Since 2009, more people have died each year from drug poisoning than from motor vehicle crashes.

Note: “Drug poisoning” is a subset of “all poisoning” and includes unintentional, intentional, and undetermined intents.

Prescription drugs as the primary driver of overdose deaths. (Top 15 drug or drug classes, US 2010)

For every 1 death there are:

- 10 treatment admissions for abuse
- 32 emergency dept visits for misuse or abuse
- 130 people who abuse or are dependent
- 825 nonmedical users

2014 ASTHO President’s Challenge
15 by 15: Reduce Prescription Drug Abuse and Deaths 15% by 2015

Goal:
• Improve health outcomes and reduce human and economic costs associated with prescription drug misuse, abuse, and overdoses.

Pledge:
• Reduce the rate of nonmedical use and the number of unintentional overdose deaths involving controlled prescription drugs (including opioid analgesics, stimulants, tranquilizers, and sedatives) 15 percent by 2015.
Building a Strategic Map: The Role of Partners

*Prioritize multi-sector efforts and identify collaborations, partnerships, stakeholders, and corresponding efforts to address prescription drug abuse.*

- American Academy of Pain Management
- American Pharmacists Association
- American Association of Poison Control Centers
- American Society of Addiction Medicine
- **PDMP Center of Excellence (Brandeis University)**
- Centers for Disease Control and Prevention
- Clinton Foundation
- Federation of State Medical Boards
- Kanawha-Charleston Health Department
- Maryland Poison Control Center
- National Alliance for Model State Drug Laws
- National Association of Chain Drug Stores
- National Association of County and City Health Officials
- National Association of State Alcohol and Drug Abuse Directors
- National Governors Association
- National Institute on Drug Abuse
- Office of the Army Surgeon General
- Ohio Department of Health
- Oklahoma State Department of Health
- Pennsylvania Department of Drug and Alcohol Programs
- Personal Advocate
- Pharmaceutical Research and Manufacturers of America
- Project Lazarus
- Safe States Alliance
- Substance Abuse and Mental Health Services Administration
- Tennessee Department of Health
- United States Department of Justice
- University of Kansas School of Medicine
- University of Rochester Medical Center
- Vermont Department of Health
- White House Office of National Drug Control Policy

**Ongoing Work:**

*"Expand and Strengthen Key Partnerships and Collaborative Infrastructure"*
Comprehensive and Cross-sector Approaches to Rx Drug Misuse, Abuse, and Diversion
ASTHO Prescription Drug Misuse and Abuse Strategic Map: 2013 - 2015

Achieve Measurable Reductions in Controlled Prescription Drug Misuse, Abuse & Overdose Using a Comprehensive Approach

Expand and Strengthen Prevention Strategies
- Promote and Implement Primary Prevention Strategies
- Provide Education/Tools for Consumers, Families & Health Care Professionals
- Expand Use of Best Practices by Health Care Professionals
- Engage & Empower Individuals and Communities in Effective Strategies
- Implement Evidence-Based Community Interventions
- Implement Overdose Prevention and Intervention Strategies

Expand and Strengthen Key Partnerships and Collaborative Infrastructure
- Secure/Align Resources and Infrastructure to Implement Comprehensive Approaches
- Use Data, Evaluation and Research to Inform Interventions and Continuous Improvement

Expand and Strengthen Control and Enforcement
- Provide Prescriber/Dispenser Education and Training on Control & Enforcement
- Improve Collaboration Between Public Health and Law Enforcement
- Strengthen and Standardize Licensure Board Oversight of Practitioners
- Implement Framework for Regulation of “Pill Mills”

Expand Access to and Use of Effective Treatment and Recovery Support
- Approach and Manage Addiction as a Treatable Chronic Illness
- Make a Powerful Business Case for Treatment and Recovery Support
- Address Legal Barriers to Seeking and Receiving Care
- Secure Payer Funding for the Full Spectrum of Evidence-Based Care
- Provide SBIRT Training and Funding for Health Care Practitioners

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Improve Monitoring and Surveillance
- Increase the Use of Clinical Monitoring Tools for Patient Care
- Optimize Effectiveness of PDMPs
- Develop, Implement, Link and Evaluate Other Data Sources
- Prioritize and Enhance Surveillance for High Risk Populations
- Use Monitoring and Surveillance to Improve Public Health and Clinical Practice

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Strategic Map

Draft 08/13/13
ASTHO & PDMP Center of Excellence (COE)

Webinar for State Health Departments: PDMP best practices and using data for public health epidemiological analyses

In-State Workshops
- Oklahoma (September 12, 2013)
  - Commissioners from: State Health Department, Bureau of Narcotics, Mental Health/Substance Abuse Agency
  - Also: Board of Pharmacy, Medicaid

- Ohio (planned for late October 2013)

- Recommendations for state health agencies with fundamental information on PDMPs and how they may be used to improve public health.

Developed a Checklist: PDMP Best and Promising Practices
“How to get the most out of your PDMP” – covers data quality, analysis and distribution, PDMP utilization, evaluation, and funding
Where PDMPs Reside in State Government
Illustrating the case for improved coordination and collaboration

Breakdown of Housing Entities*

* This information is based on the agency the PMP statute or regulation indicates is required to establish the PMP.

This information was compiled using legal databases, state agency websites, and direct communications with state PDMP representatives.

Source: National Alliance for Model State Drug Laws, August 2013
Primary areas in which PDMPs can be used to meet public health objectives include:

- **Prevention** – identifying communities/informing health care providers
- **Education** – prescribing trends and awareness of the prescription drug abuse epidemic
- **Surveillance** – incidence and prevalence of medical and non-medical uses of controlled pharmaceuticals
- **Early Intervention** – signs of addiction at initial stages of drug-seeking behavior

Some examples of PDMP initiatives in these areas:

- Brochures and web-based materials for patients and health care providers
- Geospatial analyses: Idaho, Massachusetts, South Carolina, Wyoming, Kentucky
- Proactive patient prescription history reports or electronic alerts to prescribers and dispensers help them self-monitor prescribing practices
Changes Can Be Made:
Tennessee Change in Neonatal Abstinence Syndrome

NAS in TN: 1999-2010

Data sources: Tennessee Department of Health, Office of Health Statistics; Hospital Discharge Data System (HDDS) and Birth Statistical System. Analysis includes inpatient hospitalizations with age less than 1 and any diagnosis of drug withdrawal syndrome of newborn (ICD-9-CM 779.5). HDDS records may contain up to 13 diagnoses. Infants were included if any of these diagnosis fields were coded 779.5. Note that these are discharge-level data and not unique patient data.
## Changes Can Be Made: Tennessee Cost of Neonatal Abstinence Syndrome

### Impact of NAS on Infant Health Care Expenditures, CY 2011

<table>
<thead>
<tr>
<th>Metric</th>
<th>TennCare Paid Live Births¹</th>
<th>TennCare non-LBWT Births</th>
<th>TennCare Live LBWT Births²</th>
<th>NAS Infants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of Births</strong></td>
<td>45,205</td>
<td>40,437</td>
<td>4,768</td>
<td>528</td>
</tr>
<tr>
<td><strong>Cost for Infant in first year of life</strong></td>
<td>$350,936,293</td>
<td>$171,336,964</td>
<td>$179,599,329</td>
<td>$33,249,612</td>
</tr>
<tr>
<td><strong>Average Cost per child</strong></td>
<td>$7,763</td>
<td>$4,237</td>
<td>$37,668</td>
<td><strong>$62,973</strong></td>
</tr>
<tr>
<td><strong>Average length of stay (days)</strong></td>
<td>4.8</td>
<td>3.2</td>
<td>18.3</td>
<td>32.5</td>
</tr>
</tbody>
</table>

### Percentage of Newborns in DCS Custody within One Year of Birth, CY 2011

<table>
<thead>
<tr>
<th></th>
<th>Infants born in CY 2011</th>
<th>NAS infants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total # of Infants</strong></td>
<td>55,578</td>
<td>528</td>
</tr>
<tr>
<td><strong>Total # infants in DCS</strong></td>
<td>767</td>
<td>120</td>
</tr>
<tr>
<td><strong>% in DCS</strong></td>
<td>1.4%</td>
<td>22.7%</td>
</tr>
</tbody>
</table>

¹ This sample contains only children that were directly matched to TennCare’s records based on Social Security Number.
² Any infant weighing under 2,500g at the time of birth was considered low birth weight (LBWT).
2005 Opioid-related Overdose
Rate per 100,000 by Town

Rate per 100,000 Quintiles
- 0
- 0.01 - 19.82
- 19.82 - 37.5
- 37.5 - 56.92
- 56.92 - 225.51

Source: Prescription Drug Monitoring Program Center of Excellence (COE)
Changes Can Be Made:
Decline in Opioid Deaths in Washington Since 2008
(Washington State, 1995-2011)

Source: CDC/NCHS and Washington State Department of Health, Death Certificates. Provided by Jennifer Sabel, PhD, 2013
Note for WA State: * Tramadol only deaths included in 2009, but not in prior years.
Thank You

For more information, visit www.astho.org/rx.

ASTHO Staff Contacts:
Elizabeth Romero (eromero@astho.org)
Leslie Erdelack (lerdelack@astho.org)