

Ohio House of Representatives



Prescription Drug Addiction and Healthcare
Reform Legislative Study Committee

Chairman's Report

State Representative Robert Cole Sprague, Chair

October 17, 2013

Contents:

- I. Overview of Committee: p. 3-4
 - Committee Members
 - Committee Hearings
- II. The Situation in Ohio: p. 5
- III. A State-Sponsored Problem: p. 6
- IV. Chair's Recommendations: p. 7
 - 1. Prevent more people from becoming addicted
 - 2. Don't give opioids to addicts, and keep them alive
 - 3. We need to provide better help for addicts who want to recover
- V. Possible Legislation: p. 8-9
 - Good Samaritan
 - 10- Day Prescriptions
 - H.B. 170
 - Photo ID
 - Parental Consent
 - Hospice
 - H.B. 92
 - Require OARRS Check
 - Limit Suboxone

VI. Additional Ideas: p. 10-13

1. Prevent Addiction through Education
2. Reduce the Supply of Opioids
3. Improve Treatment for Existing Drug Addicts by Expanding Specialty Dockets, Integrating Treatment, and Reforming Medicaid for Treatment

VII. Thoughts for Further Consideration: p. 14-15

- Changing the Criminal Code, Criminal Courts, and Dealing with Addicts

I. Overview of Committee:

Committee Members:

- Representative Robert Cole Sprague, Chair
- Representative Ryan Smith, Vice Chair
- Representative Nickie Antonio
- Representative Nan Baker
- Representative Denise Driehaus
- Representative Sean O'Brien
- Representative John Patterson
- Representative Barbara Sears
- Representative Fred Strahorn
- Representative Lynn Wachtmann
- Representative Ron Young

Committee Hearings:

- Total number of witnesses: 81 witnesses
- Total hours of testimony: Over 16 hours

1. August 20, 2013

Jackson, Ohio

Holzer Health System - Jackson
18 witnesses
Roundtable with area businesses
Over 3 hours of testimony
100+ people in attendance

2. August 27, 2013

Kenton, Ohio

Hardin County Courthouse
Tour of school and treatment facility attached to family court
29 witnesses
4.5 hours of testimony
100+ people in attendance

3. September 3, 2013
Toledo, Ohio

ProMedica Toledo Hospital
Tour of NICU
Roundtable lunch with medical community
16 witnesses
4.5 hours of testimony

4. September 12, 2013
Cleveland, Ohio

Lutheran Hospital
Viewed Judge Matia's specialty docket drug court
Presentation by Cleveland Clinic's treatment experts
18 witnesses
Over 4 hours of testimony

II. The Situation in Ohio

Drug overdose has become the leading cause of accidental death in Ohio, surpassing traffic accidents. Prescription opioids (painkillers such as Oxycontin, Vicodin, Percocet, etc.) are responsible for more deaths than heroin and cocaine combined (CDC). Opioids depress breathing and can cause people to suffocate to death when they take too much. Sadly, they often die in the presence of other opioid addicts who are too afraid to call for help.

Behind every overdose death are thousands more addicts who are using opioids, and they leave in their wake devastated parents, abandoned children, and drug-infested communities. Drug addiction creates large amounts of crime, and one of the judges that we heard testimony from estimates that 80% of crime has its root in drug use. According to estimates by some local Children Services directors in Ohio, around 80% of cases they see are due to behavioral health issues. It has been claimed by some that in Columbus, heroin is easier for kids to obtain than beer.

Prescription opioids are close chemical cousins of heroin, and heroin use is just a symptom of an addiction started by using opioid pills. The massive pipeline of 800 million doses of prescription opioids dispensed in Ohio last year for 11.5 million men, women, and children (Pharmacy Board) has created an epidemic, an epidemic that was created legally through our medical system. There is a direct correlation between the number of overdose cases and the rise in opioid prescriptions.

According to the Governor's Cabinet Opiate Action Team, up to 50% of patients using opioid therapy for chronic, non-cancer pain misuse their medications. After hearing from 81 witnesses, the study committee learned that some addicts get hooked after snorting opioid pills or abusing the drugs in another way with friends; they typically get these pills from family and friends who have them sitting around in their medicine cabinets. The other group of addicts started with a valid medical prescription and ended up with an addiction. People can become addicted in a matter of weeks using opioids, while addiction takes years with alcohol and other drugs. The human body and brain quickly develops a tolerance to opioids, so it takes a progressively higher dosage to get the same high.

Opioid addiction is extremely hard to overcome. It changes the way that the mind's circuitry works, hijacking the brain's normal biological feedback that the body receives about basic biological functions like sex, food, and exercise. The human body becomes physically dependent on the drug, and people have severe withdrawal symptoms if they stop taking it (shakes, fever, total body aches, diarrhea, and intense cravings). Treatment for addiction works and people recover, but it is extremely difficult.

III. A State-Sponsored Problem

The General Assembly has great regulatory control over Ohio's medical system, and this addiction epidemic could not have occurred at its current level without mistakes that were made within the General Assembly, the state medical regulatory structure, and by the individual physicians themselves. There were several contributing factors:

1. The General Assembly passed the Intractable Pain Act in 1998, opening the floodgates for doctors to treat chronic pain with prescription opioids. While the driving force was to treat terminal cancer patients, the legislation effectively allowed physicians to prescribe opioids for pain in any number of situations. Up until the late 1990s, opioids were used only sparingly.
2. The Ohio Medical Board and others throughout the country convinced the medical community to adopt pain as the 5th vital sign, putting pain on the same level as blood pressure, heart rate, breathing rate, and temperature, which effectively began an overt effort for doctors to treat all kinds and amounts of pain with opioids.
3. In the late 1990s, the FDA approved several new and powerful opioid pain medications with hydrocodone as the active ingredient, a very powerful and addictive opioid.
4. Our Medicaid and Medicare systems grade hospitals and physicians on how effectively they treat pain. Medical systems utilize patient satisfaction surveys, which can affect hospital reimbursement rates and the compensation rates of medical professionals. This system puts pressure on doctors to prescribe opioids.
5. Direct to consumer advertising has molded public opinion to think that there is a cure for everything and that people shouldn't have to be in pain.

IV. Chair's Recommendations

In general, there are three main areas that the Ohio General Assembly can focus on to reduce the opioid epidemic.

1. Prevent more people from becoming addicted
 - a. Revise the medical standards of care to reduce the amount of opioid prescriptions being made in Ohio
 - i. Follow the University Hospital guidelines, such as:
 1. Don't give opioids to susceptible populations such as kids or former (or current) addicts
 2. Use it as a last resort for pain and try other things first
 - b. Education of the teenagers who may try this at parties
 - c. Education of patients who receive these prescriptions
 - d. Reduce the amount of unused opioids in medicine cabinets
 - e. Try to stop diversion of opioids from high volume places of use, such as a hospice
2. Don't give opioids to addicts, and keep them alive
 - a. Use the OARRS system to check and see what other doctors are prescribing to a patient
 - b. Do not tolerate drug-seeking behaviors like refilling prescriptions early, going to the emergency room, filling scripts late at night, etc.
 - c. Limit use of Suboxone to legitimate treatment programs
 - d. Encourage syringe exchanges to reduce HIV and Hepatitis C, which damages their liver
 - e. Approve naloxone for use to treat overdoses
 - f. Allow people to help their friends from dying of an overdose
 - g. Prevent the opioid/benzodiazepines combination, which is extremely deadly by suppressing respiration
3. We need to provide better help for addicts who want to recover
 - a. Champion a more integrated treatment program that has the following components:
 - i. Detox; medication assisted treatment; sober and transitional housing available; intensive outpatient (counseling, psychiatrist appointments); a 12 step program with peer sponsors; a case manager who helps them from one phase to the next; urine testing
 - ii. Understanding relapses
 - b. Build on the effectiveness of drug courts and fund them since they are highly effective in reducing recidivism
 - c. Reform Medicaid so that it pays for addiction treatment and case managers that help patients navigate the complex silos that exist in the treatment field

V. Possible Legislation

- **Good Samaritan**

We need a “Dial 9-1-1 Good Samaritan Law” to help people who are overdosing on an opioid. Overdose death occurs slowly, as the opioid depresses breathing and eventually leads to suffocation. Other addicts present during the overdose are afraid to call 9-1-1 because they will be arrested and sent to jail. This legislation would allow Good Samaritans to call 9-1-1 without fear of going to prison.

Note: This may be somewhat incorporated in House Bill 170.

- **10-Day prescription**

Require all acute pain prescriptions to be in 10-day increments, refillable only to 30 days before receiving an updated checkup from the physician. This would limit the amount of unused medication in everyone’s medicine cabinets.

- **Photo ID**

Right now, if someone shows up at a pharmacist with a valid prescription and pays cash, the pharmacist has no idea if the person getting the prescription is the one to whom it was prescribed. Therefore, a law that requires showing a valid photo ID to the pharmacist in order to receive a narcotic would cut down on the diversion of these drugs.

Mechanism: Simply require the pharmacist to be shown a valid photo ID in order to pick up a narcotic prescription. One problem might be that people don’t have a photo ID. In this case, we could also accept a social security card. Rep. Barbara Sears suggested that we mimic the federal rules in place for allergy medication.

- **Parental Consent for Teens**

We should require the consent of a parent or guardian to allow a teenager to receive an opioid prescription. The Chairman also thinks that the requirements should be more in-depth than that; the doctor should only be allowed to prescribe in 10-day intervals, and the parents should have to provide a pill count log each day.

Also, mental health professionals and courts should be required to give the parent or guardian notification if a physician or mental health professional finds a mental health or addiction problem in a teen.

- **Hospice**

Require pill counts, locked medicine boxes, and an accountability person for hospice or palliative opioid prescriptions.

- **Require OARRS Check**

We need to require all pharmacists to check OARRS for every opiate prescription or schedule II prescription.

80% of OARRS is funded through grants. We should fund an interface to EPIC (fund an interface between OARRS and commonly used software in physician's offices, such as EPIC, so that the OARRS report pops up for the physician seamlessly as they are treating the patient) and other medical records systems, and we should fund OARRS from our operating budget. Medical professionals also need to document the use of OARRS.

- **Limit Suboxone: Require Behavioral Treatment**

There are legitimate uses for Suboxone; however, this opioid is addictive and will give users a high that is not as strong as hydrocodone but lasts for a much longer period of time. This drug is commonly abused, and the Country of Georgia was literally overcome by this drug, with nearly 30% of their population using it.

Suboxone will not cure someone's addiction, but can be used as a supplement for opioid users while they are trying to recover and seek treatment. However, many clinics are dispensing Suboxone for cash, with no treatment requirements for their patients. These clinics are inundating Ohio with Suboxone for addicts, who are not necessarily getting treatment for their condition. The solution to this would be to prohibit the prescription of Suboxone to patients who are not getting behavioral treatment or counseling.

- **Current Legislation Relevant to the Addiction Issue**

- **Syringe Exchange, H.B. 92 - Already introduced (Antonio/Sears)**

This piece of legislation lowers health care costs by reducing HIV and Hepatitis C. The legislation provides a pathway to treatment for addicts. While this won't help reduce the overall addiction epidemic, it will keep people healthier so they can recover from addiction.

- **Naloxone, H.B. 170 - Already Introduced (Johnson/Stinziano)**

Here is an additional thought on HB 170: Provide naloxone through every health department in the state--perhaps in the same way as flu shots—in order to instantly reverse an opiate overdose and save lives.

VI. Additional Ideas

1. Prevent Addiction through Education

- **Public Awareness Campaign**

The “Don’t Get Me Started” program is good, but some localities don’t have the local dollars necessary to promote it.

Ohio needs a general public awareness campaign that draws a clear linkage between prescription opioids and heroin addiction. We need to get this information into the health classes or re-energize the DARE program.

Somehow we need to have people secure opioids under lock and key at their home, just as they do liquor or beer.

- **Warning Labels**

Why are there not warning labels on prescription opioids? Labels should state clearly, “WARNING: EXTREMELY ADDICTIVE. OPIOIDS ARE HABIT FORMING.”

- **Require patient consent**

Create a one-page fact sheet on prescription opioid addiction, which is required to be distributed to every patient who receives an opioid prescription.

2. Reduce the Supply of Opioids and Change Prescribing Habits

- **Standards of care**

Adopt University Hospitals Standard of Care for Opioid Prescriptions for the entire state.

- **This would address several current prescribing problems:**

1. Prescribing opioids to minors
2. Prescribing opioids to current addicts who test positive for any illicit substances, or prescribing to former addicts. Prescribers should be prohibited from providing chronic opioid therapy to patients whose urine contains illicit substances or high-risk drugs. These people typically abuse multiple substances.
3. Prescribing opioids for chronic pain without first referring to a pain specialist and ensuring that all alternatives to opioids have been tried and failed
4. Failing to document a diagnosis and continuing to monitor functional improvement/status of the patient. The patient’s function and pain status should be monitored regularly during treatment, along with documenting the rationale for continuing treatment. Requests for higher opioid doses should trigger a referral to

a pain medicine specialist. Opioids should be discontinued after 1 year, as they lose 70% of their effectiveness after the first year. Over 90% of patients who responded poorly to opioids experienced improved pain and function when opioids were eliminated. Improved function may be the best indicator of this.

- **Pay for other pain medications**

Make sure that insurance companies will pay for other pain medications.

- **Update Intractable Pain Act**

Update the Intractable Pain Act. This law is the minimum standard. (There was a 2012 panel convened on this topic, which could be leveraged).

The rule for non-cancer intractable pain should be the lowest possible dose medically necessary to provide relief, over the shortest possible amount of time.

3. Improve Treatment for Existing Drug Addicts by Expanding Specialty Dockets, Integrating Treatment, and Reforming Medicaid for Treatment

- **Specialty Dockets**

We should fund the specialty dockets at a higher rate because of the more intensive use of probation and additional court time required. In Hardin County, it costs \$1,900 per month for family court to run (per case, I think) versus the \$4,000 estimated cost of that person still abusing drugs and/or landing in jail.

We need to fund the specialty docket case managers who pull together the elements of the courts, housing, NA meetings, sponsors, MAT, education, etc, for the offenders on drug court programs.

- **Successful Drug Court Process:**

1. Dedicated judge, integrated team
2. Detox in jail
3. Pre-indictment screen
4. Plead into drug court
5. Case manager
6. Medication assistance
7. Housing
 - There needs to be a follow up when you return home from detox, just like a follow up with cardiac drugs. The family needs education and an intervention so that they know what to do and what is going on. Parents and family need to be included.
8. Narcotics Anonymous

9. Sponsor
10. Intensive (12 hours/week) outpatient treatment
11. Job placement/workforce development

- **Tracking System**

There needs to be a tracking system put in place in Ohio to measure people who are coming into treatment, and their relapse rate under certain kinds of treatments. Also, there is a need to show the effect of specialty dockets like drug courts.

- **Standardize Best Treatment Practices and Demand Integration Across Treatment Silos**

It seems that in the places where addicts are successfully being treated, the judicial system, drug testing, probation, mental health psychiatry, medicated assisted treatment, counselors, peer to peer programs, and residential housing all integrate and play vital roles. In each community, it seems that different people are the glue in the effort to better treat addiction; in Hocking County it's Judge Moses, in Scioto County it's Ed Hughes, and in Pike County it's Angie Pelphrey. However, none of these people and the programs they oversee seem to be getting much compensation from the State of Ohio. Angie Pelphrey has a 57% success rate, which is unheard of in this field and a remarkable achievement. We don't seem to be funding the programs that are integrated and that work, like the programs that are run by Judge Moses, Ed Hughes, and Angie Pelphrey.

Medicaid continues to operate, along with the behavioral health community in general, in silos, whereas successful opioid treatment requires a highly integrated approach. Using an integrated team approach shortens the time needed in residential treatment. We need to fund a research project about reducing the number of in-patient days to stabilize addicts.

- **Access to Treatment**

1. Medicaid does not pay for residential treatment, or detox, which is the first step of treatment. It would be helpful to change coverage so that Medicaid pays for a best practice protocol like residential detox for 10 days, and then release with medication assistance to intensive outpatient in the patient's home county. Medicaid will not pay for the needed medication assisted therapy drugs until an addict has failed four or five times in treatment. Medication-assisted treatment is a key ingredient in treating this problem, and without it, progress will be slow in curtailing this epidemic. Medicaid should pay for medication-assisted treatment the first time that someone goes into treatment. Also, the reimbursement rate for Medicaid may be low enough that the freestanding clinics can't make that rate work—only in combination with a commercial insurance payment source can they take Medicaid.

2. Transportation is a huge issue in the rural counties. In most rural counties, there are also many old buildings and structures. Why not expand the state's treatment facilities by using money to buy physical assets (treatment, residential treatment, sober housing, transitional housing, three-quarter way housing, or community (peer) based housing) and then bid out the operations of the facilities to private operators?
3. Most private insurance does not pay for long-term treatment or medication-assisted treatment. Also, the 12-step method that is so effective is not reimbursable by insurance. We should align the commercial insurance markets to help pay for treatment. One idea to pay for this is to levy a user fee on each pill dispensed of ten cents.

VII. Thoughts for Further Consideration

- **Changing the Criminal Code, Criminal Courts, and Dealing with Addicts**

Our current criminal code is not doing a good job of preventing people from using drugs. We should work with the Commission on Sentencing Reform and other parties to examine some ways to utilize more of the drug court model, which has been widely successful in both large and small counties in Ohio. Following are some compiled notes on the problem:

- Punishment is a part of the negative consequences that get people to treatment (e.g. taking away children, jail, homelessness, etc.). If we got rid of all punishment, none of the addicts would ever try to recover.
- The judge is required under law to give a sentence to “protect the public” and punish the offender. Rehabilitation is not mentioned in the code. However, for drug addicts, rehabilitation is the cure that will prevent them from committing future crimes.
- Jail should be used in short amounts, with release to intensive probation and treatment. Probation and treatment can then be scaled down for success and up for failure.
- You should be able to “check yourself in” to a drug court if you know you need help but cannot do it on your own. Likewise, if a parent is having trouble with a grown child, but doesn’t want to risk them having their children taken away, have a felony conviction on record, lose their job, etc.
- If a parent reports that a child is stealing their medications, this offense should be a trigger that immediately places the child in the drug court.
- We need to think about the felony designation. That label sticks with people for the rest of their lives, even if they recover from the addiction.
- Judges would like access to the WORTH center for F-4 and F-5 felons.
- Bring drug paraphernalia in line with the punishment for possession of alcohol, or 180 days. This will allow courts to help addicted youths get intervention earlier. Expand judicial discretion and enable lab testing on syringes faster, so that they can charge them with drug paraphernalia.

- Allow a reduction of sentence from a felony to a misdemeanor if a person completes drug court and also gets a job, or does job training so they can get a job.
- Allow judicial discretion on whether or not to take away the driver's license.