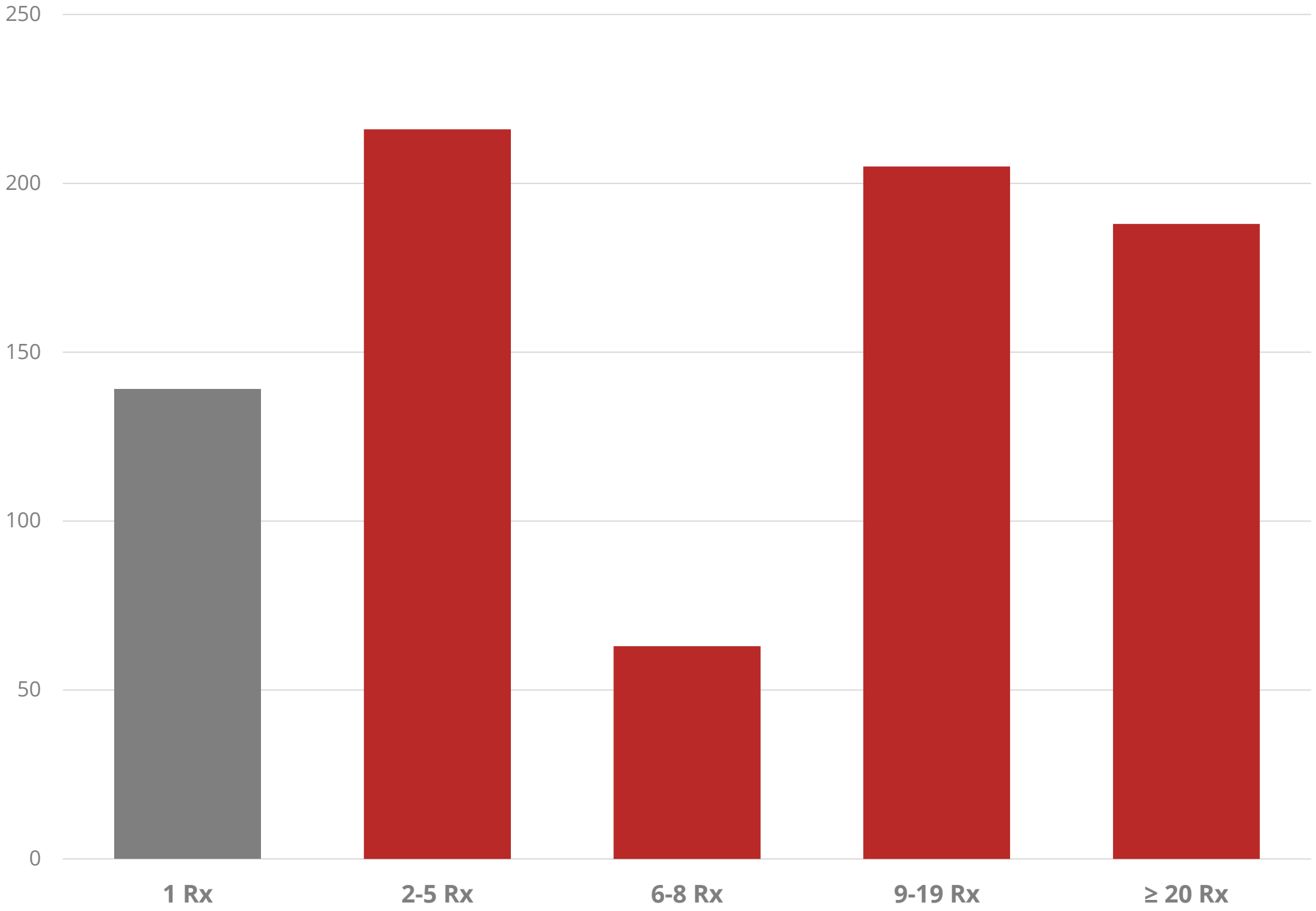
14% of individuals with a possible opioid overdose during the enhanced surveillance period were hospitalized in 2016 with an opioid-related cause.



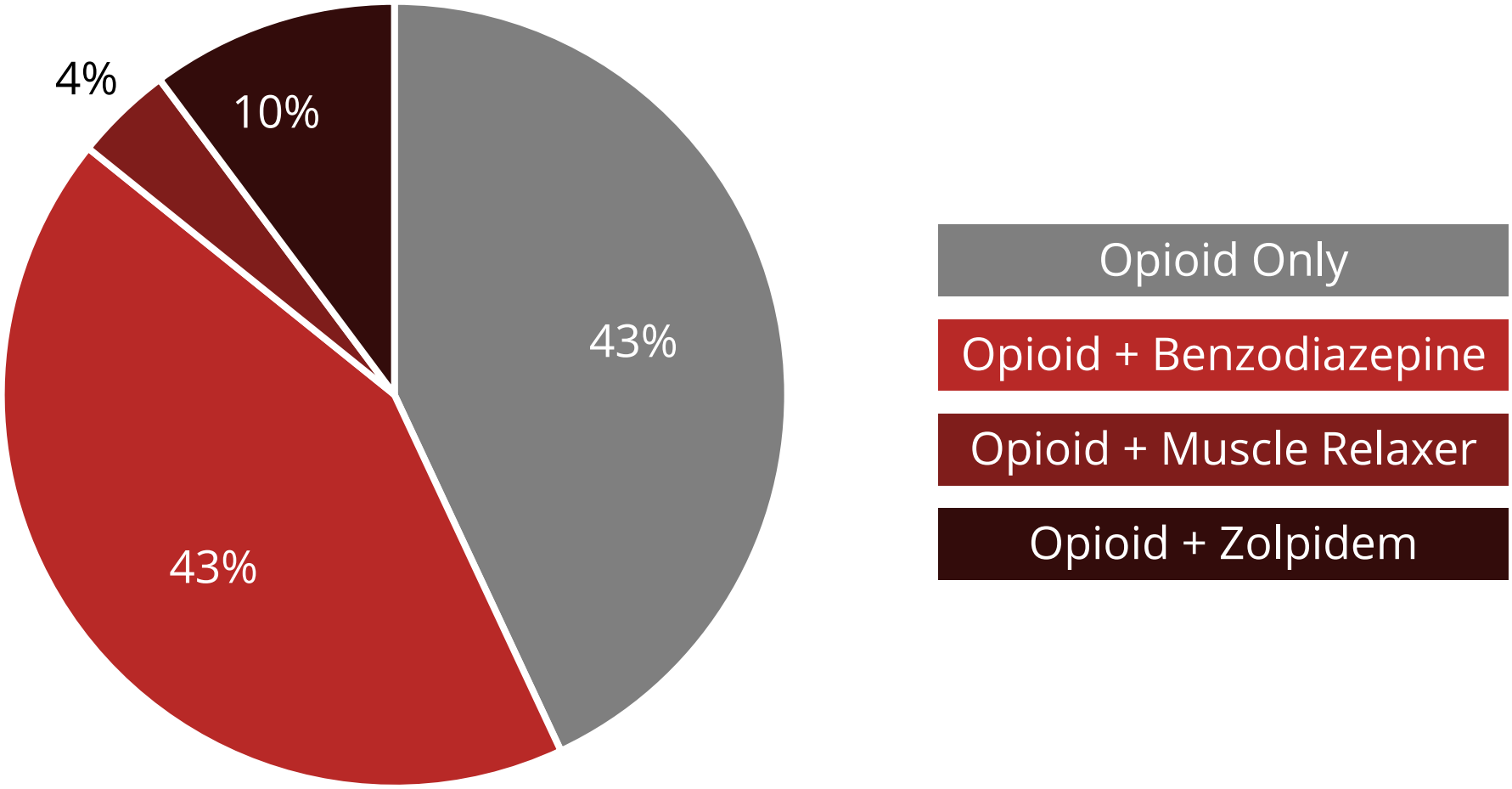
And of those hospitalized with an opioid–related cause in 2016, 9% resulted in a fatal overdose during the enhanced surveillance period.



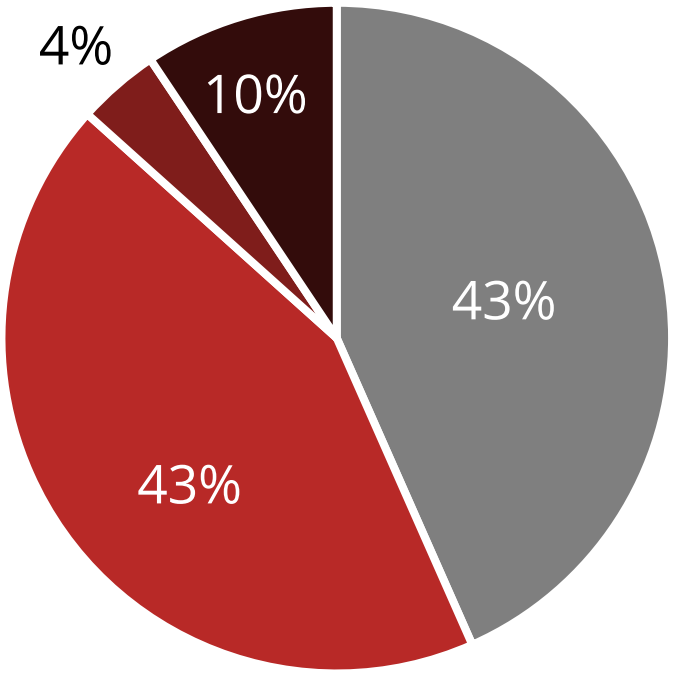
In 2017, 672 (83%) of individuals who had an opioid overdose during the enhanced surveillance period had more than one opioid prescription.



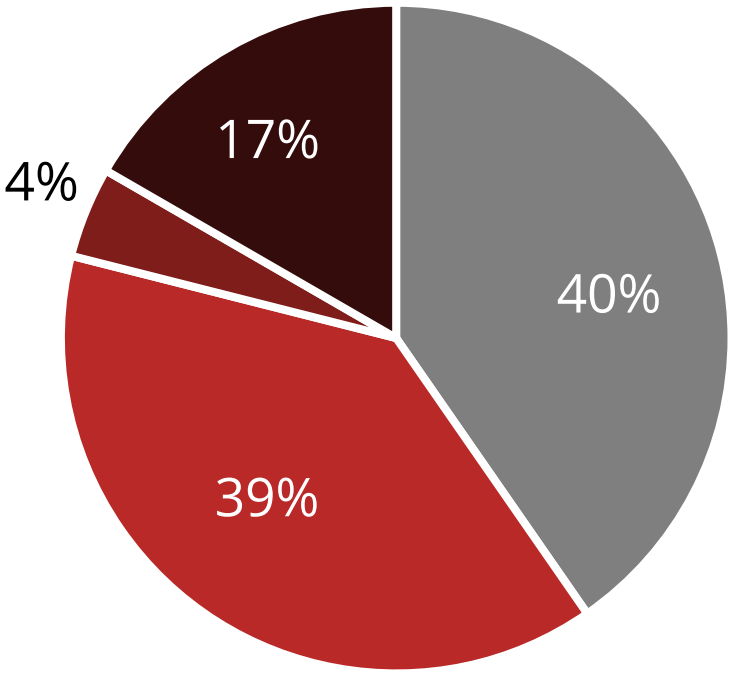
During 2017, the most common drug combination that was prescribed to individuals who had a possible opioid overdose was opioids and benzodiazepines.



For individuals with both fatal and non-fatal possible opioid overdoses reported, the most common drug combination was opioids and benzodiazepines.



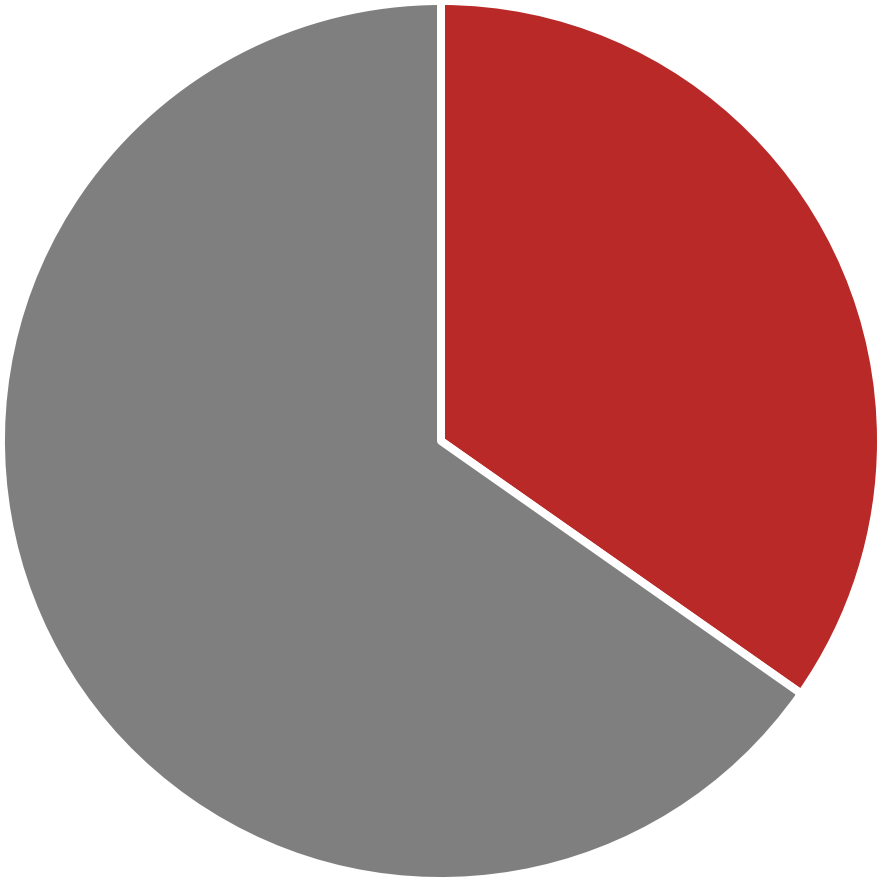
Non-fatal



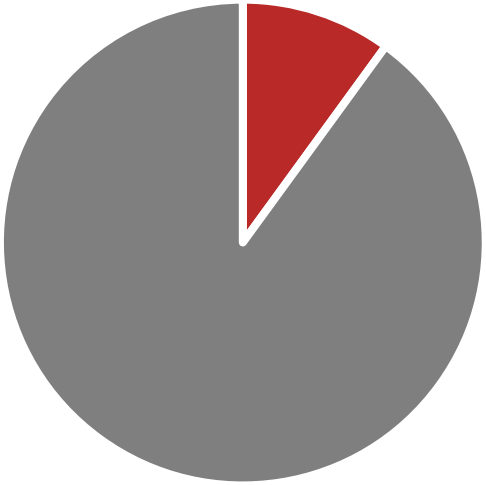
Fatal

Opioid Only | Opioid + Benzodiazepine | Opioid + Muscle Relaxer | Opioid + Zolpidem

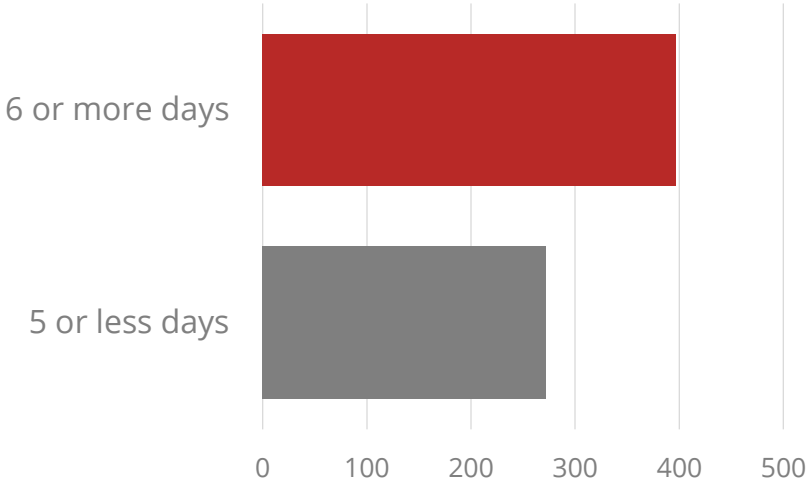
35% of individuals with a possible opioid overdose during the enhanced surveillance period had an opioid prescription two months prior to their overdose.



11% of those individuals with an opioid prescription two months prior had a fatal overdose,

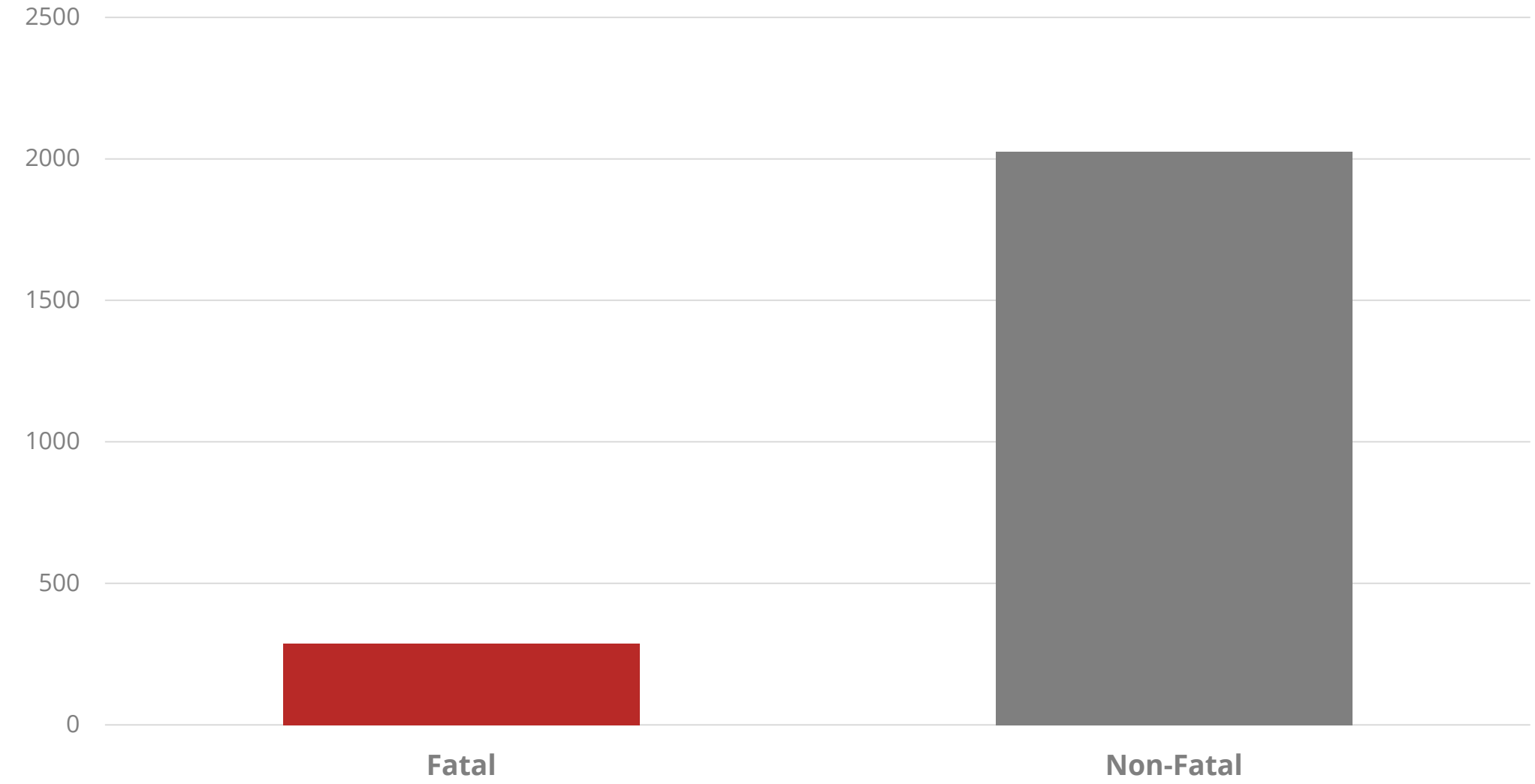


& 59% had an opioid prescription written for 6 or more days.

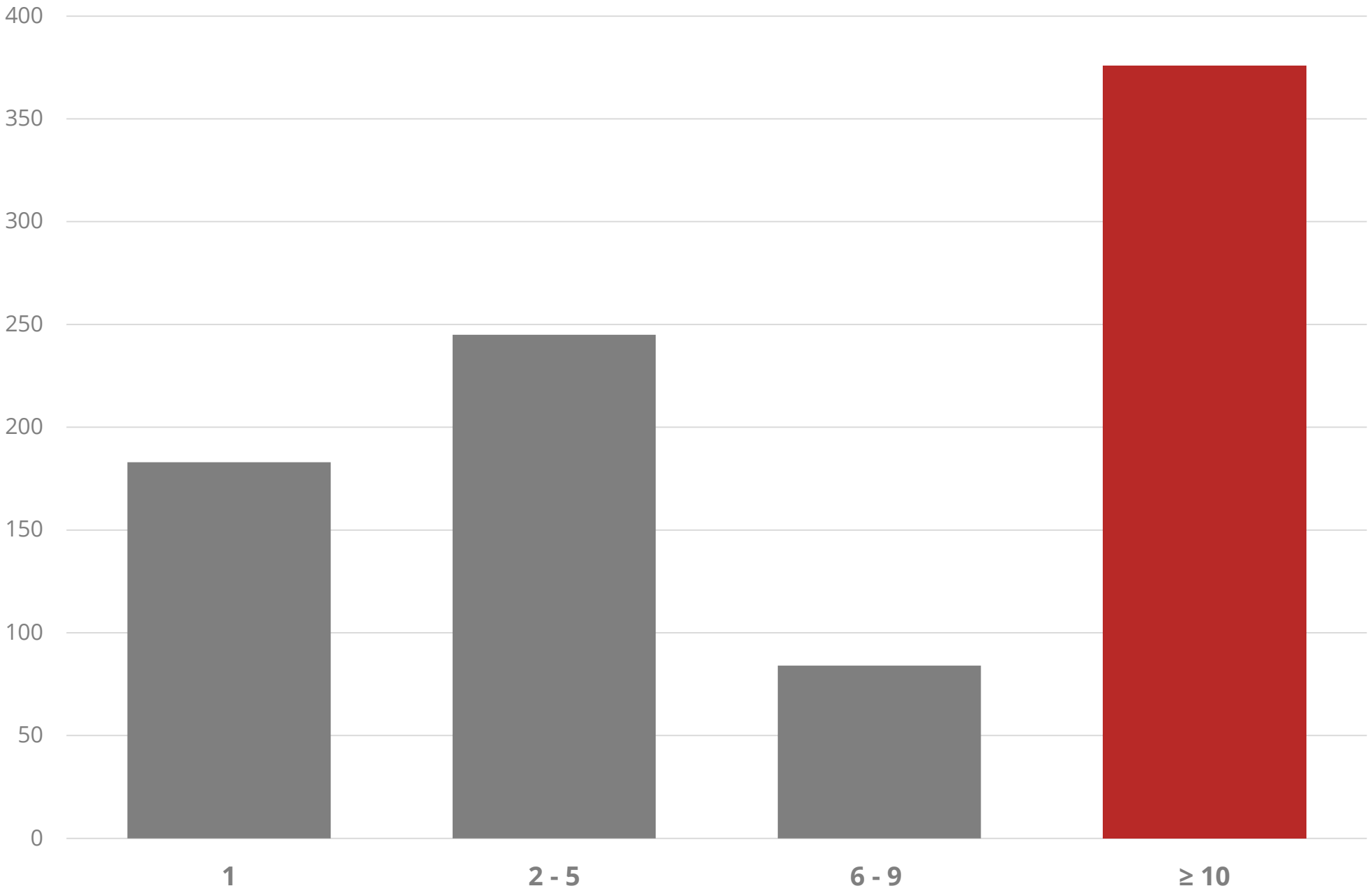


2,312 prescribers wrote an opioid prescription to individuals who had a possible opioid overdose in the year prior to the overdose.

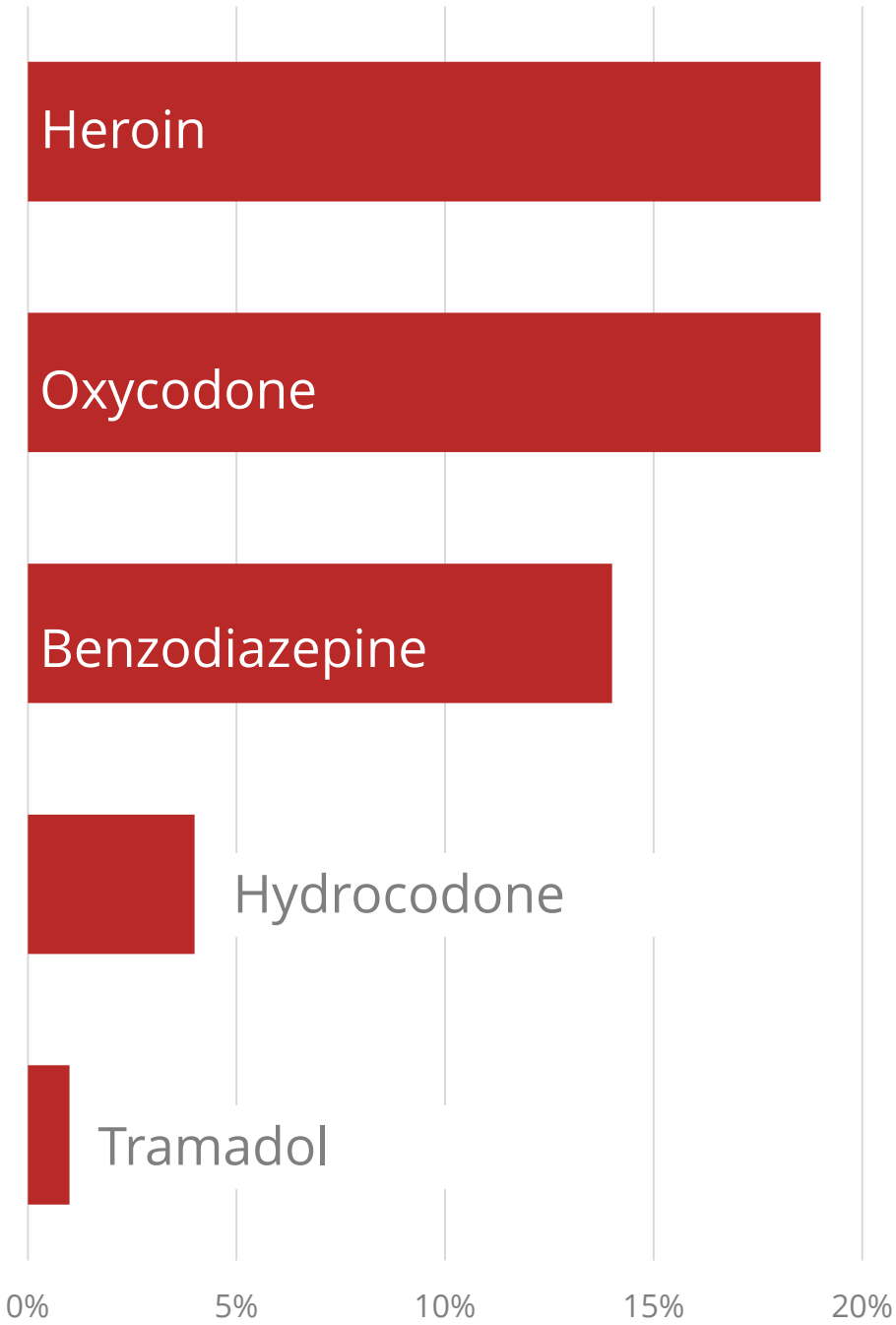
There were 2,025 providers who wrote opioid prescriptions to an individual experiencing a non-fatal possible opioid overdose and 287 providers who wrote opioid prescriptions to an individual suffering from a fatal possible opioid overdose.



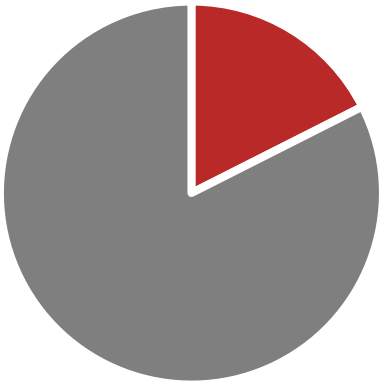
41% of individuals who experienced an overdose during the enhanced surveillance period had 10 or more providers prescribe opioids over the last year.

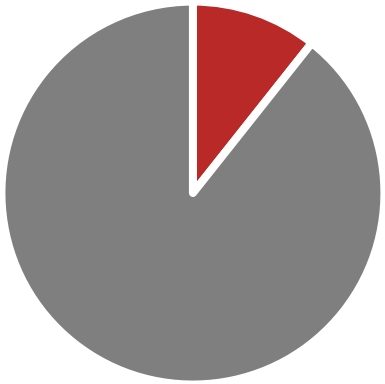


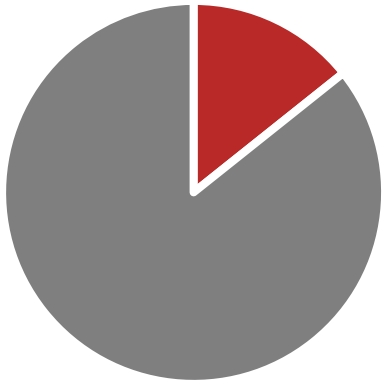
Heroin and oxycodone were the drugs most commonly noted in overdose reports.

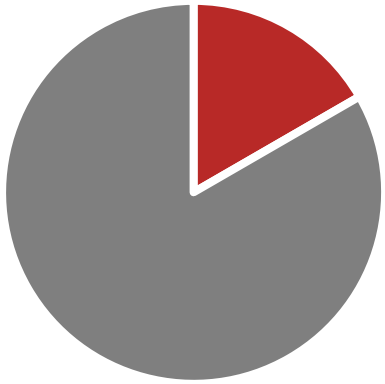


Of those with heroin noted in the overdose report, 17% were fatal.



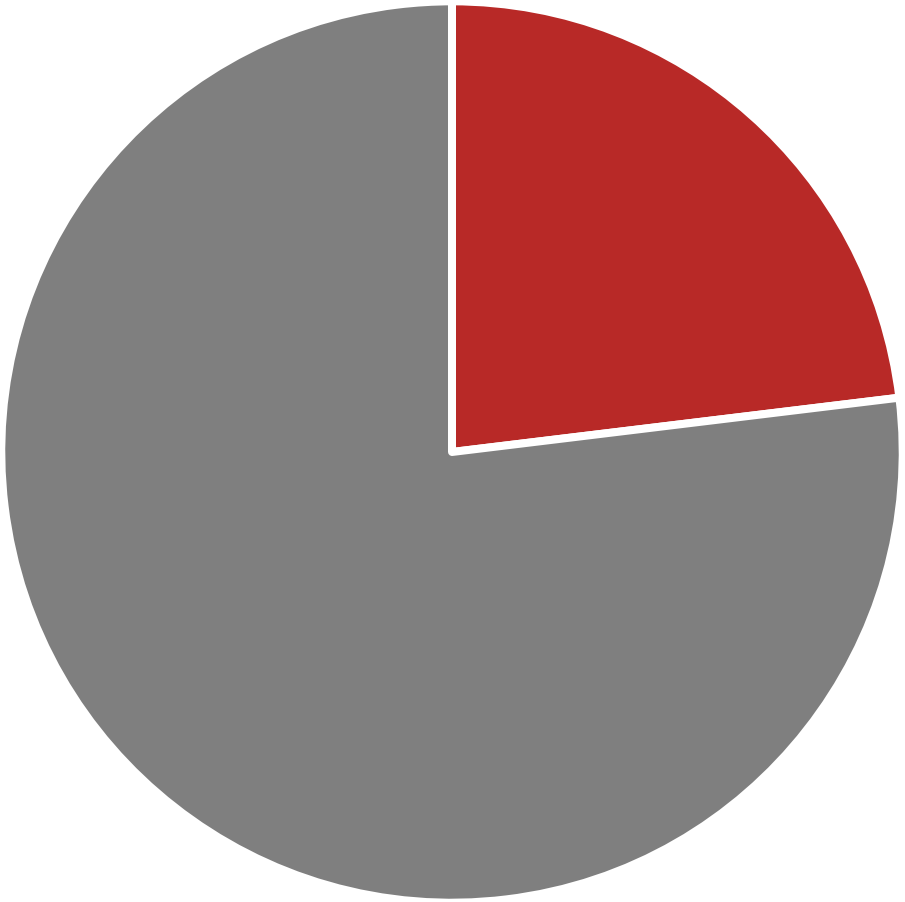






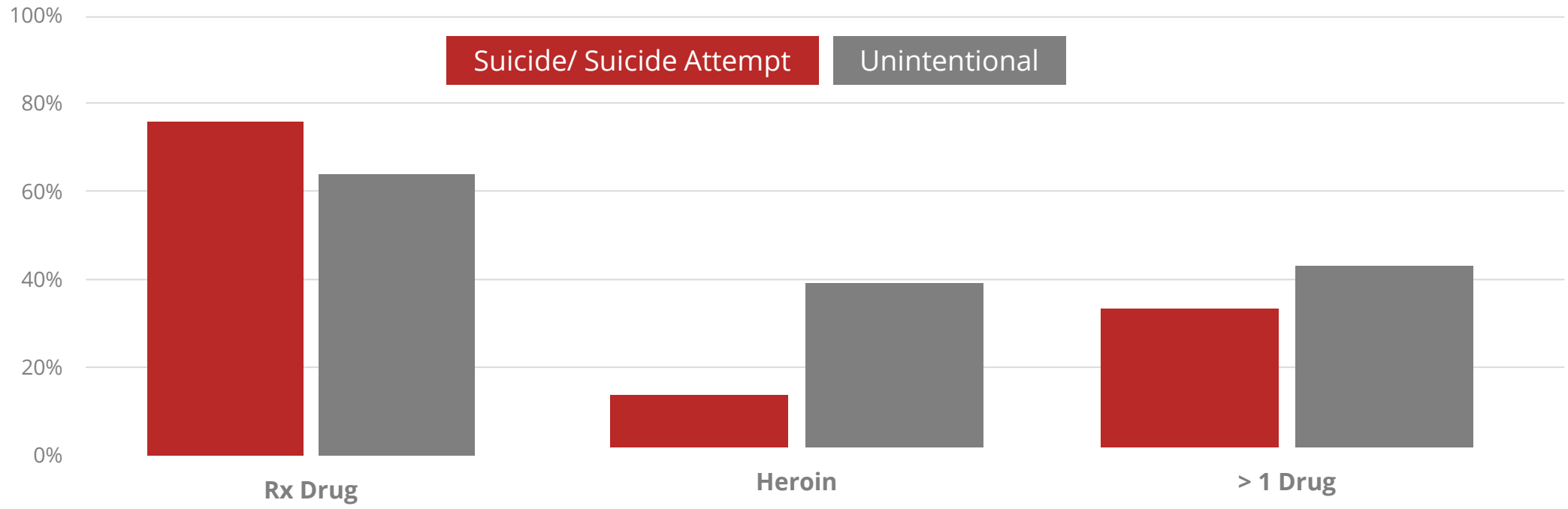
Suicide or suicide attempts were responsible for 23% of the possible opioid overdoses, where the information was available.

548 (58%) of cases did not have information about suicide available.

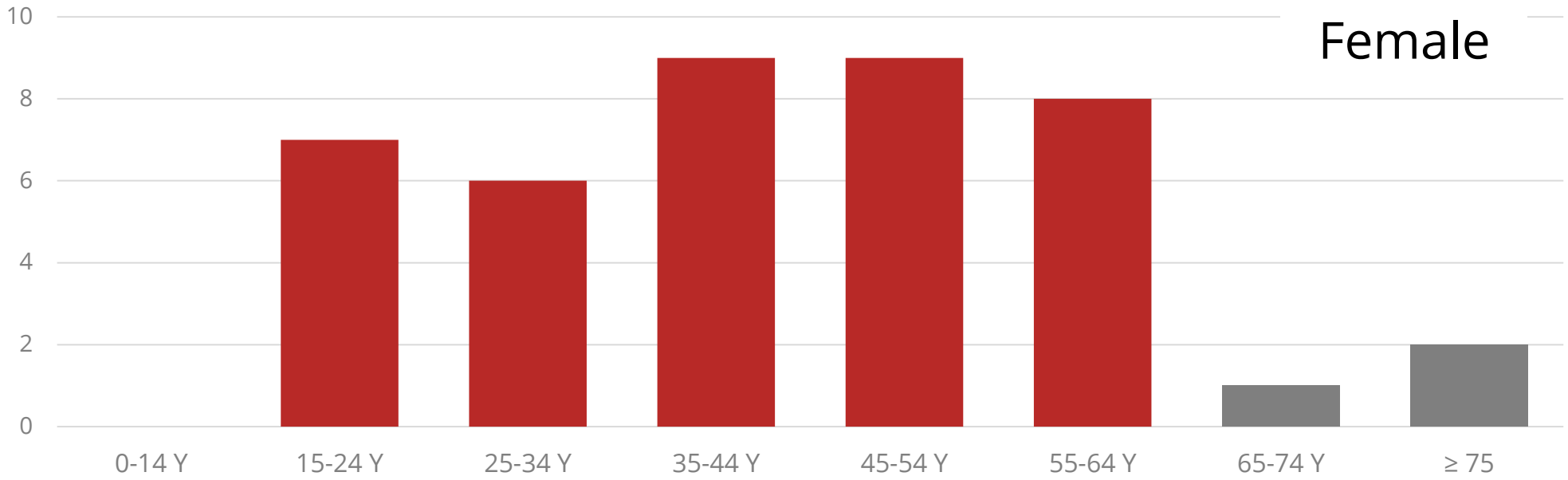


A large majority of individuals experience a suicide or suicide attempt were reported to have taken a prescription opioid.

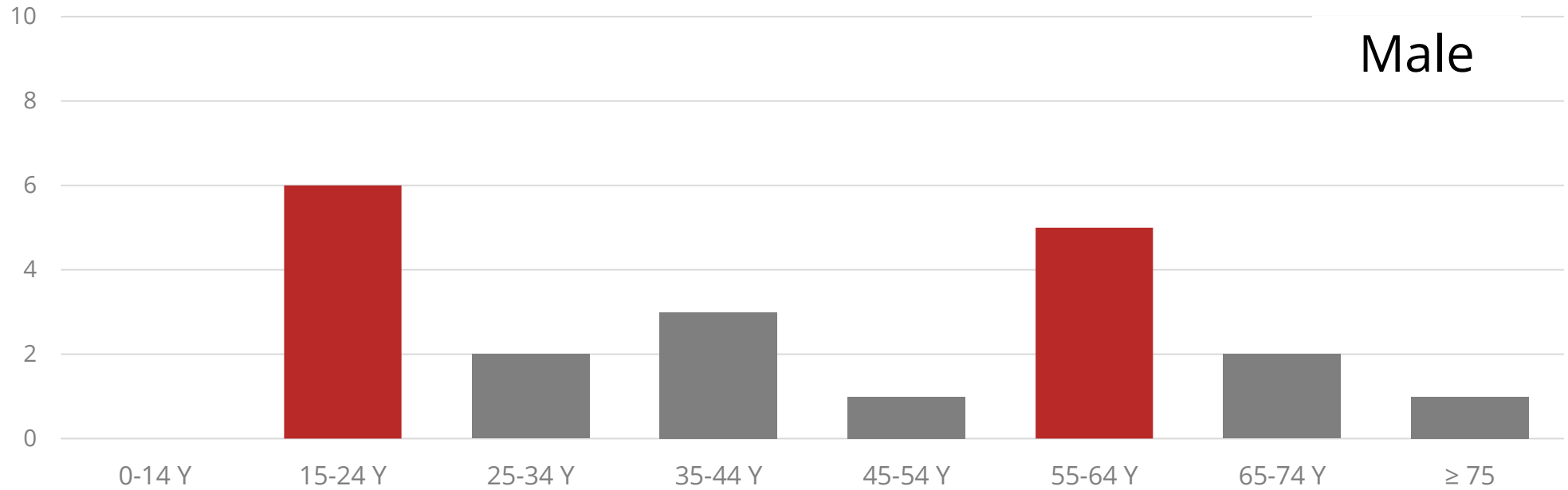
548 (58%) of cases did not have information about suicide available.



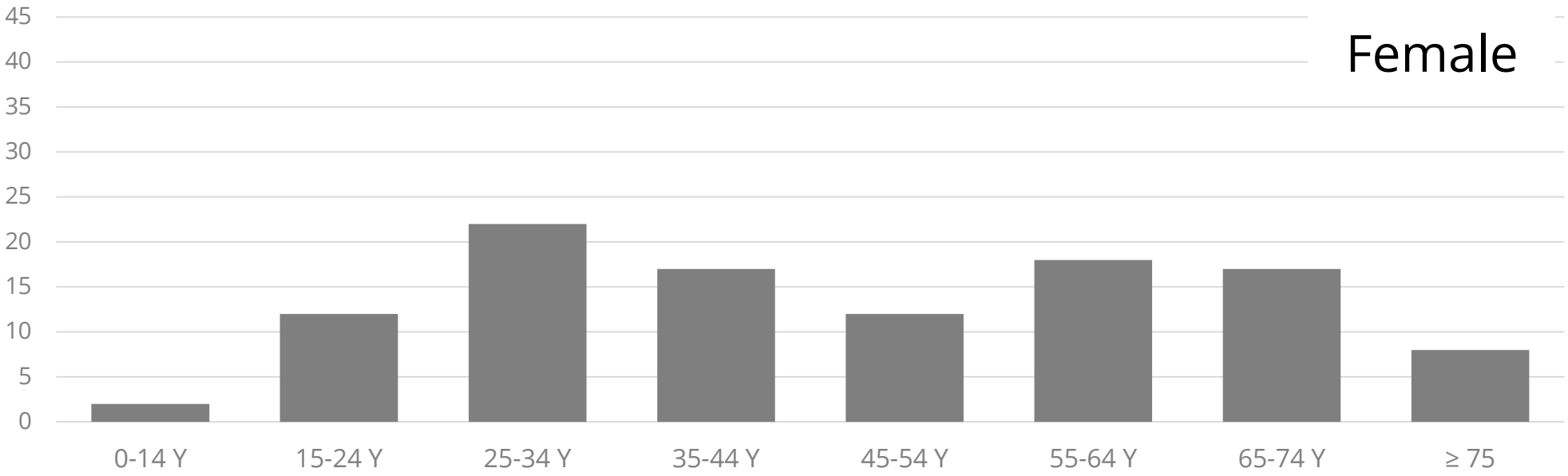
Suicides or suicide attempts were reported fairly evenly across those aged 15 to 64 years in females.



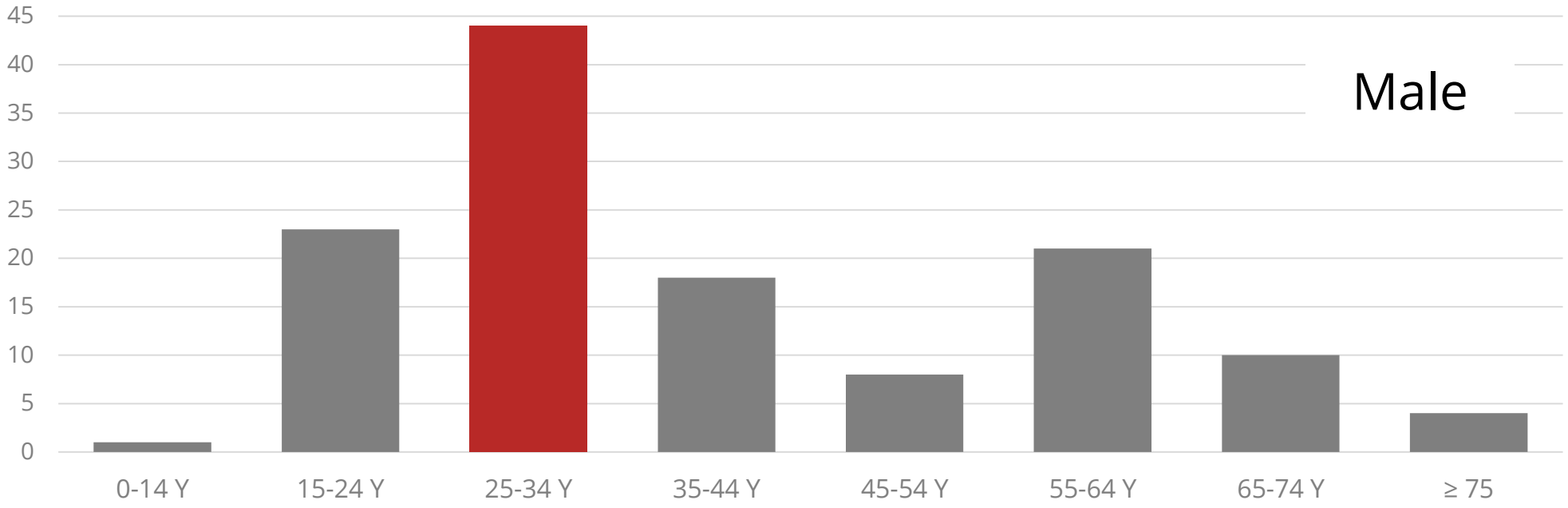
Suicides or suicide attempts were reported among the majority of males in either the 15 – 24 age group or 55 – 64 age group.



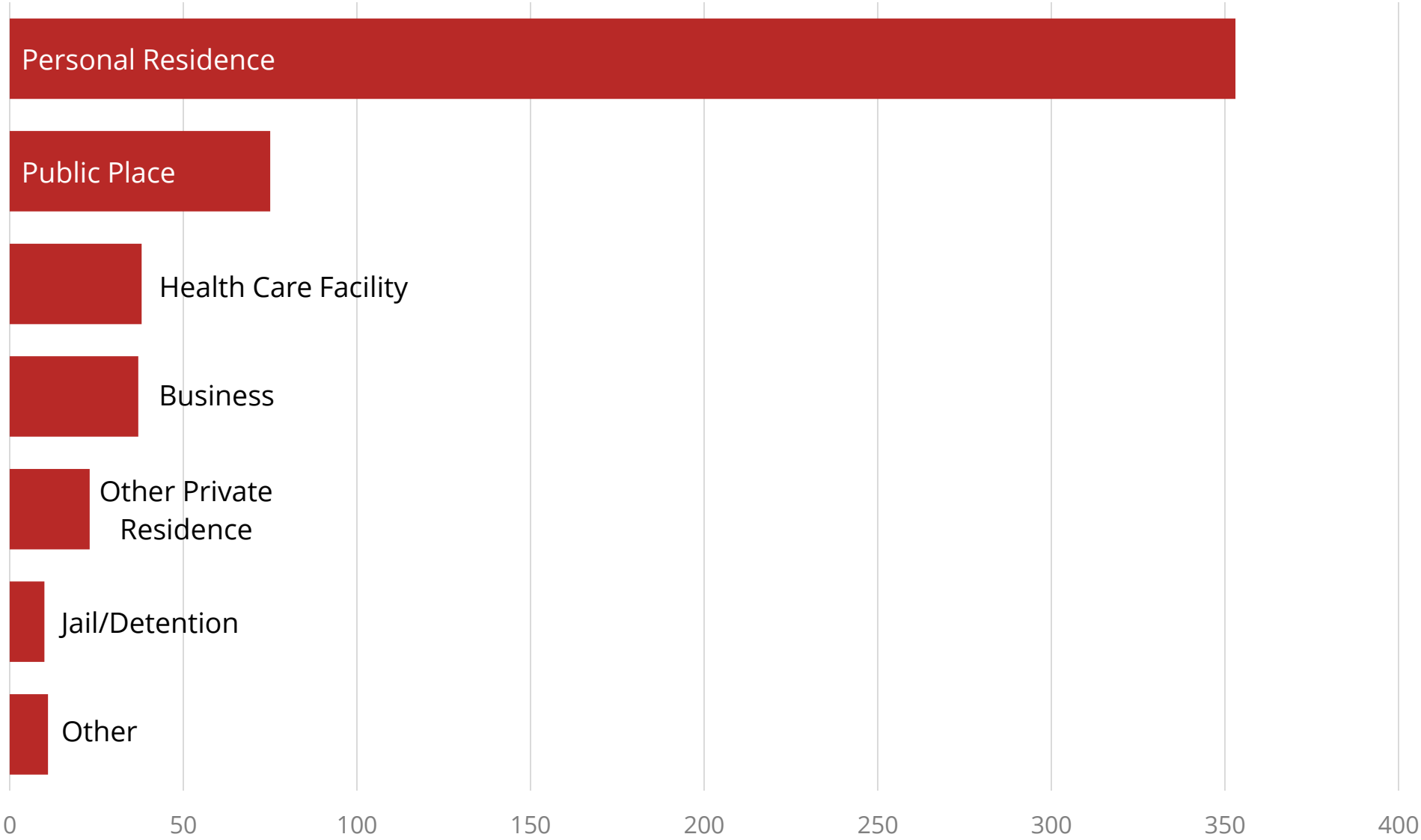
Unintentional overdoses were reported fairly evenly across all age groups in females.



Unintentional overdoses were reported in males aged 25 – 34 years of age most often.

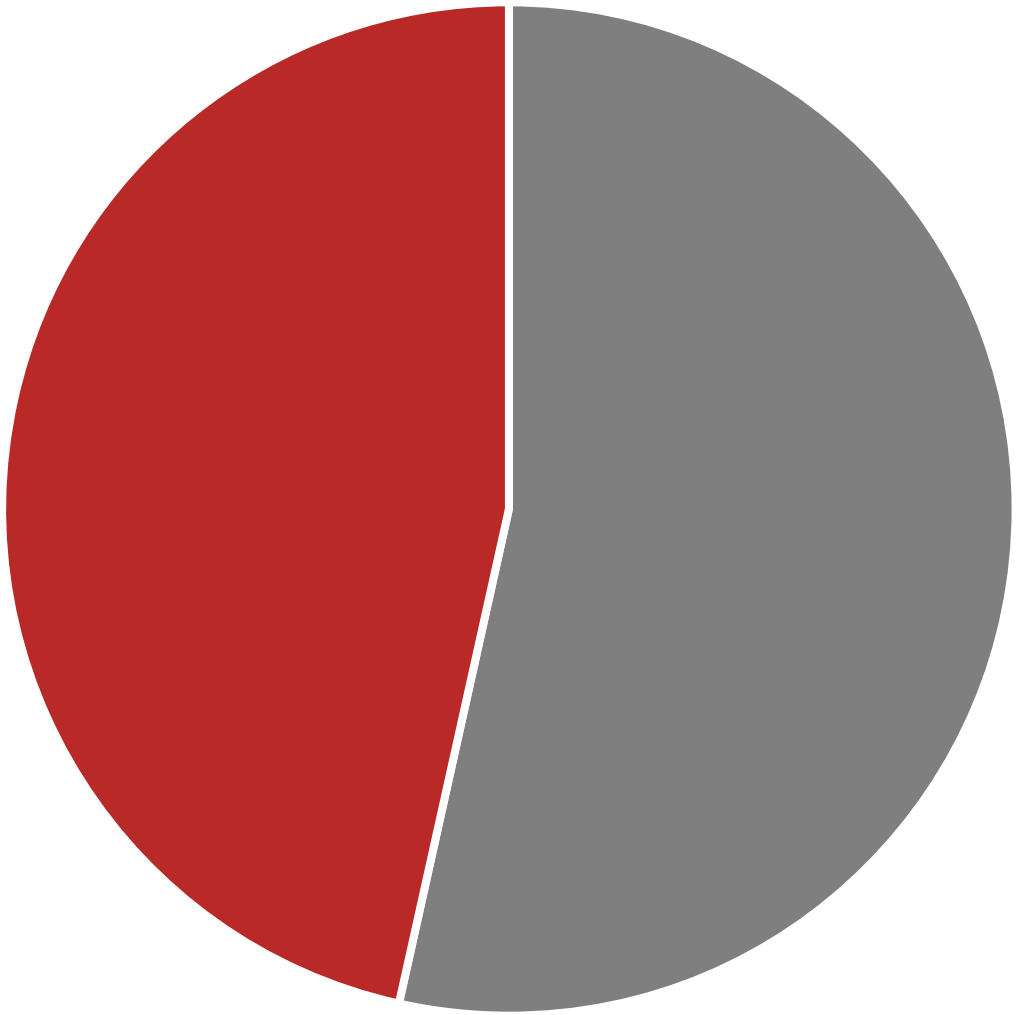


A majority of the possible opioid overdoses occurred in a personal residence.



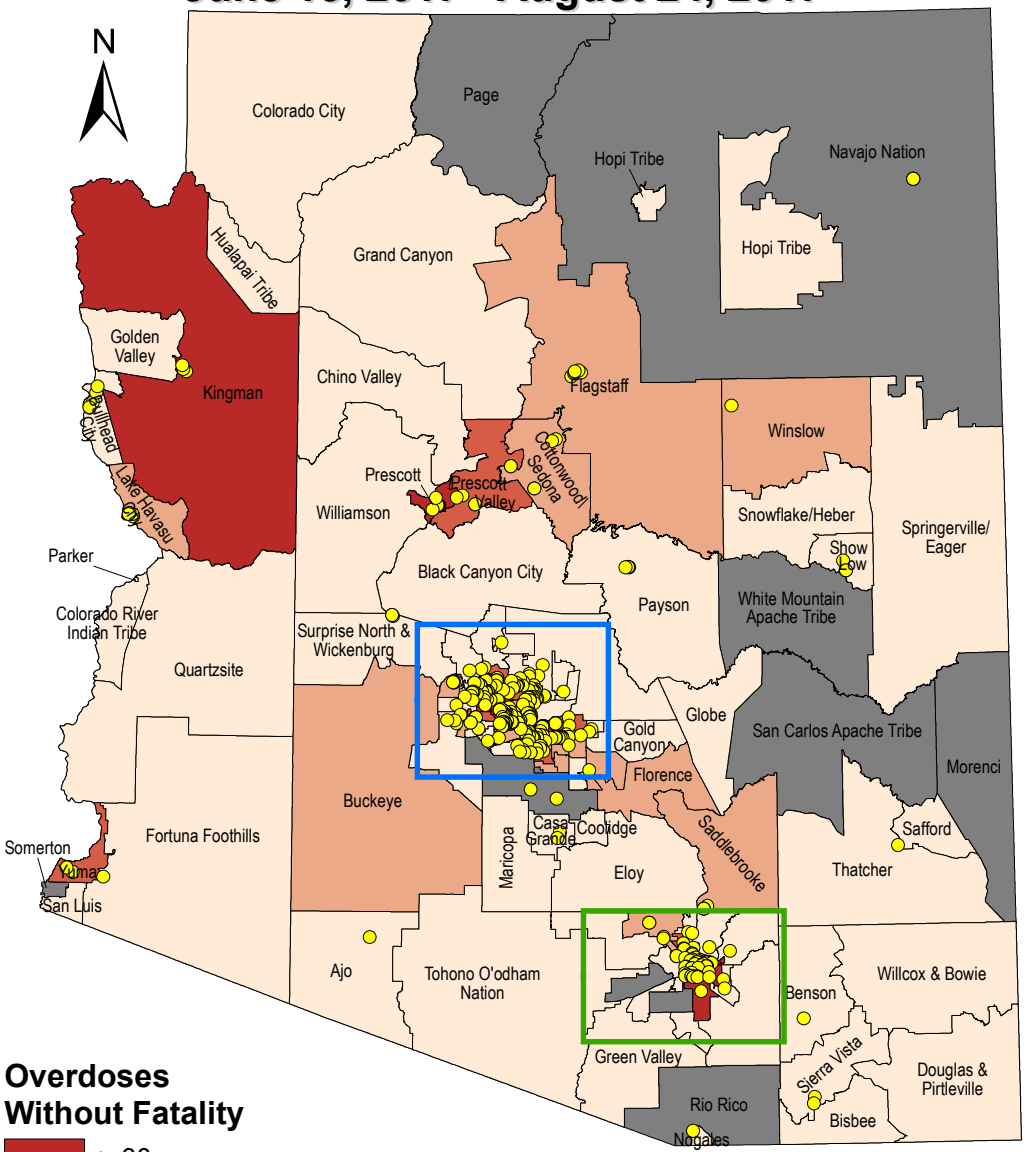
1,580 (74%) of cases did not have information about overdose location available.

47% of individuals were referred to behavioral health after their possible opioid overdose.



1,693 (79%) of cases did not have information about behavioral health referral available.

Number of Suspected Opioid Overdose Related Events Without Fatality by Primary Care Area (PCA), June 15, 2017 - August 24, 2017*



Overdoses Without Fatality

- > 30
- 21 - 30
- 11 - 20
- 1 - 10
- No Non-Fatal Overdoses

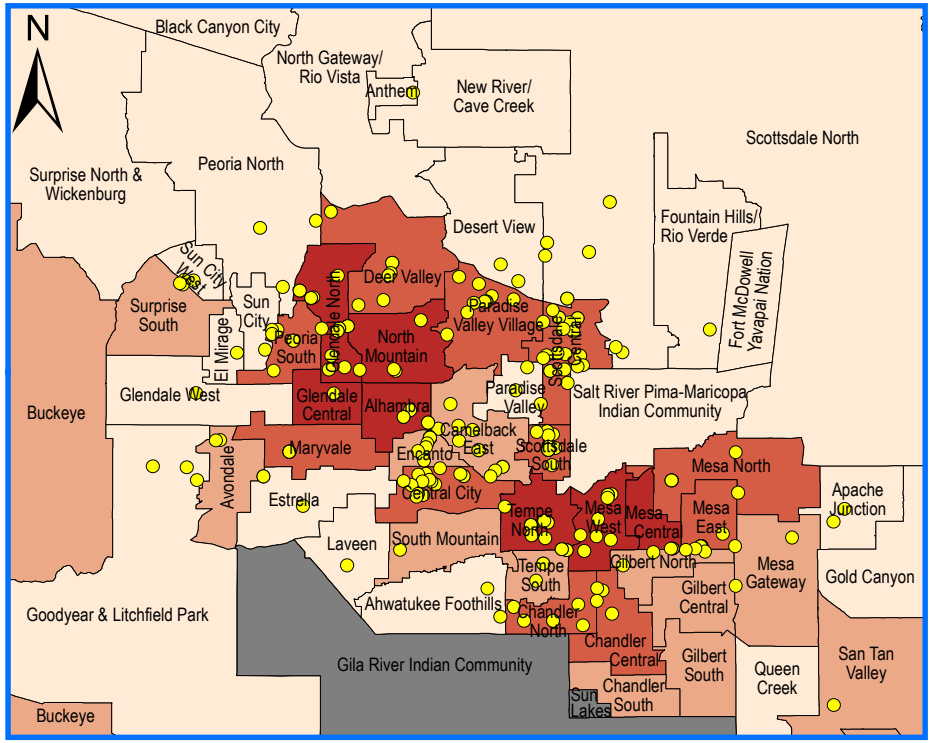
Medication-Assisted Treatment (MAT) Providers

*273 overdoses (14.6%) were not assigned a PCA

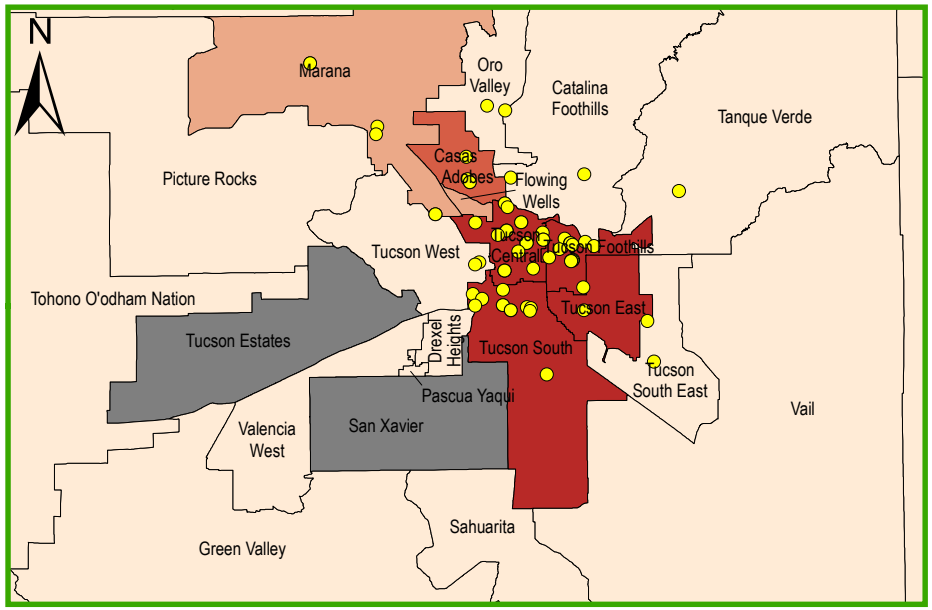
ARIZONA DEPARTMENT OF HEALTH SERVICES

Data Source: AZ-PIERS and MEDSIS

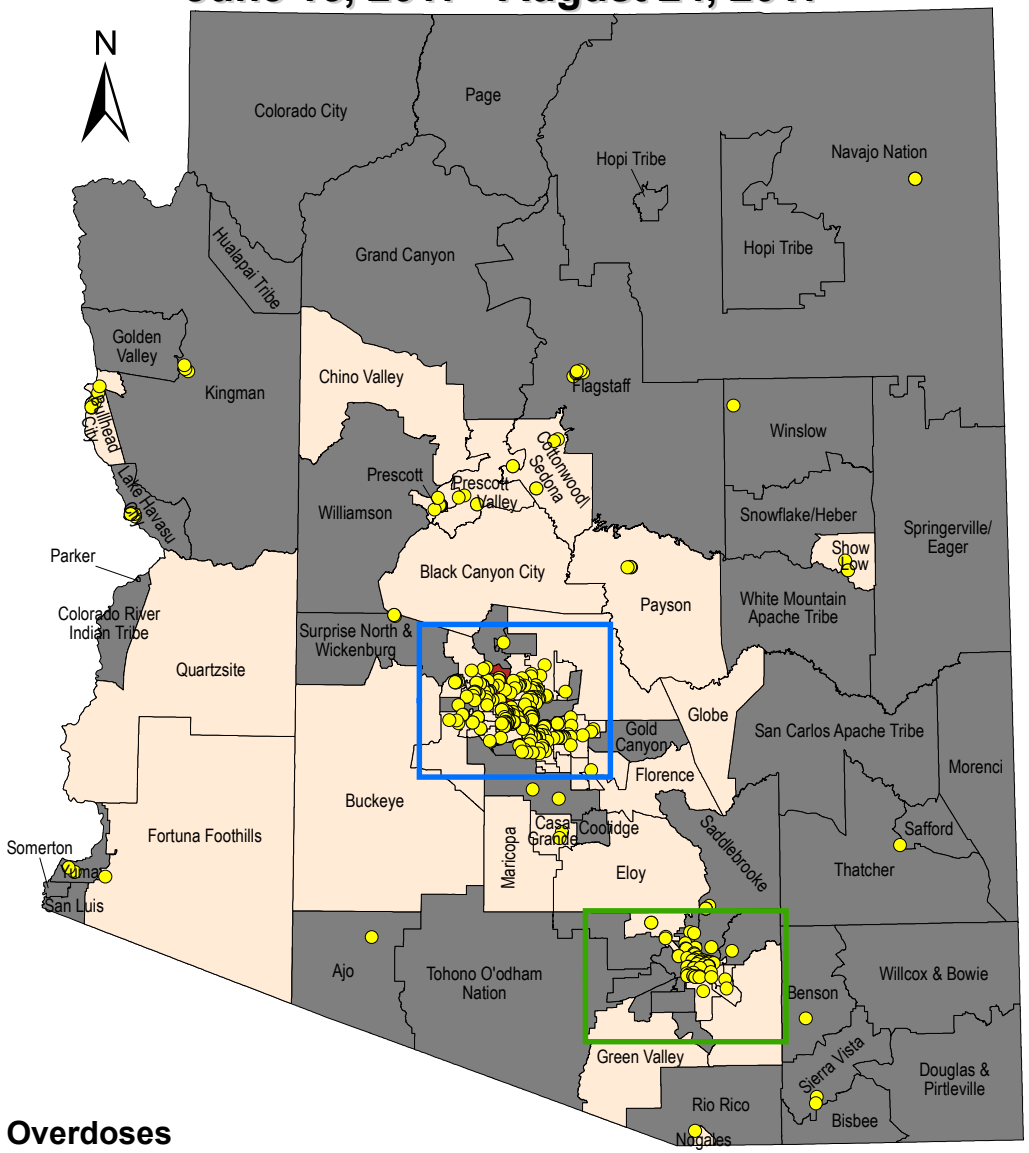
Metro Phoenix



Metro Tucson



Number of Suspected Opioid Overdose Related Events With Fatality by Primary Care Area (PCA), June 15, 2017 - August 24, 2017*



Overdoses With Fatality

- >= 15
- 11 - 14
- 1 - 10
- No Fatalities

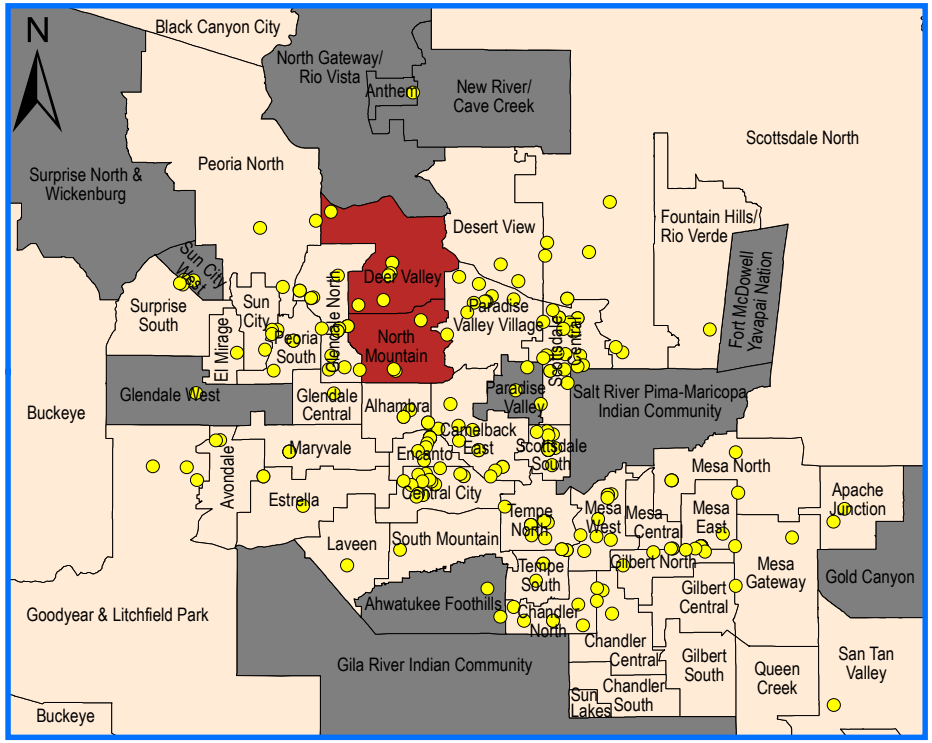
Medication-Assisted Treatment (MAT) Providers

*37 fatalities (13.6%) were not assigned a PCA

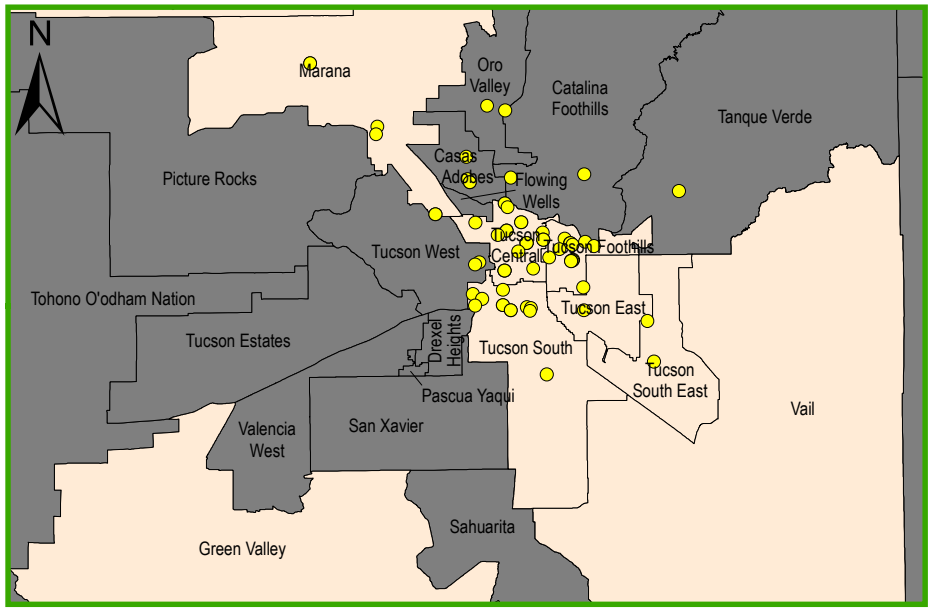
ARIZONA DEPARTMENT OF HEALTH SERVICES

Data Source: AZ-PIERS and MEDSIS

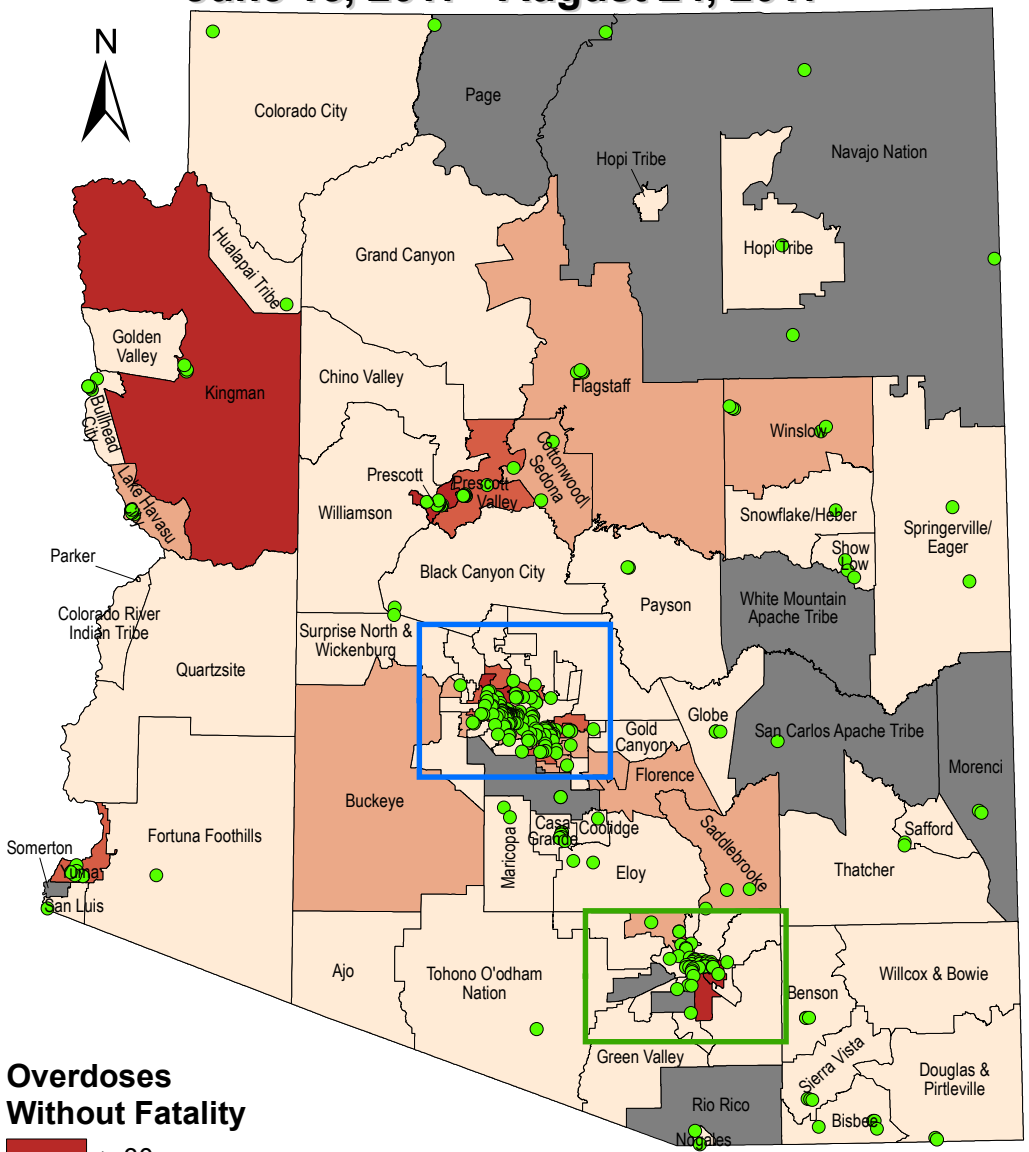
Metro Phoenix



Metro Tucson



Number of Suspected Opioid Overdose Related Events Without Fatality by Primary Care Area (PCA), June 15, 2017 - August 24, 2017*



Overdoses Without Fatality

- > 30
- 21 - 30
- 11 - 20
- 1 - 10
- No Non-Fatal Overdoses

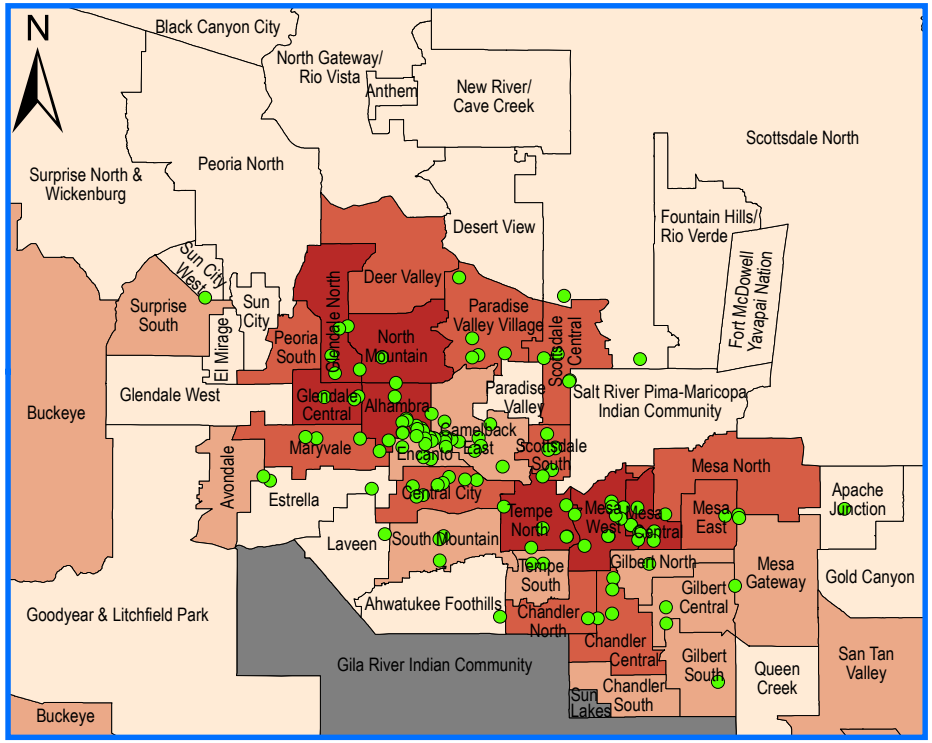
Substance Abuse (SA) Services

*273 overdoses (14.6%) were not assigned a PCA

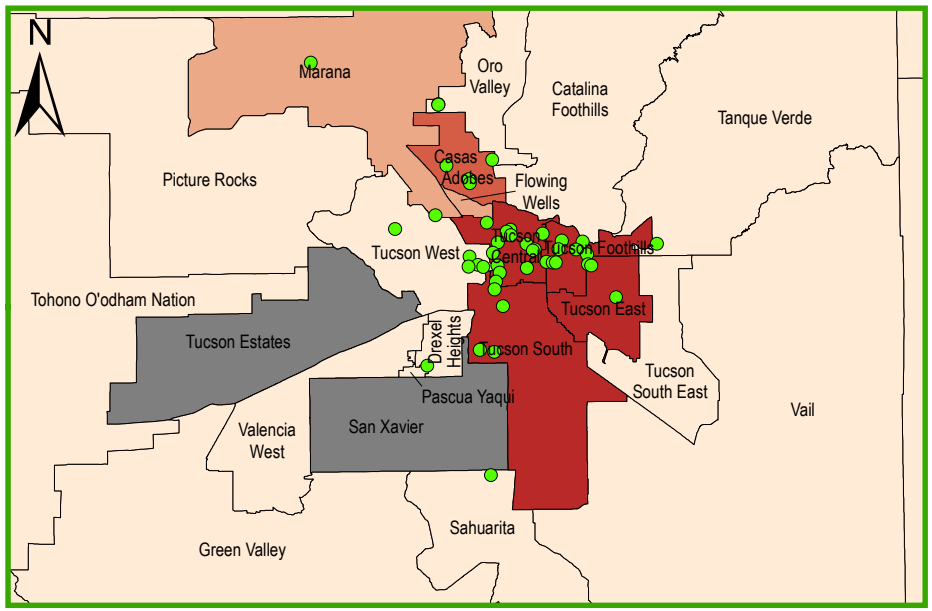
ARIZONA DEPARTMENT OF HEALTH SERVICES

Data Source: AZ-PIERS and MEDSIS

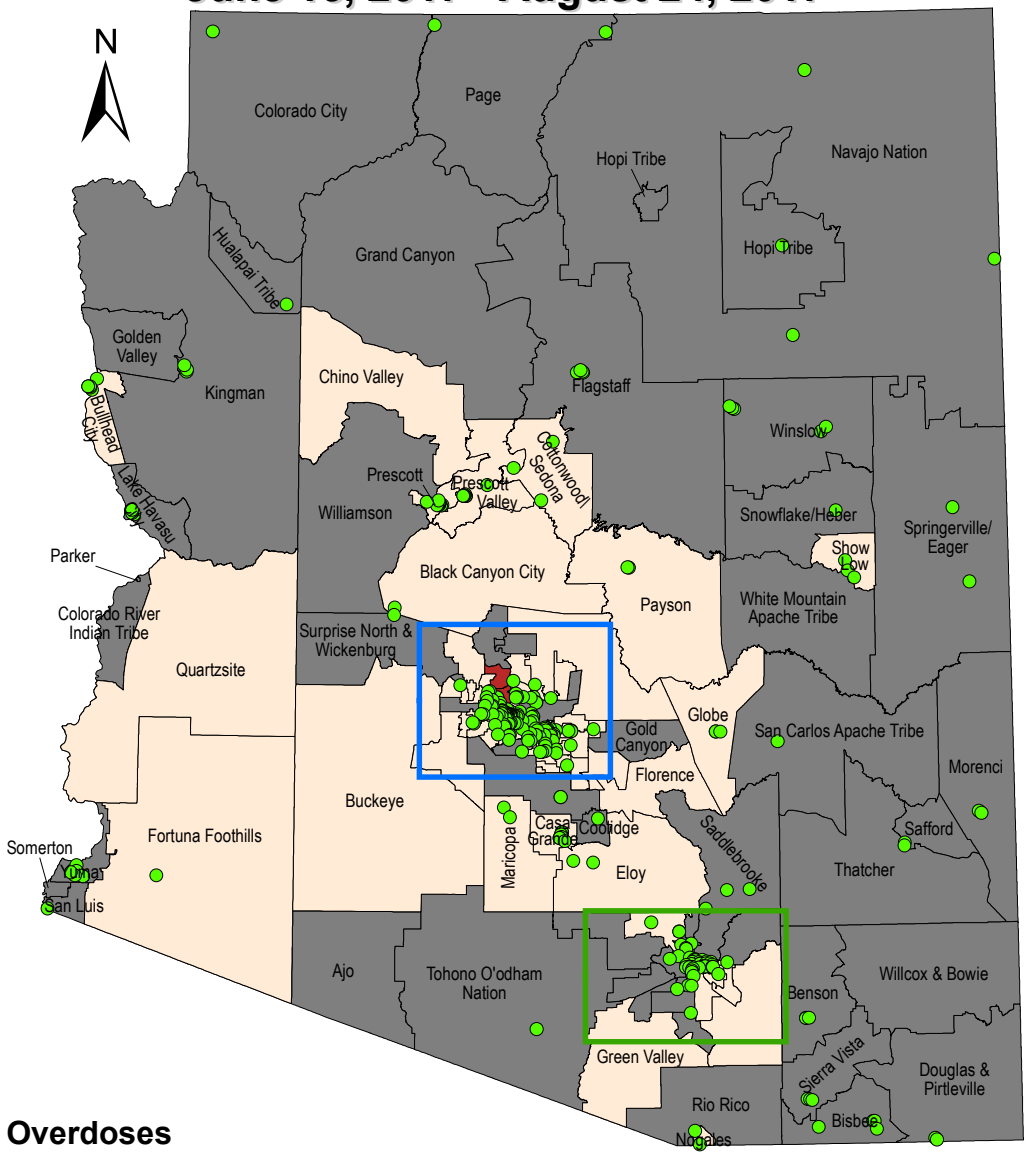
Metro Phoenix



Metro Tucson



Number of Suspected Opioid Overdose Related Events With Fatality by Primary Care Area (PCA), June 15, 2017 - August 24, 2017*



Overdoses With Fatality

- >= 15
- 11 - 14
- 1 - 10
- No Fatalities

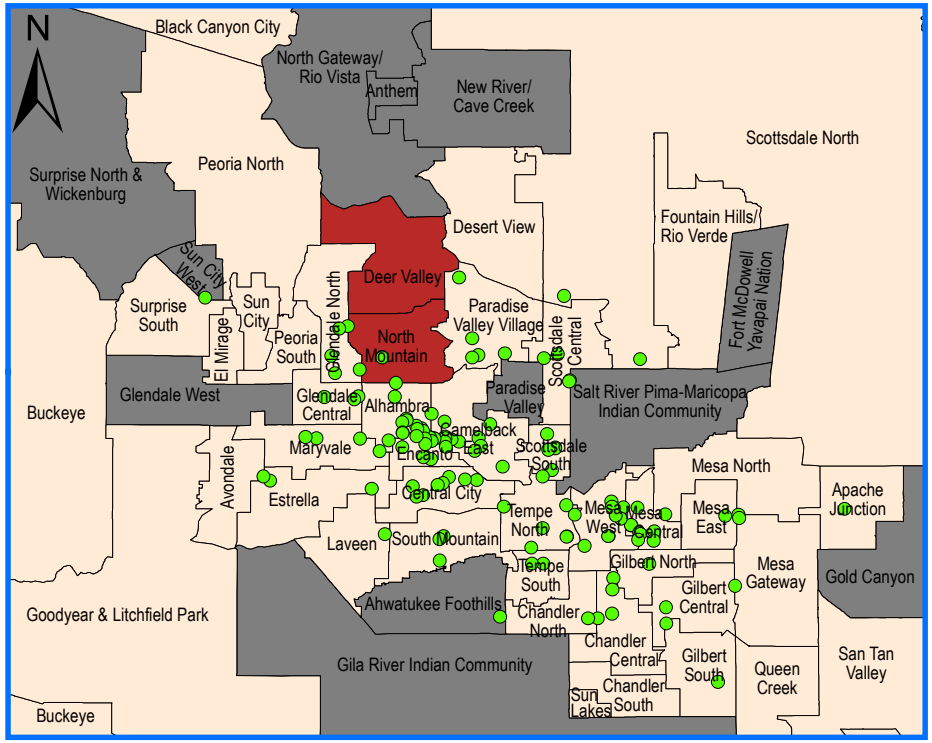
Substance Abuse (SA) Services

*37 fatalities (13.6%) were not assigned a PCA

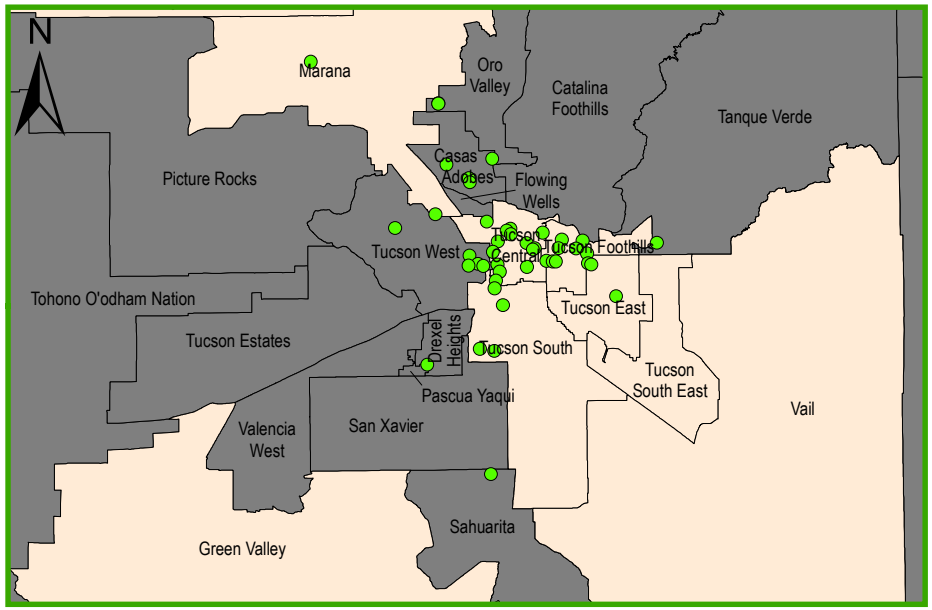
ARIZONA DEPARTMENT OF HEALTH SERVICES

Data Source: AZ-PIERS and MEDSIS

Metro Phoenix

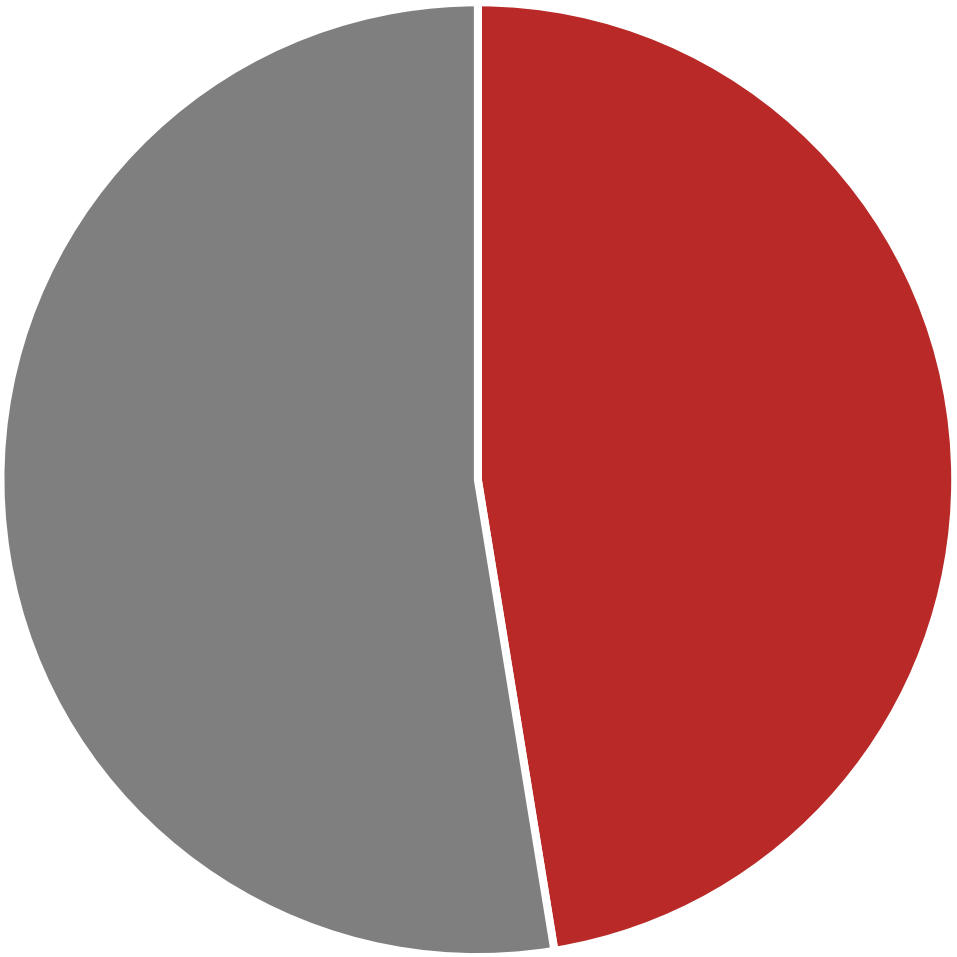


Metro Tucson

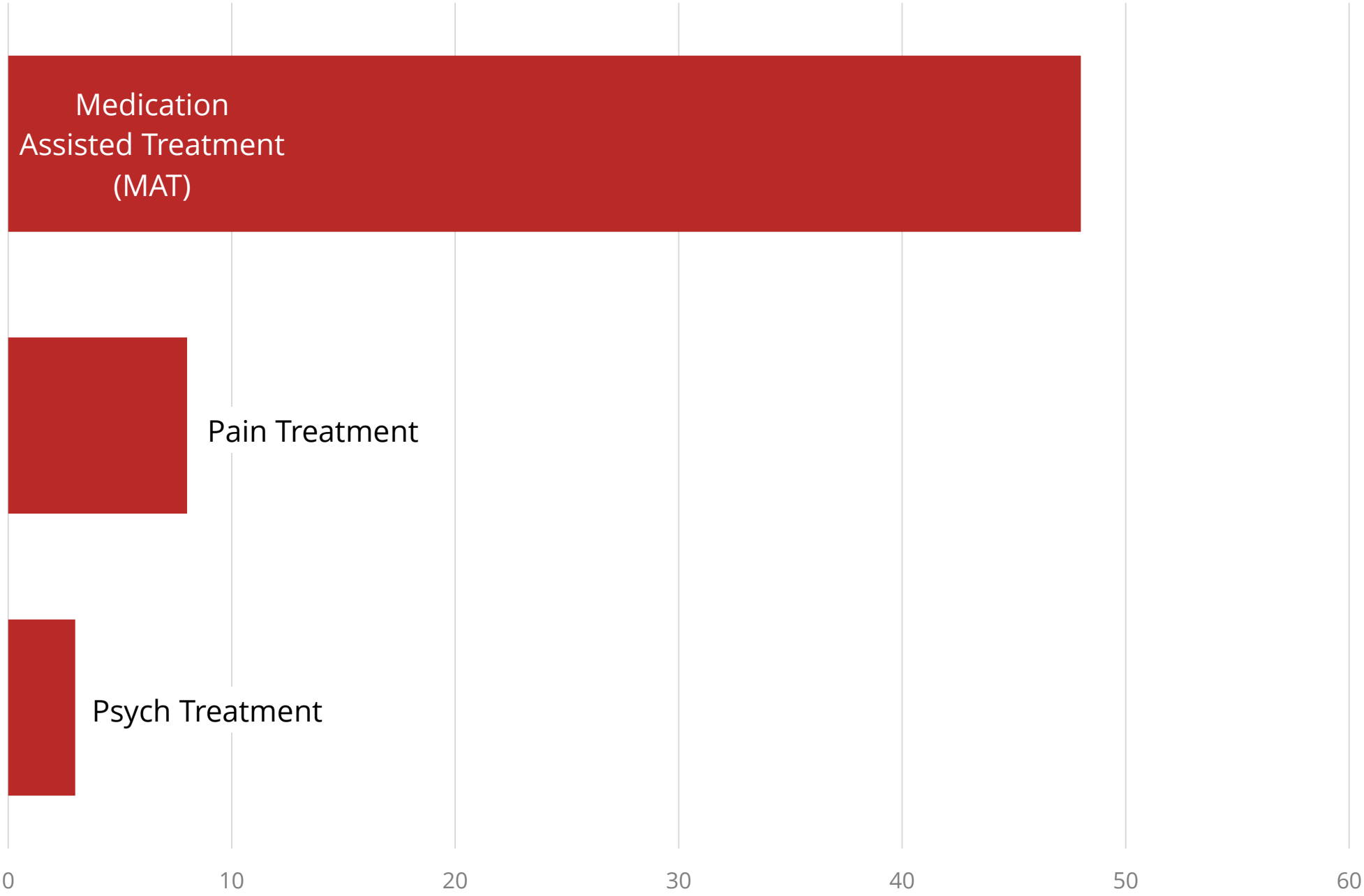


Neonatal Abstinence Syndrome

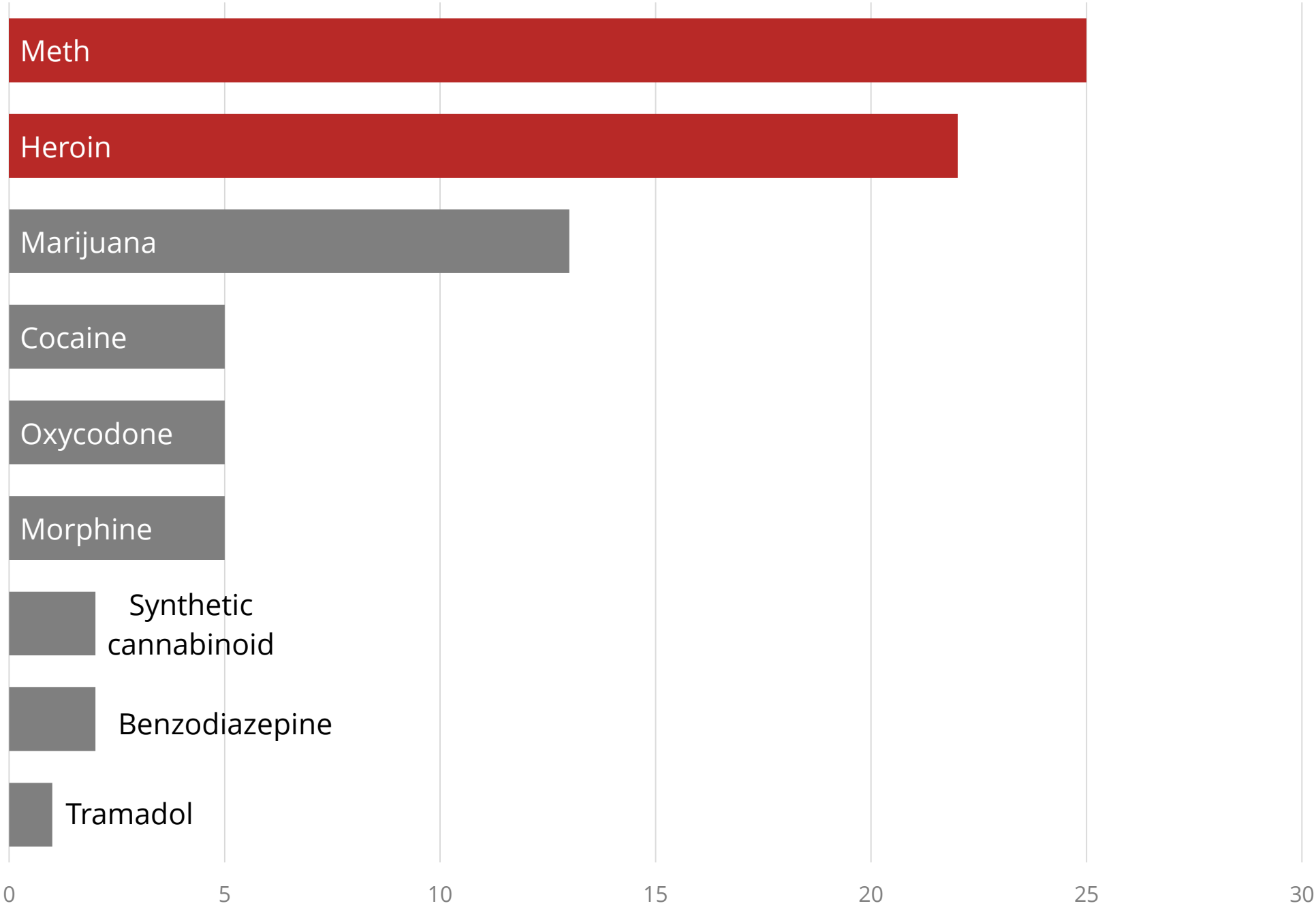
47% of mothers of NAS cases were being medically supervised while taking opioids during pregnancy.



The majority of mothers of NAS infants were being supervised by a medical professional while they were undergoing medication assisted treatment (MAT).



The majority of mothers of NAS infants presented with either meth or heroin.

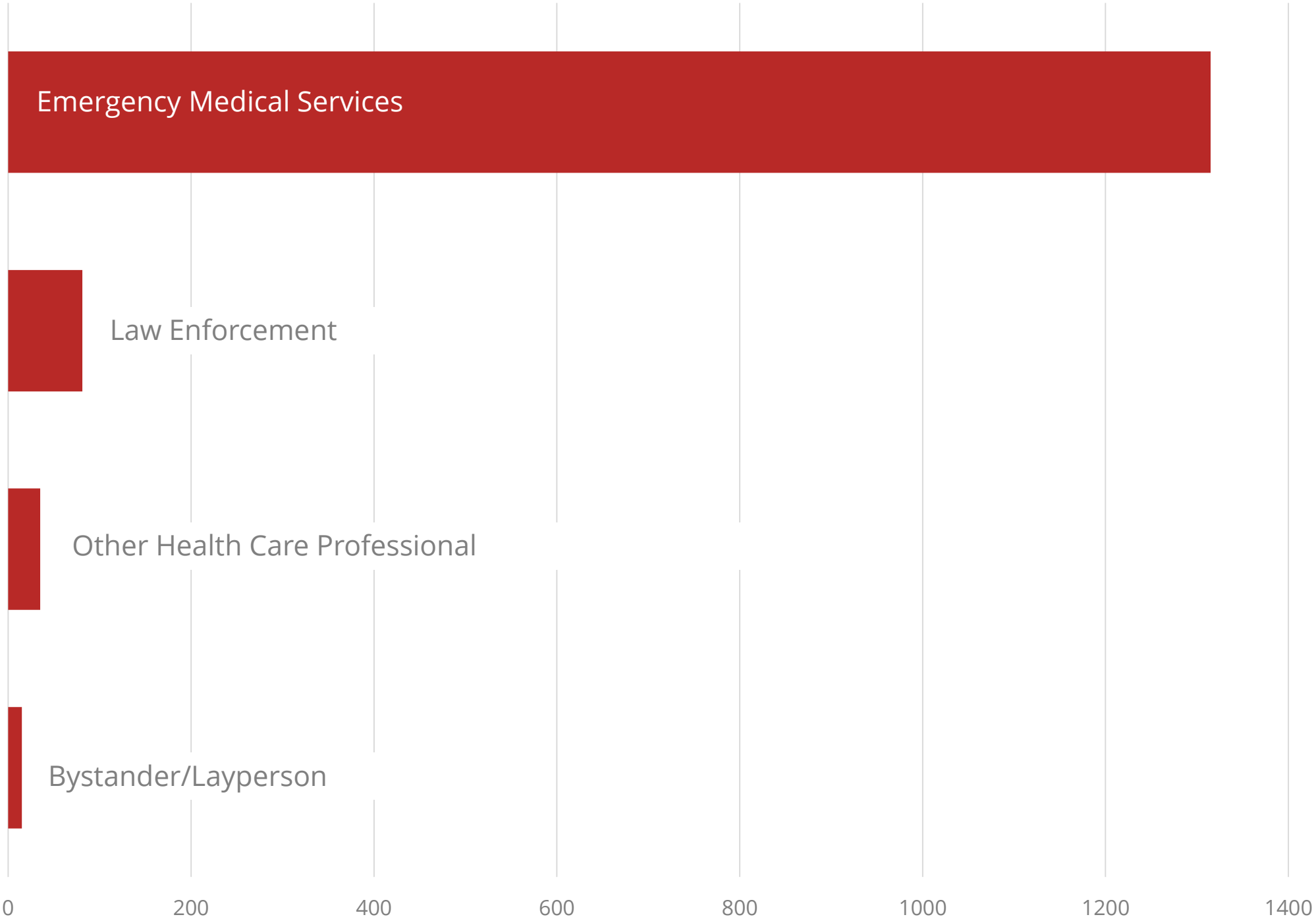


Naloxone Administration

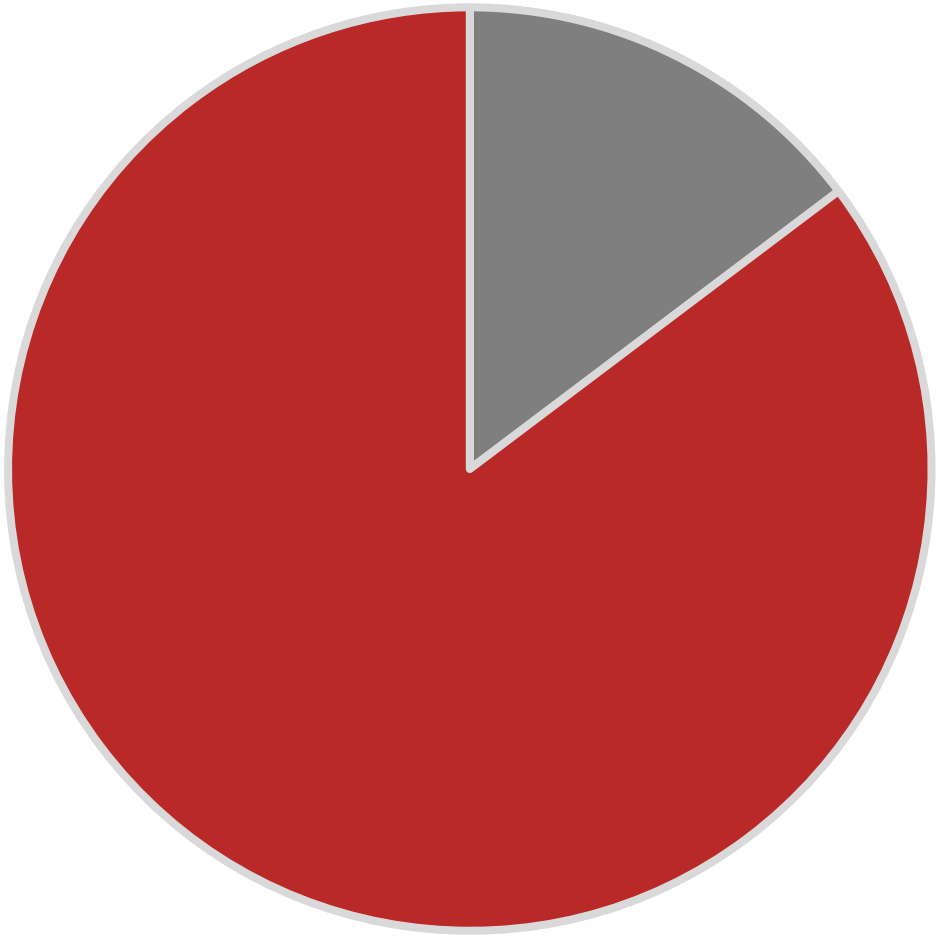
1,446

naloxone doses were administered outside of the hospital by emergency medical services, law enforcement, and others

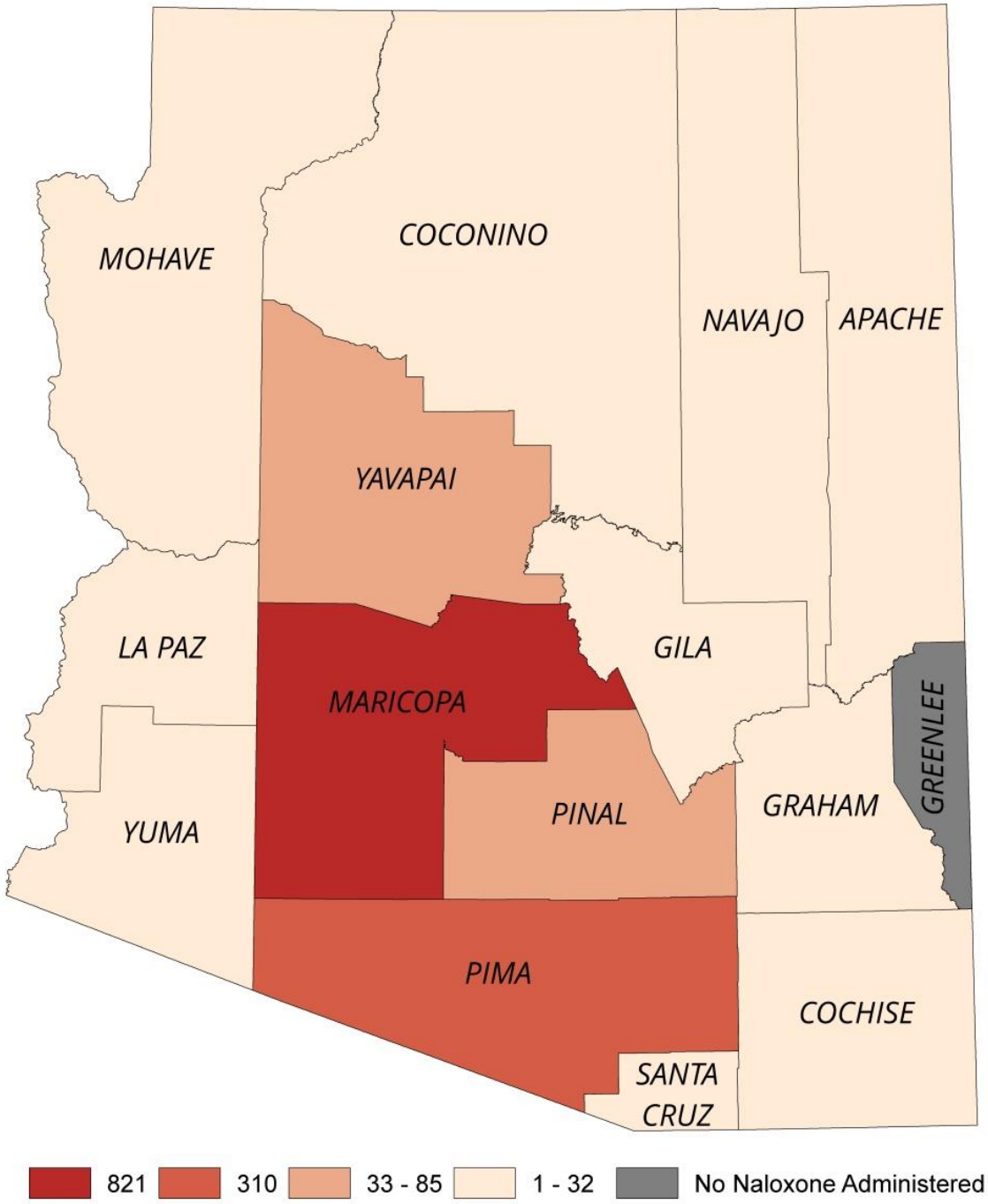
Naloxone was administered by a variety of different partners.



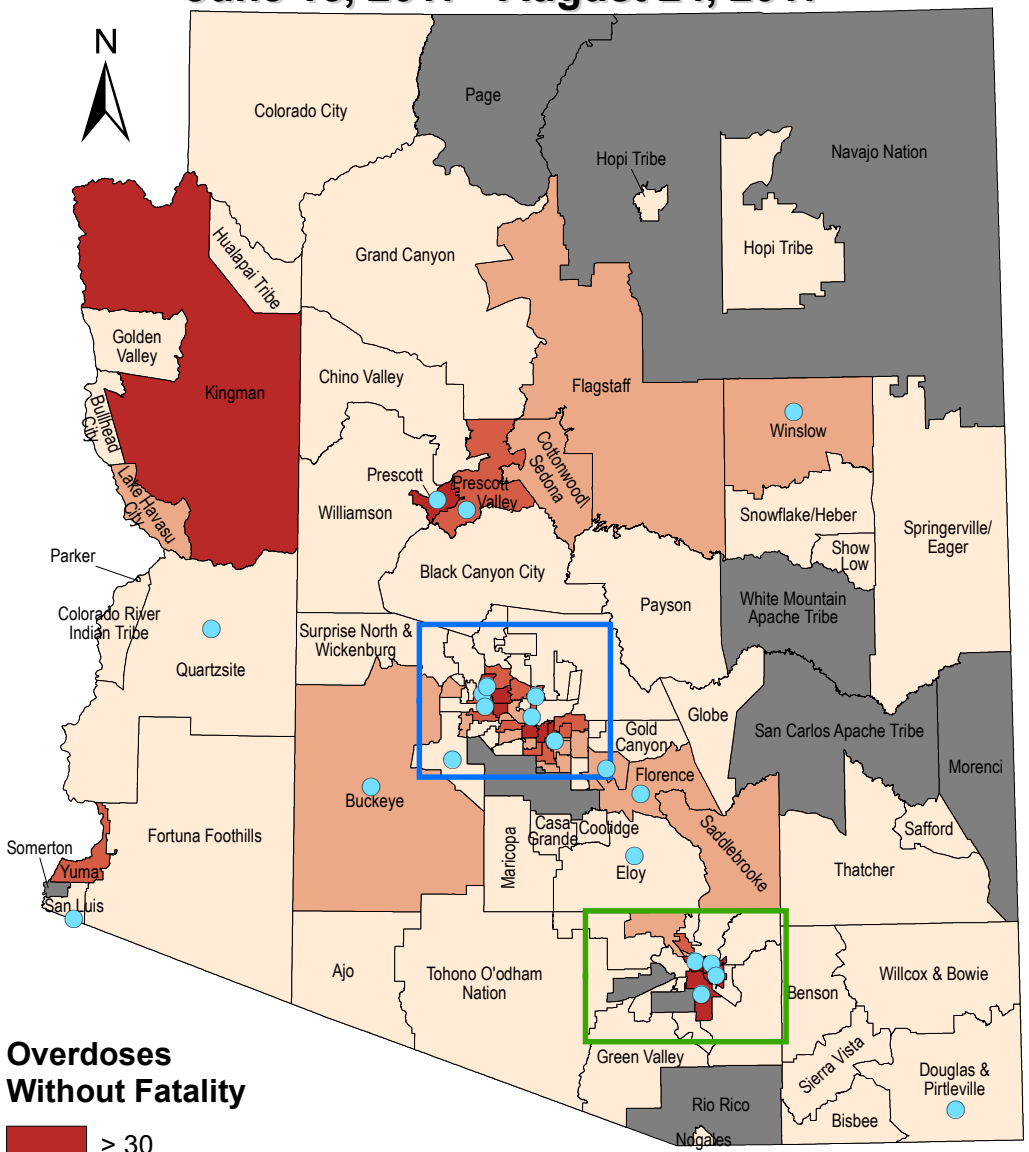
Excluding deaths, 85% of the possible opioid overdoses received naloxone pre-hospital.



Naloxone was reported to be administered in 14 of the 15 counties since June 15th.



Number of Suspected Opioid Overdose Related Events Without Fatality by Primary Care Area (PCA), June 15, 2017 - August 24, 2017*



Overdoses Without Fatality

- > 30
- 21 - 30
- 11 - 20
- 1 - 10
- No Non-Fatal Overdoses

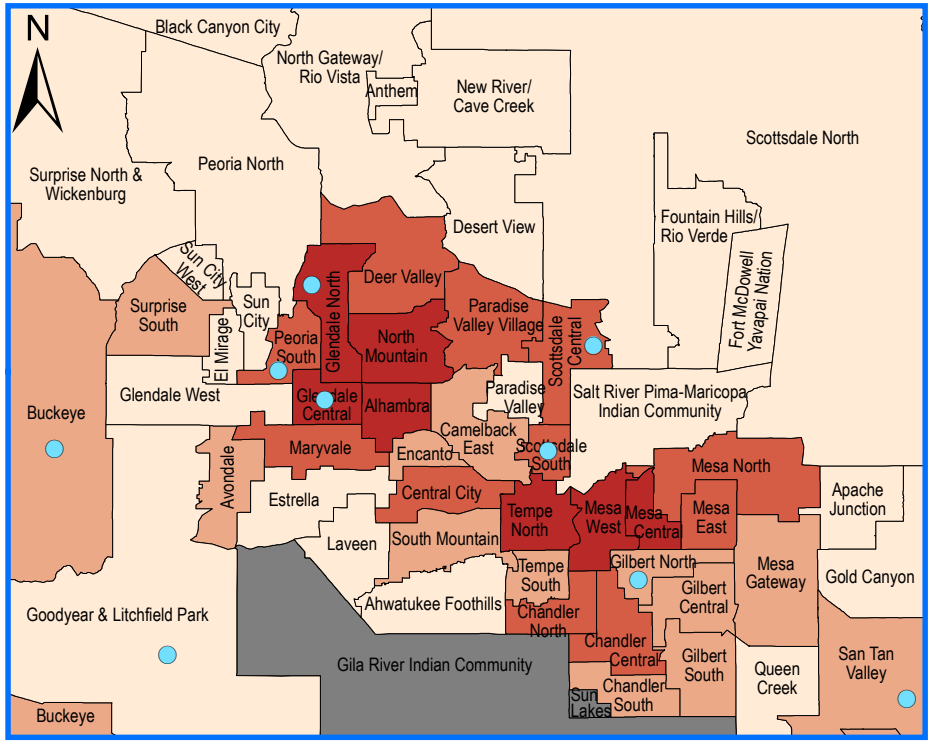
PCAs Where Overdoses Were Administered Naloxone by Law Enforcement

*273 overdoses (14.6%) were not assigned a PCA

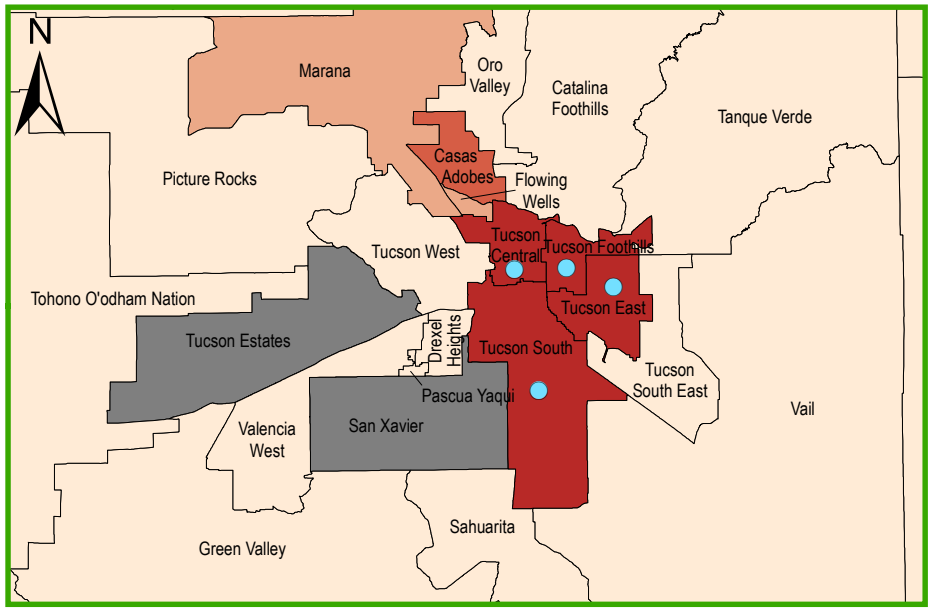
ARIZONA DEPARTMENT OF HEALTH SERVICES

Data Source: AZ-PIERS and MEDSIS

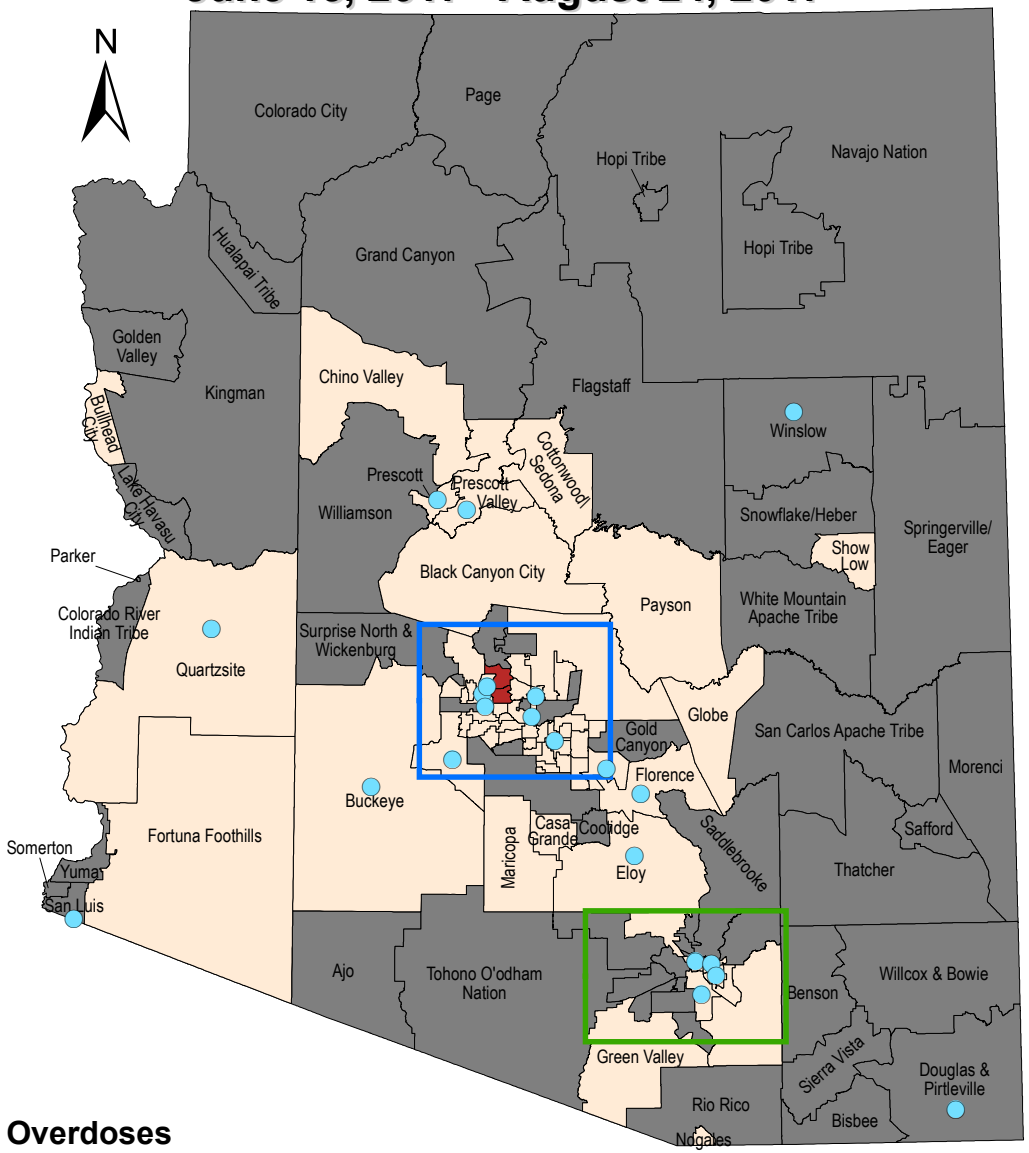
Metro Phoenix



Metro Tucson



Number of Suspected Opioid Overdose Related Events With Fatality by Primary Care Area (PCA), June 15, 2017 - August 24, 2017*



Overdoses With Fatality

- >= 15
- 11 - 14
- 1 - 10
- No Fatalities

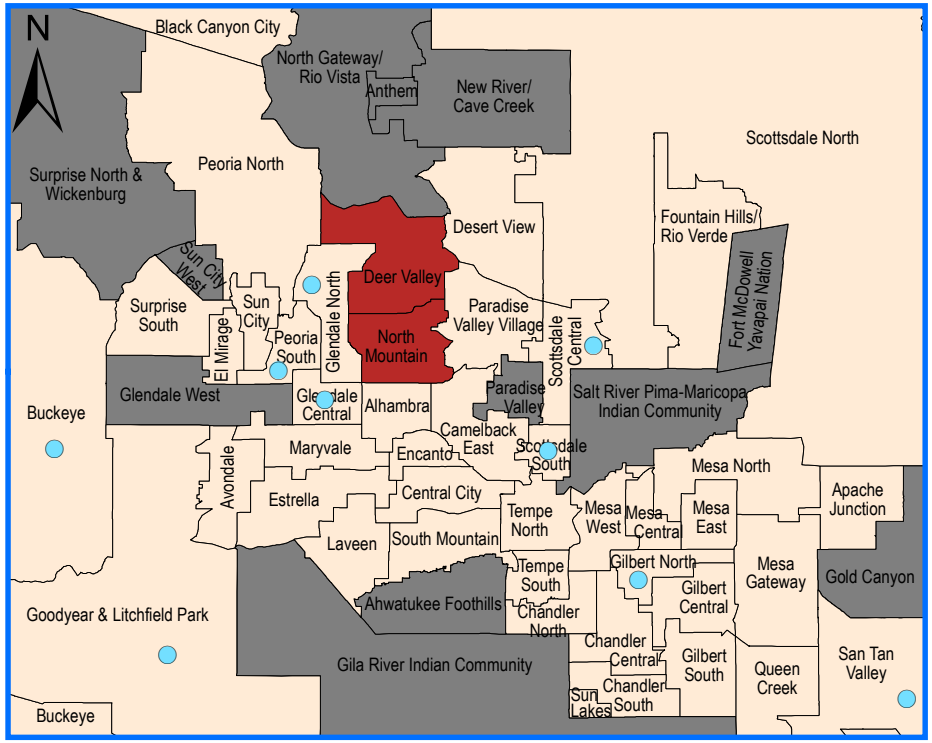
PCAs Where Overdoses Were Administered Naloxone by Law Enforcement

*37 fatalities (13.6%) were not assigned a PCA

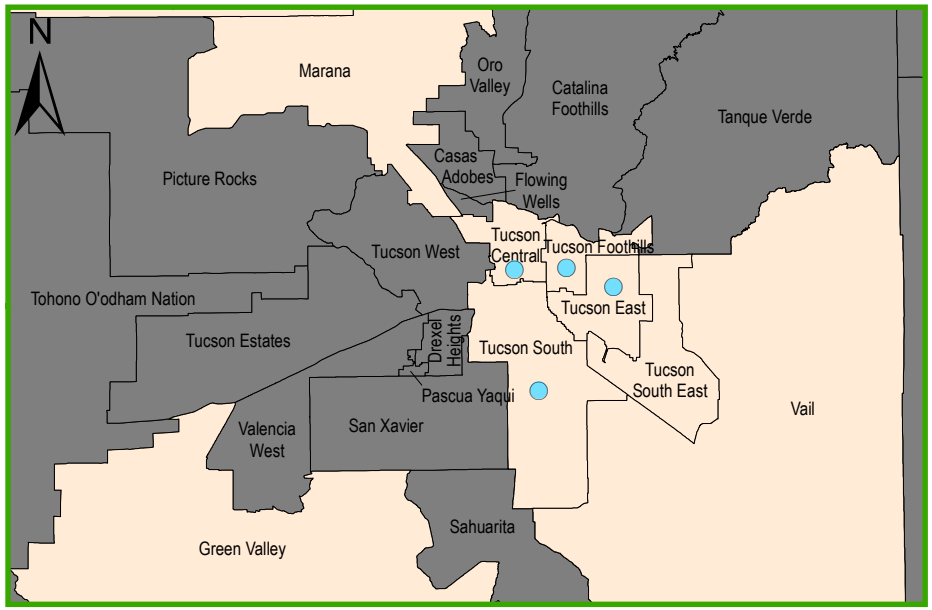
ARIZONA DEPARTMENT OF HEALTH SERVICES

Data Source: AZ-PIERS and MEDSIS

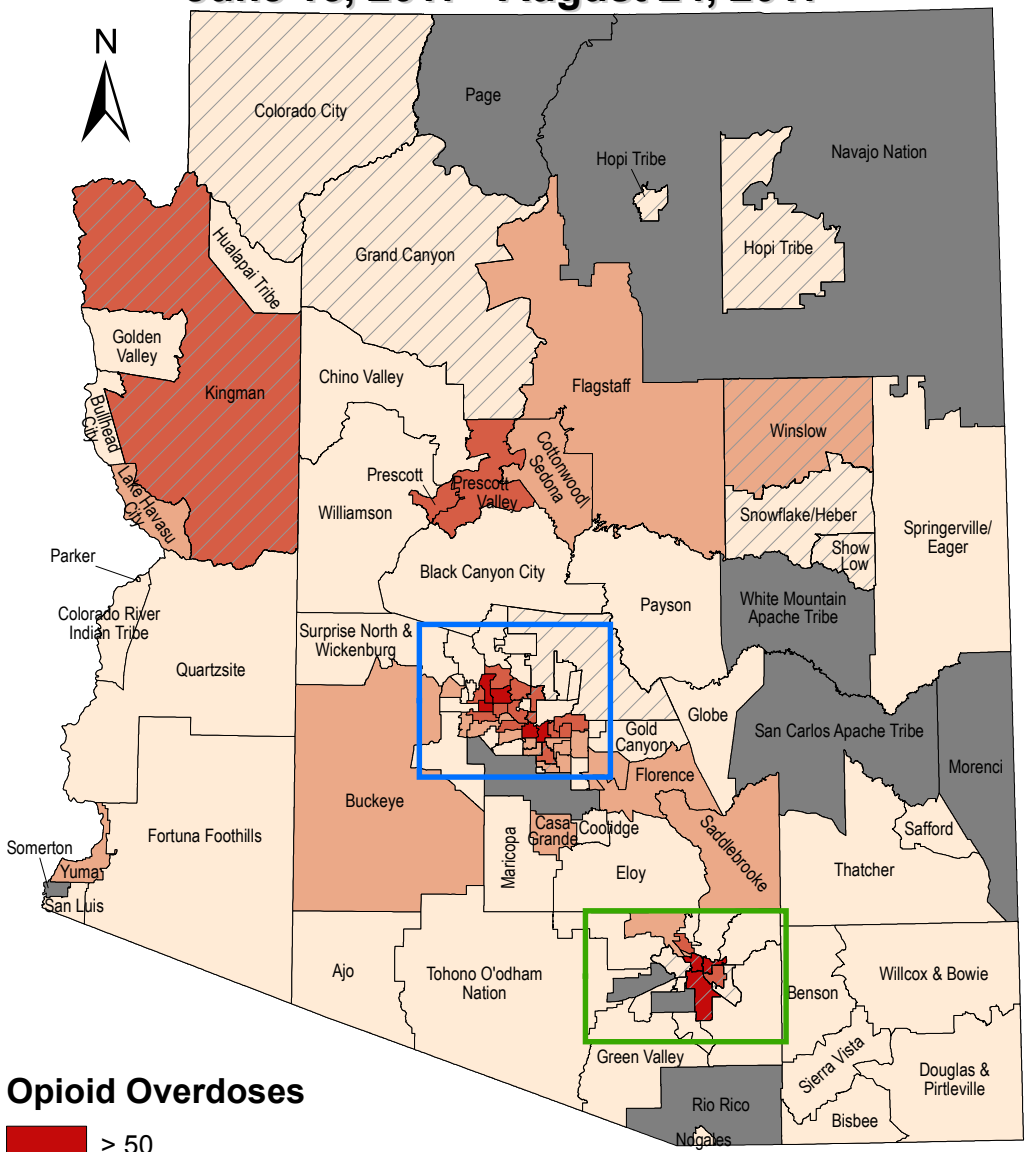
Metro Phoenix



Metro Tucson



Number of Suspected Opioid Overdose Related Events by Primary Care Area (PCA), June 15, 2017 - August 24, 2017*



Opioid Overdoses

- > 50
- 26 - 50
- 11 - 25
- 1 - 10
- No Suspected Overdoses

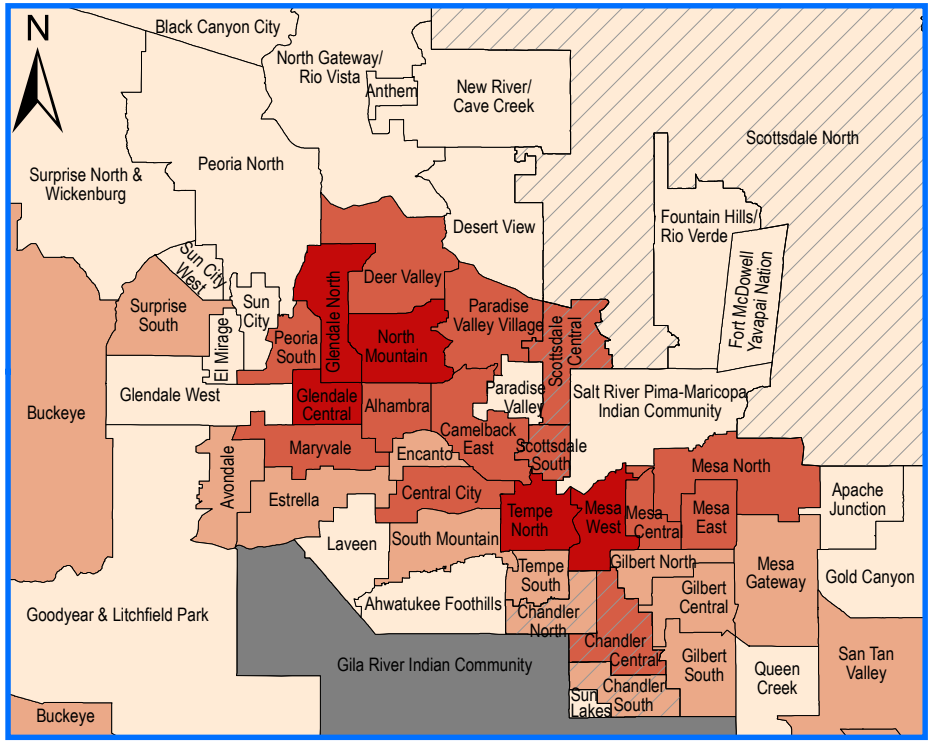
Law Enforcement Trained to Administer Naloxone (Prior to June 5, 2017)

*310 overdoses (14.5%) were not assigned a PCA

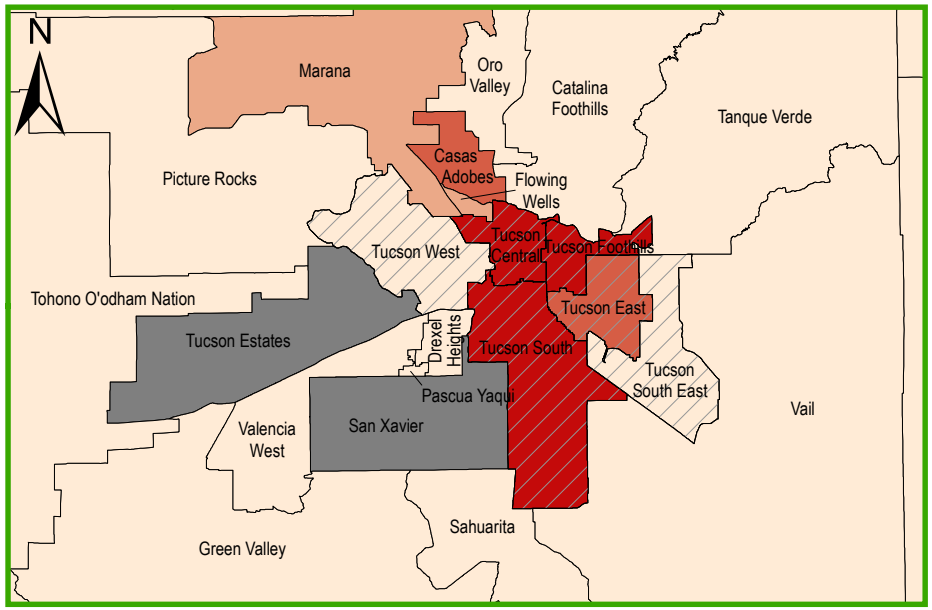
ARIZONA DEPARTMENT OF HEALTH SERVICES

Data Source: AZ-PIERS and MEDSIS

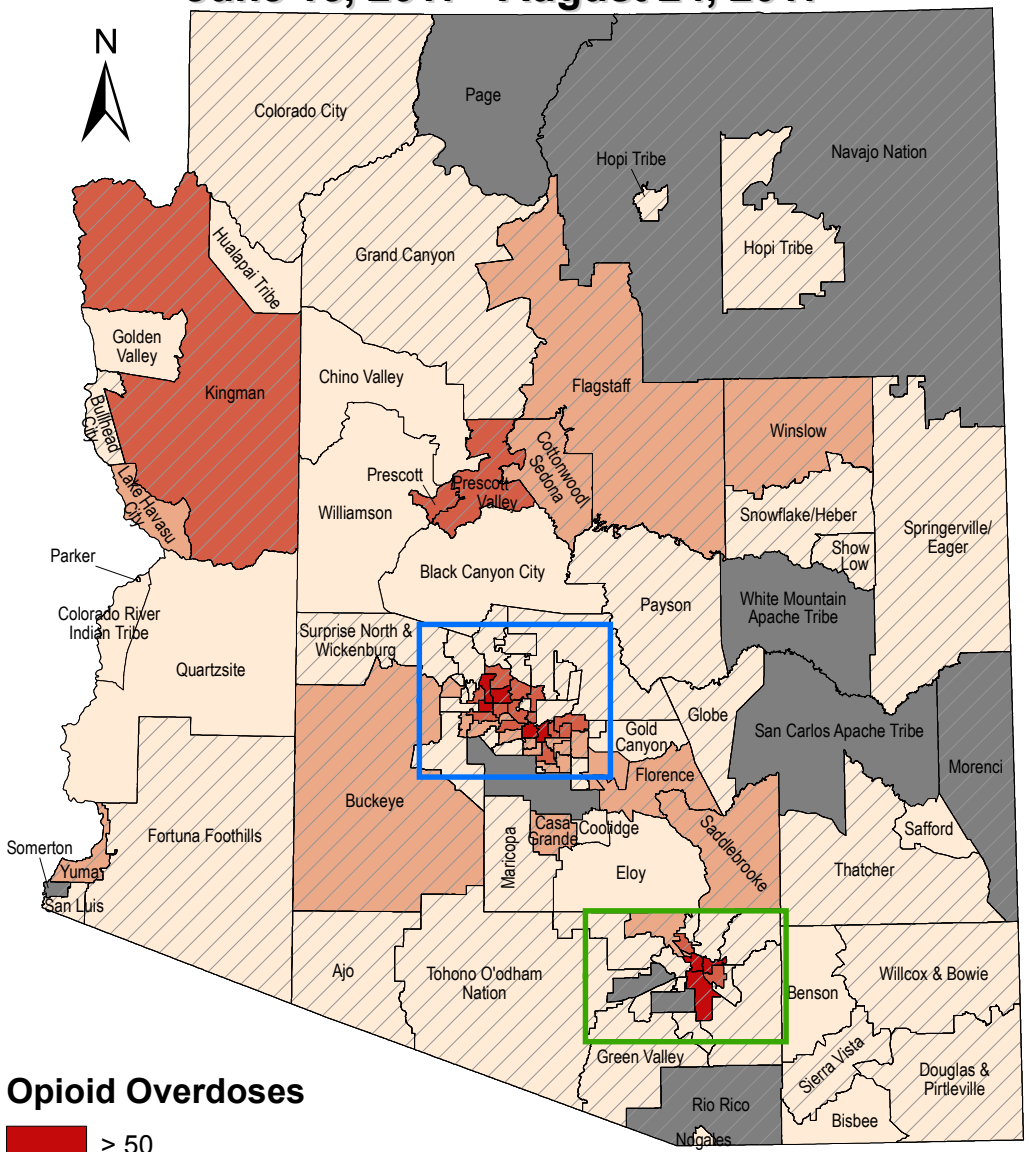
Metro Phoenix



Metro Tucson



Number of Suspected Opioid Overdose Related Events by Primary Care Area (PCA), June 15, 2017 - August 24, 2017*



Opioid Overdoses

- > 50
- 26 - 50
- 11 - 25
- 1 - 10
- No Suspected Overdoses

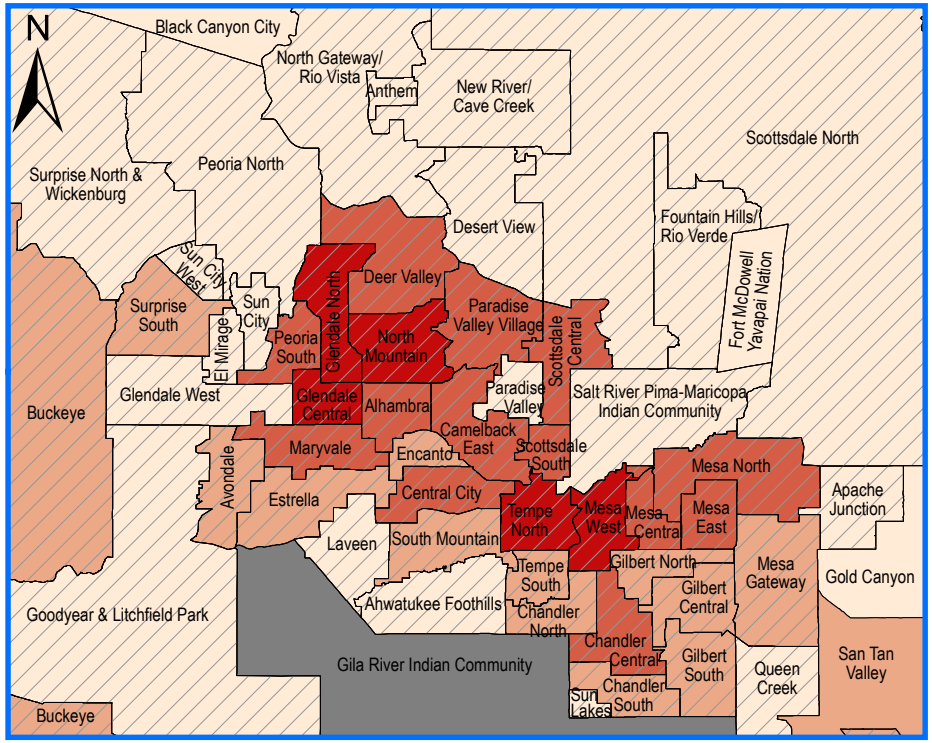
Law Enforcement Trained to Administer Naloxone

*310 overdoses (14.5%) were not assigned a PCA

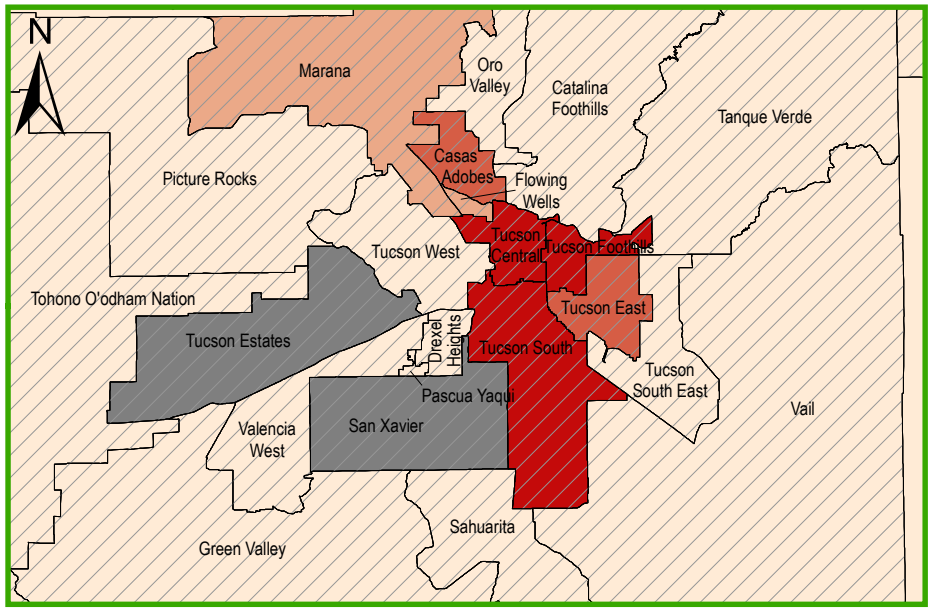
ARIZONA DEPARTMENT OF HEALTH SERVICES

Data Source: AZ-PIERS and MEDSIS

Metro Phoenix



Metro Tucson



Appendix C
Goal Council 3 – Opioid Breakthrough Project Subgroup Recommendations

Goal Council 3: Illicit Supply Recommendations

Revised 08/31/2017

The recommendations below are those moved forward by the Illicit Supply sub-group members.

Recommendations	Legislative	Policy	Programmatic	Resource	Assignment/Lead
Subgroup Priorities/Recommendations					
Continue statewide Naloxone Training and Voucher program for Law Enforcement and First Responders.			X	X	ADHS
Establish a statewide system/policy to assist DEA Tactical Diversion Squad to fill vacant local positions on the task force.		X		X	Governor's recommendations/ADHS
Work with regulatory boards and agencies to establish enforcement mechanisms for pill mills and illegal opioid dispensing.	X	X			Governor's recommendations/ADHS

Goal Council 3: Rx Supply Subgroup

Revised 08/31/2017

The recommendations below are those moved forward by the Rx Supply sub-group members.

Rx Supply Subgroup Draft Recommendations	Legislative	Policy	Programmatic	Resource	Assignment/Leads
Subgroup Priorities					
Identify models to expand use of evidence-based non-opioid pain management treatment options starting with AHCCCS as a model, and support efforts for appropriate coverage	X	X			Governor's recommendations/ADHS
Continue to enhance the CSPMP to be more robust, user-friendly, including linking to electronic health records			X		Governor's recommendations/ADHS
Promote and educate providers on the use of alternative methods of treating acute and chronic pain			X		Rx Supply Subgroup/ADHS
Subgroup Recommendations					
Promote and educate providers on the use of alternative methods of treating acute and chronic pain. Educate patients and the general public on non-narcotic options, including: a. Complementary and Alternative Medicine (CAM) to manage pain. b. Encourage providers to seek information from pain management centers of excellence to learn about non-opioid pain management modalities, including CAM. c. Educate insurers about the long-term cost-savings of reimbursements for evidence-based non-narcotic pain management options d. Educate providers on how to appropriately document recommended non-narcotic pain management approaches when submitting reimbursement claims to insurers.			X		PRIORITIZED: Rx Supply Subgroup/ADHS
Require medical, osteopathic, nursing, and dental schools to have a pain management course and safe prescribing curricula.	x				Governor's recommendations/ADHS
Support CMS efforts to eliminate pain management from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) payment score.		x			Governor's recommendations/ADHS
Support efforts to request that the Joint Commission, which accredits and certifies health care organizations, re-examine its pain management standards.		x			Governor's recommendations/ADHS

Goal Council 3: Rx Supply Subgroup

Revised 08/31/2017

The recommendations below are those moved forward by the Rx Supply sub-group members.

Rx Supply Subgroup Draft Recommendations	Legislative	Policy	Programmatic	Resource	Assignment/Leads
Require and expand prescriber education regarding opioid use for pain management.	X				Governor's recommendations/ADHS
Require pharmacists to check the CSPMP prior to dispensing an opioid or benzodiazepine	X				Governor's recommendations/ADHS
Expand interdisciplinary pain management programs (bio-medical and bio-social) to establish a team-based approach to pain management			X		Governor's recommendations/ADHS
Create a call-in line resource to provide consultation to prescribers seeking advice about prescribing opioids and caring for patients with opioid use disorder.			x	x	Governor's recommendations/ADHS
Enable the Board of Pharmacy to share prescribing outlier information with licensing boards, health plans/systems, and professional associations to target education/interventions.		X			Governor's recommendations/ADHS
Restrict pharmacies from dispensing opioids without either electronic or paper proof that the prescriber checked the CSPMP.	x				No recommended action at this time

Goal Council 3: Demand Subgroup Recommendations

Revised 08/31/2017

The recommendations below are those moved forward by the Demand sub-group members.

Demand Subgroup Recommendations	Legislative	Policy	Programmatic	Resource	Assignment/Lead
Subgroup Priorities					
Require informed consent between prescriber and patient prior to prescribing opioids. Informed consent should include at minimum the dangers of opioid use, non-opioid pain treatment options, MAT options, and treatment resources.	X				Governor's recommendations/ADHS
Implement Legislative changes to remove the burden of prior authorization for non-opioid pain treatment options.	X				Governor's recommendations/ADHS
Require insurance plans to reimburse prescribers for providing informed consent		X		X	Governor's recommendations/ADHS
Subgroup Recommendations					
Require Informed consent between prescriber and patient prior to writing for opioid prescription that includes the dangers of opioid use, available MAT options, and treatment resources.	X	X			Addressed in ADHS Health Care Institution rules/would need to expand to regulating boards
Require pharmacists to educate patients on the dangers and risks of opioids when dispensing opioids, and to post information on how to find MAT resources.	X				Demand Subgroup
Develop a Public Service Announcement to provide education to: current opioid users and family members about the risks and dangers associated with taking opioids.			X		Governor's recommendations/ADHS
Implement ADHS Chronic Pain Management Program and distribute to providers and general public for use.			X		ADHS
Incentivize insurance plans to reimburse prescribers for providing informed consent.	X	x			Governor's recommendations/ADHS
Develop and implement action plan and guidelines for the physician, process for reducing opioid usage for chronic pain patients (weaning schedule, question hotline)		X	X	X	Governor's recommendations/ADHS
Legislative changes to decrease the amount of time a prior authorization can take	X				Governor's recommendations/ADHS
Provide physicians with a call-in resource to help them with referrals, treatment guides, what to do with high risk patients, help decreasing opiates etc.			X	X	Governor's recommendations/ADHS

Goal Council 3: Treatment | Assess & Refer

Revised 08/31/2017

The recommendations below are those moved forward by the Treatment/Assess and Refer sub-group members.

Treatment Subgroup Recommendations	Legislative	Policy	Programmatic	Resource	Assignment/Lead
Subgroup Priorities					
Utilize harm reduction strategies to engage with the most vulnerable individuals to refer to care			X	X	ADHS to monitor trends
Fund and establish a call-in line and website for a 24/7 emergency information resource center for individuals seeking treatment, community members, and health care professionals to provide consultation, referrals, and general information about opioids and opioid use disorder			X	X	Governor's recommendations/ADHS
Expand on existing diversion programs (i.e., Angel, Law Enforcement Assisted Diversion, etc.) and ensure tools are available to First Responders to divert individuals with opioid use disorder to substance abuse treatment instead of jail		X	X	X	Governor's recommendations/ADHS
Subgroup Recommendations					
Develop and standardize recommendations and guidelines for medical screening, treatment and management of opioid use disorder in Arizona.			X		Governor's recommendations/ADHS
Develop and disseminate education, information, and treatment recommendations targeted to both MAT patients and providers.			X		Treatment subgroup
Develop a system for DCS (Department of Child Safety) to accept, refer, and have MAT facilities as "approved" resources within their referral or contractor resources as a service for parents.		X			Treatment subgroup
Develop a system to ensure a warm handoff of patients for both inpatient and outpatient providers.	X	X		X	Governor's recommendations/ADHS
Establish a task force to develop and implement value-based incentives to incentivize/reward physicians/practices who implement pain management strategies that improve outcomes. Require implementation of Value based purchasing across all payers.		X	X		Governor's recommendations/ADHS
Require all insurance companies to use standard criteria (as approved by Arizona Medicaid Program) to determine the level of care.		X	X	X	Governor's recommendations/ADHS
Require nurseries caring for NAS newborns to develop policies, procedures and protocols to screen for maternal substance abuse, screen and treat newborns for NAS,		X	X		Assess and refer subgroup

Goal Council 3: Treatment | Assess & Refer

Revised 08/31/2017

The recommendations below are those moved forward by the Treatment/Assess and Refer sub-group members.

Treatment Subgroup Recommendations	Legislative	Policy	Programmatic	Resource	Assignment/Lead
encourage maternal-infant bonding, and provide referrals to home visiting programs.					
Develop and enact a program to include peer supports as part of the first responder non-fatal overdose scene response (higher likelihood of navigation to treatment pathway).			X	X	Governor's recommendations/ADHS
Implement a "Street-based" reach-in program by peers in hotspot areas to provide ancillary needs (water, blankets, etc.) and navigation to medical and substance abuse treatment.			X		Governor's recommendations/ADHS
Require licensed residential treatment facilities to utilize standardized assessment criteria.		X	X	X	Assess and refer subgroup/ADHS

Goal Council 3: Treatment | Access to Care

Revised 08/31/2017

The recommendations below are those moved forward by the Treatment/Access to Care sub-group members.

Treatment Subgroup Recommendations	Legislative	Policy	Programmatic	Resource	Assignment/Lead
Subgroup Priorities					
Ensure access to all three forms of MAT across all payers and demographics					Governor's recommendations/ADHS
Implement MAT (all three medications) in state and county correctional facilities					Governor's recommendations/ADHS
Require licensed behavioral health residential facilities and recovery homes develop policies and procedures that allow individuals on MAT to continue to receive care in their facilities					Governor's recommendations/ADHS
Subgroup Recommendations					
Implement SAMHSA Guidelines for take home naloxone programs.		X	X		Treatment Subgroup
Prohibit fail-first protocols and prior authorization requirements to address the issue of treatment limits; require insurance providers to adhere to standardized medical necessity treatments, maintain an adequate provider network, provide transparent claim denials processes, and cover psychosocial treatment and MAT.	X	X		X	Governor's recommendations/ADHS
Lower the current requirements for two proofs of failed treatments and parent signature to increase access to care for juveniles.		X			Governor's recommendations/ADHS
Consider using location-specific rural hospitals (e.g. designated critical access facilities) to provide urgent, 7-days a week access to MAT. These EDs and/or the hospitals' pharmacies can be used to dispense medications.			X	X	Treatment Subgroup
Ensure access to treatment resources and programs for patients who are already opioid-addicted, provide provider reimbursement for urine drug testing, etc.			X	X	Treatment Subgroup

Goal Council 3: Death Subgroup

Revised 09/01/2017

The recommendations below are those moved forward by the Death sub-group members.

Death Subgroup Draft Recommendations	Legislative	Policy	Programmatic	Resource	Assignment/Lead
Subgroup Priorities					
Provide sustained funding to law enforcement agencies to purchase/replenish naloxone doses.		x	x	x	Death Subgroup/ADHS
Provide access to naloxone for high-risk individuals exiting an institutional facility.		x	x	x	Death Subgroup/ADHS
Provide training and access to naloxone to the general public.			x	x	Death Subgroup/ADHS
Increase Medical Intervention					
Pass a 911 Good Samaritan Law	x				Governor's recommendations/ADHS
Enable the Board of Pharmacy to share prescribing outlier information with licensing boards, health plans/systems, and professional associations to target education/interventions.		X			Governor's recommendations/ADHS
Licensing boards to mandate CE around poly-drug use	x			x	Governor's recommendations/ADHS
Include naloxone training in middle school and high school	x			x	Death Subgroup/Department of Education
Allow health care institutions and health plans access to CSPMP to help determine which physicians/legal prescribers may be over prescribing	x				Governor's recommendations/ADHS
Increase Access to Naloxone					
Provide public access points for naloxone to include public open/access areas; target high need communities; AED	x				Death Subgroup/ADHS
Provide sustained funding to law enforcement agencies to purchase/replenish naloxone doses.	x			x	Death Subgroup/ADHS
Access to naloxone to individuals with a history of opioid abuse who are discharging from a healthcare facility		x		x	Death Subgroup/ADHS
Standardized co-prescribing of naloxone with other drugs		x			Addressed in ADHS HCI rules/prescribing guidelines

Goal Council 3: Death Subgroup

Death Subgroup Draft Recommendations	Legislative	Policy	Programmatic	Resource	Assignment/Lead
Make available to homeowners "prescription lockboxes" to secure addictive prescription medications to reduce diversion opportunities.		x		x	Death Subgroup/ADHS
Establish a naloxone distribution plan based on first responder agency historical response times from 911 notification of a lethal exposure administration of naloxone and the number of naloxone doses per patient administered to elicit opioid reversal.			x		Death Subgroup/ADHS
Increase the Use of Naloxone					
Include Naloxone into CPR and other first aid training			x		Death Subgroup/ADHS
Develop and implement media and marketing campaigns			x	x	Governor's recommendations/ADHS
Expand providers to receive training/administering naloxone to EMT's, teachers, counselors other areas of practice			x	x	Death Subgroup/ADHS
Expand naloxone dosages and administration training to first responders and laypersons.			x	x	Death Subgroup/ADHS
Work with the large-chain movie theatre companies to include informative PSAs on the opioid crisis (number of deaths, age groups, family/social impacts, how to recognize an opioid overdose and to administer naloxone) before each movie/intermissions.			x		Governor's recommendations/ADHS
Other Recommendations					
Add to the ADHS Opioid Epidemic Website public accessible detailed epidemiological data beyond what's currently posted (e.g., first responder types administering naloxone doses; number of prehospital doses that saved lives, not just number doses).			x		ADHS

Goal Council 3: Youth Prevention

Revised 08/31/2017

The recommendations below are those moved forward by the Youth Prevention sub-group members.

Youth Prevention Subgroup Recommendations	Legislative	Policy	Programmatic	Resource	Assignment/Lead
Subgroup Priorities					
Mandate evidence based, emerging and best practice substance abuse prevention and early identification/curriculum be included in all Arizona middle and high schools	X				Governor's recommendations/ADHS/GOYFF
Develop and implement an ongoing intensive, effective, and evidence-based media campaign that uses clear, engaging, easy-to-remember, non-stigmatizing culturally appropriate messages discussing: a. Dangers of alcohol and drug abuse b. The importance of ongoing family conversation on drug and alcohol use c. Effective non-opioid pain-management options d. Educating the community about the addictive qualities of prescription medications and potential for unintentional drug overdose. e. Appropriate patient expectations of pain management f. Alternatives to drug/alcohol use g. Targeted information for community stakeholders (physicians, agencies, schools, EMS, etc.) on the importance and benefit of youth substance use screening and early interventions.			X	X	Governor's recommendations/ADHS/GOYFF
Form a statewide taskforce to develop community-based guidelines on substance abuse prevention programs, including out of school activities designed to reduce risky adolescent behavior			X		Governor's recommendations/ADHS/GOYFF
Subgroup Recommendations					
Establish a baseline of the effectiveness and number of youth reached through prevention programs currently offered in Arizona schools and through Student Resource Officer (SRO) programs. a. Develop a database for capturing current and ongoing prevention programs in schools and through SRO programs. b. Develop Arizona based guidelines for effective evidence based, emerging and best practice substance abuse prevention and early identification/curriculum			X	X	Youth Prevention Subgroup

Goal Council 3: Youth Prevention

Revised 08/31/2017

The recommendations below are those moved forward by the Youth Prevention sub-group members.

Youth Prevention Subgroup Recommendations	Legislative	Policy	Programmatic	Resource	Assignment/Lead
Provide drug prevention guidelines for schools to incorporate when developing and disseminating curriculum.			X		Youth Prevention Subgroup
Enhance training for school professionals (counselors, social workers, or nurses) to include the administration of behavioral health and substance abuse screening tools and the utilization of motivational interviews as problem behaviors are identified.			X	X	Youth prevention subgroup
Mandate consistent SRO training between local law enforcement the Department of Education and Arizona Student Resource Officer Association to include motivational interviewing and Drug Impairment Education Training for Education Professionals.		X	X	X	Youth Prevention Subgroup
Expand peer-to-peer prevention and collegiate recovery programs on all university and college campuses to increase student substance abuse resources and to expand drug-free events, campuses and communities.			X	X	Youth Prevention Subgroup
Expand after-school opportunities for youth from 3-6 PM to engage in prevention-based activities and life skill development.			X	X	Governor's recommendations/ADHS
Collect and analyze data on the number/percent of screenings conducted on youth under the age of 18.				X	Youth Prevention Subgroup
Conduct a literature review of screening and early intervention tools for youth through primary care physicians, hospital emergency departments, and specialists to identify screening and early intervention tools to determine which tools are most effective in identifying substance use.				X	Youth Prevention Subgroup
Train pre-hospital providers and first responders on utilizing SBIRT/DAST to identify substance use disorder in youth under the age of 18, as well as how to make			X	X	Youth Prevention Subgroup

Goal Council 3: Youth Prevention

Revised 08/31/2017

The recommendations below are those moved forward by the Youth Prevention sub-group members.

Youth Prevention Subgroup Recommendations	Legislative	Policy	Programmatic	Resource	Assignment/Lead
appropriate community-based referrals, as necessary.					
Educate physicians to screen all patients under the age of 18 for substance use disorder before prescribing any mind-altering medication or treatment. a. Include a box on the CSPMP that states, "I have screened this patient for substance use disorder." b. Work with electronic health record companies to incorporate a substance use section into their database.			X	X	Youth Prevention Subgroup
Mandate physicians/practitioners to provide families with a pamphlet on effective, non-opioid pain management options when considering opioid pain management therapies for youth under the age of 18.	X	X			Youth Prevention Subgroup
Mandate physicians/practitioners to have parents or legal guardians read and sign an informed consent form when prescribing opioids to anyone under the age of 18. The form should include but not limited to the following information: a. Appropriate expectations of pain management b. Effective forms of non-opioid pain management c. Dangers of opioid related addiction and overdose d. Danger of poly-drug use and necessity to disclose all other active medication e. Benefit of and how to obtain Naloxone f. Importance of keeping an inventory, securing all active prescriptions and how to safely dispose of any unused medications	X	X			Youth Prevention Subgroup (Informed consent is included in new rules for licensed health care institutions)

Goal Council 3: General Recommendations

Revised 08/31/2017

General Recommendations	Subgroup	Legislative	Policy	Programmatic	Resource	Assignment/Lead
Impose a limit on all first fills for opioid naïve patients for all payers	Rx Supply	X	X			Governor's recommendations/ADHS
Require different labeling and packaging for opioids ("red caps")	Demand	X	X			Governor's recommendations/ADHS
Regulate Pain Management Clinics to prohibit "pill mill" activities	Illicit	X				Governor's recommendations/ADHS
Create a task force of medical boards, pharmacy board, DEA, AGs	Illicit		X	X		Governor's recommendations/ADHS
Require Arizona medical schools to implement MAT, SBIRT, naloxone, and pain management education into the curriculum	Treatment					Governor's recommendations/ADHS
Create a task force to identify and implement an evidenced-based, early intervention program into elementary schools to prevent substance abuse	Youth Prevention		X			Governor's recommendations/ADHS
Eliminate dispensing of controlled substances by prescribers	Rx Supply	X				Governor's recommendations/ADHS
Enact a good Samarian law	Death	X				Governor's recommendations/ADHS
Require e-prescribing for schedule II controlled substance medications	Rx Supply	X	X	X		Governor's recommendations/ADHS
Require at least 3 hours of CME for all professions that prescribe/dispense opioids	Rx Supply	X	X	X		Governor's recommendations/ADHS
Establish an all payers claim database	Data	X				Governor's recommendations/ADHS
Engage the federal government to discuss the necessary federal changes to assist states with their responses to the Opioid Epidemic	Various		X			Governor's recommendations/ADHS