THE OPIOID CRISIS AND PUBLIC HEALTH EXPERIENCES IN THE DISTRICT OF COLUMBIA IN 2020
More resources available at:
https://dchealth.dc.gov/dcrx
COLLABORATORS

INNOVATION HORIZONS
TRANSFORMING IDEAS INTO ACTION

GW
School of Medicine & Health Sciences
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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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  Professor and Director of Informatics
  School of Pharmacy
  University of Maryland

• Nestor Rocha, MPH
  Bureau Chief, HIV Counseling, Testing and Referrals
  Administration for HIV Policy and Programs
  DC Health
SPEAKERS

- **Chikarlo Leak, DPH**
  Policy Director, Office of the Deputy Mayor for Health and Human Services
  District of Columbia

- **Justin Ortique, PharmD, RPH**
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  Special Populations Coordinator
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• Brian G. Choi, MD
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  Dimples Dental Suite, PC

• Palak Turakhia, MD, MPH
  Pain Medicine Specialist
  Assistant Professor of Medicine
  George Washington University School of Medicine & Health Sciences
Dr. Chikarlo Leak

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
In 2019, OCME completed a total of 1,343 forensic examinations (autopsy, external examinations, and medical records reviews).
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.
Overall, the most prevalent opioid drugs identified were fentanyl followed by heroin.

TRENDS IN THE NUMBERS OF OPIOID DRUGS CONTRIBUTING TO FATAL OVERDOSES

Fig. 2: Total Number of Opioid Drugs Contributing to Drug Overdoses by Year (All Opioids)
FATAL OVERDOSES CONTAINING FENTANYL/FENTANYL ANALOGS

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

Figure 3: Percent of Overdose Deaths Involving Fentanyl 2015-2020
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

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

Fig. 7: Percentage of Drug Overdoses due to Opioid Use by Gender and Year
The majority of decedents were residents of DC. Within DC, opioid related fatal overdoses were most prevalent in Wards 5, 7 & 8.
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.
JURISDICTION OF RESIDENCE AMONG COCAINE AND OPIOID OVERDOSES
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
https://dchealth.dc.gov/service/prescription-drug-monitoring-program
Grant funding is currently available for the integration of PDMP data into:

- Electronic Health Records (EHRs)
- Health Information Exchanges (HIEs)
- Pharmacy Management Systems

[Gateway Integration Link](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
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
NARX CARE
NARXCARE OVERVIEW: HEADER
NARXCARE OVERVIEW: SCORES AND INDICATOR

**NARX SCORES**
- Narcoic: 900
- Sedative: 620
- Stimulant: 000

**OVERDOSE RISK SCORE**
- 790 (range 0-999)

**ADDITIONAL RISK INDICATORS (3):**
1. >= 4 opioid or sedative dispensing pharmacies in any 90 day period in the last 2 years
2. >= 5 opioid or sedative providers in any year in the last 2 years
3. > 100 MME total and 40 MME/day average
NARXCARE OVERVIEW: GRAPHS
# NARXCARE OVERVIEW: FULL PRESCRIPTION DETAIL

## Rx Data

### PRESCRIPTIONS

Total Prescriptions: 4  
Total Private Pay: 2

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<th>Filled</th>
<th>ID</th>
<th>Written</th>
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<th>Qty</th>
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<td>Go Ben</td>
<td>T234</td>
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<td>20.00 mg</td>
<td>Private Pay</td>
<td>CH</td>
</tr>
</tbody>
</table>

*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 agonists. MME = morphine milligram equivalents. LME = Lornoxicam milligram equivalents. mg = dose in milligrams.
PRESCRIBER SELF-REPORT (MYRX)
Set Shopper Alert Thresholds

Trigger a PMP Patient Report Alert when: *

- Count of Prescribers ≥ 4
- Count of Pharmacies ≥ 4

Within a Time Period of: *
- 3 Months
- 6 Months
- 12 Months
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.
• 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
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/


• 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)

Racial Distribution of Opioid Overdose Deaths in DC Compared to the US Population (2019)
DATA EXCHANGE

- Emergency Response
  - Fire and EMS
  - Police
  - Hospitals

- Testing
  - Forensic Sciences
  - ME

- Public Health Response
  - DC HEALTH
  - Behavioral Health
  - Human Services
  - Non-profits/Harm Reduction

- Criminal Justice System
  - Corrections
  - MPD and DEA
  - Probation and Parole
  - US Attorney
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
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)
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
Running count of overdoses by number of doses of naloxone administered.
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

Spike Alert

Overdose Spike Cluster
- DBH/ DHS/ DC Health/ Harm Reduction/ FEAMS/ MPD organize call for information
- DBH/ DHS/ DC Health/ Harm Reduction inform all providers and deploy outreach workers in the determined location
- Providers and Outreach Workers provide messaging and distribute naloxone
- Check-in calls within 24 hours of response

Overdose Spike Non-cluster
- DBH/ DHS/ DC Health inform providers

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?
WARNING!

Spike in opioid 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:

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<thead>
<tr>
<th>Fiscal Year</th>
<th># of units</th>
<th># of saves</th>
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<td>1,511</td>
<td>277</td>
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<td>FY18</td>
<td>4,373</td>
<td>738</td>
<td>85%</td>
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<tr>
<td>FY19</td>
<td>6,023</td>
<td>1,165</td>
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<tr>
<td>FY20</td>
<td>24,706</td>
<td>1,115</td>
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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

Expected MIPS Bonus Payment for PDMP Query in 2019 by Practice Size:

- **Solo**: $15
- **Small (2-15)**: $80
- **Medium (16-99)**: $9,700
- **Large (100+)**: $23,000
- **System (500+)**: $120,000

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
HEALTH SYSTEM INFORMATICS SUPPORT OF OPIOID PRESCRIBING REGULATIONS AND DATA NEEDS

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
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
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.