THE OPIOID CRISIS AND PUBLIC HEALTH EXPERIENCES IN THE DISTRICT OF COLUMBIA IN 2020

More resources available at:
https://dchealth.dc.gov/dcrx

COLLABORATORS

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OVERVIEW

- This module will feature a reflection of public health data on the opioid crisis aimed at providers and pharmacists in DC. The DC government has undertaken a multi-pronged strategy to thwart deaths and morbidity associated with opioid use disorder (focus on prescribed opioids). An update on non-fatal opioid event outcomes will be presented and reflect strategic interventions.
- This module will give providers an update on strategies and their roles in mitigating the harmful effects of opioid medications. Clinical perspectives will be provided from acute pain management, chronic pain interventions, and health system information systems to support responsible opioid management.

LEARNING OBJECTIVES

- Learners using this module will attain an up-to-date understanding of key statistics and regulations that reflect the DC strategic plan in addressing opioid overprescribing and opioid use disorder.
- Learners will attain an understanding of the use of Prescription Drug Monitoring Program in responsible prescribing of opioid medications.
- Health care professionals will learn from peers about perspectives for best practice applications of evidence-based pain management practices and responsible use of opioid medications.
- Learners will gain practical insights about health informatics infrastructure supporting responsible opioid prescribing practices and patient management.

COURSE ADVISORS

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  School of Pharmacy
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  Administration for HIV Policy and Programs
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  District of Columbia
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  Supervisory Pharmacist, Health Regulation and Licensing Administration

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Policy Director, Office of the Deputy Mayor for Health and Human Services

TRENDS IN FATAL OPIOID OVERDOSES IN THE DISTRICT OF COLUMBIA IN 2020

Chikarlo Leak, DrPH, MPH
Policy Director, Office of Deputy Mayor for Health and Human Services

2019 OCME CASE STATISTICS

In 2019, OCME completed a total of **1,343** forensic examinations (autopsy, external examinations, and medical records reviews).

Suicide 5%
Undetermined 1%
Accident 43%
Natural 39%
Homicide 12%

Top 3 Causes of Accidental Deaths

Asphyxia
Blunt Injury
Intoxication

0 100 200 300 400 500

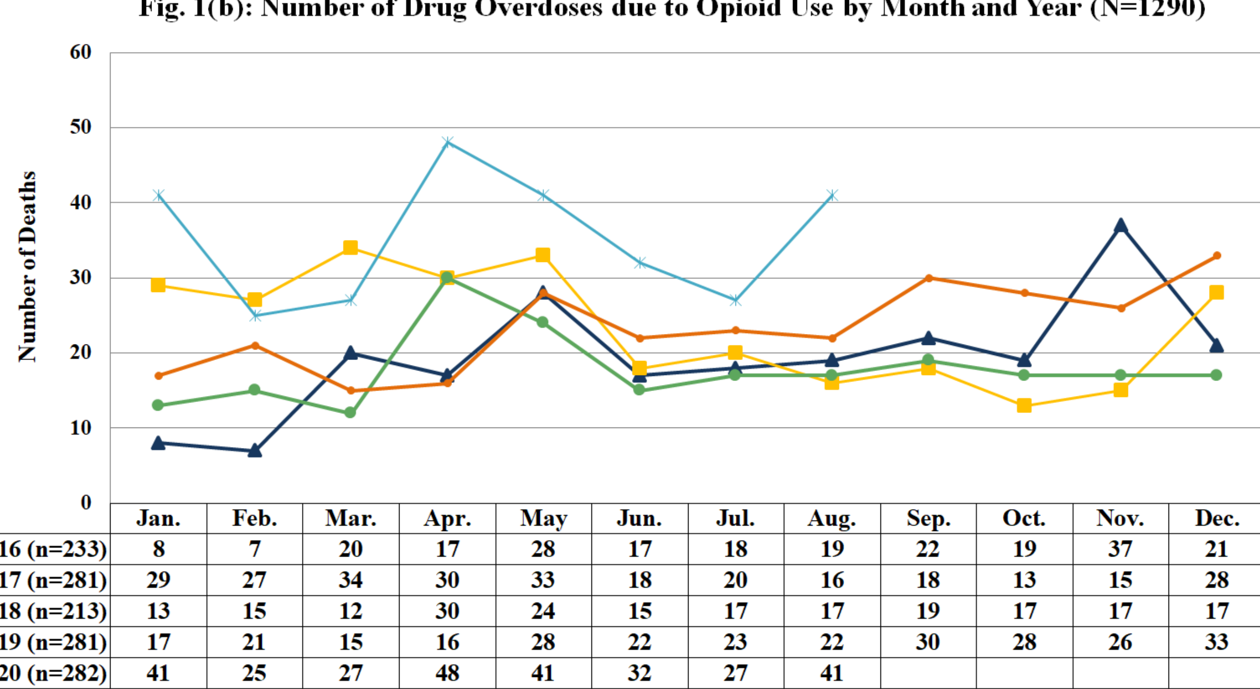
OFFICE OF THE CHIEF MEDICAL EXAMINER

- The DC Office of the Chief Medical Examiner (OCME) has investigated a total of **1290** opioid-related fatal overdose from January 2016 to August 31, 2020.

- Fatal overdose data – death investigation, social/medical history, forensic examination, toxicology

TRENDS IN NUMBER OF FATAL OVERDOSES DUE TO OPIOID USE

- From 2017 to 2018, we saw a decrease in average numbers of opioid overdoses per month, from 23 to 18. In 2019 however, the average number of fatal overdoses per month returned to 23.
- **There have been a total of 282 opioid overdoses in 2020 year to date.**

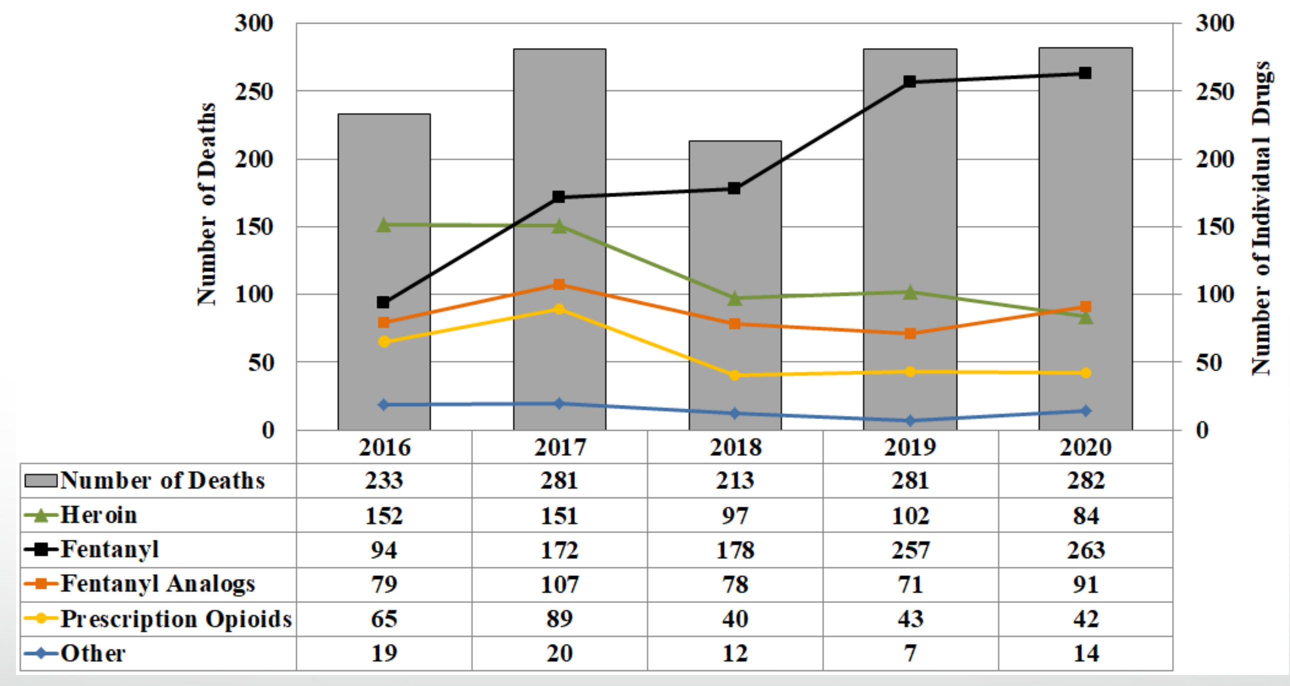


	Jan.	Feb.	Mar.	Apr.	May	Jun.	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.
2016 (n=233)	8	7	20	17	28	17	18	19	22	19	37	21
2017 (n=281)	29	27	34	30	33	18	20	16	18	13	15	28
2018 (n=213)	13	15	12	30	24	15	17	17	19	17	17	17
2019 (n=281)	17	21	15	16	28	22	23	22	30	28	26	33
2020 (n=282)	41	25	27	48	41	32	27	41				

Fig. 1(b): Number of Drug Overdoses due to Opioid Use by Month and Year (N=1290)

TRENDS IN THE NUMBERS OF OPIOID DRUGS CONTRIBUTING TO FATAL OVERDOSES

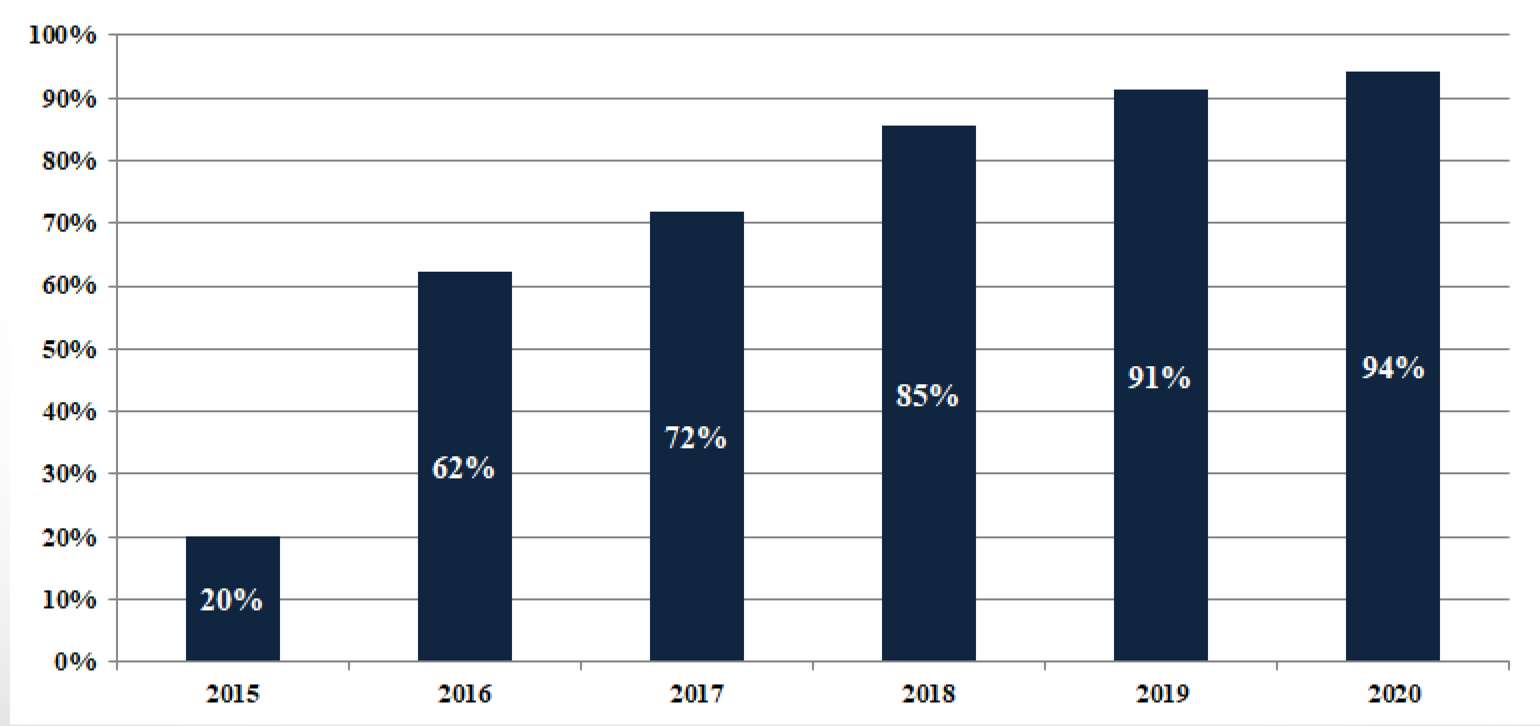
Overall, the most prevalent opioid drugs identified were fentanyl followed by heroin.



	2016	2017	2018	2019	2020
Number of Deaths	233	281	213	281	282
Heroin	152	151	97	102	84
Fentanyl	94	172	178	257	263
Fentanyl Analogs	79	107	78	71	91
Prescription Opioids	65	89	40	43	42
Other	19	20	12	7	14

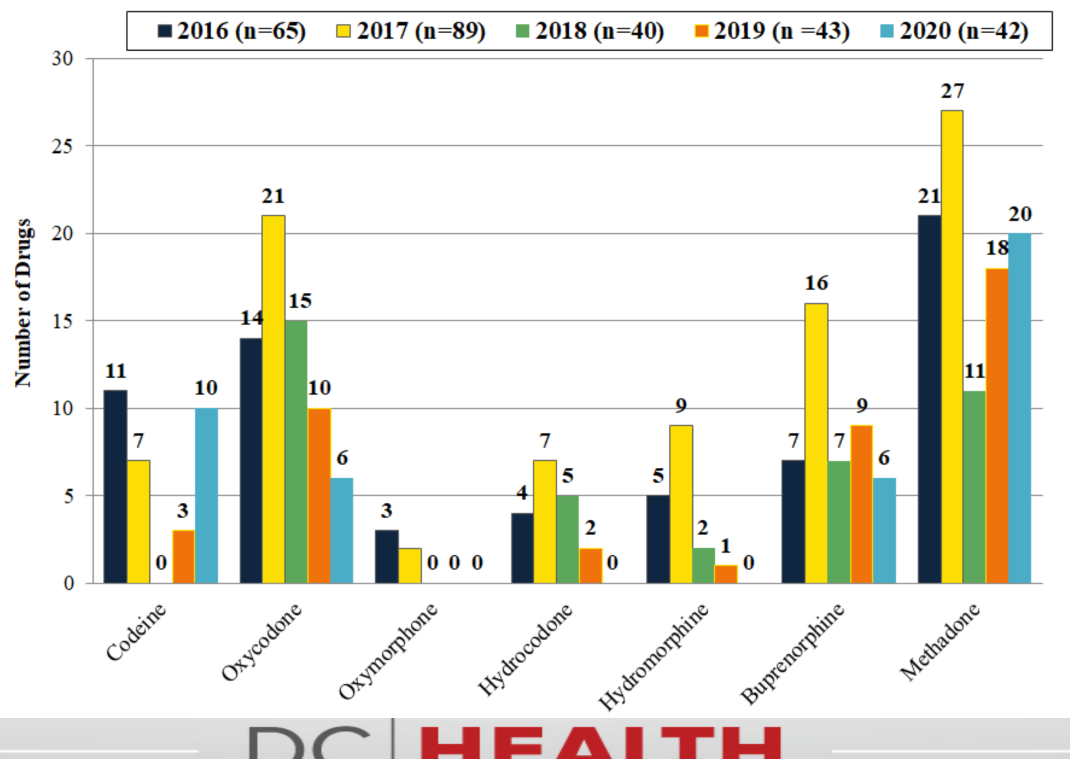
FATAL OVERDOSES CONTAINING FENTANYL/FENTANYL ANALOGS

The percentage of cases containing fentanyl or a fentanyl analog has gradually increased since 2015.



TRENDS IN PRESCRIPTION OPIOIDS IN FATAL OVERDOSES

The number of prescription opioids found in opioid related overdoses has varied over the years of data collection, however methadone and oxycodone are currently the most prevalent prescription opioids identified.



OVERALL DEMOGRAPHICS

- 74% of the decedents are males
- 76% of the decedents are between the ages of 40-69
- 84% of the decedents are African American

DEMOGRAPHIC FIGURES

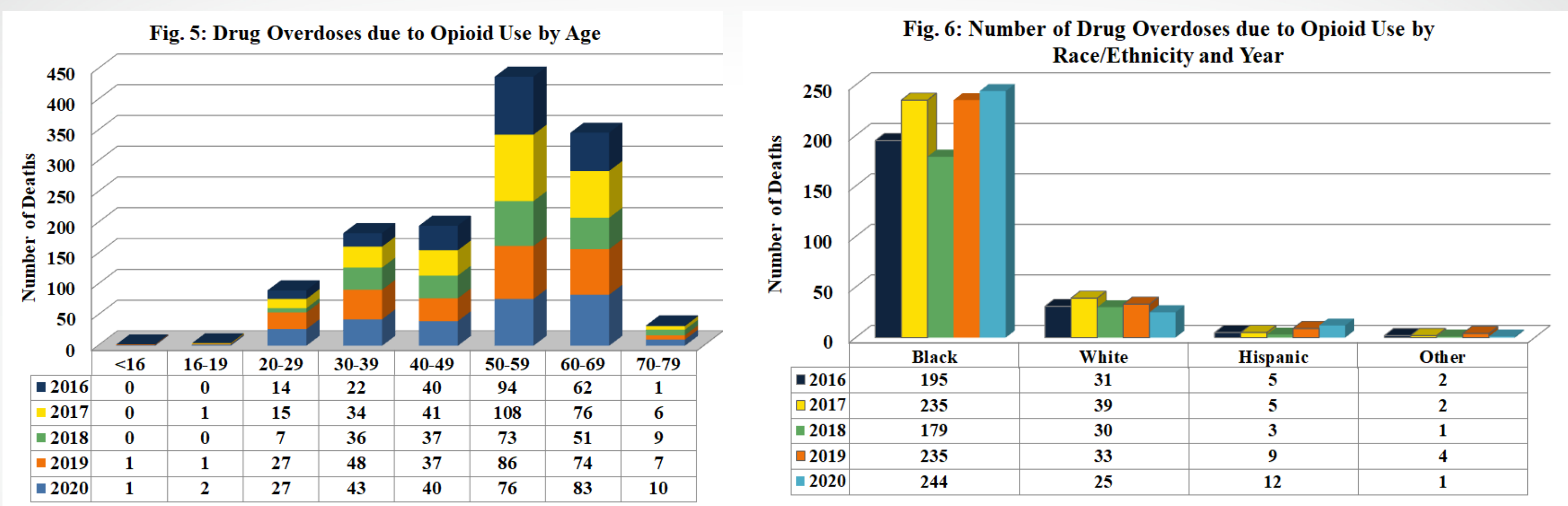


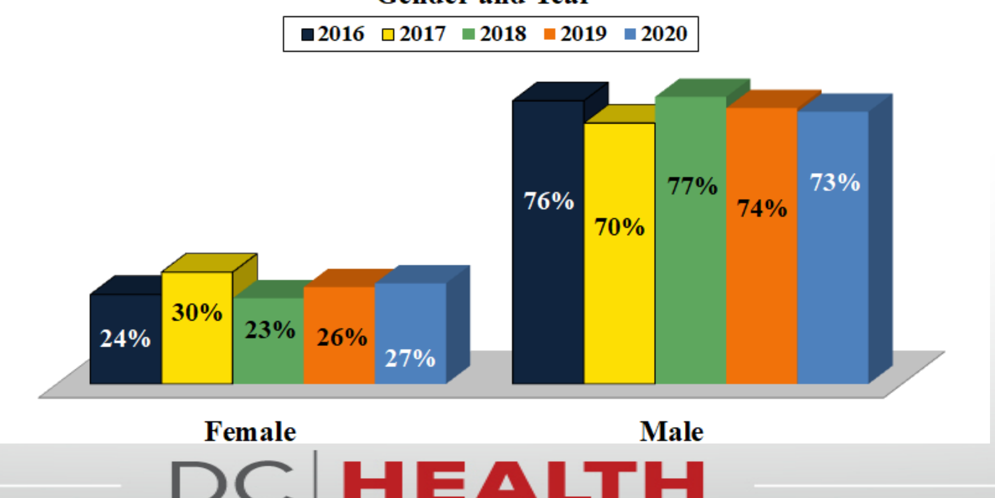
Fig. 5: Drug Overdoses due to Opioid Use by Age

	<16	16-19	20-29	30-39	40-49	50-59	60-69	70-79
2016	0	0	14	22	40	94	62	1
2017	0	1	15	34	41	108	76	6
2018	0	0	7	36	37	73	51	9
2019	1	1	27	48	37	86	74	7
2020	1	2	27	43	40	76	83	10

Fig. 6: Number of Drug Overdoses due to Opioid Use by Race/Ethnicity and Year

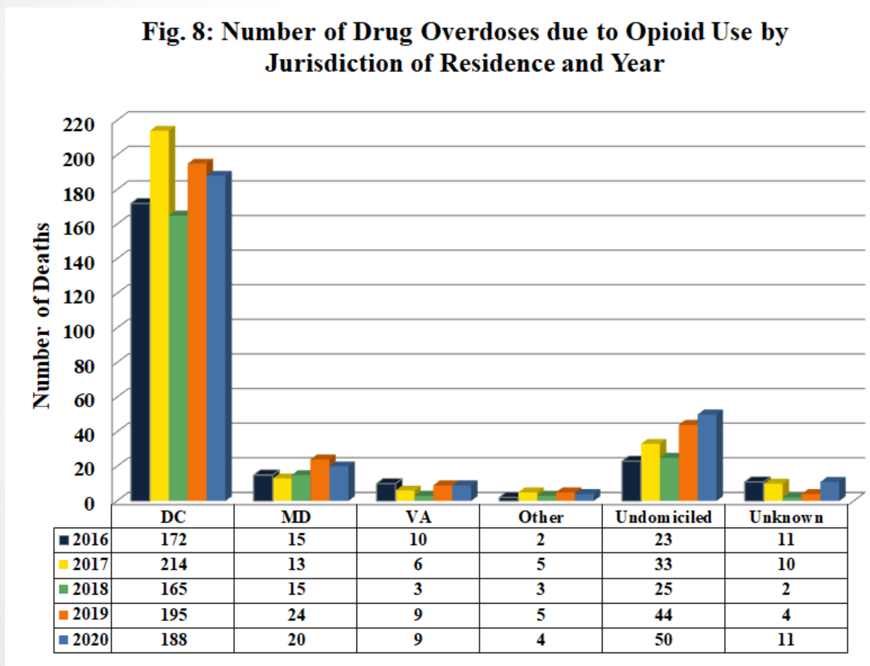
	Black	White	Hispanic	Other
2016	195	31	5	2
2017	235	39	5	2
2018	179	30	3	1
2019	235	33	9	4
2020	244	25	12	1

Figure 7: Percentage of Drug Overdoses due to Opioid Use by Gender and Year

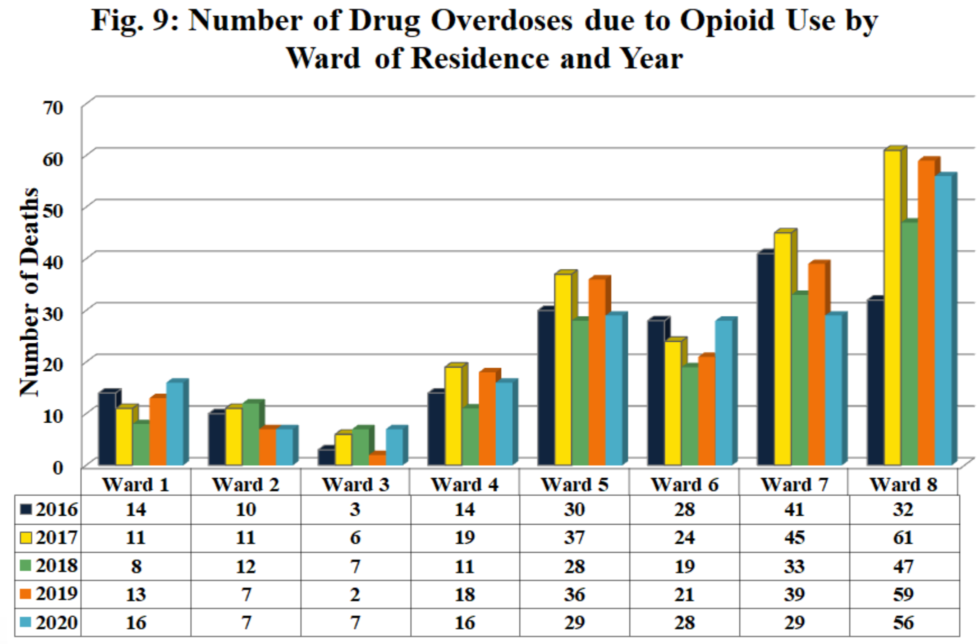


JURISDICTION OF RESIDENCE

The majority of decedents were residents of DC. Within DC, opioid related fatal overdoses were most prevalent in Wards 5, 7 & 8



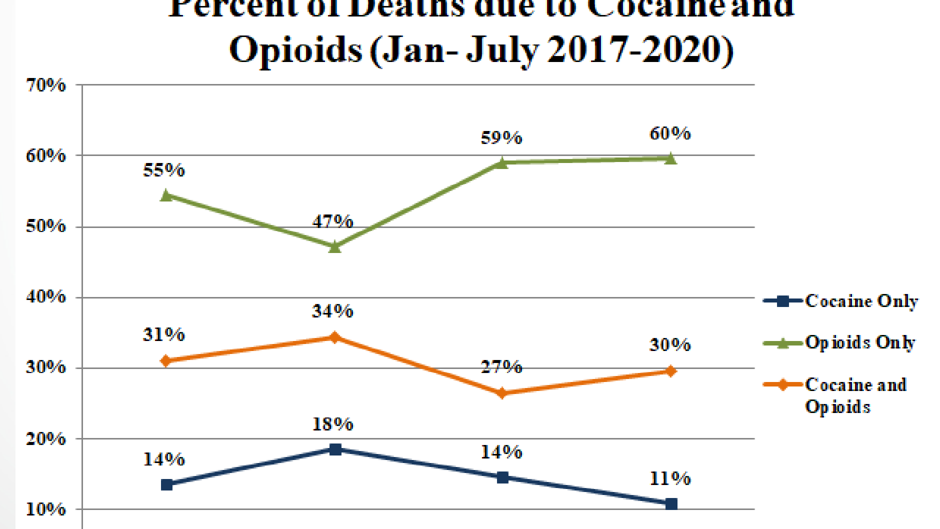
	DC	MD	VA	Other	Undomiciled	Unknown
2016	172	15	10	2	23	11
2017	214	13	6	5	33	10
2018	165	15	3	3	25	2
2019	195	24	9	5	44	4
2020	188	20	9	4	50	11



	Ward 1	Ward 2	Ward 3	Ward 4	Ward 5	Ward 6	Ward 7	Ward 8
2016	14	10	3	14	30	28	41	32
2017	11	11	6	19	37	24	45	61
2018	8	12	7	11	28	19	33	47
2019	13	7	2	18	36	21	39	59
2020	16	7	7	16	29	28	29	56

TRENDS IN COCAINE AND OPIOID OVERDOSES

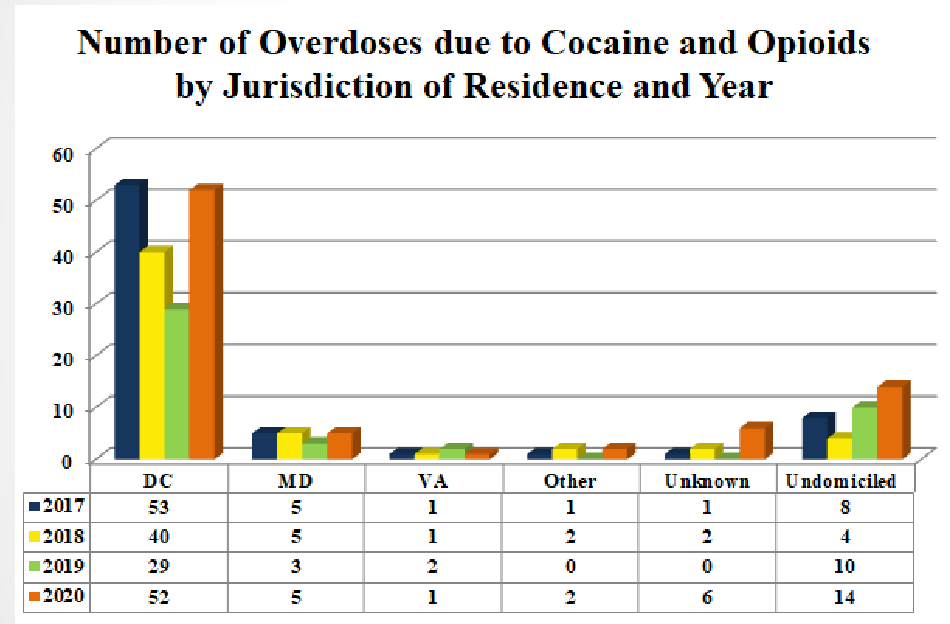
The percentage of overdoses due to a combination of opioids and cocaine has varied over the years. Notably, between 2018 and 2019 (January through July), the percentage of overdoses involving only opioids increased, while overdoses containing both cocaine and opioids and overdoses containing only cocaine decreased. Demographically, there has been a significant increase in both Black Males and Females from 2019 to 2020.



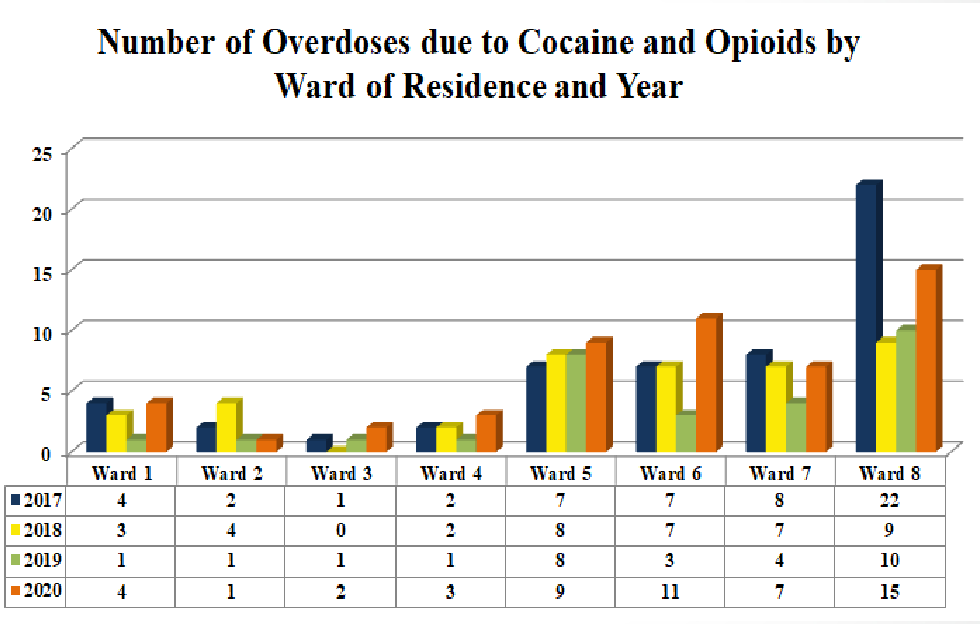
Breakdown of Cocaine and Opioid Overdoses by Year, Race and Gender (Jan- July)

	2017	2018	2019	2020
Black				
Male	40	39	24	44
Female	22	9	13	26
White				
Male	4	3	3	5
Female	2	2	2	2
Other				
Male	1	1	1	3
Female	0	0	1	0

JURISDICTION OF RESIDENCE AMONG COCAINE AND OPIOID OVERDOSES

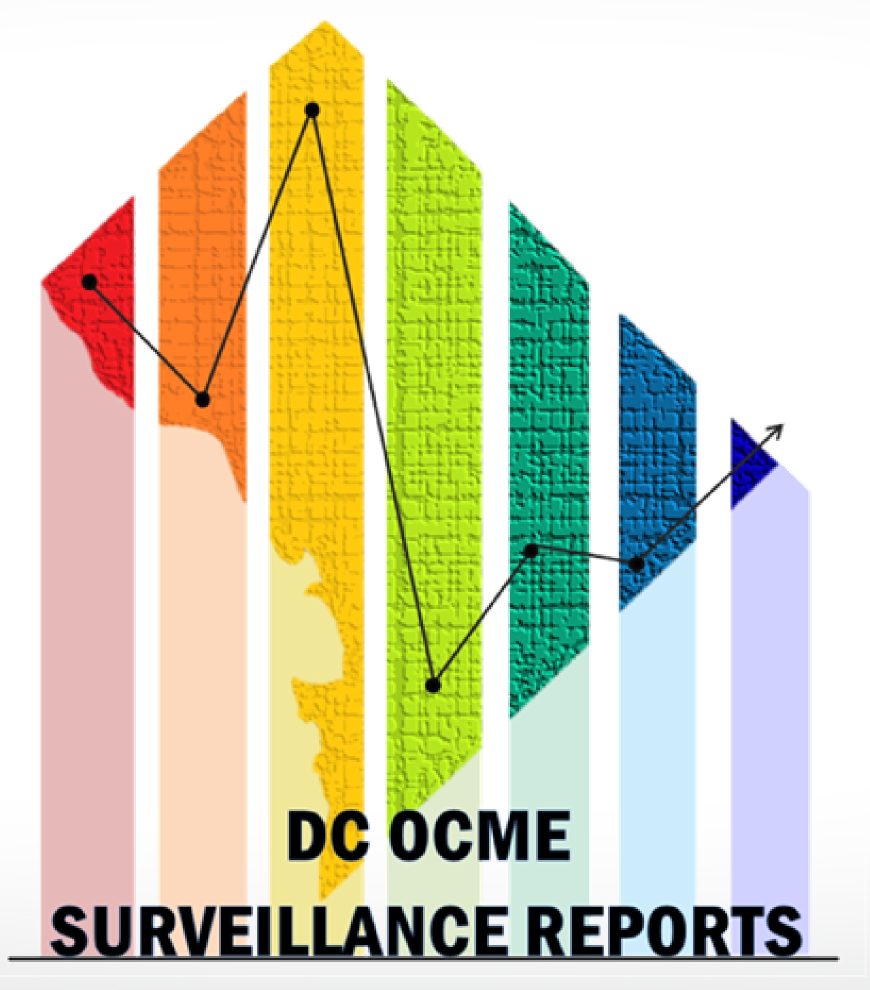


	DC	MD	VA	Other	Unknown	Undomiciled
2017	53	5	1	1	1	8
2018	40	5	1	2	2	4
2019	29	3	2	0	0	10
2020	52	5	1	2	6	14



	Ward 1	Ward 2	Ward 3	Ward 4	Ward 5	Ward 6	Ward 7	Ward 8
2017	4	2	1	2	7	7	8	22
2018	3	4	0	2	8	7	7	9
2019	1	1	1	1	8	3	4	10
2020	4	1	2	3	9	11	7	15

QUESTIONS/COMMENTS?



The Opioid Crisis and Public Health Experiences in the District of Columbia in 2020

Justin D. Ortique, Pharm.D., RPh,
Supervisory Pharmacist at the District of Columbia Department of Health

LEARNING OBJECTIVES

- Briefly summarize the purpose and history of the DC PDMP
- Highlight of Gateway Integration and its benefits
- Analyze an example Prescriber Report
- Outline a Patient Query and NarxCare Report
- Discuss Mandatory Registration, Mandatory Query, and the SUPPORT Act
- Review the PDMP website, resources, and communications

DISCLAIMERS

- The DC PDMP should be used as a tool to assist providers with their treatment decisions
- There are no punitive consequences intended for providers who use the DC PDMP
- There are no penalties associated with failure to query the DC PDMP
- There are (currently) no mandates for providers to query the DC PDMP

WHAT IS A PRESCRIPTION DRUG MONITORING PROGRAM?

- PDMPs are electronic databases used to monitor prescription trends within a jurisdiction by reporting the dispensation of targeted controlled drugs.
- Information is collected from dispensers to monitor controlled substance dispensations
- Prescriber's and dispensers are encouraged to use PDMP data to make informed patient care decisions
- This information may be used to monitor matters of substance abuse, fraud or diversion
- PMP AWARxE (developed by Appriss) is the software vendor for the DC PDMP

DEFINITIONS

- Covered Substance
  - All drug products containing cyclobenzaprine, butalbital, or gabapentin
  - All controlled substances included in schedule II, III, IV and V
- Administer
  - The direct application of a controlled substance, whether by injection, inhalation, topical application, ingestion, or any other means, to the body of a patient or research subject by a practitioner (or in the practitioner's presence, by the practitioner's authorized agent) or the patient or research subject at the direction of and in the presence of the practitioner
- Dispense
  - To distribute a drug to an ultimate user or research subject by or pursuant to the lawful order of a practitioner, including the prescribing, administering, packaging, labeling, or compounding necessary to prepare the substance for that delivery
- Reporting Period
  - The 24-hour time period immediately following the dispensing of a covered substance

DEFINITIONS

- Prescriber
  - A practitioner or other authorized person who prescribes a controlled substance or other covered substance in the course of his or her professional practice
- Dispenser
  - A practitioner who dispenses a covered substance to the ultimate user
- PDMP Advisory Committee
  - The multi-discipline committee established pursuant to section 3 of the Act, which functions under the Department to advise the Director on the implementation and evaluation of the District's prescription drug monitoring program
- Interoperability
  - The ability of that program to share electronically reported prescription information with another state, district, or territory of the United States' prescription drug monitoring program or a third party, approved by the Director, which operates interstate prescription drug monitoring exchanges

PDMP FLOW CHART

RxCheck (Federal)

Maryland PDMP (CRISP)

Health Care Practitioner

District of Columbia PDMP

NABP

Virginia PDMP

Rx

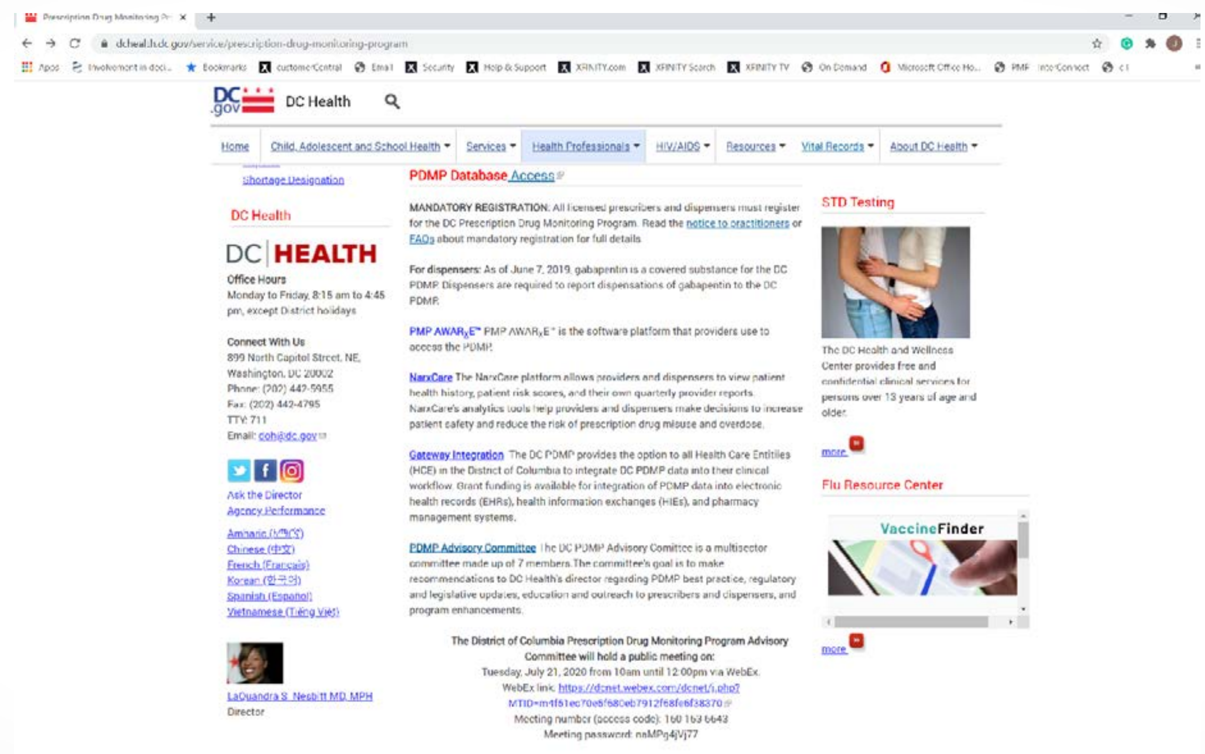
Gateway™ Integration

EHR, PMS & HIE (CRISP DC)

Pharmacy

Pharmacy Management System

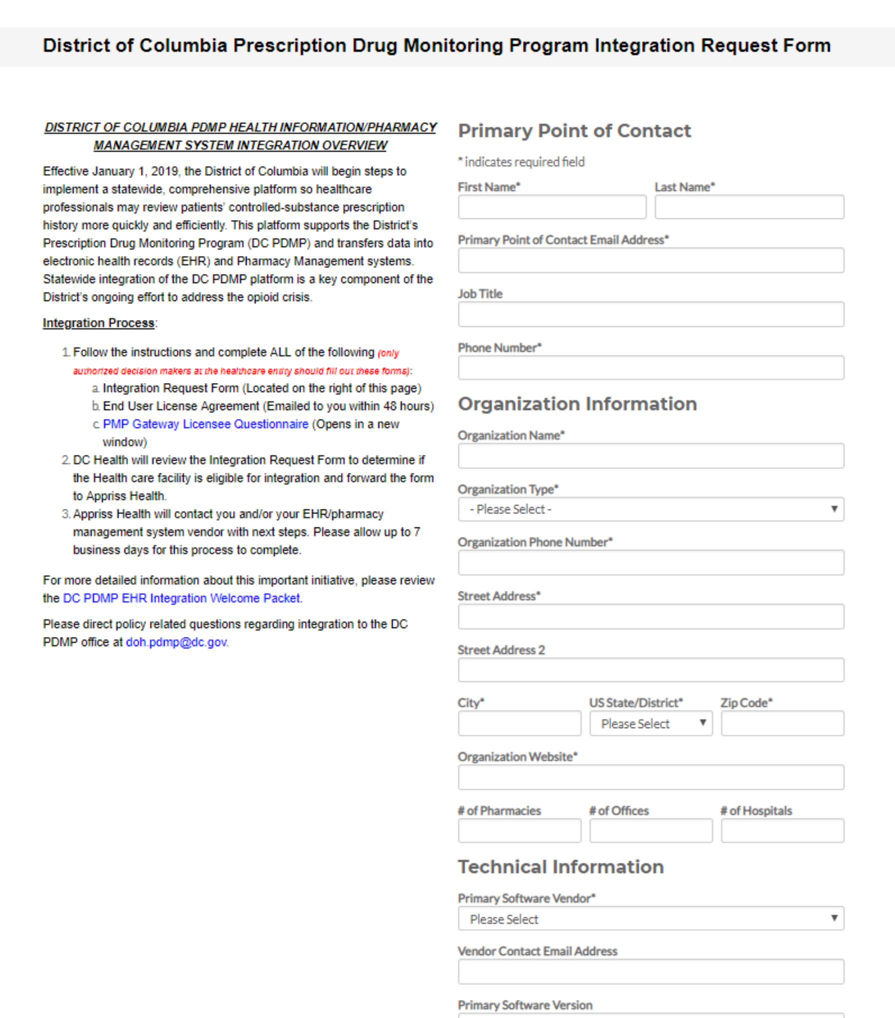
GATEWAY INTEGRATION



https://dchealth.dc.gov/service/prescription-drug-monitoring-program

GATEWAY INTEGRATION

- Grant funding is currently available for the integration of PDMP data into:
  - Electronic Health Records (EHRs)
  - Health Information Exchanges (HIEs)
  - Pharmacy Management Systems



District of Columbia Prescription Drug Monitoring Program Integration Request Form

DISTRICT OF COLUMBIA PDMP HEALTH INFORMATION/PHARMACY MANAGEMENT SYSTEM INTEGRATION OVERVIEW

Effective January 1, 2019, the District of Columbia will begin steps to implement a statewide, comprehensive platform so healthcare professionals may review patients' controlled-substance prescription history more quickly and efficiently. This platform supports the District's Prescription Drug Monitoring Program (DC PDMP) and transfers data into electronic health records (EHR) and Pharmacy Management systems. Statewide integration of the DC PDMP platform is a key component of the District's ongoing effort to address the opioid crisis.

Integration Process:

1. Follow the instructions and complete ALL of the following *(only authorized decision makers at the healthcare entity should fill out these forms)*:
   a. Integration Request Form (Located on the right of this page)
   b. End User License Agreement (Emailed to you within 48 hours)
   c. PMP Gateway Licensee Questionnaire (Opens in a new window)
2. DC Health will review the Integration Request Form to determine if the Health care facility is eligible for integration and forward the form to Appriss Health.
3. Appriss Health will contact you and/or your EHR/pharmacy management system vendor with next steps. Please allow up to 7 business days for this process to complete.

For more detailed information about this important initiative, please review the DC PDMP EHR Integration Welcome Packet.

Please direct policy related questions regarding integration to the DC PDMP office at doh.pdmp@dc.gov.

Primary Point of Contact

* indicates required field

First Name* | Last Name*

Primary Point of Contact Email Address*

Job Title

Phone Number*

Organization Information

Organization Name*

Organization Type*: - Please Select -

Organization Phone Number*

Street Address*

Street Address 2

City* | US State/District*: Please Select | Zip Code*

Organization Website*

# of Pharmacies | # of Offices | # of Hospitals

Technical Information

Primary Software Vendor*: Please Select

Vendor Contact Email Address

Primary Software Version

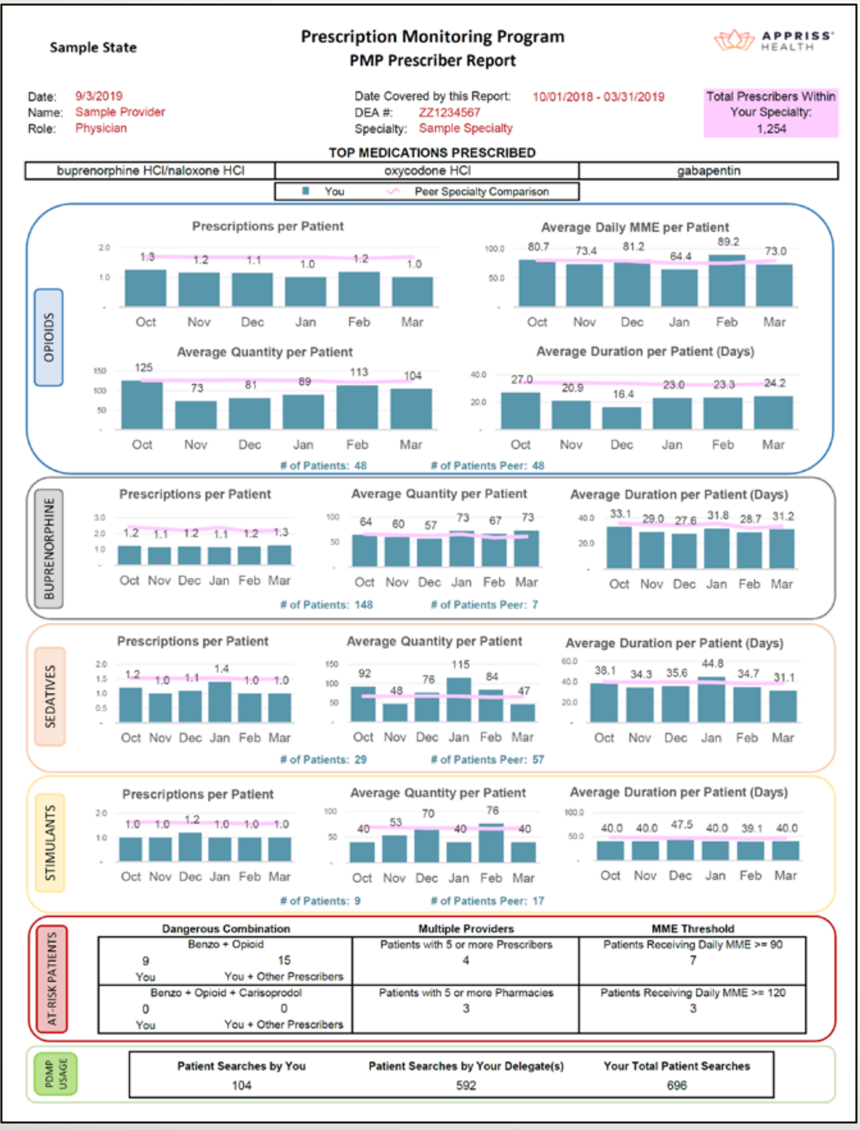
https://info.apprisshealth.com/dcpdmpehrintegration

NABP PMP INTERCONNECT

DC PDMP currently shares data with the following:

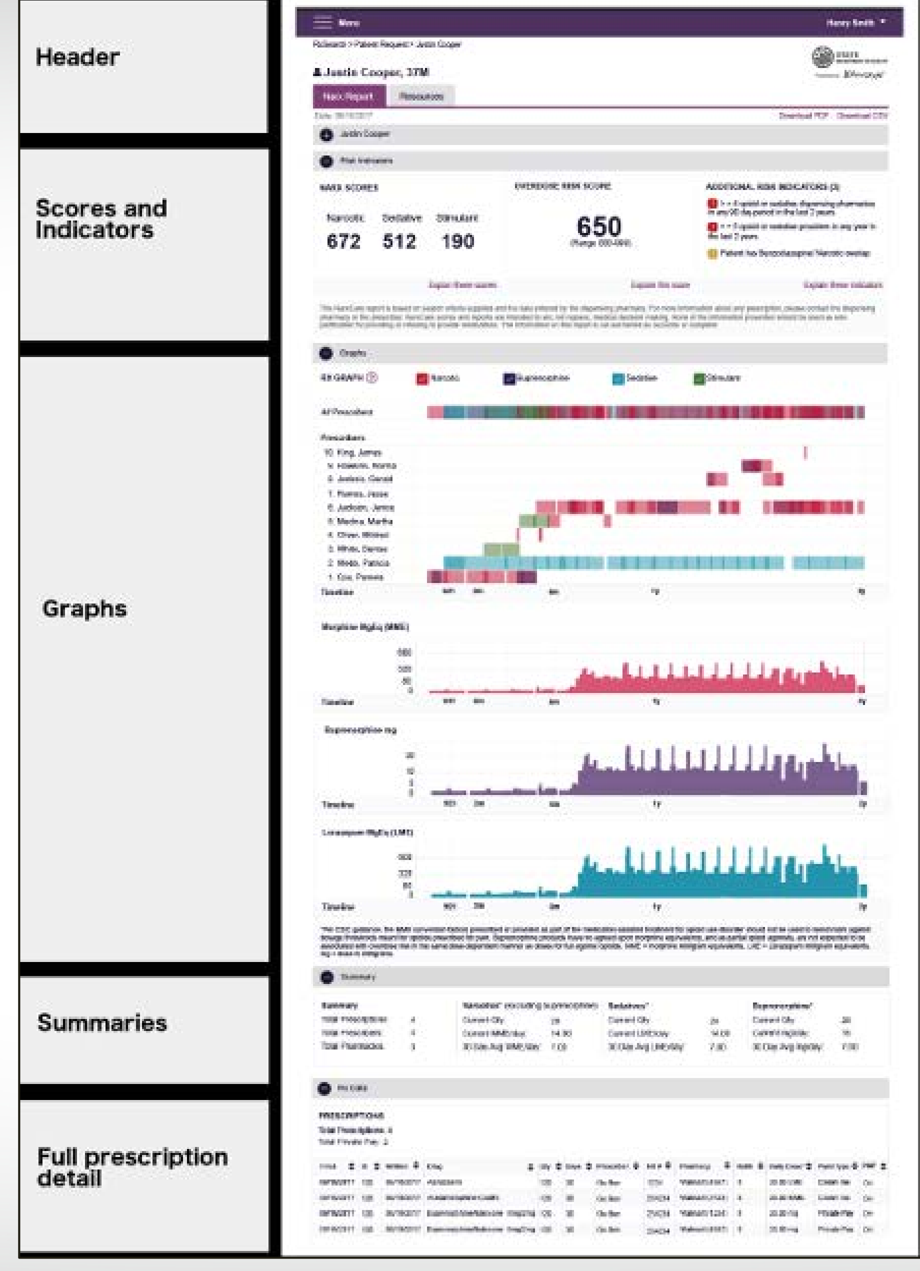
- Alabama
- Connecticut
- Delaware
- Georgia
- Indiana
- Iowa
- Kansas
- Louisiana
- Maryland
- Massachusetts
- Michigan
- Military Health System
- Minnesota
- Mississippi
- New Jersey
- New York
- North Carolina
- North Dakota
- Pennsylvania
- Puerto Rico
- Rhode Island
- South Carolina
- Texas
- VHA
- Virginia
- Washington
- West Virginia

PRESCRIBER REPORTS



- This report provides a summary of a healthcare provider's own prescribing history, compared to a prescriber of the same specialty
- Launched April 2018, updated February 2020
- Available on a quarterly basis to all registered prescribers who have prescribed at least 1 controlled substance in past 6 months
- Prescribers can access their Prescriber Report on their AWARxE Dashboard
- Report is not punitive and only shared with the prescriber

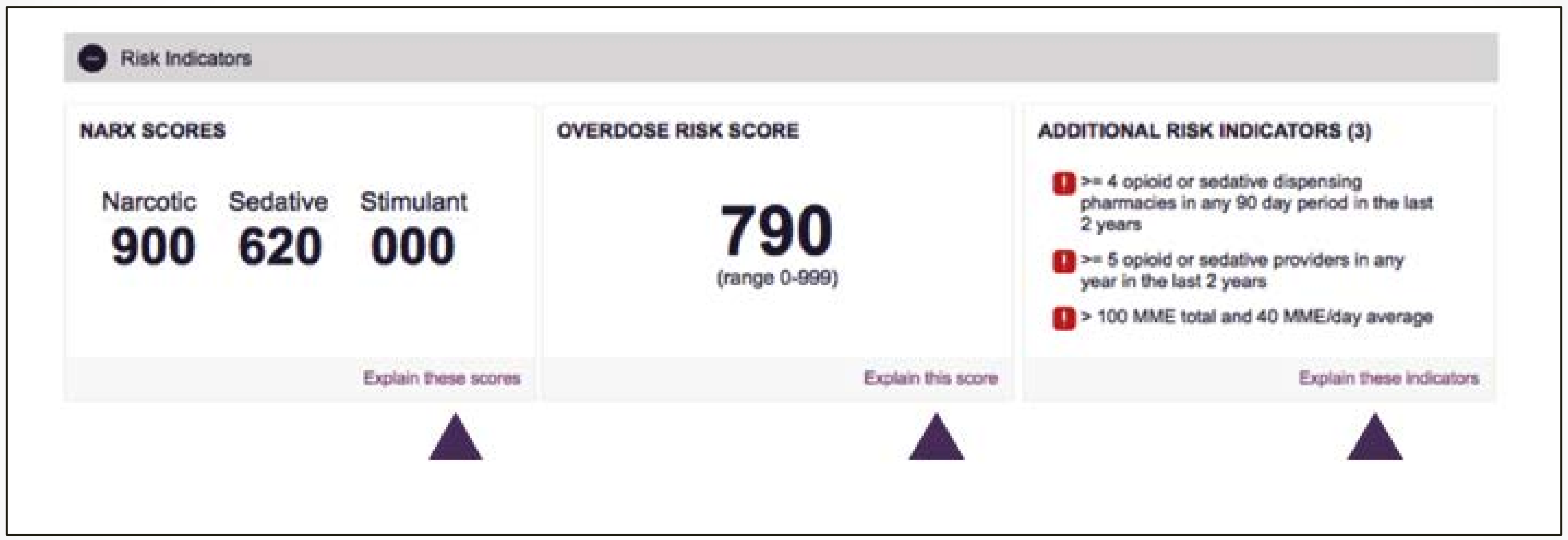
NARXCARE


Header
Scores and Indicators
Graphs
Summaries
Full prescription detail
Narcotic
Sedative
Stimulant
672
512
190
650

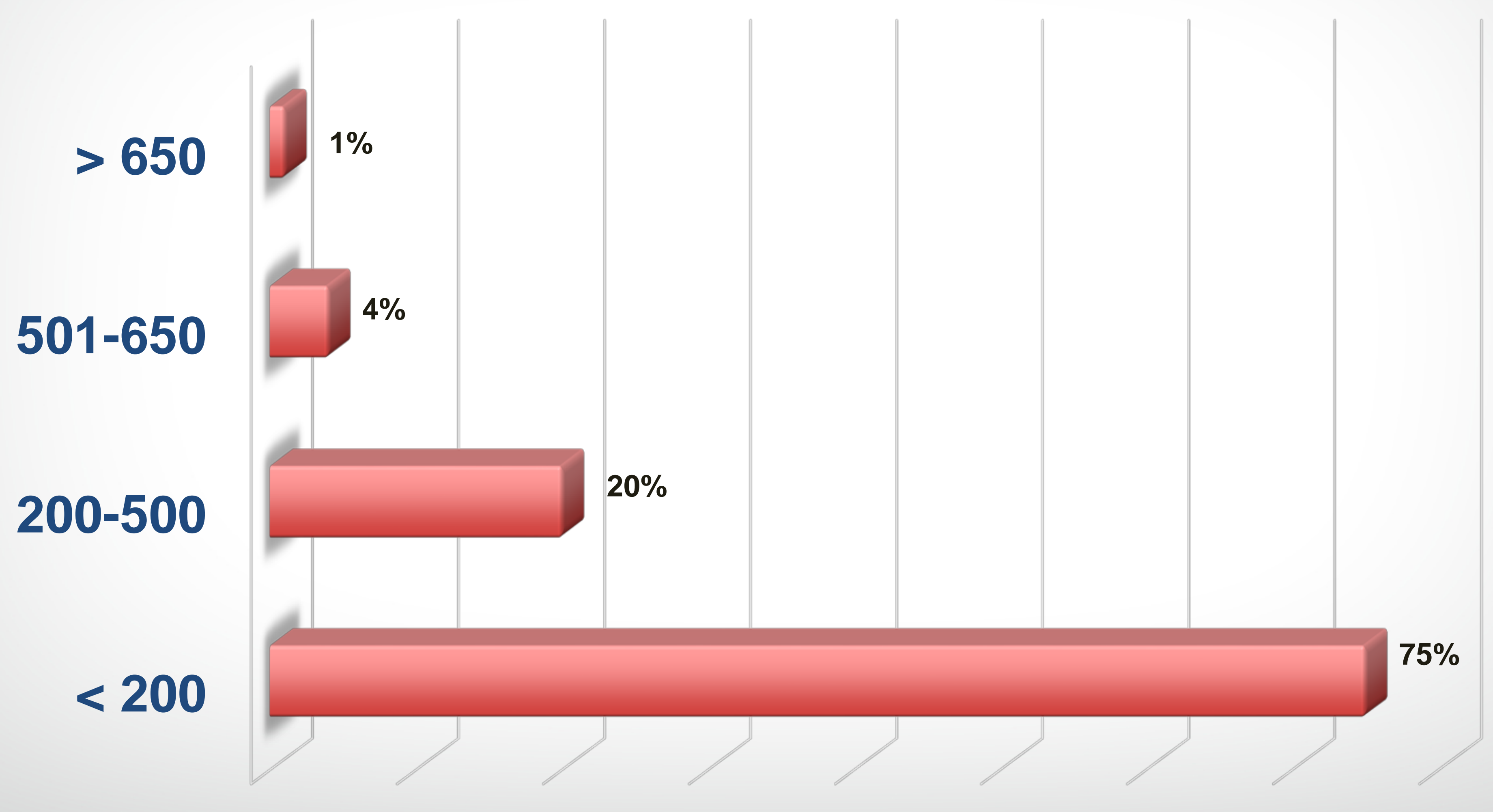
DC HEALTH

NARXCARE OVERVIEW: HEADER

NARXCARE OVERVIEW: SCORES AND INDICATOR



NARX SCORE DISTRIBUTION



DC | HEALTH

NARXCARE OVERVIEW: GRAPHS

Graphs

RX GRAPH ? Narcotic Buprenorphine Sedative Stimulant

All Prescribers

Prescribers

10. King, James
9. Hawkins, Norma
8. Jenknis, Gerald
7. Ramos, Jesse
6. Jackson, Janice
5. Medina, Martha
4. Oliver, Mildred
3. White, Denise
2. Webb, Patricia
1. Cox, Pamela

Timeline 9/21 2m 6m 1y 2y

Graphs

RX GRAPH ? Narcotic Buprenorphine Sedative Stimulant

All Prescribers

Prescribers

10. King, James
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7. Ramos, Jesse
6. Jackson, Janice
5. Medina, Martha
4. Oliver, Mildred
3. White, Denise
2. Webb, Patricia
1. Cox, Pamela

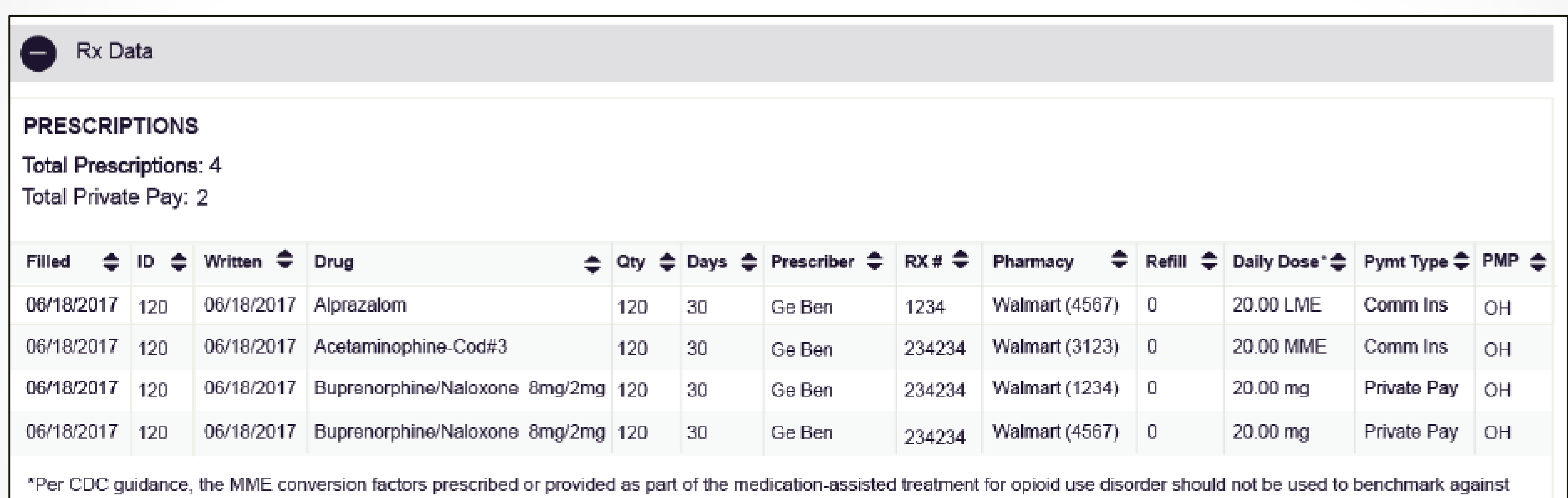
Timeline 9/21 2m 6m 1y 2y

Drug Details

Fill Date	Drug	Qty	Days	Prescriber	Pharm	Refill	MgEq	MgEq/Day
1/10/2017	MORPHINE 2 MG/ML SYRINGE	1	30	MAR PAT	WALL D	0	6.00	0.20
1/5/2017	HYDROCODONE-ACETAMIN 5-325 MG	10	5	MAR PAT	CVS	0	50.00	10.00
1/5/2017	HYDROCODONE-ACETAMIN 5-325 MG	28	5	HOL HEL	CVS	0	140.00	28.00

Close

NARXCARE OVERVIEW: FULL PRESCRIPTION DETAIL



Rx Data

PRESCRIPTIONS

Total Prescriptions: 4
Total Private Pay: 2

Filled	ID	Written	Drug	Qty	Days	Prescriber	RX #	Pharmacy	Refill	Daily Dose*	Pymt Type	PMP
06/18/2017	120	06/18/2017	Alprazalom	120	30	Ge Ben	1234	Walmart (4567)	0	20.00 LME	Comm Ins	OH
06/18/2017	120	06/18/2017	Acetaminophine-Cod#3	120	30	Ge Ben	234234	Walmart (3123)	0	20.00 MME	Comm Ins	OH
06/18/2017	120	06/18/2017	Buprenorphine/Naloxone 8mg/2mg	120	30	Ge Ben	234234	Walmart (1234)	0	20.00 mg	Private Pay	OH
06/18/2017	120	06/18/2017	Buprenorphine/Naloxone 8mg/2mg	120	30	Ge Ben	234234	Walmart (4567)	0	20.00 mg	Private Pay	OH

*Per CDC guidance, the MME conversion factors prescribed or provided as part of the medication-assisted treatment for opioid use disorder should not be used to benchmark against dosage thresholds meant for opioids prescribed for pain. Buprenorphine products have no agreed upon morphine equivalency, and as partial opioid agonists, are not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids. MME = morphine milligram equivalents. LME = Lorazepam milligram equivalents. mg = dose in milligrams.

PRESCRIBER SELF-REPORT (MYRX)

Menu
Admin

RxSearch > MyRx > MyRx Request

MyRx Request | MyRx History

My Rx

Prescriptions Written

From* MM/DD/YYYY
To* MM/DD/YYYY

DEA Numbers

Generic Drug Name (Optional)

Drug Name

Search

CLINICAL ALERTS

MANDATES

B22-0459 - Opioid Abuse Treatment Act of 2017

- Requires Prescribers and Pharmacists licensed in the District of Columbia to register with the DC PDMP.

- Prohibits Health Occupations Boards from licensing, renewing, reactivating, or reinstating a licensee that is required to be registered, without proof that the licensee has registered with the PDMP.

- Allows the FBI to obtain reports related to drug investigations.

- Enables the Program to take action against an individual that submits a false statement to the program to gain access to the database or who falsely alters information in the database.

- Allows the Program to review and analyze data collected in the system to identify misuse or abuse of covered drugs, possible violations of law or breaches of professional practice (pursuant to developed criteria), and to report this information to the relevant prescriber or dispenser.

TITLE 22-B DCMR, PUBLIC HEALTH AND MEDICINE CHAPTER 10

- 1003.2 Beginning August 1, 2019, prior to applying for renewal of a controlled substance registration, a practitioner shall be registered with the District of Columbia Prescription Drug Monitoring Program (PDMP).

- 1003.3 The department shall not renew a controlled substance registration for a practitioner that is not registered with the PDMP.

NATIONAL PDMP SNAPSHOT

MANDATORY REGISTRATION

- 33 states and D.C. require both prescribers and dispensers
- 9 states require prescribers only
- 8 states plus Puerto Rico have no mandates
- Guam requires dispensers only

MANDATORY QUERY

- 19 states require both prescribers and dispensers
- 27 states plus Puerto Rico and Guam require prescribers only
- 4 states plus Puerto Rico and D.C. have no mandates

FEDERAL SUPPORT ACT HIGHLIGHTS

On October 24, 2018, the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act was signed into law

Medicaid Partnerships

- Beginning October 1, 2021, Medicaid providers will be required to query the PDMP before prescribing a covered substance

Inclusion of more timely or real-time data contained within a PDMP:

- Sending proactive (or unsolicited) reports to providers
- Designing, validating, or refining algorithms for identifying high-risk prescribing activity to use as a trigger for proactive reports
- Improving PDMP infrastructure or information systems to support proactive reporting and data analysis, including enhancing reporting system to increase frequency and quality of reporting
- Developing and disseminating information or guidance to aid in proactive reporting (example guidance for opioid naïve patients, patients with overlapping opioids and benzodiazepines)

FEDERAL SUPPORT ACT HIGHLIGHTS

- Integrating tools such as cumulative morphine milligram equivalent (MME) calculations into patient PDMP reports
- Incorporating prescriber notification of patient overdose deaths
- Requiring pharmacists to check the prescription drug history of covered individuals through a qualified prescription drug monitoring program before dispensing controlled substances to such individuals
- Ensuring that PDMPs are easy to use and access by providers:
  - Facilitate improved delegate access and training
  - Expand access to PDMPs via integration into electronic health records, pharmacy management systems and health information exchanges

DELEGATE REGISTRATION

Registration Requirements

- Must be licensed, registered, or certified by a health occupations board
- Must be employed at the same location and under the direct supervision of the prescriber or dispenser
- Separate applications for delegate registration

Registration Process

- Application must include individual license, registration or certification number and a copy of another government issued ID
- Application must be co-signed by supervising prescriber or dispenser

Expiration of Registration

- Registration for delegates expire June 30th of every even-numbered year
- If the delegate becomes ineligible, the program must be notified in writing within 24 hours

RESOURCES

- For more information on the DC PDMP, please visit the District of Columbia, DC Health website at https://dchealth.dc.gov/pdmp
- For questions about the program, email doh.pdmp@dc.gov
- For free educational programs about opioids, please visit https://dchealth.dc.gov/dcrx
- Prescription Drug Monitoring Program Training and Technical Assistance Center (PDMP TTAC) at Brandeis University - http://www.pdmpassist.org/
- CDC Guideline for Prescribing Opioids for Chronic Pain - https://www.cdc.gov/drugoverdose/pdf/guidelines_at-a-glance-a.pdf
- For technical assistance, please contact Appriss at (855) 932-4767

QUESTIONS?

Opioid Overdose Surveillance in the District of Columbia

Kenan Zamore, MPH

OVERDOSE SURVEILLANCE

- 3 pronged strategy – fatal overdose surveillance – medical examiner, death certificate, toxicology

- Non-fatal overdose surveillance – ESSENCE, FEMS

- Dissemination

- Multi-agency work group sharing information

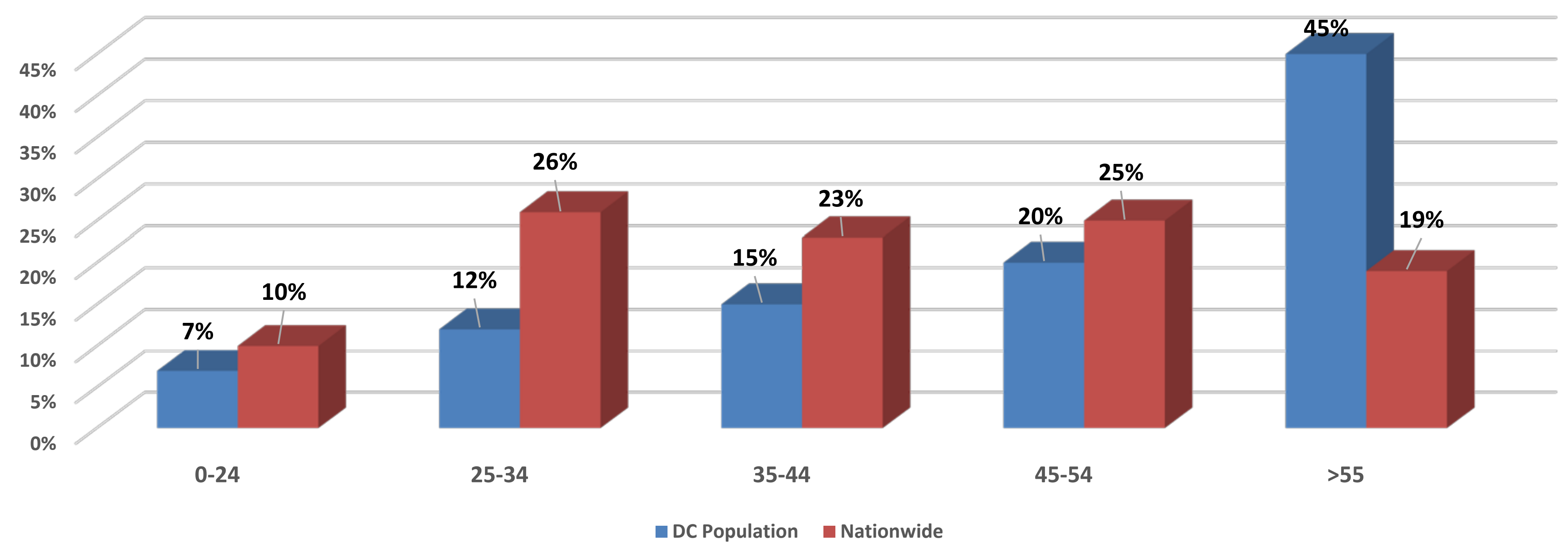
- Accurate picture of the typical opioid user in the District of Columbia/ Respond to and Prevent Overdose Clusters

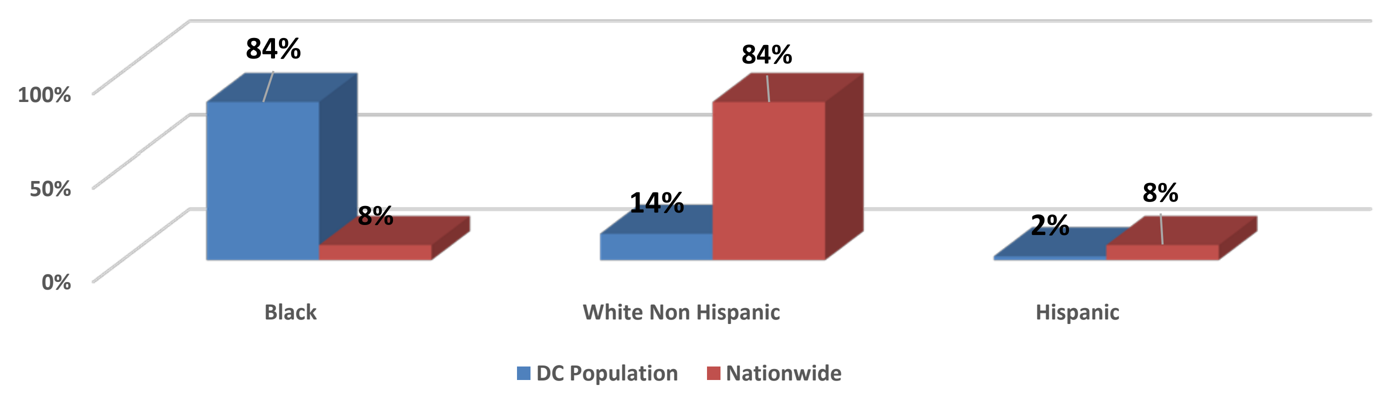
OPIOID OVERDOSE IN DC: SCOPE OF THE ISSUE

- DC Fire & EMS Narcan administration/ Deaths:
- 2014: 1,520 /83
- 2015: 1,731 / 131
- 2016: 1,831 / 231
- 2017: 2,118 / 279
- 2018: 2,078 / 213
- 2019: 2,265 / 278
- Naloxone administrations have more than
- Doubled (DC Fire and EMS Data)
- Deaths up over 200% in same period. Opioids now account for ~80% of drug poisoning deaths.

DC VS REST OF AMERICA

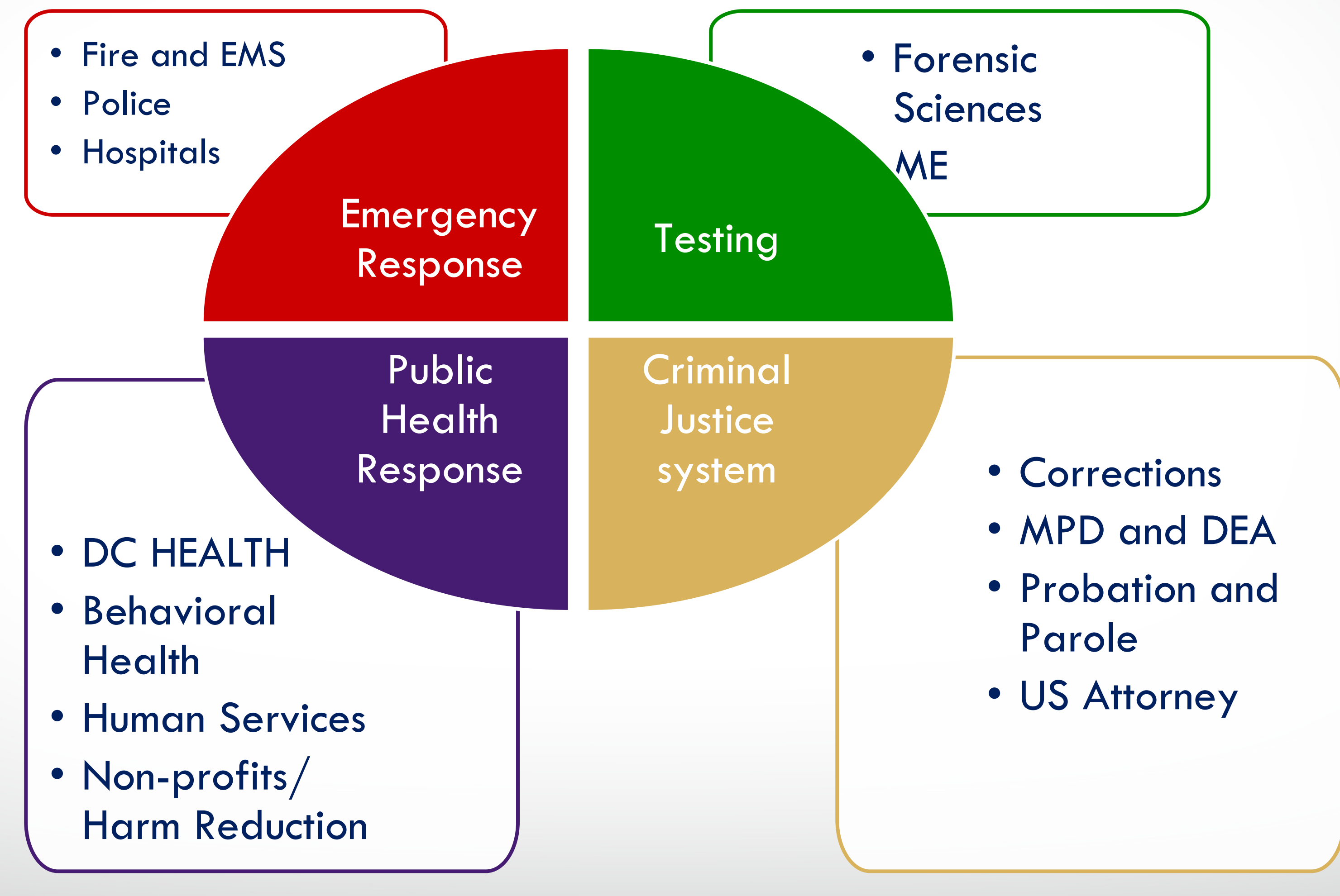
- Very different core group of users
- Average Opioid addict is older (mean age 54 years), less racially diverse (80% African-American)
- Long history of use
- Concentrated in smaller enclaves within the city (Wards 5, 7 and 8)


Age Distribution of Opioid Overdose Deaths in DC Compared to the US Population (2019)
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
7%
10%
12%
26%
15%
23%
20%
25%
45%
19%
0-24
25-34
35-44
45-54
>55
DC Population
Nationwide


Racial Distribution of Opioid Overdose Deaths in DC Compared to the US Population (2019)
100%
50%
0%
84%
8%
14%
84%
2%
8%
Black
White Non Hispanic
Hispanic
DC Population
Nationwide

DC HEALTH

DATA EXCHANGE



Key Elements of the D.C. Approach to the Opioid Overdose Epidemic

1. **Build a Big Table:** Convene working groups that involving all relevant disciplines: including public health, public safety, criminal justice, healthcare providers, private entities. Remove barriers to data sharing

2. **Use Big Data**: Leverage large datasets (EMS, Hospital Billing/Discharge Data, Syndromic Surveillance) to identify the problem, track trends

3. **Prevent Death**: Provide useful and timely data to stakeholders and prevention partners

4. **Guide People to Treatment**: Use findings to drive targeted community and individual public health interventions.

ESSENCE SYNDROMIC SURVEILLANCE OVERVIEW

- **ESSENCE** = Electronic Surveillance System for the Early Notification of Community-Based Epidemics
- Monitors health indicators of public health importance in the Emergency Department (ED) and identify outbreaks
- Near real-time de-identified data
  - 8 acute care DC hospitals
  - Data elements include sex, DOB, chief complaint, discharge diagnosis etc.

Customized Queries

Acute Opioid Poisoning

- Opioid poisoning ICD9/10 discharge diagnosis code(s)

Acute/Suspected Acute Opioid Poisoning

- Acute opioid poisoning above, OR
- Non-poisoning opioid ICD 9/10 discharge diagnosis code(s) AND overdose/unresponsiveness/poisoning in chief complaint

Non-acute Opioid Problem

- Non-poisoning opioid ICD 9/10 discharge diagnosis code(s) AND
- No overdose/unresponsiveness/poisoning in chief complaint

Suspected Overdose-Related Complaint

- Overdose/unresponsiveness/poisoning in chief complaint

ESSENCE DATA

Acute Opioid Poisoning

Acute Opioid Poisoning

Data: Normal · Data: Warning · Data: Alert

Last Updated: 28Sep20 10:48 AM

Suspected Acute Opioid Poisoning

Suspected Acute Opioid Poisoning

Data: Normal · Data: Warning · Data: Alert

Last Updated: 28Sep20 10:48 AM

Non-acute Opioid Problem

Non-acute Opioid Problem

Data: Normal · Data: Warning · Data: Alert

Last Updated: 28Sep20 10:48 AM

Suspected Opioid OD Chief Complaint

Suspected Opioid OD Chief Complaint

Data: Normal · Data: Warning · Data: Alert

Last Updated: 28Sep20 10:48 AM

ED Overdose Encounters, 2017 to 9/27/2020 n=3,872

180
160
140
120
100
80
60
40
20
0

January
February
March
April
May
June
July
August
September
October
November
December

78
80
106
112
115
118
170
133
86

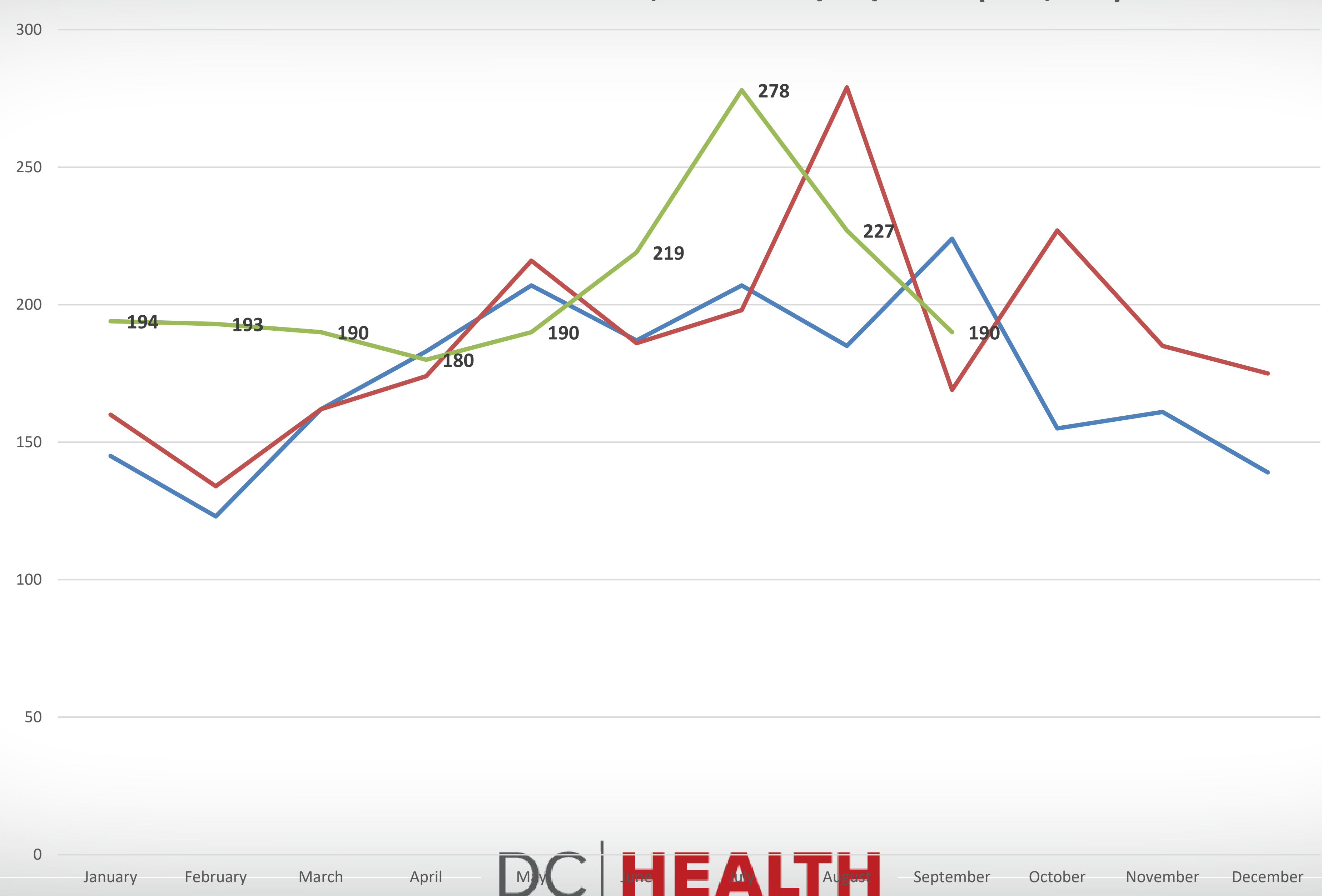
2017
2018
2019
2020

AVERAGE DC OPIOID USER

- Mean age 53
- Primarily Male (70%)
- Two-thirds live in Wards 5, 7 and 8
- Non-Residents account for about 20% of our Overdoses (MD, VA)
- Largely African-American (>80%)

WHY FIRE AND EMS DATA?

- Every firefighter, EMT and Paramedic can give Narcan. Almost complete coverage of overdoses in the city
- X-Y coordinates, actual location
- Identifying information, including date of birth, patient address, even insurance information. Previous encounters can be examined
- Real-time nature of data allows us to use an outbreak model
- Hospital data is insufficient (a large percentage decline transport)



DC HEALTH

LINKAGE TO PREVENTION

- 2 key roles :

- Detect and warn of unusual patterns
- Feed data for targeted interventions

- **Our Goals (Surveillance)**

- **Identify** Emerging Threats
- **Estimate** the magnitude of the problem
- **Monitor** risk factors and spread of the problem
- **Evaluate** research priorities/effectiveness of interventions

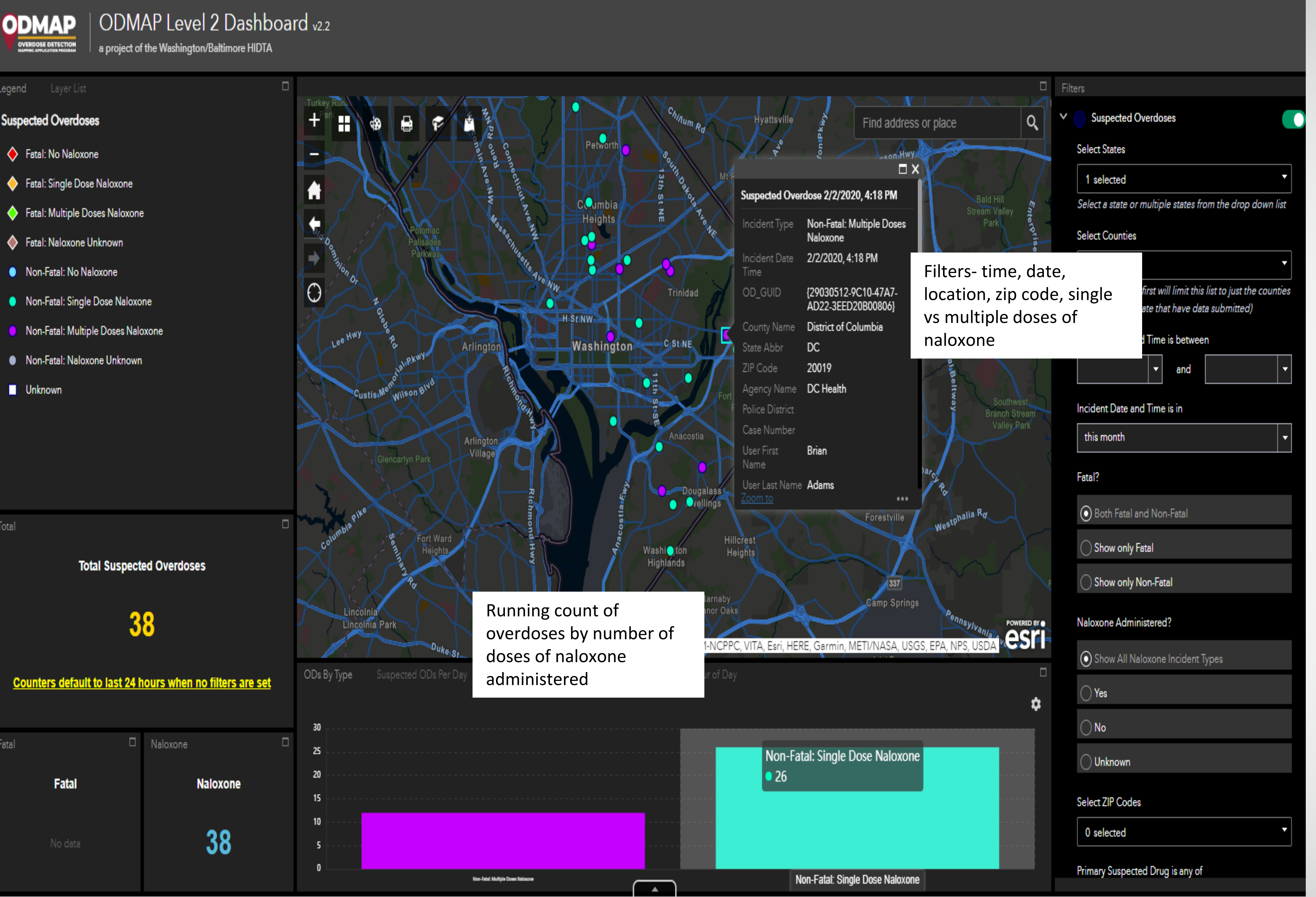
ODMAP

BENEFITS

- Easy to use, scrubbed, de-identified
- Fast way to disseminate information and reduce data requests

CONS

- Insufficient information
- Doesn't really address clustering
- Inability to add additional layers – eg service areas, homeless shelters, landmarks



DC | HEALTH

Non-fatal Opioid Overdoses

Washington, DC

Number of EMS calls

1 61

Geographic View

Timespan

Neighborhood

Refused Transport/Eval

Crosstab

No refusal

Refused

Data updated as of:

9/26/2020

7/2/20 7/5/20 7/8/20 7/11/20 7/14/20 7/17/20 7/20/20 7/24/20 7/28/20 7/31/20 8/3/20 8/6/20 8/9/20 8/12/20 8/15/20 8/18/20 8/21/20 8/24/20 8/27/20 8/30/20 9/2/20 9/5/20 9/8/20 9/11/20 9/14/20 9/17/20 9/20/20 9/23/20

%Refused 32.0%

Neighborhood	Number of EMS calls
LINCOLN HEIGHTS	61
TRINIDAD	57
SAINT ELIZABETHS	46
LOGAN CIRCLE/SHAW	44
TWINING	44
CHINATOWN	43
COLUMBIA HEIGHTS	43
NAYLOR/HILLCREST	37
CONGRESS HEIGHTS/SHIPL..	35
U ST/PLEASANT	34
UNION STATION	34
FORT DUPONT	31
BELLEVUE	30
HISTORIC ANACOSTIA	29
EASTLAND GARDENS	27
WASHINGTON HIGHLANDS	27
BLOOMINGDALE	26
KINGMAN PARK	24
PETWORTH	24
SW/WATERFRONT	23
DOUGLASS	22
BRENTWOOD	21
LAMOND RIGGS	21
HILL EAST	18
FORT LINCOLN/GATEWAY	16
MARSHALL HEIGHTS	14
BRIGHTWOOD	13
CAPITOL HILL	13
BRIGHTWOOD PARK	11
16th ST HEIGHTS	10
GWU	9
SOUTH COLUMBIA HEIGHTS	9
ADAMS MORGAN	8
EDGEWOOD	8
MOUNT PLEASANT	8
STADIUM ARMORY	8
NATIONAL MALL	7
Null	5
CATHEDRAL HEIGHTS	4
MICHIGAN PARK	4
DC MEDICAL CENTER	3
GEORGETOWN	2
GEORGETOWN EAST	2
WOODRIDGE	2
FOREST HILLS	1

© 2020 Mapbox © OpenStreetMap

KEY INFORMATION SHARED

- Name, DOB, Address
- Location of OD
- Past OD in 90 days, if yes # and time in between
- Transport Destination (Induction vs non-induction facility)

- Sadly, we can not get back data on treatment history or clinical information, other than in aggregate form due to 42 CFR

- Internal Dashboard is only shared with DC Government prevention. Currently working to get it to Harm Reduction

- More data can be shared if patients directly opt in. We are piloting that at treatment intake and with some MAT programs

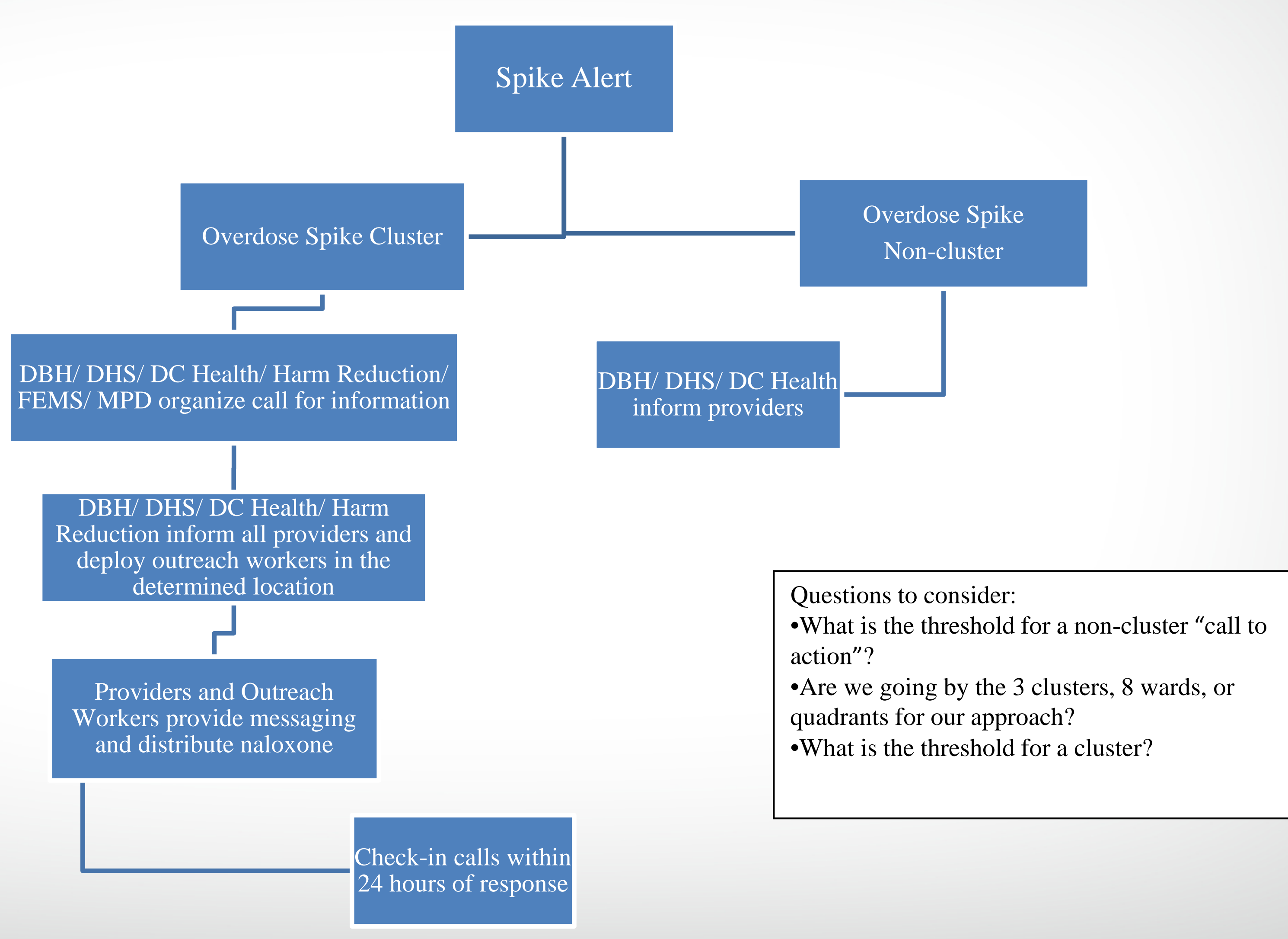
PREVENTION

- DC HEALTH- 8 rapid peer responders
- Department of Behavioral Health – Mobile Outreach team, providers, crisis responders
- Department of Human Services- Dedicated outreach staff working in service areas
- Fire and EMS- Overdose reversals, can leave naloxone behind in affected areas
- Harm Reduction – Syringe exchange services, treatment, medical care, wraparound services

OVERDOSE RESPONSE FRAMEWORK

List of service providers and their point of contact.

Call information to gather:
- Possibility of the type of drug
- Details of who is overdosing (age, race, housing situation etc.)
- Details of where they are overdosing (street, home, library, etc)
- Determine messaging



Questions to consider:
- What is the threshold for a non-cluster “call to action”?
- Are we going by the 3 clusters, 8 wards, or quadrants for our approach?
- What is the threshold for a cluster?

MESSAGING- HARM REDUCTION

WARNING!

Spike in opiod overdoses in DC in the past 24 hours
(Feb 4, 2020)

mostly Howard University and Kenilworth/East Capitol Street areas

here are some ways to help avoid a fatal overdose

Use with a friend who has naloxone/narcan or can call 911

Get naloxone or testing strips from HIPS
10-4pm 906 H st, NE
1 800 676 4477 for delivery

Use less to start to help you figure out an appropriate dose

Offer to help/check in on your friends and family who use

UTILITY OF EMS DATA

- Viewing overdoses as an 'outbreak'
- Flooding staff/resources to provide outreach in hot-spot areas
- Linkage to screening, treatment, support services

- Can be used for weekly/strategic planning. The more data we share the better our partners can allocate their resources and position their staff.
- **We have to be careful not to stigmatize neighborhoods or drive demand. Very fine line, but mostly avoided by taking a harm reduction approach. Telling people why they need naloxone and where to find it is our main focus.**

OTHER DATA SOURCES

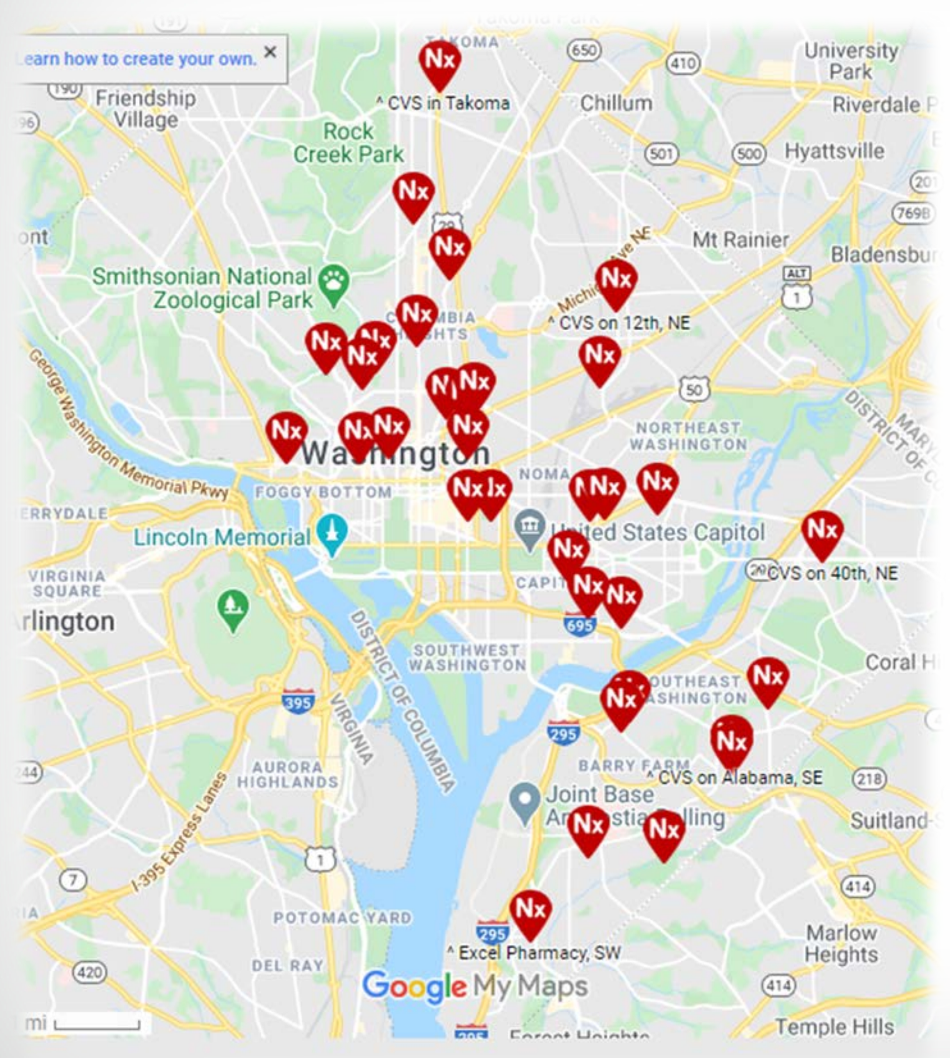
- Prescription Drug Monitoring Program (PDMP)
- SUDORS – State Unintentional Drug Overdose Reporting System
- Opioid Fatality Review Board
- Treatment/ MAT data
- Arrest Data

QUESTIONS/COMMENTS?

Naloxone Distribution in DC

Shea Davis, M.Ed.

NALOXONE DISTRIBUTION IN DC



Community-Based Organizations:

Fiscal Year	# of units	# of saves	% saved
FY17	**1,511**	277	51%
FY18	**4,373**	738	85%
FY19	**6,023**	1,165	85%
FY20	**24,706**	1,115	81%

Pharmacies:

Number of units of Naloxone: **3,502**

PROGRAM REQUIREMENTS

- Signed Standing Order
- Complete the DC Health OEND Training
- Report Monthly
- Provide overview short training to client/patient before dispensing
- ****No need to verify identification**

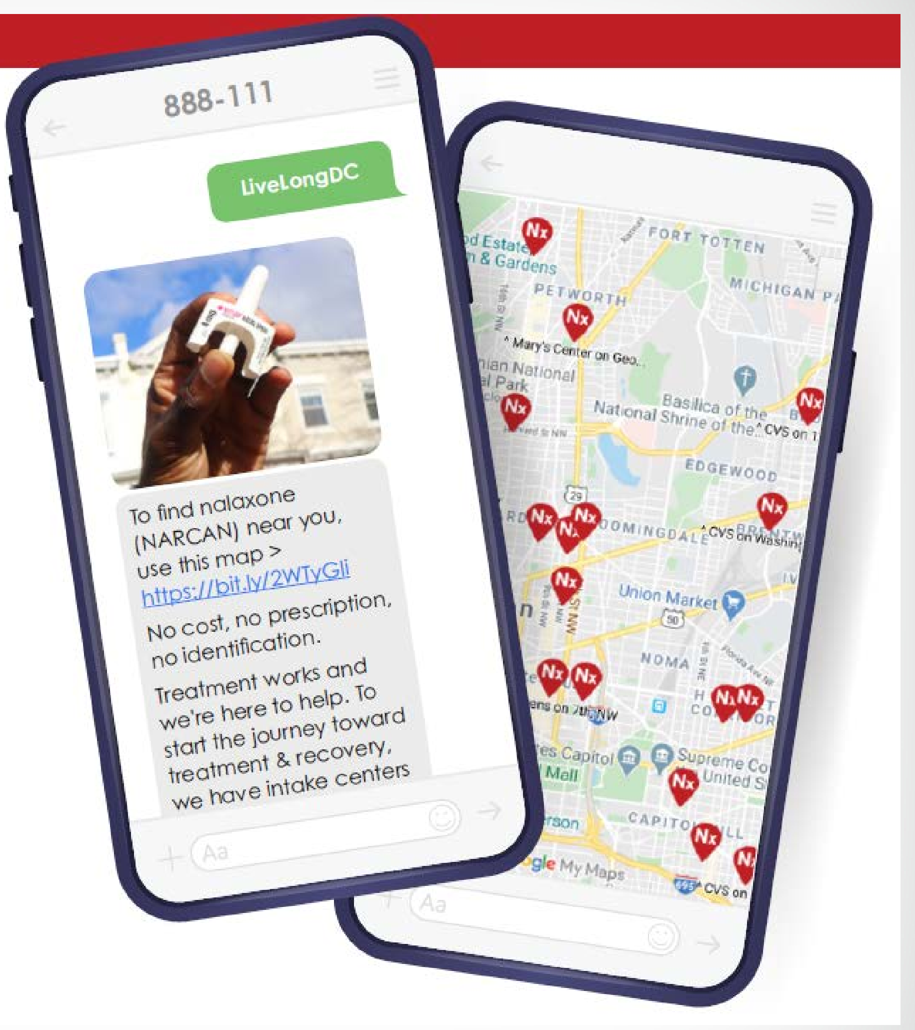
HOW CAN YOU GET INVOLVED?

1. **Co-prescribe** (Medicaid & BupDAP cover naloxone)
2. Inform your patients about the **Text-to-Live number** so that they can pick up naloxone
3. **Partner with DC Health** to distribute Narcan Nasal Spray
4. Carry naloxone, **save a life**

TEXT-TO-LIVE NUMBER

Easy way to find Narcan in DC

Text LiveLongDC to 888-111



CONTACT INFORMATION

If you are interested in training and/or becoming a distribution partner, please contact:

Shea Davis

Email: shea.davis@dc.gov

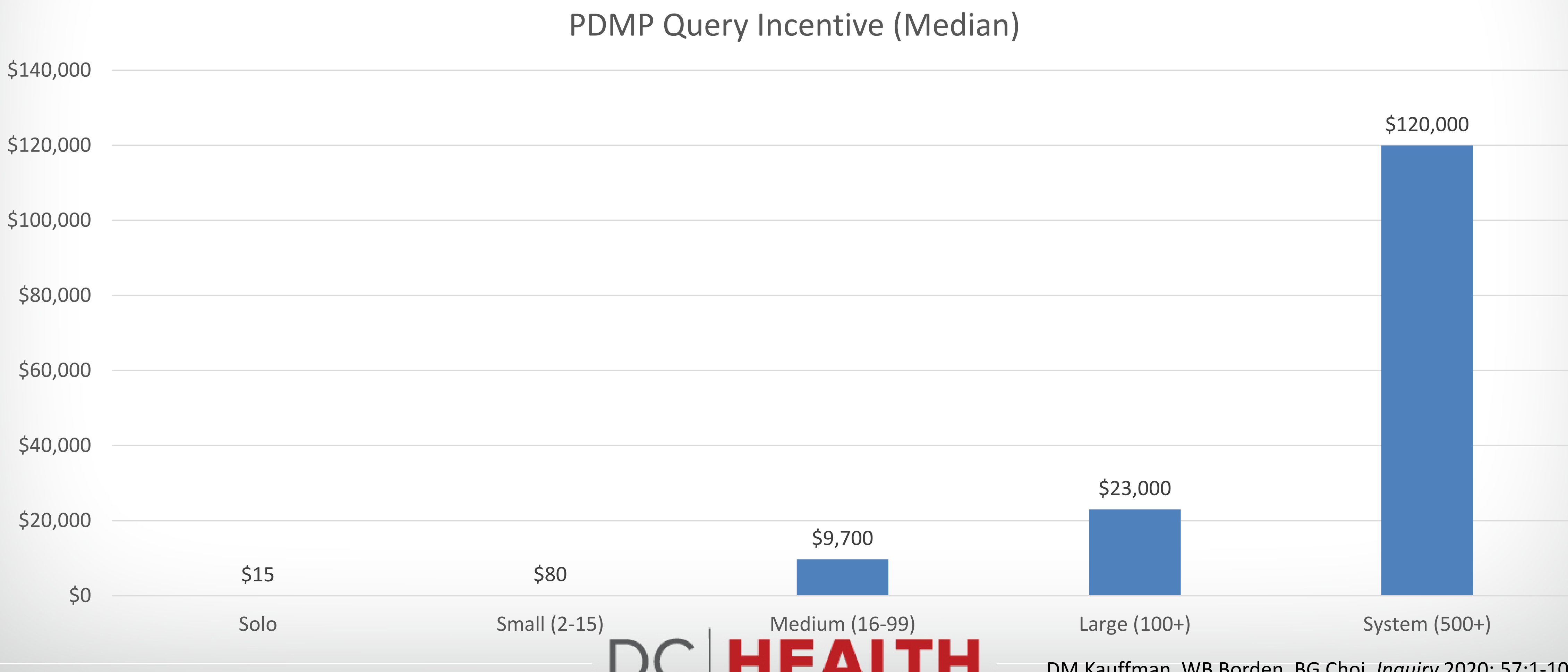
Phone: 1(202) 527-1357

Health System Informatics Support of Opioid Prescribing Regulations and Data Needs

Brian G. Choi, MD, MBA, FACC
Professor of Medicine and Radiology, The George Washington University
Chief Medical Information Officer, GW Medical Faculty Associates

HEALTH SYSTEM INFORMATICS SUPPORT OF OPIOID PRESCRIBING REGULATIONS AND DATA NEEDS

Expected MIPS Bonus Payment for PDMP Query in 2019 by Practice Size: Systems have much larger financial incentive to overcome hurdle costs



DC HEALTH

DM Kauffman, WB Borden, BG Choi. *Inquiry* 2020; 57:1-10.

HEALTH SYSTEM INFORMATICS SUPPORT OF OPIOID PRESCRIBING REGULATIONS AND DATA NEEDS

GW Support for Provider Registration and Compliance

- PDMP required courses provided via internal Learning Management System
- Assistance with ID verification and 2-Factor authentication enrollment
- Monthly report of all Controlled Substance prescriptions

Unique Aspects to Practicing in the DMV Region

- Virginia has required EPCS since July 1, 2020
- Virginia requires EPCS for gabapentin
- Virginia-based providers must use the Commonwealth's PDMP, not via CRISP
- DC CS number does not cross interface properly for EPCS

HEALTH SYSTEM INFORMATICS SUPPORT OF OPIOID PRESCRIBING REGULATIONS AND DATA NEEDS

Clinical Decisionmaking Support (CDS) for Controlled Substance Prescription

- Tools are EMR vendor dependent
  - MEDD presentation at time of order entry
  - Abuse and overdose potential risk scoring
  - Adjust order defaults to lower doses
  - Facilitate ease-of-access to PDMP
  - Track prescribing patterns of individual providers
  - Prevent controlled substance prescriptions in specific contexts
- Cross-platform tools are under investigation

HEALTH SYSTEM INFORMATICS SUPPORT OF OPIOID PRESCRIBING REGULATIONS AND DATA NEEDS

Information Gaps Hinder Full Potential for CDS

- Systems are lacking to intake patient-reported data to manage pain and daily function to support reduced use
- CDS generally lacks personalization
- PDMP may not be comprehensive of all prescriptions

Opioid Management for Chronic Non-Cancer Pain

Palak Turakhia, MD MPH
Assistant Professor, Department of Anesthesiology and Critical Care
George Washington University

MANAGEMENT OF PATIENTS ON CHRONIC OPIOID THERAPY

- Prior to initiation
- How to initiate opioids for chronic non-cancer pain
- Maintenance of opioid therapy

Consider non-pharmacologic and non-opioid therapy as first-line for chronic pain

PRIOR TO INITIATION

- History and Physical
- Risk Assessment
- Informed Consent

HISTORY AND PHYSICAL

Perform a History & Physical

History of the present illness, including appropriate diagnostic testing, previous therapies tried	Previous medical history	Family history and other psychosocial factors

RISK ASSESSMENT

- Several risk stratification tools exist – Opioid Risk Tool (ORT), Screener and Opioid Assessment of Patients with Pain (SOAPP-1, SOAPP-2)
- Check state prescription drug monitoring program – CDC recommends prior to initiating opioid therapy and regularly afterwards
- Consider performing urine drug screen
- Consider prescribing naloxone for high risk individuals

INFORMED CONSENT

- Establish and measure goals for pain and function
- Discuss benefits/risks of opioid therapy
- Consider Implementing Opioid Agreement

INITIATION OF OPIOID THERAPY

- Start with lowest effective dose, immediate-release opioids preferable to long-acting opioids
- In the acute pain setting, avoid long-acting/extended-release opioids and prescribe only what is necessary
- Avoid combination of opioids and benzodiazepines when possible

MAINTENANCE OF OPIOID THERAPY

Analgesia

Activity

Aberrant Behavior

Adverse Effects

MAINTENANCE

- Follow up and re-evaluate on a regular basis, arrange for treatment of opioid-use disorder when needed
- For higher risk patients
  - More regular visits
  - Consider psychotherapeutic cointerventions
  - Consider opioid substitution therapy

CONCLUSIONS

- There is still limited evidence for offering opioid therapy in chronic non-cancer pain for patients who have failed conservative treatments
- The CDC guidelines exist to improve patient-provider communication, improve safety and decrease risks associated with chronic opioid therapy but also have several criticisms
- Much research needs to be done on various aspects of chronic opioid therapy

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Thank you for participating.