SUBSTANCE ABUSE RESEARCH ALLIANCE (SARA)

GEORGIA PREVENTION PROJECT

Prescription Opioids and Heroin Epidemic in Georgia

- A White Paper

2017

SARA Executive Committee

Jim Langford – *Chair, SARA; Executive Director, Georgia Prevention Project*

Dr. Amanda Abraham – *Assistant Professor, School of Public and International Affairs, University of Georgia*

Dr. Aaron Johnson – *Associate Professor, Institute of Public and Preventive Health, Augusta University*

Dr. Merrill Norton – *Clinical Associate Professor, College of Pharmacy, University of Georgia*

Dr. Glenda Wrenn – *Associate Professor, Director of Behavioral Health, Satcher Health Leadership Institute, Director, Kennedy Center for Mental Health Policy, Morehouse School of Medicine*

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Prescription Opioids and Heroin Epidemic in Georgia

Introduction

Substance Abuse Research Alliance (SARA) is a program of the Georgia Prevention Project, and it initiated this study in April of 2016 as the organization's first collaborative project with a primary goal to assist the Georgia State Senate Study Committee on Opioids and Heroin in its work.

With more than 60 participants, SARA includes researchers and practitioners with a wide spectrum of experience in substance misuse work. SARA participants represent the following organizations:

- Applied Research Services, Inc.
- Augusta University
- Carter Center Mental Health Program
- Centers for Disease Control and Prevention
- Emory University – *multiple departments and programs*
- Georgia Council on Substance Abuse
- Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD)
- Georgia Department of Public Health (DPH)
- Georgia Prevention Project
- Georgia Southern University
- Georgia State University – *multiple departments and programs*
- Lab Solutions, Inc.
- Mercer School of Medicine
- Morehouse School of Medicine – *multiple departments and programs*
- Parkaire Consultants, Inc.
- Partnership for Drug-Free Kids
- Skyland Trail
- The Council on Alcohol and Drugs
- University of Georgia – *multiple departments and programs*

SARA believes that opioid and heroin use in Georgia seriously threatens the health, prosperity and general well-being of Georgians throughout the state, across almost all sectors of life and work.

Like Georgia, several other states struggle over how to ameliorate the suffering and death rates associated with prescription opioids and heroin, how to prevent citizens from misusing these substances, and how to intervene effectively to treat opioid use disorder and promote long-term recovery.

SARA stands ready to assist the Georgia Legislature and the State Senate Study Committee in any way that we can.

What you need to know now

The U.S.

200 percent prescription opioid overdose (OD) deaths increase since 2000

125 million Americans who reported misusing prescription pain relievers in the past year

80 percent of heroin users reported using prescription opioids for non-medical reasons before beginning to use heroin

Georgia

549 opioid drug ODs in 2015

29 counties where drug OD rates outpace U.S. average

11 Georgia ranks among top 11 states with most prescription opioid OD deaths

Executive Summary

Georgia's prescription opioid and heroin problem threatens the well-being of every Georgian at every socio-economic level and in every geographic region of the state.

This study by the Substance Abuse Research Alliance (SARA) seeks to educate public officials and the general public about the opioid epidemic that is devastating communities across the country and here in Georgia. We answer key questions and also offer a proposed legislative agenda to consider as Georgia legislators move to address this pervasive and growing challenge in our lives and communities.

What Are Opioids? How Do They Affect The Human Body?

Opioids are a class of drugs that act on the body's opioid receptors including natural, semi-synthetic and synthetic opioids. Natural opioids include drugs such as morphine, which are derived from the resin of the opium poppy, semi-synthetic opioids such as hydrocodone and oxycodone, and synthetic opioids such as fentanyl and methadone.

Opioids are often used medically to relieve moderate to severe pain, but can also be used for other conditions -- for example, to suppress cough, to treat diarrhea and even to treat opioid use disorder. Opioids are very effective for treating severe pain such as that associated with cancer, post-surgery, or accident-related injuries. While opioids provide pain relief, they also cause physical dependence, respiratory depression, euphoria, reduced intestinal motility and other desired and undesired effects. Since these pharmacologic effects focus on blocking pain, opioids have high potential for misuse.

Opioid drugs mimic the body's natural response to pain by stimulating the body's opioid receptors, most prominently the Mu (μ) receptors. Mu receptors account for most of the effects of opioids and are primarily located in the brain, spinal cord, peripheral nervous system, and intestinal tract.

By stimulating the Mu receptors, opioids reduce the perception of pain by slowing down and blocking pain signal transmission to the brain while also triggering the release of dopamine, a neurotransmitter used in the brain's pleasure or reward system. When activated, dopamine produces a pleasurable and often euphoric feeling.

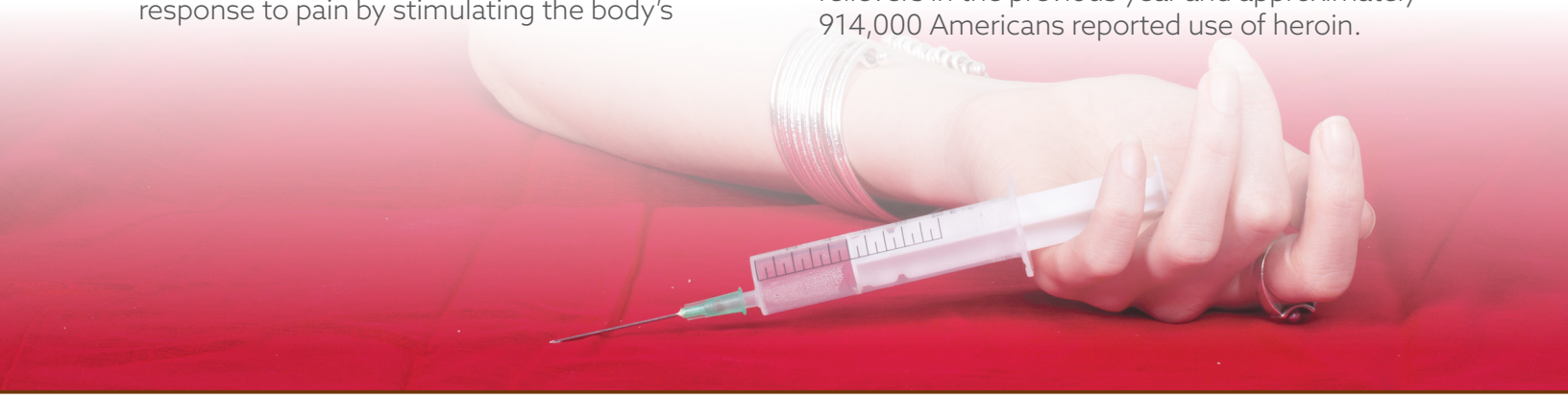
Use of opioids for more than a short period of time leads to tolerance and physical and psychological dependence. This means opioid users must take larger doses of opioids over time to achieve the same effect. Additionally, opioid users must not stop taking these drugs abruptly, or they will experience withdrawal symptoms such as agitation, anxiety, muscle and bone pain, insomnia, vomiting or diarrhea. Withdrawal symptoms occur when the amount of opioids used decreases or stops.

How Did We Get To A U.S. Opioid Epidemic?

Opioid overdoses - including prescription opioids and heroin - kill 78 people daily. This number has quadrupled since 1999. In 2015 alone, opioids were involved in over 28,470 deaths.

Despite the staggering statistic, the number of prescriptions written for opioid analgesics continues to increase.

Misuse of prescription opioids, and heroin use, are also on the rise. In 2015, approximately 12.5 million Americans reported misusing pain relievers in the previous year and approximately 914,000 Americans reported use of heroin.



And, the costs of this epidemic of prescription opioid overdose and misuse are high, estimated at $78.5 billion in 2013 alone.

Who Is At Greatest Risk?

The highest rates of prescription opioid overdose deaths from 1999 to 2014 were among non-Hispanic whites and American Indian or Alaskan Natives, persons aged 25 to 54, and men. Rates of prescription overdose deaths are on the rise for women (Centers for Disease Control, CDC, 2016). Risk factors for prescription opioid misuse and overdose include doctor shopping (i.e., receiving overlapping prescriptions from multiple providers and pharmacies), taking high daily doses of prescription pain relieves, having mental illness or a history of substance misuse, being low-income, and living in a rural area (CDC, 2016).

According to Centers for Disease Control and Prevention, people at highest risk for heroin addiction are those addicted to prescription opioid painkillers, cocaine, marijuana and alcohol; people 18 to 25 years of age living in large metropolitan areas, and people without insurance or enrolled in Medicaid.

What Is The Relationship Between Non-Medical Use Of Prescription Opioids And Heroin Use?

Several descriptive and observational studies suggest a link between non-medical use of prescription opioids and heroin, particularly among people with frequent nonmedical use or people with prescription-opioid use disorder.

Two recent national studies found that about 80 percent of heroin users reported using prescription opioids for non-medical reasons before beginning use of heroin. However, it is important to note that only a small percentage (less than 5 percent) of people who use prescription opioids for non-medical reasons begin using heroin. This small percentage translates to several hundred thousand new heroin users per year and should not be minimized.

While some argue that implementation of policies to address misuse and inappropriate prescribing of prescription opioids (e.g., PDMPs) may be a driver of increased deaths from heroin overdose, there is little empirical evidence of a causal link.

Instead, the evidence suggests that market forces such as increased availability, reduced price and increased purity of heroin could be more important drivers of increased heroin use and heroin overdose deaths.

What Is The Impact Of Opioid Use In Georgia?

Similar to national trends, deaths related to opioid overdose continue to rise in Georgia. Recent data from the Georgia Department of Public Health indicate that deaths related to drug overdose are now almost equal to deaths due to motor vehicle crashes (Figure 1).

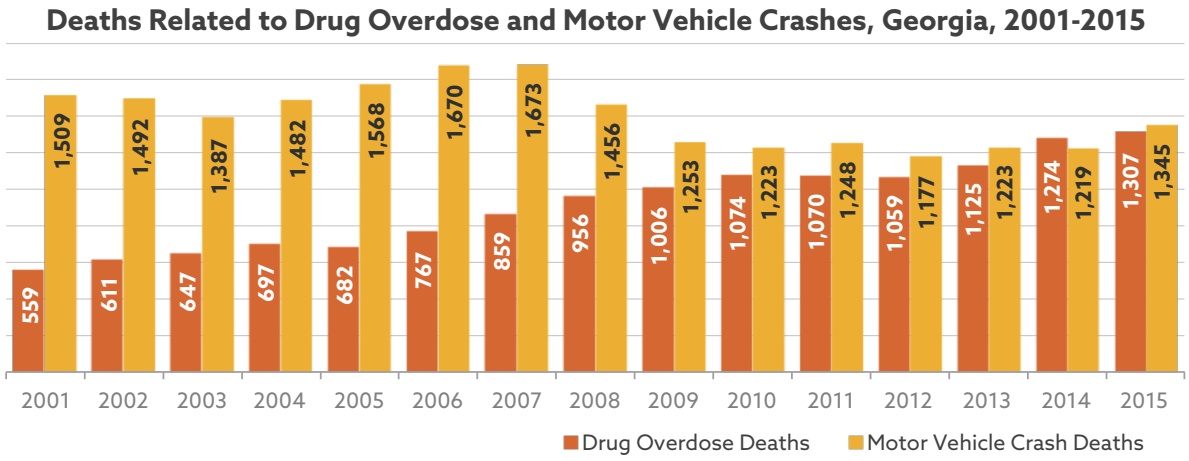
Opioids, primarily prescription pain relievers and heroin, are the main driver of drug overdose deaths. Of the 1,307 drug overdose deaths in 2015 in Georgia, 900 or 68 percent were due to opioid overdoses including heroin (Figure 2). Further, a statistically significant increase in the drug overdose death rate occurred from 2013 to 2014, and overdose deaths tripled between 1999 and 2013 in Georgia.

Prescription opioid overdose deaths in Georgia increased tenfold to 549 deaths, or a rate of 5.5 per 100,000 age-adjusted deaths, between 1999 and 2014. Georgia: Among top 11 states with the most prescription opioid overdose deaths (Figure 3).

Recent data indicate that 55 of Georgia's 159 counties had higher drug overdose rates than the U.S. average in 2014. This marks a significant increase from 11 years ago, when just 26 Georgia counties exceeded the U.S. average.

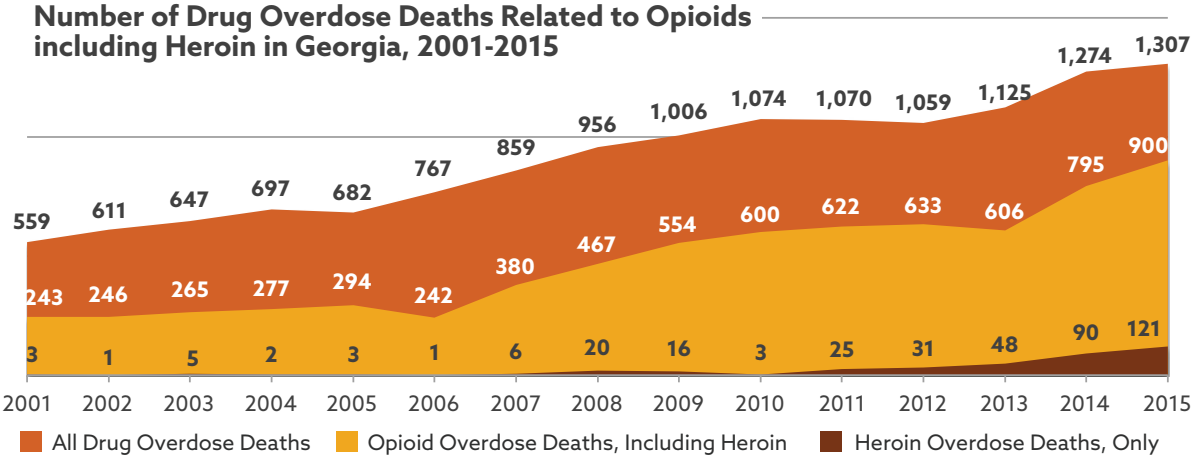
Sixty percent of the 55 counties with drug overdose rates higher than the national average in 2014 are located in rural areas with limited access to substance use disorder treatment and/or medication-assisted treatment. These numbers suggest that two-thirds of ***all*** counties in Georgia and 77 percent of ***rural*** counties have limited or no access to an evidence-based practice for opioid use disorder.

Figure 1:



Source: Georgia Department of Public Health, Office of Health Indicators for Planning, Death files.

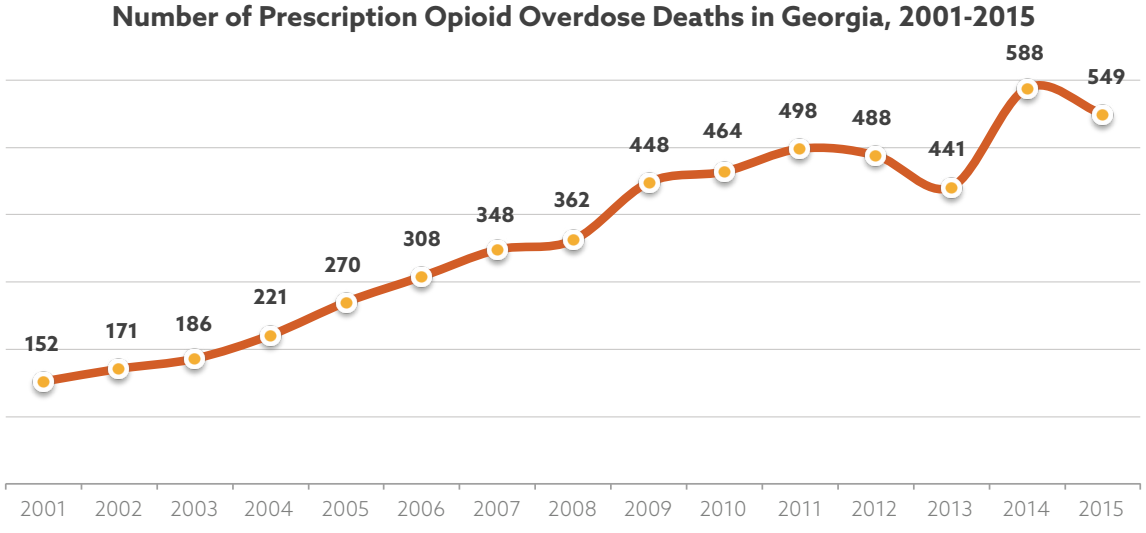
Figure 2:



Source: Office of Health Indicators for Planning (OHIP), Georgia Department of Public Health.

While prescription opioid deaths declined last year, users began shifting from prescription opioids to heroin. Hence, the spike in opioid deaths which include heroin.

Figure 3:



Source: Centers for Disease Control and Prevention (CDC), National Center for Health Statistics. Multiple Cause of Death 1999-2014 on CDC WONDER Online Database. Data are from the Multiple Cause of Death Files, 1999-2015.

What Is The Cost Of Opioid Use And Misuse In Georgia And The U.S.?

The economic burden of prescription opioid overdose, misuse and disorders in the U.S. is estimated at $78.5 billion in 2013 with over one third of this amount coming from increased health care and substance use treatment costs ($28.9 billion). The health care costs associated with opioid misuse in Georgia alone were estimated at $447 million in 2007 with estimated per-capita costs at $44. Given the increase in overdose deaths and misuse of opioids in Georgia over 11 years, some estimates indicate that health care costs associated with opioid misuse in Georgia have increased by 80 percent since 2007.

Hospitalizations related to opioid use and misuse in Georgia also have skyrocketed, from about 302,000 in 2002 to about 520,000 in 2012. Similarly the cost of opioid related inpatient care more than doubled during the same time period, rising to $15 billion in 2012.

What Has Congress Done?

Three major pieces of federal legislation addressed substance use disorders (SUD) in the past decade:

- Mental Health Parity and Equity Addictions Act of 2008
- Patient Protection and Affordable Care Act of 2010
- Comprehensive Addiction and Recovery Act of 2016.

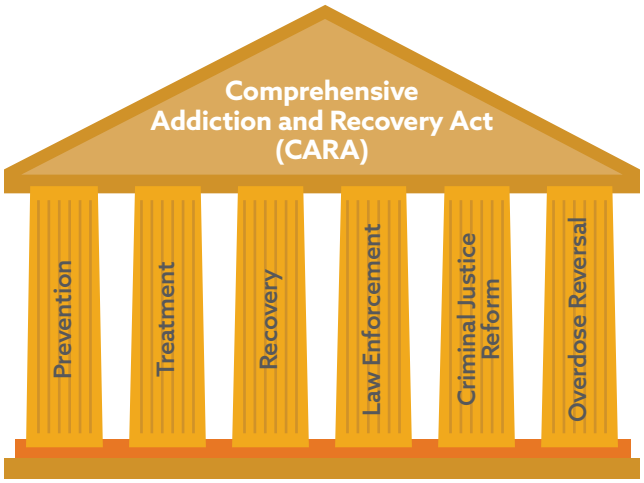
The Mental Health Parity and Equity Addictions Act of 2008 requires private group health plans with 50 or more employees and Medicaid managed care plans that cover SUD treatment do so in a manner that is no more restrictive than coverage of other medical and surgical procedures. **Parity requirements have not been extended to private plans in state health insurance exchanges and Medicaid expansion plans.**

The Patient Protection and Affordable Care Act (ACA) of 2010 provides greater access to SUD treatment through major coverage expansions, regulatory changes requiring coverage of SUD treatments in existing insurance plans, and requirements for SUD treatments to be offered on par with medical and surgical procedures. The ACA enables states to address the opioid epidemic through four primary mechanisms: insurance coverage expansions, regulatory insurance reforms that require inclusion of SUD treatments, enhanced parity, and opportunities to integrate SUD treatment and mainstream healthcare.

On July 22, 2016, President Obama signed **the Comprehensive Addiction and Recovery Act (CARA)**. This is the most comprehensive effort undertaken by Congress to address the opioid epidemic.

While it authorizes over $181 million each year in new funding to fight the opioid epidemic over the next 10 years, monies must be distributed annually through the regular appropriations process. CARA establishes a comprehensive, coordinated, and balanced strategy through enhanced grant programs that would expand prevention and education efforts, while also promoting treatment and recovery. The bill passed the U.S. Senate in March 2016, by a vote of 94-1. The bill passed the U.S. House of Representatives in May 2016, by a vote of 400-5.

CARA Six Pillars of Coordinated Response: Solving the Opioid and Heroin Problem.



Key Provisions of CARA

- **Expand** prevention and educational efforts—particularly aimed at teens, parents and other caretakers, and aging populations—to prevent the use of methamphetamines, opioids and heroin, and to promote treatment and recovery
- **Expand** the availability of naloxone to law enforcement agencies and other first responders to help in the reversal of overdoses to save lives
- **Expand** resources to promptly identify and treat incarcerated individuals suffering from substance use disorders by collaborating with criminal justice stakeholders and by providing evidence-based treatment
- **Expand** disposal sites for unwanted prescription medications to keep them out of the hands of our children and adolescents
- **Launch** an evidence-based opioid and heroin treatment and intervention program to expand best practices throughout the country
- **Launch** a medication assisted treatment (MAT) and intervention demonstration program
- **Strengthen** prescription drug monitoring programs (PDMP) to help states monitor and track prescription drug diversion and to help at-risk individuals access services

What should Georgia do?

After a careful review of recent recommendations from the National Safety Council and the National Governors Association, SARA proposes a legislative agenda for Georgia as briefly outlined below. SARA provides detailed recommendations in the body of this study.

In addition to the legislative agenda outline below, SARA recommends that the State conduct a comprehensive needs assessment specifically related to the opioid crisis and develop both a strategic plan and an implementation plan to guide the State's response to this epidemic.

Phase I – Georgia's most urgent needs

1. Increase access to naloxone.

More than 1,300 Georgians die each year from prescription opioid and heroin overdoses. Many of these deaths could be avoided with the use of naloxone, an opioid antagonist medication that reverses opioid overdose without significant negative side effects. First responders, parents, and educators should have easy access to naloxone and should have training in how to administer the drug.

2. Improve access to opioid use disorder treatment including medication-assisted treatment (MAT) and recovery support services.

Anyone misusing prescription opioids or using heroin should have access to the full range of opioid use disorder treatment services including medically managed detoxification/withdrawal management, behavioral therapy, medications and recovery support services. These services should include support for 1) families who have members in recovery and 2) community organizations that focus on recovery.

(continued next page)

3. Increase funding for substance misuse prevention programs.

The Georgia Legislature significantly reduced funding to DBHDD in 2010 for substance misuse prevention programs and administration. While DBHDD distributes and manages Federal substance misuse prevention funds, total State spending on substance misuse prevention within DBHDD currently is only $232,000 per year. Prescription drug education programs should target teens, young adults and parents.

4. Increase funding and improve mechanisms to address neonatal abstinence syndrome (NAS).

Some hospitals in Georgia are overwhelmed with infants born with NAS. The problem is on the rise, and these hospitals need significant assistance in treating and managing the care of these infants.

Moreover, health care providers need better education and training on how to deal with NAS. Our recommendations focus on three areas: 1) reducing incidence of NAS, 2) reducing NAS severity and optimizing health outcomes, and 3) leveraging resources and reducing costs of NAS.

5. Strengthen the Prescription Drug Monitoring Program (PDMP).

While Georgia implemented important changes and enhancements to its PDMP during the 2016 legislative session, much work remains to be done. The PDMP helps track the writing and filling of prescriptions of controlled substances, particularly opioid-based painkillers.

Phase II – Comprehensive and systematic approaches for Georgia

1. Increase oversight of pain clinics.

Georgia passed the Pain Management Clinic Act in 2013. Consistent with the National Safety Council and the National Governor's Association recommendations, Georgia should do two things: 1) require pain clinics to register with and use Georgia's PDMP, and 2) conduct an evaluation of the legislation to determine if it is being enforced and what impact it has had on opioid prescribing and overdose deaths.

2. Create standards for prescriber education.

The Georgia Composite Medical Board (CME) should mandate that a minimum of 5 hours of the 40 hours of required biannual credit hours focus specifically on the Georgia PDMP, pain management, and guidelines for prescribing opioid medications for chronic pain and/or substance use disorders.

Longer term, Georgia should create a task force to address more detailed methods of educating all levels of health professionals on pain management and incorporating technology that integrates the PDMP more directly with patient electronic health records (EHR).

3. Create a recurring "blue-ribbon" commission on substance use and recovery.

The Georgia Legislature, in collaboration with the Governor's Office, should create a recurring commission that convenes every 5-7 years to establish strategy and statewide goals, recommend appropriations, and review progress on reducing substance misuse and expanding local systems of recovery supports and treatment services in Georgia.

The Georgia Prevention Project

The Georgia Prevention Project - SARA's host organization - is a statewide not-for-profit effort that focuses on reducing the use of dangerous substances among teens and young adults. We accomplish our work through awareness campaigns, educational programming and strategic partnerships with national and community based organizations.

The Georgia Prevention Project evolved from the Georgia Meth Project founded in 2009. Created by the Siebel Foundation, the national Meth Project effort won more than 45 national and international awards for its hard-hitting educational campaigns that helped reduce first-time Meth use by more than 65 percent in its first two years in Montana. Subsequent launches in Idaho and Wyoming saw similar results and led to the addition of Hawaii, Colorado and Georgia as part of the Meth Project family.

In Georgia, the campaign led to significant changes in teens' perceptions of risk associated with Meth. During the media portion of the campaign of 2010-2012, the Georgia Meth project ran more than 26,000 radio spots, placed 23,000 television ads, and placed more than 588 billboards all over Georgia. This saturation effort significantly changed teens' perceptions of risk about the drug and produced results very similar to the Montana program.

Riding the momentum of the successful "Not Even Once" Meth prevention campaign, the Georgia Prevention Project launched in 2014 capitalizing on the Meth Project techniques and expanding its focus to include prescription drug misuse and heroin use.

The Georgia Prevention Project partners with community members, schools and prevention professionals to develop strategy, build coalitions and provide drug education resources to bring attention to the health and future of youth.

Through its Teacher Substance Abuse Training Program, GPP has worked to ensure that large numbers of Georgia teens gain in-depth knowledge of the risks associated with the misuse of prescription drugs and the misuse of dangerous substances such as methamphetamine and heroin.

For more information, or to discuss this Executive Summary, please contact us.

Jim Langford

Executive Director, Georgia Prevention Project; Chair, SARA

3715 Northside Parkway
Suite 1-320
Atlanta, GA 30327

404-831-1959

Email: info@georgiapreventionproject.org;
jlangford@georgiapreventionproject.org

Web sites: www.georgiamethproject.org;
www.georgiapreventionproject.org

SUBSTANCE ABUSE RESEARCH ALLIANCE (SARA)

GEORGIA PREVENTION PROJECT

Prescription Opioids and Heroin Epidemic in Georgia

- Findings and Policy Recommendations

2017

I. Opioid Overview

1. What opioids are

Opioids are a class of drugs that act on the body's opioid receptors including natural, semi-synthetic and synthetic opioids. Natural opioids include drugs such as

- **morphine**, derived from the resin of the opium poppy
- **semi-synthetic opioids** such as hydrocodone and oxycodone
- **synthetic opioids** such as fentanyl and methadone

Opioids are often used medically to relieve moderate to severe pain, but can also be used for example, to suppress cough, treat diarrhea, and even treat opioid use disorder. Opioids are very effective for treating severe pain such as that associated with cancer, post-surgery or accident-related injuries. While opioids provide pain relief, they also cause physical dependence, respiratory depression, euphoria, reduced intestinal motility and other desired and undesired effects. Since these pharmacologic effects focus on blocking pain, opioids have high potential for misuse.

2. How opioids affect the human body

Opioid drugs mimic the body's natural response to pain by stimulating the body's opioid receptors, most prominently the Mu (μ) receptors. Mu receptors account for most of the effects of opioids and are primarily located in the brain, spinal cord, peripheral nervous system, and intestinal tract.

By stimulating the Mu receptors, opioids reduce the perception of pain by slowing down and blocking pain signal transmission to the brain, while also triggering the release of dopamine, a neurotransmitter used in the brain's pleasure or reward system. When activated, dopamine produces a pleasurable, often euphoric feeling, which contributes to opioid misuse, as people seek to repeat these sensations.

Use of opioids for more than a short period of time leads to tolerance, physical and psychological dependence. This means opioid users must take larger doses of opioids over time to achieve the same effect. Additionally, opioid users must not stop taking these drugs abruptly or they will experience withdrawal symptoms such as: agitation, anxiety, muscle and bone pain, insomnia, vomiting or diarrhea. Withdrawal symptoms occur when the amount of opioids decrease or are stopped.

"Substance use disorders are a chronic medical illness characterized by clinically significant impairments in health, social function and voluntary control over substance use (not a moral failing or character flaw)." - Surgeon General's Report, Facing Addiction in America, 2016.

3. The U.S. Opioid epidemic

In 2015, overdose deaths associated with prescription and illicit opioids increased to 33,091, from 28,647 in 2014 (CDC), suggesting that 90 people die daily on average in the U.S. from opioid overdoses. Over the past 15 years, overdose deaths related to opioids have reached epidemic proportions (Rudd et al., 2015). The rate of opioid-related overdose deaths has increased over 200% since 2000. Between 2011 and 2015, deaths related to heroin more than tripled to 12,990 (National Center for Health Statistics).

Despite these staggering increases in deaths related to opioid overdose, the number of prescriptions written for opioid analgesics continues to increase (Volkow et al. 2014). The number of written prescriptions for opioid medications rose from 75.5 to 209.5 million over the past decade (National Institutes of Health, 2014). According to a recent report, sales of opioid analgesics quadrupled from 1999 to 2010 (Frenk et al., 2015).

Misuse of prescription opioids and heroin use is also on the rise. In 2015, approximately 12.5 million Americans reported misusing pain relievers in the previous year and 2.0 million Americans had a pain reliever drug use disorder (SAMHSA, 2016). In the same year, approximately 914,000 Americans reported use of heroin and 519,000 Americans met diagnostic criteria for a heroin use disorder (SAMHSA, 2016). The cost of prescription opioid misuse is high, estimated at $78.5 billion in 2013 alone (Florence et al., 2016). *Also see opioids deaths by type of opioid: heroin: 2014 chart (Kaiser Family Foundation) in Appendix.*

The highest rates of prescription opioid overdose deaths from 1999 to 2014 were among non-Hispanic whites and American Indian or Alaskan Natives, persons aged 25 to 54, and men. The rates of prescription opioid overdose deaths are on the rise for women (CDC, 2016).

Risk factors for prescription opioid misuse and overdose:

- **doctor shopping (i.e., receiving overlapping prescriptions from multiple providers and pharmacies)**
- **taking high daily doses of prescription pain relievers**
- **having mental illness or a history of substance abuse**
- **being low-income**
- **living in a rural area**

(CDC, 2016).

See Appendix for opioids overdose deaths by Type of Opioid: Heroin, 2014. Kaiser Family Foundation State Health Facts.

Studies show a shift in the demographics of heroin users in recent years. In the 1960s, those initiating heroin use were predominantly young men from minority groups living in urban areas. Now those initiating heroin use tend to be somewhat older (mean age of first use is 22.9 years compared to 16.5 years), more concentrated in rural and suburban areas, and white (Cicero et al., 2014).

According to the CDC, people at highest risk for heroin addiction are those addicted to prescription opioid painkillers, cocaine, marijuana and alcohol, people 18 to 25 years of age living in large metropolitan areas, and people without insurance or enrolled in Medicaid (CDC, 2016 http://www.cdc.gov/vitalsigns/heroin/).

4. Relationship between nonmedical use of prescription opioids and heroin use

Studies found that about 80% of heroin users reported using prescription opioids for nonmedical reasons before beginning use of heroin (Jones, 2013; Muhuri et al. 2013).

Overall, these studies suggest a link between nonmedical use of prescription opioids and heroin, particularly among people with frequent nonmedical use, or people with prescription-opioid use disorder. However, it is important to note that only a small percentage (less than 5% of people who use prescription opioids for nonmedical reasons) begin using heroin. This small percentage translates to several hundred thousand new heroin users per year and should not be minimized (Compton et al., 2016).

While some argue that implementation of policies to address misuse and inappropriate prescribing of prescription opioids (e.g., PDMPs) could be a driver of increased deaths from heroin overdose, there is little empirical evidence of a causal link. Instead, the evidence suggests that market forces such as increased availability, reduced price and increased purity of heroin could be more important drivers of increased heroin use and heroin overdose deaths (Compton et al., 2016).

Public health efforts to address either prescription opioids or heroin use must consider interrelationships between prescription opioid

and heroin use and focus on a comprehensive approach that includes all levels of prevention (i.e., primary, secondary, and tertiary), with emphasis on harm reduction approaches as a principal tertiary prevention strategy (Kolodny et al., 2015).

5. Impact of opioid use

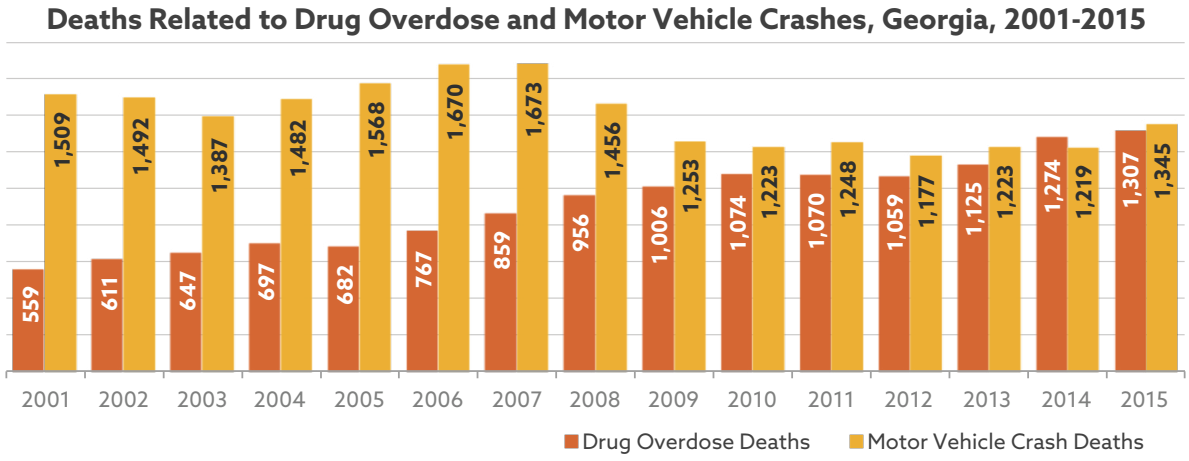
a. Overdose deaths in Georgia

Opioid overdose death rates including heroin in Georgia increased significantly - from 0.6 to 5.5 per 100,000 persons between 1999 and 2014 - while a comparable increase from 1.4 to 5.9 per 100,000 persons in the U.S. occurred during the same time period.

However, the rate of increase in opioid deaths in Georgia was much higher than the rate of increase of opioid deaths in the U.S. Sales of opioids also quadrupled in the U.S. between 1999 and 2014.

Similar to national trends, deaths related to opioid overdose continue to rise in Georgia. Even more alarming, recent data from the Georgia Department of Public Health indicate that deaths related to drug overdose surpassed deaths due to motor vehicle crashes in 2014.

Figure 1:

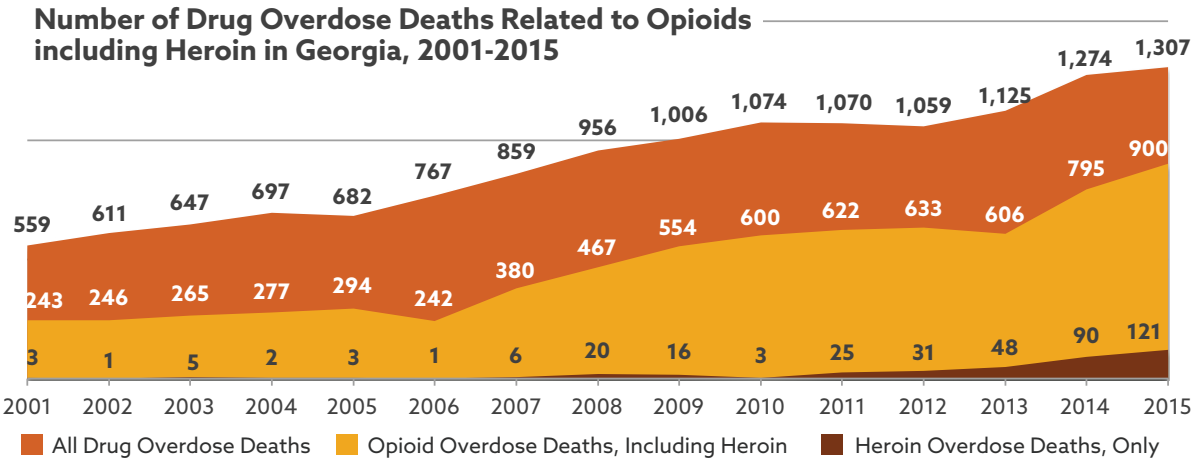


Source: Georgia Department of Public Health, Office of Health Indicators for Planning, Death files.

Opioids, primarily prescription pain relievers and heroin, are the main driver of drug overdose deaths. Of the 1,307 overdose deaths in 2015 in Georgia, 900, or 88% were due to opioids.

Further, the state experienced a statistically significant 10.2% increase in the overdose death rate from 2013 to 2014 (CDC, 2016), and a tripling of overdose deaths between 1999 and 2013.

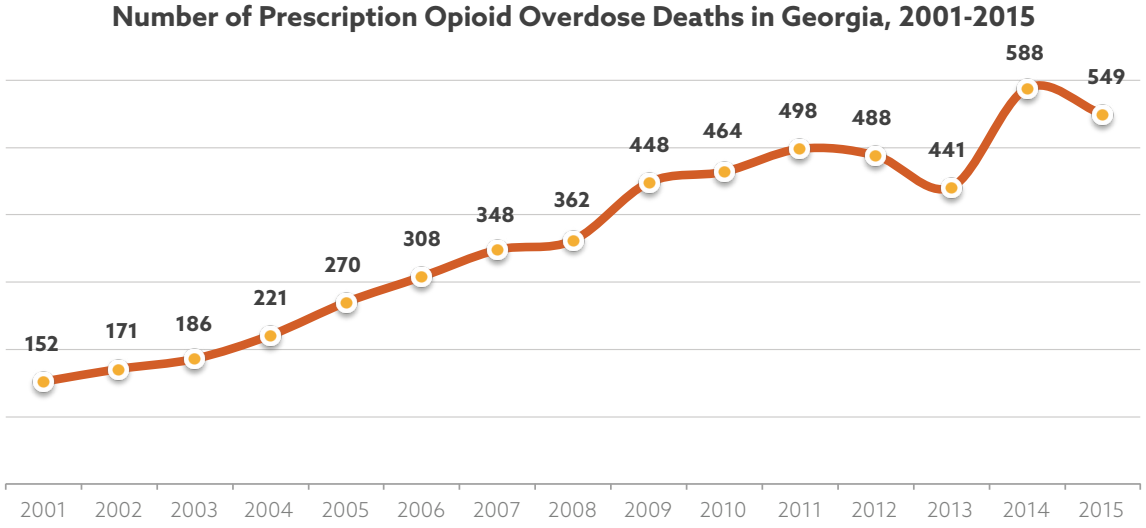
Figure 2:



Source: Office of Health Indicators for Planning (OHIP), Georgia Department of Public Health.

Prescription opioid overdose deaths also significantly increased in Georgia, according to the CDC WONDER Online Database (see Figure 6, retrieved from http://wonder.cdc.gov/mcd-icd10.html).

Figure 3:



Source: Centers for Disease Control and Prevention (CDC), National Center for Health Statistics. Multiple Cause of Death 1999-2014 on CDC WONDER Online Database. Data are from the Multiple Cause of Death Files, 1999-2015.

While 50 prescription opioid overdose deaths occurred in 1999, resulting in a rate of 0.6 per 100,000 age-adjusted deaths, the most recent available data show a tenfold increase to 588 deaths, or a rate of 5.8 per 100,000 age-adjusted deaths, in 2014.

This puts Georgia in the top 11 states nationwide with the most prescription opioid overdose deaths.

b. How Georgia compares to other states and the nation

While Georgia has a lower rate of all drug overdose deaths (11.9 per 100,000) compared to the U.S. average (14.7 per 100,000) (CDC, 2016), 55 of the 159 counties in the state had higher rates than the U.S. average in 2014 (CDC/NCHS, National Vital Statistics System, mortality data (see http://www.cdc.gov/nchs/deaths.htm); and Health Indicators Warehouse (see http://www.healthindicators.gov/Indicators/Drug-poisoning-deaths-per-100000_10016/Profile).

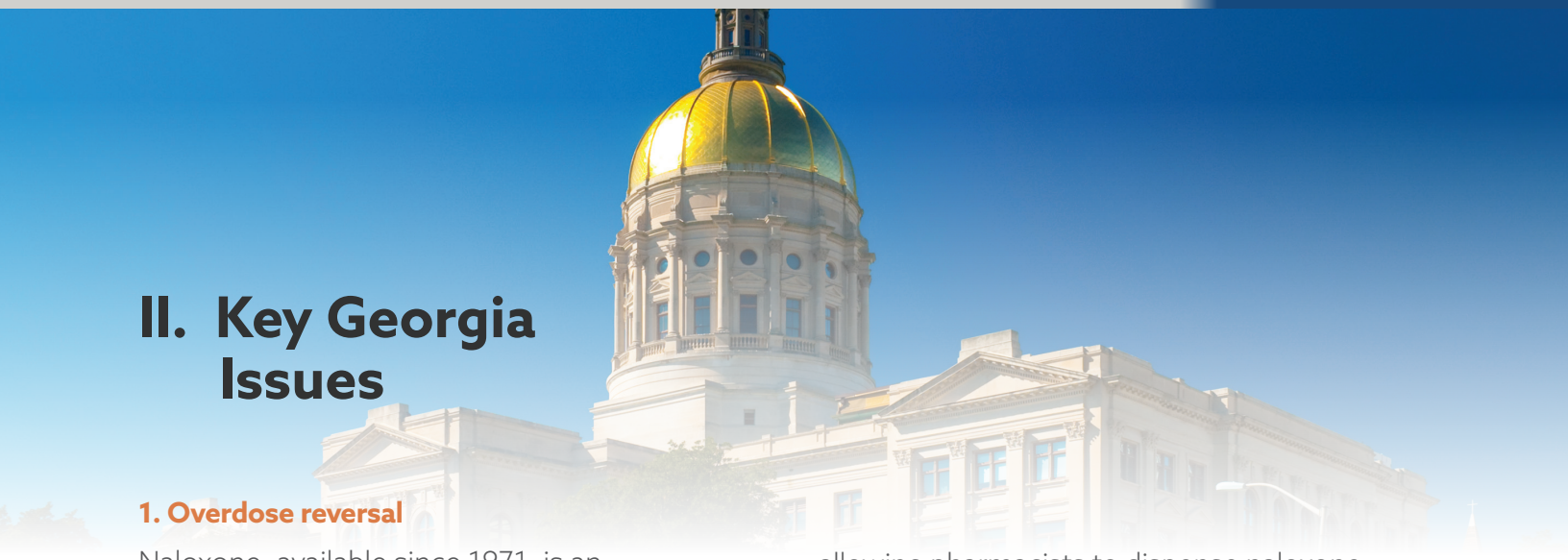
This marks a significant increase from 11 years ago, when just 26 counties in Georgia had overdose death rates that were higher than the U.S. average.

It is important to note that 60% of the 55 counties with overdose rates that were higher than the national average in 2014 are located in rural areas.

6. Economic costs of opioid misuse in Georgia and the United States

The economic burden of prescription opioid overdose, misuse and dependence in the U.S. was estimated at $78.5 billion in 2013 with over one third of this amount coming from increased healthcare and substance use treatment costs ($28.9 billion) (Florence et al., 2016). The healthcare costs associated with opioid misuse in Georgia alone were estimated at $447 million in 2007 and the estimated per-capita costs were $44 in Georgia.

Given the increase in overdose deaths and use of opioids in Georgia since 2007, some experts have estimated a rise in those costs of at least as 80% since that time. Those same experts agree that the state needs to monitor the escalation. Hospitalizations related to opioid use and dependence in Georgia also have skyrocketed from about 302,000 in 2002 to about 520,000 in 2012. Similarly, the cost of opioid related inpatient care more than doubled during the same time period, rising to $15 billion in 2012.



II. Key Georgia Issues

1. Overdose reversal

Naloxone, available since 1971, is an opioid antagonist used to reverse opioid overdose through intravenous, intranasal (NARCAN® Nasal Spray), and intramuscular formulations. Intramuscular delivery is available by syringe in various generic forms or by auto-injector (EVZIO®).

Naloxone is highly effective and safe and quickly (within a few minutes) restores breathing. It binds to opioid receptors, blocking the effects of opioids and endorphins. Side effects include withdrawal symptoms in most cases; while they are uncomfortable, they are not life threatening. It produces no effect in persons who do not have opioids present. Naloxone is not designated as a controlled substance and does not produce tolerance.

Because the nature and concentration of the opioid causing the overdose is unknown, treatment may require multiple doses of naloxone depending on the severity of respiratory depression. Fentanyl (50 to 100 times more potent than morphine) or Carfentanil (10,000 times more potent than morphine) may unknowingly be present in other substances (e.g., heroin, cocaine, marijuana, counterfeit benzodiazepines, etc.), significantly increasing overdose risk due to high concentration of opioids in undetectable quantities (e.g., size of a grain of salt or smaller) and require more doses to reverse overdose.

States can increase access to naloxone through a number of mechanisms including allowing naloxone to be prescribed with standing orders, allowing pharmacists to dispense naloxone, and passing Good Samaritan legislation. The National Safety Council and Governors Association submitted recommendations in 2016 for increasing access to naloxone (NSC, 2016; NGA, 2016). *See Appendix.*

Georgia's Naloxone Legislation

House Bill 965, the Georgia 911 Medical Amnesty Law, signed on April 24, 2014, expanded access to naloxone. The law authorizes administration of naloxone by trained first responders (law enforcement, firefighters, EMS personnel) for overdose reversal. Additionally, the law allows for medical professionals to write naloxone prescriptions, in good faith, to those at risk of opioid-related overdose.

This law also allows for administration of naloxone by lay people to persons suspected of experiencing an opioid overdose and provides protection from arrest and prosecution for people who call 911 seeking medical assistance for those experiencing alcohol or other drug-related overdose.

Ultimately this means that neither the caller nor victim can be arrested, charged, or prosecuted for small amounts of drugs, alcohol, or drug paraphernalia if the evidence was obtained as a result of seeking medical assistance. This is important because the timely administration of naloxone has been proven to reverse the effects of opioids such as heroin and opioids including hydrocodone, oxycodone, methadone and others drugs.

Victims of opioid overdose who receive naloxone in time are less likely to die or suffer long-term brain or tissue damage than those who do not. Removing barriers to health-seeking behavior is a crucial step in the fight against opioid related deaths.

Naloxone Availability in Georgia

Pharmacies. Naloxone is available from some pharmacies in Georgia. Individuals can ask for naloxone without bringing in their own prescription at pharmacies because of standing orders that allow dispensing to individuals who meet specified criteria. Georgia residents may obtain Narcan without a prescription from Georgia pharmacies.

Adapt Pharma, a manufacturer of naloxone, provides a naloxone prescription request form with a National Drug Code (NDC) number to facilitate filling the prescription by pharmacies. However, no centralized information exists on which pharmacies in Georgia carry naloxone. Individuals need to contact pharmacies directly to find out whether the pharmacy carries it and how to obtain it.

The Georgia Pharmacy Association participated in Project DAN (Deaths Avoided by Naloxone) to help make naloxone available to pharmacies and first responders. Georgia Pharmacy Foundation partnered with Medical Association of Georgia (MAG) Foundation's *Think About It* campaign to distribute naloxone to pharmacies in 13 northeast counties in 2015. This effort included working to encourage pharmacies to carry naloxone.

Community organizations that legally can hand out naloxone (syringe kits or Narcan) are those with a standing order prescription on file from a medical director, and a pharmacy through which to order the prescription.

Two organizations meet these criteria – the Georgia Overdose Prevention and the Davis Direction Foundation. Naloxone kits are distributed through the Atlanta Harm Reduction Coalition by the Georgia Prevention Project. Availability is supported by grant funding from DBHDD and donations.

Georgia Overdose Prevention. GOP (georgiaoverdoseprevention.org) is a grassroots organization of parents, healthcare professionals, harm reduction advocates and friends of those who have lost loved ones to accidental drug overdose. GOP formed to create and advocate for the passage of the Georgia 911 Medical Amnesty Law described above. The GOP provides overdose reversal training and a simple message based on the belief that when one is breathing, there is still hope: Don't run, call 911.

First Responders. The extent to which police departments, fire departments, and emergency medical services have naloxone available across the state is unknown. Not all police precincts have naloxone, and precincts differ in the availability of naloxone to officers. Cost and the shelf life of naloxone are concerns.

Medical settings. Naloxone availability or distribution from various types of medical settings is unknown. Autoinjectors have been distributed free of charge from EVZIO® donations to opioid treatment provider clinics.

Schools. Because overdose may occur in schools, naloxone availability in schools is receiving increasing attention. The National School Nurses Association sees naloxone availability in schools as an element of a school's emergency and response plan for safe and effective reversal of opioid pain reliever overdose.

Adapt Pharma is offering NARCAN free to schools around the country. The Clinton Foundation's Health Matters Initiative is a partner in this effort. (http://www.drugfree.org/news-service/naloxone-offered-free-high-schools-around-country/) Pennsylvania was the first state to make naloxone available in all public schools through this program (http://fox43.com/2016/02/01/heroin-overdose-drug-naloxone-to-be-provided-free-to-all-pa-public-schools/). States, such as Vermont, Delaware, Illinois, and New York have made naloxone available in schools.

Home. Naloxone availability at home provides for rapid overdose reversal. Overdose may occur not only from heroin use and non-prescription use of opioid medications, but

also from prescription use. Errors in use, sharing of medications, and use according to prescription may result in overdose. Co-prescribing of naloxone with opioid medication can reduce overdose. (Coffin et al., 2016; https://www.drugabuse.gov/news-events/news-releases/2016/06/co-prescribing-naloxone-in-primary-care-settings-may-reduce-er-visits). H.R. 3680 - Co-Prescribing to Reduce Overdoses Act of 2016 was passed by the U.S. House of Representatives in May 2016 and is under review by the Senate. https://www.congress.gov/bill/114th-congress/house-bill/3680/text

Escalating Naloxone Cost

Naloxone costs have increased substantially over the past decade, particularly since 2014. Naloxone increased from $.92 per dose in 2005 to $15 - $17 per dose by one manufacturer in 2014 and up to $41 per dose in 2015 by another. Narcan costs $63 per single dose, but sells at about half that cost to government agencies, community organizations and those without insurance.

The cost of Evzio auto-injectors is substantially higher, having jumped in price from $287.50 in July 2014 to $375 in November 2015, with further increases in 2016 to $2,250 per single dose. Since scrutiny of these prices increases, manufacturers have responded with discounts and rebates. ADAPT makes Narcan available free of charge to schools and has donated 50,000 doses, and Kaleo has donated 150,000 autoinjectors to first responders and nonprofits.

Most insurance covers naloxone including Medicaid, and EVZIO promotes a zero co-pay option.

Naloxone Concerns

Although Georgia has made progress in this area, additional efforts to increase access to naloxone are needed. General concerns about naloxone fall into the five areas: outline below.

1. **Possible perception as safety net for risk opioid use.** Some groups and individuals are concerned that availability of overdose reversal medication may be perceived as a safety net by opioid users at risk of overdose, and that naloxone availability does not directly address reducing opioid misuse. There is no evidence that availability of life saving overdose reversal medication increases opioid overdose risk.
2. **Awareness, availability, and training on use.** Limited awareness about the potential for overdose and the availability of overdose reversal medication is a concern among those who may encounter opioid overdose but who have not been properly trained on administration procedures.
3. **Cost of medication and medication expiration.**
4. **Limited data on reversals.** The ability to track overdose reversals is limited to documentation by first responders and emergency rooms. Information from multiple sources needs to be collected and validated in a single system. When naloxone is administered by individuals without the involvement of first responders or medical services, no information on use is available. A system for centralized data collection from entities that distribute naloxone would provide more accurate information.
5. **Linkage to services following reversal**. Successful overdose reversals without linkage to services to reduce or prevent future overdose of the same individual is a concern. First responders report multiple reversals on the same individual. Furthermore, subsequent overdoses may lead to death because intervention with reversal medication did not occur in time. Evidence-based, effective systems are needed to link individuals experiencing an overdose reversal to services preferably via assertive case management and warm hand-offs.

At present, Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) is developing business-card size materials to distribute. More effective measures for reducing repeat overdose are needed, such as creating linkage directly between individuals who can provide direct, culturally congruent support and ongoing recovery services. These efforts have been put in place in other communities, and need exploration for their use in Georgia.

SARA Makes the Following Recommendations Regarding Medications

1. Increase awareness about overdose and overdose reversal medication.
2. Increase access to naloxone and training on use of the medication.
3. Develop a plan to address naloxone cost.
4. Implement information technology systems to improve tracking of naloxone use.
5. Establish immediate linkages to recovery services following overdose reversal to
   - reduce the potential for repeat overdose, and
   - increase the likelihood of sustained recovery
6. **Mandate Insurance Coverage for Opioid Overdose-Reversal Medication:** Naloxone revives an individual from a heroin or other opioid overdose and has saved thousands of Georgians' lives.

   It has no psychoactive effects and concomitantly, no misuse potential. To expand access to this life-saving medication, the new legislation requires insurance companies to cover the costs of naloxone when prescribed to a person who is addicted to opioids and/or to his/her family member/s on the same insurance plan.

2. Medication assisted treatment & recovery support services

To meet the needs of patients with OUD, it is important for patients to have access to the full range of SUD treatment services including:

- outpatient treatment
- intensive outpatient treatment
- residential treatment
- detoxification
- medications
- recovery support services

(ASAM, 2016).

According to a National Safety Council report, Georgia does not meet the indicator for "meets need for OUD treatment", measured by sufficient buprenorphine treatment capacity.

Ongoing treatment and recovery support of individuals affected by opioid use disorders involves addressing physical dependence (including overdose risk) and the behavioral and psychosocial skills required for managing recovery. Treatment decisions could depend upon a range of factors including substance use history (e.g., duration, substances used, prior recovery efforts), co-occurring disorders, treatment availability, cost/payment options, family support, and legal requirements.

Behavioral counseling, a key component of Georgia's recovery-oriented systems of care for opioid addiction, generally follows the National Institute on Drug Abuse (NIDA)'s ***Principles of drug addiction treatment: A research-based guide*** (2012; 3rd edition: drugabuse.gov/publications/principles-drug-addiction-treatment/evidence-based-approaches-to-drug-addiction-treatment/behavioral-therapies).

How Georgia's public behavioral health treatment system is managed currently

The Department of Behavioral Health and Developmental Disabilities' mission is to lead an accountable and effective continuum of care to support Georgians with behavioral health challenges, and intellectual and developmental disabilities in a dynamic healthcare environment. State funds and federal

block grants support a network of six regional offices that administer each region's hospital and community resources. (Community services are provided through contracts with private, for-profit, non-profit, and quasi-public agencies under contract with DBHDD through the regional offices. Services focus on addictive diseases, behavioral health, behavioral health prevention and other services.

Key Terms and Implications

Medication-assisted Treatment (MAT)

Medication-assisted treatment (MAT) refers to multi-faceted individualized substance use disorder treatment models that employ both medications and other services and supports for recovery maintenance.

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) recognizes that MAT provides specific interventions for reducing and/or eliminating the use of illicit opioids and other drugs of misuse; while developing the individual's social support network and necessary lifestyle changes; psychoeducational skills; pre-vocational skills leading to work activity (by reducing substance use as a barrier to employment); social and interpersonal skills; improved family functioning; the understanding of addictive disease; and the continued commitment to a recovery and maintenance program.

Medically Managed Detoxification/Withdrawal Management

Opioid withdrawal, whether from prescription medication or heroin, often produces extreme and extended discomfort. Symptoms include: sweating, shaking, chills, body aches, yawning, large pupils, headache, drug craving, nausea, vomiting, abdominal cramping, diarrhea, inability to sleep, confusion, agitation, depression, anxiety, ... and other behavioral changes, and can last for days and weeks. Fear of withdrawal symptoms is a significant deterrent to discontinuing opioid use, and a frequent reason for relapse.

Because opioid withdrawal is not considered life threatening, detoxification is generally not covered by Medicaid and private insurance, making access to inpatient or outpatient opioid detoxification services and medication extremely limited in Georgia.

Medications to manage withdrawal symptoms during detoxification from opioids include methadone, buprenorphine alone or with naloxone (Suboxone®), milder opioids, and clonidine. The length of the detoxification process varies by individual factors and goals. It may include use of multiple medications concurrently or sequentially. Individual differences may include level of tolerance, substances used, length of use, and medical complications.

In addition to becoming opioid free, goals may include transition to methadone, buprenorphine, or extended-release injectable naltrexone, each of which may affect length of time required. Transition to extended-release injectable naltrexone requires a 7-10 day opioid free period to avoid precipitating withdrawal.

Gaps in medication may make an individual vulnerable to using substances in their recovery process. Establishing systems for the most effective implementation of treatment protocols can lessen these vulnerabilities and provide greater supports for recovery.

Management of tapers or transitions from the opioid agonists, methadone or buprenorphine, to extended-release injectable naltrexone could be affected by approved usage of transitional medications.

Reduction in use of methadone and buprenorphine requires a long taper. The length of the taper can be reduced with use of alternative medications, such as milder opioids, which may not be approved for opioid tolerance management. Longer tapers increase cost and impact the viability of transitioning clients.

Access to medically managed detoxification for opioids and other substances differs broadly across the country, from no availability to free walk-in 24/7, for anyone, regardless of insurance status.

Outpatient and inpatient options might be appropriate for opioid detoxification. Insurance coverage restrictions, as well as lack of available beds or outpatient services, limit access to detoxification for many individuals ready to

stop using opioids. Publicly funded outpatient detoxification services, previously available in Georgia, were cut from the budget in 2010. See The ASAM National Practice Guideline For the Use of Medications in the Treatment of Addiction Involving Opioid Use for a more complete description of the treatment of opioid withdrawal.

SARA Makes the Following Recommendations about Detoxification Services

Detoxification services linked to housing and behavioral health treatment and recovery support can reduce the revolving door of recurring withdrawals, save money, unburden emergency rooms and jails, and foster early recovery. Mary Hall Freedom House, Inc. proposes to open a 25-bed social model detoxification facility in Downtown Atlanta. The facility will be designed to receive females who are under the influence of alcohol and/or drugs, who also may have a co-occurring mental health disorder, and who are not presenting life-threatening withdrawal symptoms.

1. Examine availability of detoxification/ withdrawal management services, level of need, and factors impacting access to assure sufficient available services.
2. **Build a range of detox services in Georgia:** Individuals needing detoxification are often "high system users" with unique health needs. Individuals with substance use disorders often experience co-occurring mental health disorders which further complicate withdrawal. High system users can burden law enforcement and emergency rooms and can pose a threat to public safety.
3. Examine cost barriers to detoxification/ withdrawal management, including insurance barriers to identify and implement solutions.
4. Examine barriers to treatment for those receiving detoxification/withdrawal management services to identify and implement strategies for overcoming these barriers.

Medication-Assisted Treatment/Medication-Assisted Recovery

Effective treatment strategies for managing recovery from opioid use disorders include behavioral therapies, medication, and psychosocial supports. Evidence-based behavioral therapies may be used alone or in combination with medication management, along with other services and supports.

Medication to assist recovery has been demonstrated to reduce relapse and extend opioid free periods in combination with behavioral treatment services.

Services and supports to reduce or eliminate the use of opioids or other drugs of misuse address the whole person in recovery including development of social support networks, lifestyle changes, psycho-educational skills, improved access to employment, social and interpersonal skills, improved family functioning, knowledge of addictive disease, and commitment to recovery and a maintenance program.

Long-term continuing care services have been demonstrated to be the most significant factor in extended sobriety and relapse prevention. Individualized management of treatment services should include the ability to address changes in medication and other treatment needs throughout the recovery process, without barriers such as lack of access to medications, or other treatment services.

Because individuals with opioid use disorder may have co-occurring mental health conditions, a thorough assessment of both mental health and substance use should inform treatment decisions, and treatment providers should provide both types of services.

Because providers may not be cross-trained in both mental health and substance use disorders, treatment teams need to include professionals skilled in each, for both behavioral and medication treatment.

Medications Approved by the FDA for Opioid Treatment

Medications, used in conjunction with behavioral therapy, are considered the gold standard in treatment of opioid use disorder. Currently four medications are approved by the U.S. Food and Drug Administration (FDA) for treatment of opioid use disorder or relapse to opioids — methadone, buprenorphine, oral naltrexone and extended-release injectable naltrexone.

Methadone is a full *mu*-opioid agonist, approved by the FDA in 1972 for use in treating opioid dependence. While its effectiveness has been demonstrated in several studies, stigma associated with it (Barnett et al., 2001; Schwartz et al., 2008) and the daily dosing that is required (CSAT, 2005) are barriers to its use.

Methadone is available as liquid oral solution or diskettes. Methadone can only be provided for opioid use disorder management by licensed opioid treatment programs (OTPs). Research shows that methadone maintenance is more effective as an adjunct to individual and/or group counseling, with even better outcomes when combined with other needed medical/psychiatric, psychological, and social services (e.g., employment or family services). Methadone clinics in Georgia can be located via http://www.opiateaddictionresource.com/treatment/methadone_clinic_directory/ga_clinics

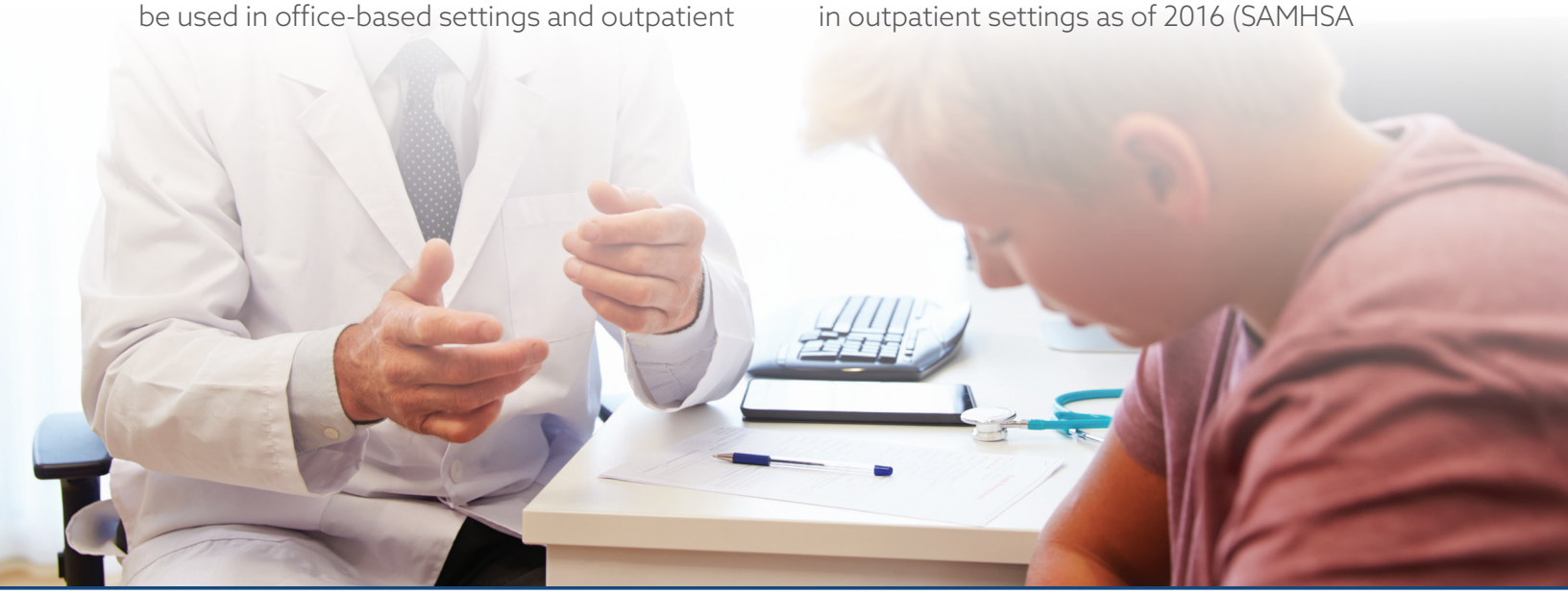
Buprenorphine is a partial *mu*-opioid agonist, approved by the FDA in 2002 for the treatment of opioid dependence. Unlike methadone, it can be used in office-based settings and outpatient treatment programs. Research indicates that the use of buprenorphine is associated with fewer withdrawal symptoms, a lower risk of misuse and overdose, and increased treatment retention (Bell, et al., 20009; Fiellin et al., 2002; Ling et al., 2005; Amass et al., 2004).

Buprenorphine is prescribed either alone (Subutex) or in a combination form with naloxone (Suboxone). The brand name formulations are only available in sublingual strips. Generic and other formulations (e.g., Zubsolv) are available as sublingual tablets. In May 2016, the FDA approved the buprenorphine implant, probuphine for maintenance treatment of opioid dependence.

It is not considered appropriate for new entrants into treatment or those that have not achieved clinical stability.

Buprenorphine has a ceiling effect, which is a barrier to use as treatment for those with higher opioid tolerance. Those with higher tolerance cannot be transitioned directly to buprenorphine. In these cases, a waiting period of 3-4 days upon stopping opioid use or transition to methadone, with a step down to buprenorphine could be required to avoid precipitous withdrawal.

Buprenorphine can be prescribed in settings other than Opioid Treatment Programs (OTPs). Physicians prescribing buprenorphine must apply for a physician waiver from SAMHSA with demonstrated completion of 8 hours of required training. Physicians may be approved to treat up to 100 patients with buprenorphine in outpatient settings as of 2016 (SAMHSA



2016). There are no limitations on use in inpatient settings for managing withdrawal, or by licensed OTPs. Barriers to physician buprenorphine training and dispensing include stigma related to the patient population, limited behavioral health knowledge, lack of support, lack of connection to behavioral health services, staffing needs, and required paperwork.

Naltrexone is an opioid antagonist. Unlike opioid agonists, naltrexone works by blocking the opioid receptors so that they are unable to be activated. Any healthcare provider licensed to prescribe medications can prescribe Naltrexone. The oral formulation (ReVia®, Depade®) is generally taken once per day. Research suggested that patient compliance with oral naltrexone is a significant problem (Gueorguieva et al., 2013; Kranzler et al., 2008; Swift et al., 2011; Volpicelli et al., 1997).

Extended-release injectable naltrexone (Vivitrol®) was developed to address the challenge of patient compliance, hence a single monthly injection. It was approved by the FDA for relapse to opioids in 2010 after being initially approved as a treatment for alcohol use disorder in 2006.

The medication is intended for opioid patients who have gone through detoxification and are free of opioids or opioid-containing medications, including buprenorphine or methadone, for a minimum of 7-10 days. The use of extended-release injectable naltrexone for opioid use disorder has been linked to abstinence rates, longer duration of opioid-free days, improved treatment retention, less craving, and lower relapse occurrence (Gastfriend, 2011; Syed & Keating, 2013). Yet, only 15% of all substance use disorder treatment programs in Georgia offer buprenorphine, 7.65% offer extended-release injectable naltrexone, and 11.9% offer oral naltrexone.

Taking these medications as prescribed promotes employment, reduces crime and violence, and minimizes exposure to HIV by stopping or decreasing injection drug use and drug-related high-risk sexual behavior. Patients stabilized on these medications also engage more readily in counseling and other behavioral interventions essential to recovery.

See Resources for what the National Institute on Drug Abuse and the state of Georgia provide on medication-assisted treatment.

See Appendix for the National Institute of Drug Abuse resources on medication-assisted treatment.

Substance Use Disorder Providers in Georgia

Georgia's Department of Behavioral Health and Developmental Disability (DBHDD) contracts with two MAT providers, Southside Medical Center and Alliance Recovery Center (Decatur, Conyers). These clinics provide methadone, buprenorphine, and counseling and other support services. There are 60 licensed private MAT providers in Georgia in 2016. According to the SAMHSA Treatment locator, 206 buprenorphine providers and 225 substance use and mental health treatment providers are operational in Georgia in 2016.

Buprenorphine providers are concentrated primarily in urban areas and there is limited access to buprenorphine providers in many rural areas of the state. For example, over half the state's counties (n=84, 53 percent) do not have a single physician who can prescribe buprenorphine for opioid use disorder, and an additional 22 counties (14%) have just one physician with a buprenorphine waiver (SAMHSA buprenorphine treatment physician locator - http://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator).

Similarly, of the 85 rural Georgia counties, 54 (or 64 %) have no access to buprenorphine providers and 11 (or 13%) have only one provider who can prescribe the medication. These numbers suggest that two-thirds of ***all*** Georgia counties and 77 percent of ***rural*** counties have limited or no access to an important evidence-based practice for opioid dependence.

According to the National Survey of Substance Abuse Treatment Services (NSSATS), there were 353 substance use disorder treatment providers in Georgia in 2014, the latest year for which survey data are available (NSSATS, 2014). Of these, 56 (or 15.86 percent) were OTPs. Georgia

passed a bill in 2016 to suspend licensure of additional narcotic treatment clinics (SB 420). See Appendix Table XX for details of OTP and non-OTP services and coverage in Georgia in 2014.

In Georgia, fee for service (FFS) Medicaid covers methadone maintenance, buprenorphine/naloxone, and extended-release injectable naltrexone. FFS coverage for substance use disorder counseling and documentation of buprenorphine /naloxone or extended-release injectable naltrexone counseling is unknown (ASAM, 2014).

Suboxone and extended-release injectable naltrexone are pharmacy benefits, and preauthorization is required for both. Maximum daily dose limits for buprenorphine after 6 months of therapy are 16.

Only the publicly contracted MAT providers accept Medicaid, and only limited subsidies to offset treatment costs are available. For individuals not covered by Medicaid, insurance, or subsidies, cost of treatment is a barrier to recovery. Gaps in coverage caused by Georgia's rejection of Medicaid expansion particularly affect these populations, particularly men, and women who do not have children.

Requirements of the Commission on Accreditation of Rehabilitation Facilities (CARF) for programs providing Methadone or Suboxone treatment state that they must offer counseling. In Georgia, counseling is not required for treatment for opioid use disorder. However, each individual program could have requirements for attendance of individual or group counseling sessions.

Georgians can find treatment on the SAMHSA treatment locator, which provides information on alcohol, drug and mental health treatment facilities, as well as physicians and treatment programs authorized to treat opioids including MAT(https://findtreatment.samhsa.gov) (http://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator).

Public Awareness

The State Department of Behavioral Health and Development Disabilities (DBHDD) Office of Addictive Diseases (OAD) collaborates with Opioid Treatment Providers of Georgia (OTPGA; https://www.otpgeorgia.org/) to increase awareness and provide education on treatment options, including MAT.

OTPGA is a non-profit organization of treatment providers, counselors, and other interested persons concerned about treatment, recovery and traditional and alternative options for heroin and other opioid addiction.

During OTPGA's annual November conference, abstinence based and MAT providers share information and receive training about evidence-based MAT practices. The conference is open to the public. The Georgia School of Addiction Studies, held annually in August, also offers training on MAT. **With medically assisted treatment come these potential hurdles:**

1. High cost of medications, and limited access to private insurance or Medicaid coverage for medications.
2. Limited access to Medicaid billable MAT and challenges for those not Medicaid eligible to receiving medication.
3. Potential limitations to access to various types of medication that limit ability to develop and implement individualized treatment plans.
4. Limitations in access to comprehensive recovery support services that include medication.
5. Need for review of available MAT services, state of the art, and approaches implemented elsewhere to improve programs in Georgia.
6. Stigma associated with the use of MAT among treatment providers, family and friends of opioid users, and the general public.
7. Availability of physicians and nurses to prescribe medications and medically monitor patients receiving medications.

SARA Makes the Following Recommendations for Medically Assisted Treatment

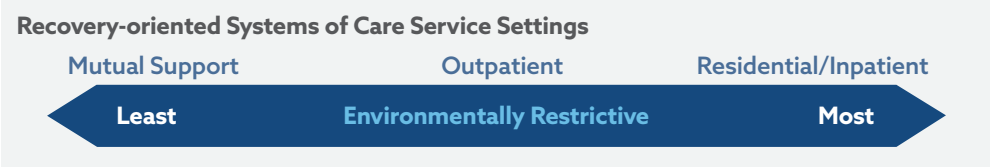
1. **Review MAT approach in Georgia in relation to current recommendations for best practice, and compare to other effective programs to identify strategies for strengthening quality and effectiveness of Georgia programs.**
2. **Review availability and access to MAT and determine barriers and facilitators to develop strategies to improve access to MAT.**
3. **Examine costs and financial barriers and solutions to providing effective, evidence-based treatment.**
4. **End Prior Insurance Authorization to Allow for Immediate Access to Inpatient Treatment as Long as Such Treatment is Needed:**
   People suffering from addiction who seek treatment need immediate access to services. However, prior authorization requirements by insurance companies are often a roadblock to admission to inpatient programs. This legislation requires insurers to cover necessary inpatient services for the treatment of substance use disorders for as long as an individual and her/his service provider says it is needed.
   - The Legislation establishes that utilization review by insurers can begin only after the first 14 days of treatment, ensuring that every patient receives at least two weeks of uninterrupted covered care before the insurance company becomes involved.
   - Department of Community Health, Office of Healthcare Facilities Regulation, Drug Abuse Treatment and Education Programs, Section Client Referral, Intake, Assess, Admission, 290-4-2-.13(1)(b)1., is changed to ensure that barriers to access to intake are minimized.
   - End Prior Insurance Authorization to Allow for Greater Access to Drug Treatment Medications: People seeking medication to manage withdrawal symptoms or maintain recovery must often request prior approval from their insurance company, which slows or stops the individual from getting needed medication. This legislation prohibits insurers from requiring prior approval for emergency supplies of these medications. Similar provisions will also apply to managed care providers treating individuals on Medicaid who seek access to buprenorphine and injectable naltrexone.
5. **Require All Insurance Companies Use Objective State-Approved Criteria to Determine the Level of Care for Individuals Suffering from Substance Abuse:** Insurance companies often use inconsistent criteria to determine the covered level of care for persons suffering from substance use disorder, which often prevents receiving care. This legislation will require all insurers operating in Georgia to use objective, state-approved criteria such as the ASAM Criteria when making coverage determinations for all substance use disorder treatment in order to make sure individuals get the treatment they need.
6. **Activate the Medicaid codes for SBIRT.** With more than half of Georgia's youth enrolled in Medicaid or PeachCare, this is a critical strategy for ensuring that youth receive the preventive services they need. Provide professionals and mentors with training for motivational interviewing techniques that educate the individual about the potential consequences of substance use and identify ways to reduce subsequent risky use. Individuals demonstrating substantial risk on the initial screen are referred to mental health or substance use treatment and other prevention or recovery service providers.

Recovery Supports

Effectively promoting recovery from addiction to heroin and/or prescription pain relievers typically involves one or more combinations of:

1. Peer recovery mutual support
2. Pharmacological interventions
3. Behavioral counseling

These are available in Georgia along a continuum of peer and professional recovery support services ranging from environmentally restrictive inpatient or residential programs to standard and intensive outpatient programs and least-restrictive-- yet essential mutual support groups and recovery community organizations.



The likelihood of continuing abstinence-based recovery jumps from 36% for people with less than a year in recovery to 86% for those with 4-7 years showing that recovery takes time and effort. Importantly, sustained connections, not abstinence alone, are the opposite of addiction and continuing care is a key challenge for acute or medical treatment models. Managing addiction as a chronic condition, Dennis and Scott (2007: ncbi.nlm.nih.gov/pmc/articles/PMC2797101; slideplayer.com/slide/1393773)

Support for ongoing recovery services as an essential model of recovery, with the goal of sustained, prosocial engagement with the community, recovery community organizations and people in long-term recovery are also addressed in: (Kaskutas, 1999; numerons.files.wordpress.com/2012/04/7the-social-model-approach-to-substance-abuse-recovery.pdf) (dbhdd.georgia.gov/georgia%E2%80%99s-recovery-definition-and-guiding-principles-values)

Below is a representative, partial list of peer recovery supports available throughout Georgia.

The Faces and Voices of Recovery (facesandvoicesofrecovery.org/), Georgia Council on Substance Abuse (gasubstanceabsue.org) (facesandvoicesofrecovery.org/guide/support) (facesandvoicesofrecovery.org/resources/mutual-aid).

Recovery occurs via many pathways including "natural" or on your own, faith-based programs, medication and other treatment, physical health routines, meditation or mindfulness practices, and others.

Alcoholics Anonymous (aa.org) and Narcotics Anonymous (na.org). Ninety meetings in 90 days is the conventional wisdom for initiating recovery during which time one or more "sponsors" assist with understanding and applying the Twelve Steps and Twelve Traditions. district8aami.org/assets/doc_12_12.pdf).

Recovery matures by serving others seeking or in recovery in roles that are valued by both the individual and the community, enhancing a sense of personal worth and belonging that counteracts pervasive stigma and discrimination.

Additional faith-based and secular programs:

- Buddhist Recovery Network: buddhistrecovery.org/index.php/meetingslisting.htm
- Celebrate Recovery: celebraterecovery.com
- Double Trouble in Recovery: gmhcn.org/dtr.html
- Dual Recovery Anonymous: draonline.org/meetings_dra/usa/georgia.html
- Overcomers Outreach: overcomersoutreach.org/sitebuilder/Groups.html
- Reformers Unanimous: rurecovery.com
- SMART Recovery: smartrecovery.org

Georgia was the first state in the U.S. to develop a peer support workforce. Since 2001, the Georgia Mental Health Consumer Network (GMHC; gmhcn.org) has trained over 1400 Certified Peer Specialists (CPS;

gacps.com) including Forensic Peer Mentors. CPSs implement peer support services that are Medicaid reimbursable under Georgia's Rehab Option as part of Assertive Community Treatment Teams, Community Support Individuals, and in a variety of roles that assist peers in accomplishing personal recovery journeys. The GMHC also oversees five (so far) Peer Support, Wellness and Respite Centers (gmhcn.org/wellnesscenter/index.html).

In 2011, the Georgia Council on Substance Abuse (GCSA; gasubstanceabuse.org) started to train over 400 Certified Addiction Recovery Empowerment Specialists (CARES aka CPS–AD).

GCSA is also assisting with the development of Recovery Community organizations operated by peers currently in seven cities (facesandvoicesofrecovery.org/who/arco). Recently the DBHDD Office of Children, Young Adults and Families (dbhdd.georgia.gov/office-cyf-services) initiated training for CPS-Youth/Young Adults and CPS-Parents who work in psychiatric residential treatment facilities, crisis stabilization units, care management services and resiliency support clubhouses serving children (5+ years old) and transition aged youth and young adults (14-26 years old).

SARA Makes the Following Recommendations for Recovery Supports

1. Require hospitals to provide follow-up treatment and recovery support options to individuals upon hospital discharge.
2. Require hospital medical staff to provide discharge-planning and self-selected connections between patients who have or are at-risk for substance use disorder, and suitable treatment and recovery support options.
3. Provide funding for demonstration projects in two Georgia trauma centers or hospital-operated emergency departments to provide a pair of Certified Addiction Recovery Empowerment Specialist (CARES) who serve as initial recovery resources for individuals who present due to an overdose of alcohol or other drugs. The CARES will also sustain supportive interactions with the identified patient and or family to promote recovery, de-escalate tense situations, and demonstrate the power and possibility of lived recovery.
4. Expand peer-based recovery support services to support long-term recovery. Individuals leaving treatment are at significant risk for relapse. A peer-based recovery support program would be optimal, to provide the services of a nationally-certified recovery community organization (RCO), as individuals transition into and out of hospitals, treatment, and juvenile and criminal justice programs.

   Services would also include linkages to: education and employment resources, legal services, social services, transportation assistance, childcare services, and peer support groups. They could also fund family support navigators across Georgia who assist substance misusers and their families with locating and accessing treatment and other options for coping with addiction.
5. Restore 2010 cuts to funding for "non-medically necessary community services". These funds would be used to build on DBHDD's recovery community organization network by providing start-up and ongoing support for up to six RCOs across the state to help Georgians suffering from substance misuse disorder and to expand vital recovery resources -- in addition, support the expansion of recovery-oriented systems of care including resources provided by members of the Georgia Association of Recovery Residences.

3. Prevention education

Definitions of Prevention

Prevention refers to actions or interventions that reduce risks or threats to a person's health and include primary, secondary and tertiary methods. Primary prevention methods prevent the incidence of disease or illness before it occurs, secondary prevention provides immediate responses when a disease or injury occurs to contain or minimize the negative effects, and tertiary prevention, commonly referred to as treatment, intervenes on the impact of ongoing illnesses or injuries.

In the case of a substance use disorder, this could include treating the physical (medical) and emotional consequences of drug use and facilitating entry into recovery-oriented systems of care so further disability is minimized.

Primary prevention methods often target children, adolescents and other at-risk groups. These programs exist at both the national, state and local community levels. Some are federal or state created and funded, while others originate with non-profit organizations that use government funding to, for example, create public service messages and promote positive alternatives to alcohol and other drug use. Primary prevention methods and programs aimed at teens and young adults are discussed in more detail below.

Prescription Drug Monitoring Programs (PDMPs) are another form of primary prevention. PDMPs are state-run electronic databases that track the prescription and dispersion of controlled prescription drugs to patients.

These programs monitor the information for identified prescription drugs and diversion by assisting prescribers or pharmacists to identify high-use patients for early interventions. The CDC recommends that prescribers check the database at least once every 3 months and prior to writing every opioid prescription.

Another primary method is Prescription Drug Take-Back Programs through the Drug Enforcement Administration (DEA), which promotes appropriate disposal of medications to prevent medication use by individuals for whom the prescriptions were not written.

The Drug Disposal Act of 2010 amended the Controlled Substances Act by providing drug take-back programs for the disposal of certain controlled substances as determined by the U.S. Attorney General.

The final rule of the Disposal of Controlled Substances in September 2014 lists local programs, mail-back programs and collection receptacles for the proper disposal of medications.

Finally, Screening, Brief Intervention and Referral to Treatment (SBIRT), is a combined primary and secondary prevention methodology. SBIRT's public health approach delivers early intervention and treatment services with individuals at risk of injury due to alcohol or other drug use or who display evidence of developing substance use disorders.

SBIRT provides opportunities for early intervention with at-risk substance users before more severe consequences occur, and it has been adapted for use in many different settings including two major hospitals in Georgia. Providing treatment referrals for patients whose assessment suggests a substance misuse disorder is a secondary prevention method.

For opioid misuse or dependence, medications are the principal means of secondary and tertiary prevention. Detoxification medications are available for short-term use to relieve symptoms of opioid withdrawal. To prevent relapse to drug use, maintenance medications, such as methadone, buprenorphine, and naltrexone, are available for longer-term use. (See Appendix: CARA Title III: Treatment and Recovery provisions).

Primary Prevention Efforts: A Detailed View

Supported by Federal funds, the largest providers of local-level substance abuse prevention services are public schools, law enforcement agencies, and community organizations.

Nearly 140,000 schools educate over 75,000,000 U.S. children with persistent messaging about safe and healthy lifestyles and not using drugs embedded within their health and family life curriculum. Many prevention classroom-based programs focus on developing the knowledge, attitudes,

and skills needed to make healthy choices or change harmful behaviors.

Universal prevention approaches include the use of environmental prevention strategies that are tailored to local community characteristics and address the root causes of risky behaviors by creating environments that make it easier to act in healthy ways.

The successful execution of these strategies often involves lawmakers, local officials, and community leaders, as well as the acceptance and active involvement of members from various sectors of the community such as the business, faith, schools, and health sectors.

Environmental change strategies have specific advantages over strategies that focus exclusively on the individual. The targeting of a broader audience has the potential to produce widespread changes in behavior at the social or group level. Further, they can create shifts in both individual attitudes and community norms that can have long-term, substantial positive effects.

National Primary Prevention programs are explored in the appendix.

State Providers

Department of Behavioral Health and Developmental Disabilities (DBHDD) and its Office of Behavioral Health Prevention (OBHP)

Georgia Prescription Drug Abuse Prevention Collaborative (GADAPC)

Statewide Non-profit Providers

The Georgia Prevention Project (GPP)

The Council on Alcohol and Drugs (TCAD)

Georgia Teen Institute (GTI)

SARA Offers These Recommendations for Substance Misuse Prevention Education

1. **Restore Substance Abuse Prevention Services that were cut in 2010 from the DBHDD budget.** These programs promote the health and wellbeing of children, youth, families and communities through preventing the use and/or misuse of alcohol, tobacco and drugs.
2. **Restore cuts to training initiatives that help fund public education programs:** Make individuals, families and communities aware of the dangers associated with alcohol and drug misuse.
3. **Mandate Pharmacists provide easy to understand information on risks associated with drug addiction and misuse:** Consumers may not understand the addiction and misuse risks posed by prescription opioids. To improve consumer awareness about these risks the legislation requires pharmacists to provide educational materials to consumers about the risk of addiction, including information about local treatment and recovery support services.

4. Neonatal Abstinence Syndrome (NAS)

According to information published by the Center for Disease Control's Mortality and Morbidity Report (MMWR), more than a third of reproductive-aged women enrolled in Medicaid (39%) and more than a quarter of those with private insurance (28%) filled a prescription for an opioid pain medication each year during 2008-2012. The most commonly prescribed opioids among both groups of women were hydrocodone, codeine and oxycodone.

The CDC researchers analyzed 2008-2012 data from two large health insurance claims datasets: one of women aged 15-44 years with private insurance and another of women in the same

age group enrolled in Medicaid. Geographic region data available in the private insurance claims indicated that opioid prescription rates were highest among reproductive-aged women in the South and lowest in the Northeast.

Race/ethnicity information was available for the Medicaid data and indicated opioid prescriptions were nearly one and a half times higher among non-Hispanic white women of reproductive age compared to non-Hispanic black or Hispanic women.

Research studies on opioid use during pregnancy suggest that when these medications are used during early pregnancy, they can be associated with:

- congenital heart defects such as conoventricular septal defects, atrioventricular septal defects and hypoplastic left heart syndrome
- neural tube defects such as spina bifida
- abdominal wall defects such as gastroschisis

When opioids are used in later pregnancy, they are often associated with Neonatal Abstinence Syndrome (NAS), which is a cluster of symptoms that a newborn may experience when prenatally exposed to opioids.

Symptoms of NAS include:

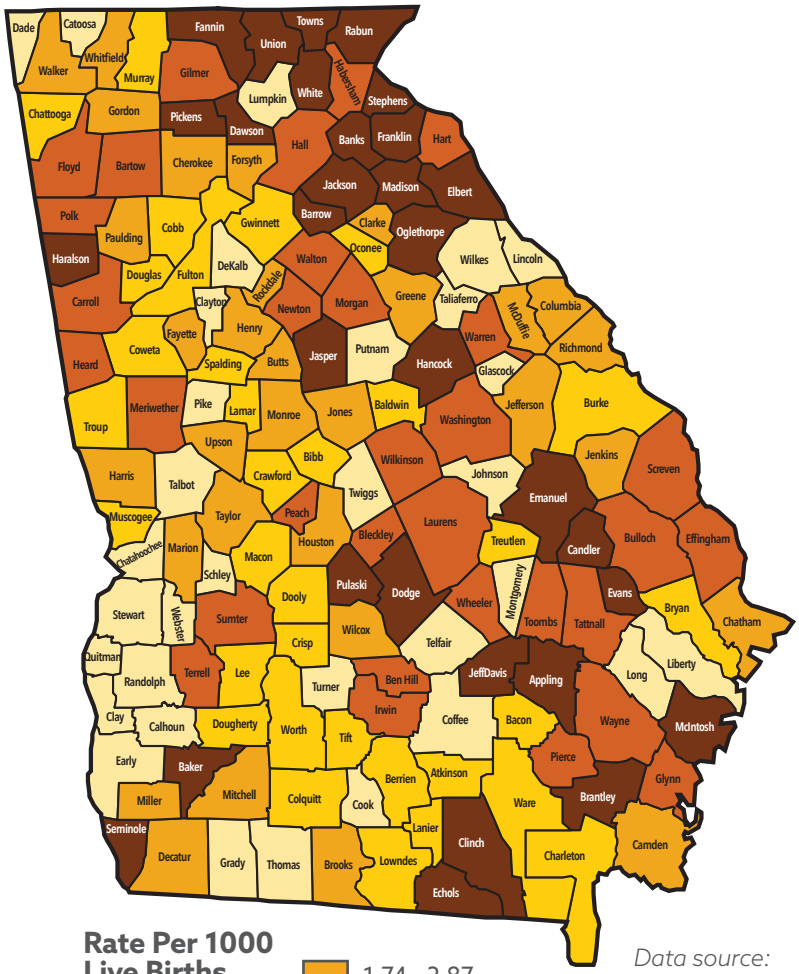
- difficulty breathing
- extreme drowsiness
- poor feeding
- irritability
- sweating
- tremors
- vomiting
- diarrhea

Occasionally seizures and death have occurred in severe, untreated cases of withdrawal. With proper treatment, most babies can be supported through the withdrawal process.

The latest Georgia Department of Public Health records indicate a growing problem with NAS across our state. What follows below is the most recent DPH data gathered between 2010-2014, which is the latest data available. The commissioner of DPH announced that as of January of 2016, NAS is a mandated reportable condition across our state. This should address the issue of a more accurate count of the true nature of the impact of the current opioid epidemic and its impact on our newborns prenatally exposed to prescription opioids as well as heroin.

Inpatient hospitalizations with any diagnosis of Neonatal Abstinence Syndrome,
Georgia, 2010 - 2014

N=1,365, charges=$52,856 per Baby



Rate Per 1000 Live Births

4.75 - 13.76	1.74 - 2.87
2.88 - 4.75	0.85 - 1.73
	0.00 - 0.84

Data source: Georgia Department of Public Health; Office of Health Indicators for Planning.

Numerator is number of inpatient hospitalizations where age < 1 year and any diagnosis (principal or otherwise) of neonatal abstinence syndrome (ICD9-CM 779.5). Data are of discharges and not unique patients. Denominator is total live births. Data are by county of residence.

SARA Recommends the Following for Neonatal Abstinence Syndrome

Look at model states, such as Tennessee, North Carolina, Arizona and California – almost all involve both primary and secondary/tertiary prevention strategies to address NAS such as:

1. **Reduce incidence**
   - Screen all pregnant women and then refer those testing positive for brief intervention and/or referral to treatment (SBIRT)
   - Professional education of all health care providers
   - Public health campaign to educate the public
   - Use of PDMP by all OB/GYN's
   - Develop portfolio of "key messages" similar to the NC Pregnancy and Opioid Exposure Project (POEP)
2. **Reduce NAS severity and optimize health outcomes**
   - Encourage adoption of a standardized protocol for assessing and scoring of a newborn testing positive for opioids
   - Encourage adoption of standardized treatment protocol for all newborns testing positive for opioids
   - Universal developmental follow-up of all newborns testing positive for opioids
3. **Leverage resources and reduce costs associated with NAS**
   - Development of a statewide NAS Task Force
   - Collaboration across multiple stakeholders: primary care, substance abuse/MAT providers, the courts, etc.
   - Encourage information-sharing across state agencies to reduce costs and prevent redundancy

5. Controlling access to opioids

a. Prescription Drug Monitoring Program

Prescription Drug Monitoring Programs (PDMPs) are electronic databases that track prescriptions of controlled substances (CDC, 2016). PDMPs promote safe prescribing and are considered effective tools for detecting prescription drug misuse.

PDMP data are utilized by a variety of end users, including practitioner licensure boards, law enforcement and drug control agencies, medical examiners, drug courts and criminal diversion programs, substance use disorder treatment programs, public and private third-party payers, and other public health and safety agencies (Clark et al., 2012).

PDMPs are now authorized in 49 states (except Missouri). While PDMPs are widely implemented, their features vary by state. For example, in 2015, 33 state PDMPs monitored at least four drug schedules and 48 state PDMPs updated program data at least weekly (Patrick et al., 2016).

According to a recent report, 40 states allow physicians and dispensers to appoint delegates or staff from their practice to access PDMP data (NSC, 2016). As of May 2016, 30 states had adopted some version of a prescriber use mandate. In some states, these mandates apply only to certain classes of practitioners and/or prescriptions (COE Briefing, 2016a).

A Prescription Drug Monitoring Program Center of Excellence report identified 35 potential PDMP best practices The strongest evidence was identified for eight PDMP best practices: 1) collecting data on all schedules of controlled substances; 2) instituting serialized prescription forms; 3) conducting epidemiological analyses; 4) providing continuous online access to automated reports; 5) sending unsolicited reports and alerts; 6) conducting promotional campaigns; 7) improving data timeliness and access; and 8) conducting user education (Clark et al., 2012).

The National Safety Council and National Governors Association recommendations for state PDMPs are in the Appendix. (NSC, 2016; NGA, 2016).

Georgia's PDMP

Georgia's PDMP became effective in May 2013 (Senate Bill (SB) 36). SB 36 requires dispensers to electronically submit certain information to the Georgia Drugs and Narcotics Agency (GDNA) regarding prescriptions dispensed for Schedule II, III, IV and V controlled substances on at least a weekly basis but no later than 10 days after the prescription is dispensed.

The bill also specifies that database information access include (but is not limited to) law enforcement or prosecutorial officials pursuant to a search warrant, Georgia-licensed prescribers of controlled substances for the purpose of providing medical treatment to a specific patient, and governmental entities for research purposes if all identifying information is removed.

The bill also authorizes the creation of an Electronic Database Review Advisory Committee to consult with the GDNA. However, SB 36 does not mandate use of the PDMP or authorize the sharing of information from the PDMP with out-of-state providers (Leitman, 2013).

HB 900 (GA Code §§16-13-57 to -65), effective July 1, 2016, authorized changes to the original legislation. The major changes include: 1) allowing delegates of prescribers and dispensers to access data base information under certain conditions; 2) retention of database information for two years; 3) revising language related to subpoenas and search warrants; 4) providing for access to database information for the purposes of investigation of potential misuse; and 5) providing for the release of non-patient specific data to the GDNA for instructional, drug misuse prevention, and research purposes.

Research on the effectiveness of PDMPs

Numerous research studies have examined the impact of PDMPs on opioid overdose deaths and prescribing behavior. While some studies have found little or no evidence of a relationship between PDMP implementation and opioid overdose deaths (Paulozzi, Kilbourne, and Desai, 2011; Li et al., 2014), other research has found a relationship between PDMP use and reduction of: doctor shopping, opioid diversion, inappropriate prescribing, and deaths from opioid overdose (Clark et al., 2012; Boa et al., 2016; Patrick et al., 2016).

One recent study of PDMPs in 24 states found that implementation of a PDMP was associated with more than a 30% reduction in the rate of prescribing of Schedule II opioids (Bao et al., 2016). Another recent study found that implementing PDMPs with advanced features was associated with a reduction in opioid overdose deaths (Patrick et al., 2016).

Specifically, implementation of PDMPs that monitored four or more drug schedules and updated their data at least weekly were associated with greater reductions in opioid-related overdose deaths than PDMPs without these characteristics (Patrick et al., 2016).

A 2016 report on mandatory PDMP prescriber use highlights the recent experiences of Kentucky, Tennessee, New York and Ohio. Data from these states indicate that mandated PDMP use can result in a rapid increase in enrollment and requests for prescription information, as well as a decrease in the rate of doctor shopping (i.e., multiple provider episodes, MPEs) and the number of prescriptions for opioid pain relievers (COE Briefing, 2016a).

Kentucky's PDMP legislation

Passed by the Kentucky legislature in April 2012, HB1, requires enrollment and use of the state's PDMP, KASPER. Prescribers are required to query KASPER prior to prescribing Schedule II and hydrocodone in Schedule III for all patients and at least every 90 days thereafter, with some limited exceptions. The mandate was later extended to all Schedule II, III and IV controlled substances.

Before prescribing Schedule I and II drugs, providers are required to conduct a complete medical history, conduct a physician exam and document the exam, query KASPER for all available information on the patient, write a treatment plan, discuss risks and benefits with the patient, and obtain written consent for treatment.

The law also specifies requirements for ongoing evaluation and record keeping. HB1 authorizes the sharing of PDMP data with other states under certain conditions.

Kentucky is one of 34 states that currently participates in the National Association of Boards of Pharmacy's PMP InterConnect, a program which facilitates the transfer of prescription monitoring program data across state lines to authorized users (NABP, 2016).

After passage of HB1, KASPER enrollment increased from 7,911 registered prescriber and pharmacist users in April 2012 to 25,409 by the end of July 2013. Utilization of Kasper also increased; the total number of KASPER prescription history reports requested by users increased from 811,000 in 2011 to 2,691,000 in 2012 (over a 230% increase) and to 4,586,500 in 2013 (a 70 % increase).

Overall dispensing of controlled substances also decreased after the mandate, from 7.39 million doses in the 12-month period from August 2011 to July of 2012, to 6.76 million doses from August 2012 to July of 2013 (a decrease of 8.5 percent). After the mandate went into effect, there was also a decrease in multiple provider episodes (MPEs), hospitalizations, overdose, and deaths attributable to prescription opioids (COE Briefing, 2016a; Freeman et al., 2015).

SARA Recommends the Following for Prescription Drug Monitoring

(Consistent with the PDMP best practices and research evidence)

1. Require all providers to check the PDMP before prescribing Schedule II, III and IV controlled substances
2. Require providers to report to the PDMP within 24 hours
3. Conduct and evaluation of the GA PDMP to determine: 1) whether the law is being enforced as intended; 2) whether the legislation is meeting its intended goals; and 3) specifically whether the rate of doctor shopping, prescription drug misuse and abuse, opioid overdose deaths, and other relevant outcomes have decreased as a result of the legislation
4. Adopt unsolicited reporting of PDMP data to prescribers, dispensers, licensing boards, and law enforcement agencies (COE Briefing, 2016b)
5. Authorize the sharing of PDMP data across state lines
6. Integrate PDMP data into physician and hospital electronic health record systems
7. Continue to evaluate the effectiveness of GA's PDMP; use evaluation results to better tailor the program to align with best practices

b. Pain clinics

Another strategy states can employ to address the opioid epidemic is the enactment of legislation that increases the oversight of pain management clinics or "pill mills." Pill mills can be defined as a "pain management clinic whose providers operate outside the boundaries of standard medical practice by prescribing large quantities of opioids and other controlled substances with minimal medical oversight (Lyapustina et al., 2016)." To date, 12 states (AL, FL, GA, IN, KY, LA, MS, OH, TN, TX, WV, WI) including Georgia have adopted legislation that regulates pain clinics or pain management services. *See the Appendix for recommendations of The National Safety Council and National Governors Association regarding pill mill legislation.*

Georgia's pill mill legislation

Georgia's Pain Management Clinic Act (HB 178) became effective July 1, 2013. Georgia HB 178 defines pill mills as a medical practice that advertises "treatment of pain" or a medical practice or clinic that has greater than 50 percent of its annual patient population being treated for pain for nonterminal conditions by prescribing Schedule II or III controlled substances.

The legislation requires all pain management clinics in the state to be licensed by the Georgia Composite Medical Board and requires clinics to biennially renew their license to continue to be eligible to operate at a specified location. Pain management clinics must also be registered with the Georgia State Board of Pharmacy

and owners of the clinics are required to meet continuing education and training requirements prior to renewing a license.

The law requires all pain management clinics to be owned by physicians licensed in the state, with the exception of pain management clinics that existed prior to June 30, 2013. The law also prohibits any person convicted of a felony from owning a pain management clinic.

SARA Offers the Following Recommendations for Pain Clinics

(Consistent with the NSC and NGA recommendations and research evidence)

1. Require pain management clinic providers to register with and use GA's PDMP
2. Conduct an evaluation of GA's pill mill legislation to determine: 1) whether the law is being enforced as intended; (2) whether the legislation is meeting its intended goals; and (3) specifically whether the rate of opioid prescribing, opioid overdose deaths, and related outcomes have decreased as a result of the legislation
3. Continue to monitor and evaluate the implementation of GA's pill mill legislation and enforcement efforts; use evaluation results to better tailor the legislation to align with best practices

c. Prescriber education

Mandatory prescriber education

In May 2016 a joint meeting was held of the Drug Safety and Risk Management Advisory Committee and the Anesthetic and Analgesic Drug Products Advisory Committee of the Food and Drug Administration (FDA). At this meeting they discussed the Risk Evaluation and Mitigation Strategy (REMS) for Extended-Release (ER) and Long-Acting (LA) opioid analgesic medications.

The ER/LA Opioid Analgesics REMS was approved in July 2012 to address the serious adverse outcomes of overdose, addiction, and death resulting from inappropriate prescribing, misuse, and abuse of these products.[1] The ER/LA Opioid Analgesic REMS is one of many national and state strategies to reduce the risk of abuse, misuse, addiction, overdose and deaths due to prescription opioid analgesics. The central component of the ER/LA Opioid Analgesics REMS is an education program targeted to prescribers—e.g., physicians, nurse practitioners, physician assistants.

Under the REMS, application holders of ER/LA opioid analgesics are required to make education programs available to healthcare providers who prescribe of these agents. This is provided through educational grants to accredited continuing medical education (CME) providers who offer training to prescribers at no or nominal cost.

The FDA's efforts to address prescription opioid misuse are part of a larger governmental response to the crisis. In 2011, the White House Office of National Drug Control Policy launched a plan to reduce prescription drug abuse focused on four major areas: education, monitoring, proper medication disposal, and enforcement.

The Secretary of the Department of Health and Human Services also launched a plan aimed at combating opioid misuse. Additionally, there are other critical federal efforts that FDA is supporting, including the draft National Pain Strategy, developed by the Interagency Pain Research Coordinating Committee and the Centers for Disease Control and Prevention's (CDC) recently published Guidelines for Prescribing Opioids for Chronic Pain. Currently, 17 states, not including Georgia, have mandatory prescriber education regulations.

The training gap regarding appropriate prescribing of opioid medications is well documented. According to current research, practicing physicians receive fewer than 12 hours of pain management education in medical school and 60% of surveyed physicians did not receive training on "identifying prescription drug abuse and addiction" in medical school.

In an effort to address this training gap, Kentucky, another southeastern state that

shares similarities to Georgia, passed state legislation (House Bill (HB) 1) in 2012. HB1 focuses on the regulation of pain clinics and prescription drug misuse in Kentucky. Among other changes, HB1 called for amendments to the state regulations regarding CME.

Primary goals of the legislation were to (1) augment CME requirements to mandate that physicians who prescribe or dispense controlled substances in Kentucky complete a minimum of 4.5 hours of CME annually specifically related to the use of the state's electronic reporting system--Kentucky All Schedule Prescription Electronic Reporting (KASPER) system, pain management, addiction disorders, or a combination of two or more of these subjects; (2) increase registration and utilization of the KASPER system; and (3) increase reporting of prescribing to KASPER within one day of prescribing.

After the Legislature enforced the mandates, the number of doses of hydrocodone dispensed in Kentucky over a ten-month period dropped 9.5% from 198 million to 179 million doses; the number of doses of oxycodone dropped 10.5% from 72 million to 64 million does; the number of prescribers enrolled in the KASPER program increased from 7,545 to more than 24,000 with a tripling of enrollee queries to the KASPER database for patient reports from 811,000 to 2.7 million.

Additionally, the numbers of prescriptions dispensed for Schedules of Controlled Substances CII – CV decreased by 4 to 8% in the post-HB1 period.

SARA Recommends the Following for Prescriber Education

1. Require Ongoing Education on Addiction & Pain Management for All Physicians and Prescribers**:** Physicians and other opioid prescribers are important partners in preventing addiction linked to misuse of prescription opioids. To ensure that prescribers understand the risks presented by prescription opioids, the legislation mandates that these health care professionals complete three hours of education every three years on addiction, pain management, and palliative care.
2. The Georgia Composite Medical Board mandate that a minimum of 5 hours of the 40 hours of required biennial CME credit hours focus specifically on the Georgia Prescription Drug Monitoring Program, pain management, guidelines for prescribing opioid medications for chronic pain, and/or addiction disorders.
3. A Georgia specific task force, including but not limited to representatives from the Georgia Department of Public Health (DPH), health professional training institutions, health information technology (HIT) vendors, and health professional subject matter experts be developed with the aims of— (1) incorporating training regarding the Prescription Drug Monitoring Program, guidelines for prescribing opioid medications for chronic pain, pain management, and addiction disorders into all health professional training programs; (2) collaborating with HIT vendors to ensure seamless interoperability and connectivity between patient electronic health records (EHR) and the Georgia Prescription Drug Monitoring Program.

   Ultimately the goal would be to have a self-guided electronic prompt appear in patients EHR which links directly to the PDMP encouraging physicians to check the database prior to writing opioid prescriptions for flags without having to close out their patients EHR; and (3) developing and funding a grant to support academic detailing regarding appropriate opioid prescribing for health care providers across the state.

Opioid Prescribing Guidelines

According to the Centers for Disease Control and Prevention (CDC), an estimated 20 percent of patients presenting to physicians with non-cancer pain symptoms or a pain-related diagnosis (including acute and chronic pain) received an opioid. In 2012, health care providers wrote 259 million prescriptions for opioid pain medication, equaling about 1 prescription per U.S. adult. Additionally, opioid prescriptions per capita increased 7.3 percent between 2007 and 2012, with opioid prescribing rates increasing more for primary care providers--family practice, general practice, and internal medicine physicians--than other physician specialties.

Since opioid prescribing rates vary significantly across states in ways that are not related to the underlying health status of state populations, it is evident that there is a lack of consensus among clinicians on how to dispense opioids for pain management. As a result, CDC updated existing guidelines for prescribing opioid medications for chronic pain in 2016.

CDC's guidelines for chronic pain management are intended for primary care clinicians prescribing opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. Specifically these guidelines address (1) when to initiate or continue opioids for chronic pain; (2) opioid selection, dosage, duration, follow-up, and discontinuation; and (3) assessing risk and addressing harm in opioid management. CDC developed these guidelines using the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) framework, and recommendations were made based on a systematic review of the scientific evidence and considerations of benefits and harms, values and preferences, and resource allocation management.

Though Georgia does not have specific opioid prescribing guidelines, in May 2013, Georgia HB178 was signed into law making Georgia the ninth U.S. state to pass legislation regulating the ownership and operation of pain management clinics. The "Georgia Pain Management Clinic Act," which went into effect on July 1, 2013, is intended to inhibit illegal sales of opioid drugs. Under HB178, the Georgia Composite Medical Board is granted the power to license and regulate pain management clinics and establish minimum standards for prescribing controlled substances for pain management (with a few notable exceptions for pre-existing facilities).

HB178 also requires all pain management clinics to be owned by physicians licensed in Georgia. Additionally, no person with a felony conviction of any kind can have ownership or interest in opioid prescribing clinics, including owners of pre-existing facilities. HB178 further stipulates that all pain management clinics that dispense controlled substances be registered with the Georgia State Board of Pharmacy. There are notable exceptions to HB178, including facilities owned or operated by licensed hospitals; health systems; ambulatory surgical centers; skilled nursing facilities; hospice or other licensed home health agencies. Finally, based on this law, any person who operates a pain management clinic in Georgia without a license is guilty of a felony.

Tennessee developed state guidelines for the appropriate treatment of chronic pain, similar to the federal guidelines. These guidelines were developed to support clinicians in their treatment of patients with chronic pain and placed particular emphasis on prescribing of opioid medications. Tennessee's guidelines were developed based on a review of national expert panel recommendations and state practice guidelines; multiple listening sessions with clinicians in the state; oversight by a multidisciplinary steering committee; and recommendations from an advisory committee with strong representation by clinicians with specialty training in pain management. Additionally, draft clinical guidelines were disseminated to a broader group of professional associations within Tennessee, including but not limited, to mental health and substance abuse professionals and workers.

Tennessee organized their guidelines into three sections and provided appendices with additional tools and further guidance.

Of importance to note, Tennessee's guidelines were specifically not targeted to end-of-life care, emergency room care or acute pain management but rather to management across settings of chronic pain. Specifically Tennessee's guidelines address (1) considerations prior to initiating opioid therapy; (2) initiating opioid therapy for chronic non-malignant pain; and (3) ongoing therapy for chronic non-malignant pain.

Since there are now evidence-based federal guidelines regarding opioid prescribing practices, it is critical that Georgia commit resources to support dissemination and integration of these guidelines in healthcare settings at the point of care.

SARA Recommends the Following for Controlling Access to Opioids

1. Reduce prescription limits for opioids from 30 to 7 days: there is a well-established link between the rise in opioid prescriptions and the current heroin crisis. To reduce unnecessary access to opioids, the legislation lowers the limit for opioid prescriptions for acute pain from 30-days to no more than a 7-day supply, with exceptions for chronic pain and other conditions.
2. Georgia DPH should provide signage highlighting the main points for consideration in CDC's guidelines for chronic pain management that can be posted in exam rooms and waiting rooms of prescribing providers' offices.
3. A task force, including but not limited to representatives from Georgia DPH, health professional training institutions, HIT vendors, and health professionals be developed with the aim of collaborating with HIT vendors to support integration of CDC opioid prescribing guidelines across treatment protocols and templates. This includes appropriate warnings and pop-up screens if prescriptions do not appear consistent with the underlying diagnosis.

While federal level guidelines are an important step in the right direction, by incorporating these guidelines in the physical space and EHRs, providers will have real time prompts to promote evidence based opioid prescribing at the point of care.

III. Proposed legislative agenda for Georgia

What should Georgia do?

After a careful review of recent recommendations from the National Safety Council and the National Governors Association, SARA proposes a legislative agenda for Georgia as briefly outlined below. SARA provides detailed recommendations in the body of this study.

In addition to the legislative agenda outline below, SARA recommends that the State conduct a comprehensive needs assessment specifically related to the opioid crisis and develop both a strategic plan and an implementation plan to guide the State's response to this epidemic.

Phase I – Georgia's most urgent needs

1. Increase access to naloxone.

More than 1,300 Georgians die each year from prescription opioid and heroin overdoses. Many of these deaths could be avoided with the use of naloxone, an opioid antagonist medication that reverses opioid overdose without significant negative side effects. First responders, parents, and educators should have easy access to naloxone and should have training in how to administer the drug.

2. Improve access to opioid use disorder treatment including medication-assisted treatment (MAT) and recovery support services.

Anyone misusing prescription opioids or using heroin should have access to the full range of opioid use disorder treatment services including medically managed detoxification/withdrawal management, behavioral therapy, medications and recovery support services. These services should include support for 1) families who have members in recovery and 2) community organizations that focus on recovery.

3. Increase funding for substance misuse prevention programs.

The Georgia Legislature significantly reduced funding to DBHDD in 2010 for substance misuse prevention programs and administration. While DBHDD distributes and manages Federal substance misuse prevention funds, total State spending on substance misuse prevention within DBHDD currently is only $232,000 per year. Prescription drug education programs should target teens, young adults and parents.

4. Increase funding and improve mechanisms to address neonatal abstinence syndrome (NAS).

Some hospitals in Georgia are overwhelmed with infants born with NAS. The problem is on the rise, and these hospitals need significant assistance in treating and managing the care of these infants.

Moreover, health care providers need better education and training on how to deal with NAS. Our recommendations focus on three areas: 1) reducing incidence of NAS, 2) reducing NAS severity and optimizing health outcomes, and 3) leveraging resources and reducing costs of NAS.

5. Strengthen the Prescription Drug Monitoring Program (PDMP).

While Georgia implemented important changes and enhancements to its PDMP during the 2016 legislative session, much work remains to be done. The PDMP helps track the writing and filling of prescriptions of controlled substances, particularly opioid-based painkillers.

Phase II – Comprehensive and systematic approaches for Georgia

1. Increase oversight of pain clinics.

Georgia passed the Pain Management Clinic Act in 2013. Consistent with the National Safety Council and the National Governor's Association recommendations, Georgia should do two things: 1) require pain clinics to register with and use Georgia's PDMP, and 2) conduct an evaluation of the legislation to determine if it is being enforced and what impact it has had on opioid prescribing and overdose deaths.

2. Create standards for prescriber education.

The Georgia Composite Medical Board (CME) should mandate that a minimum of 5 hours of the 40 hours of required biannual credit hours focus specifically on the Georgia PDMP, pain management, and guidelines for prescribing opioid medications for chronic pain and/or substance use disorders.

Longer term, Georgia should create a task force to address more detailed methods of educating all levels of health professionals on pain management and incorporating technology that integrates the PDMP more directly with patient electronic health records (EHR).

3. Create a recurring "blue-ribbon" commission on substance use and recovery.

The Georgia Legislature, in collaboration with the Governor's Office, should create a recurring commission that convenes every 5-7 years to establish strategy and statewide goals, recommend appropriations, and review progress on reducing substance misuse and expanding local systems of recovery supports and treatment services in Georgia.

SARA believes that the current State Senate Study Committee has been a valuable and well-managed process for addressing many substance abuse issues, and the recurring commission structure could be implemented as a simple extension and expansion of the current committee's work – with new agenda items and expanded participation. Alternatively, the recurring commission could take the form of 1) a joint Senate-House Study Committee, 2) a Governor's commission, or 3) a privately run and funded commission.

We believe that while any of the above scenarios can be successful, the best structure would include maximum participation from key lawmakers, the Governor's Office, and the heads of certain state agencies. Non-profit organizations, for-profit companies, and private individuals can also add great value to the work of such a commission.

A recurring commission structure gives everyone an opportunity to review progress against goals, plan appropriations over multiple years, and continually re-educate the participants about the issues associated with the subject matter.

The Georgia Prevention Project

The Georgia Prevention Project - SARA's host organization - is a statewide not-for-profit effort that focuses on reducing the use of dangerous substances among teens and young adults. We accomplish our work through awareness campaigns, educational programming and strategic partnerships with national and community based organizations.

The Georgia Prevention Project evolved from the Georgia Meth Project founded in 2009. Created by the Siebel Foundation, the national Meth Project effort won more than 45 national and international awards for its hard-hitting educational campaigns that helped reduce first-time Meth use by more than 65 percent in its first two years in Montana. Subsequent launches in Idaho and Wyoming saw similar results and led to the addition of Hawaii, Colorado and Georgia as part of the Meth Project family.

In Georgia, the campaign led to significant changes in teens' perceptions of risk associated with Meth. During the media portion of the campaign of 2010-2012, the Georgia Meth project ran more than 26,000 radio spots, placed 23,000 television ads, and placed more than 588 billboards all over Georgia. This saturation effort significantly changed teens' perceptions of risk about the drug and produced results very similar to the Montana program.

Riding the momentum of the successful "Not Even Once" Meth prevention campaign, the Georgia Prevention Project launched in 2014 capitalizing on the Meth Project techniques and expanding its focus to include prescription drug misuse and heroin use.

The Georgia Prevention Project partners with community members, schools and prevention professionals to develop strategy, build coalitions and provide drug education resources to bring attention to the health and future of youth.

Through its Teacher Substance Abuse Training Program, GPP has worked to ensure that large numbers of Georgia teens gain in-depth knowledge of the risks associated with the misuse of prescription drugs and the misuse of dangerous substances such as methamphetamine and heroin.

For more information, please contact:

Jim Langford

Executive Director, Georgia Prevention Project; Chair, SARA

3715 Northside Parkway
Suite 1-320
Atlanta, GA 30327

404-831-1959

Email: info@georgiapreventionproject.org;
jlangford@georgiapreventionproject.org

Web: www.georgiamethproject.org;
www.georgiapreventionproject.org

SUBSTANCE ABUSE RESEARCH ALLIANCE (SARA)

GEORGIA PREVENTION PROJECT

Prescription Opioids and Heroin Epidemic in Georgia

- Appendix & References

2017

APPENDIX

Prescription Opioids and Heroin Epidemic in Georgia

I. Opioids Overview

Opioid overdose deaths by type of opioid: heroin, 2014

National public policy strategies to address the prescription opioid and heroin epidemic:

- Mental Health Parity Addiction Equity Act (MHPAEA) of 2008
- Patient Protection and Affordable Care Act (ACA) of 2010
- Comprehensive Addiction and Recovery Act (CARA 2016)

II. Key Georgia Issues and III. Proposed Legislative Agenda for Georgia

Georgia prevention programs

National primary prevention programs

The National Safety Council and National Governors Association recommendations for state PDMPs (NSC, 2016; NGA, 2016)

The National Safety Council and National Governors Association recommendations for pill mill legislation (NSC, 2016; NGA, 2016)

The National Safety Council and National Governors Association recommendations for increasing access to naloxone (NSC, 2016; NGA, 2016)

The National Safety Council and National Governors Association recommendations for expanding state capacity to treat opioid use disorder (NSC, 2016; NGA, 2016)

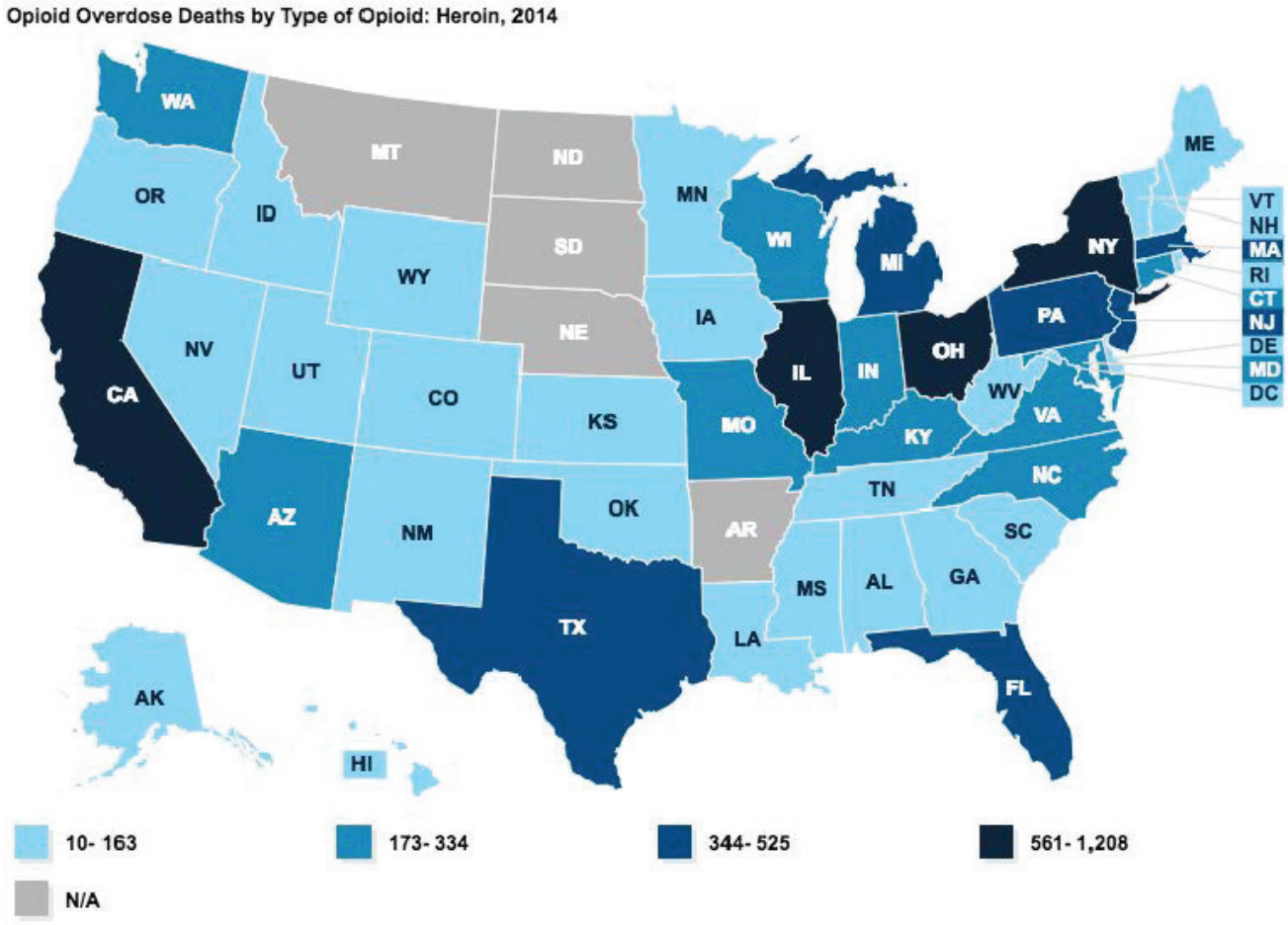
Georgia Medication-assisted Treatment Programs

Table XX: Opioid Treatment Program (OTP) and non-OTP services and coverage in Georgia in 2014 (NSSATS, 2014)

Research on the effectiveness of pill mill legislation

Recurring Blue-Ribbon Commission on Substance Abuse and Recovery - Notes.

I. Opioids Overview



SOURCE: Kaiser Family Foundation's State Health Facts.

NATIONAL PUBLIC POLICY STRATEGIES TO ADDRESS THE PRESCRIPTION OPIOID AND HEROIN EPIDEMIC

Three major pieces of federal legislation addressed substance use disorders (SUD) in the past decade.

Mental Health Parity Addiction Equity Act (MHPAEA) of 2008

The Mental Health Parity and Addiction Equity Act (MHPAEA) Requires private group health plans with 50 or more employees and Medicaid managed care plans that cover SUD treatment do so in a manner that is no more restrictive than coverage of other medical and surgical procedures. More specifically, the financial requirements applicable to SUD benefits and treatment limitations cannot be more restrictive than those for medical and surgical benefits and there cannot be separate cost-sharing requirements for SUD benefits.

Patient Protection and Affordable Care Act (ACA) of 2010

Historically, SUD treatment services were have either not been covered under private and public insurance plans or had been limited through the use of higher copayments, annual visit limits, and placing medications on higher tiers than medication for other types of medical conditions. Result: those in need As a result, many Americans in need were unable couldn't to access affordable SUD treatment.

Enter the Patient Protection and Affordable Care Act (ACA), which is dramatically changing this picture. The ACA provides greater access to SUD treatment through major coverage expansions, regulatory changes requiring coverage of SUD treatments in existing insurance plans, and requirements for SUD treatment to be offered on par with medical and surgical procedures in conjunction with Parity. The ACA enables states to address the opioid epidemic through four primary mechanisms: insurance coverage expansions, regulatory insurance reforms that require inclusion of SUD treatments, enhanced parity, and opportunities to integrate SUD treatment and mainstream healthcare.

Summary of Affordable Care Act

First, the ACA extends insurance coverage to millions of previously uninsured Americans through Medicaid expansion and state health insurance exchanges. An estimated 1.6 million Americans with SUD have gained insurance coverage in Medicaid expansion states (Humphreys and Frank, 2014). The ACA also extends coverage to children up to the age of 26 through their parent's insurance, a population with high rates of opioid use disorders (Substance Abuse and Mental Health Services Administration, 2016), and bans insurers from refusing to sell insurance to individuals with pre-existing conditions. Specifically, those with a prior treatment admission for OUD can no longer be denied insurance.

Second, the ACA requires coverage of SUD screening and brief intervention for all insurance plans, and coverage of the Essential Health Benefit (EHB) package under Medicaid expansion programs and qualified health plans offered on state health insurance exchanges. While federal guidance on the EHB requires coverage of SUD treatment, it does not specify which services must be included. Thus, states have wide latitude in determining the optimal range of treatment services to cover for patients with SUD. For the first time in history there are coverage requirements for SUD treatment. Given these requirements, which are largely funded by the federal government, states have the opportunity to address critical gaps in treatment services for Americans with OUD.

Third, the ACA extension of the Mental Health Parity and Addiction Equity Act of 2008, which requires that insurers cover SUD treatment in a no more restrictive way than medical and surgical services. Federal parity rules now apply to all private plans including those offered on state exchanges and Medicaid expansion programs.

Fourth, the ACA offers newly expanded and newly reimbursable opportunities to improve care for Americans with SUD by promoting integration of SUD treatment and mainstream healthcare. Innovations such as Medicaid Health Homes, Coordinated Care Entities, Accountable Care Organizations and Patient Centered Medical Homes, promote a broad range of these reimbursable services under a unified budget -- thus creating incentives to increase integration and coordination of care across SUD, mental health and medical care needs. Given the complex needs of most SUD patients, especially those with OUD, integrating services with primary and other specialty services, including community-based social supports, is considered crucially important.

Comprehensive Addiction and Recovery Act (CARA 2016)

On July 22, 2016, President Obama signed into law the Comprehensive Addiction and Recovery Act (CARA; P.L. 114-198). This is the most ambitious comprehensive effort undertaken to to addresses the opioid epidemic.These are and encompasses allits six pillars of a coordinated response – Pillars diagram here

While it authorizes over $181 million each year in new funding to fight the opioid epidemic over the next 10 years, monies must be distributed annually, through the regular appropriations process. CARA establishes a comprehensive, coordinated and balanced strategy through enhanced grant programs that would expand prevention and education efforts, while also promoting treatment, and

recovery. The bill passed the U.S. Senate in March 2016 by a vote of 94-1. The bill passed the House of Representatives in May 2016, by a vote of 400-5. Funding must be appropriated through the annual appropriations process for the funds to be distributed in accordance with the law.

The CARA's comprehensive, coordinated, and balanced strategy expands prevention and education grants while also promoting treatment and recovery.

- Expand prevention and educational efforts—particularly aimed at teens, parents and other caretakers, and aging populations—to prevent the abuse of methamphetamines, opioids and heroin, and to promote treatment and recovery.
- Expand the availability of naloxone to law enforcement agencies and other first responders to help in the reversal of overdoses to save lives.
- Expand resources to identify and treat incarcerated individuals suffering from SUDs promptly by collaborating with criminal justice stakeholders and by providing evidence-based treatments.
- Expand disposal sites for unwanted prescription medications to keep them out of the hands of children and adolescents.
- Launch an evidence-based opioid and heroin treatment and intervention program to expand best practices throughout the country.
- Launch a medication-assisted treatment and intervention demonstration program.
- Strengthen prescription drug monitoring programs to help states monitor and track prescription drug diversion and to help at-risk individuals access services.

Section-by-Section Summary of CARA Provisions

Title I: Prevention and Education

Sec. 101 – Develop Best Practices for Prescribing of Prescription Opioids: This section requires establishing an inter-agency task force, composed of representatives from HHS, VA, DEA, CDC, and other federal agencies, as well as addiction treatment organizations and other stakeholder communities to develop best practices for pain management and pain medication prescribing. It also requires the Task Force to submit a report to Congress outlining a dissemination strategy and other recommendations.

Sec. 102 – Awareness Campaigns: This section requires HHS and the Attorney General to advance the education and awareness of the public of the risk of abuse of prescription opioid drugs if they are not taken properly. It also establishes a national drug awareness campaign led by the Office of National Drug Control Policy (ONDCP) to bring attention to the association between prescription opioid abuse and heroin use, as well as focus on the dangers of fentanyl.

Sec. 103 – Community-Based Coalition Enhancement Grants to Address Local Drug Crises: This section authorizes HHS, in consultation with the Director of ONDCP, to make grants to entities suffering from drug crises (experiencing above average rates of prescription drug, heroin, or methamphetamines abuse for extended periods or sudden spikes) to implement community-wide prevention strategies.

Title II: Law Enforcement and Treatment

Sec. 201 – Treatment Alternative to Incarceration Programs: This section authorizes HHS, in coordination with the Attorney General, to make grants to states, local governments, Indian tribes, or nonprofits to develop, implement, or expand treatment alternatives to incarceration under specific circumstances (including with the consent of prosecuting and defense attorneys, corrections officials, and other appropriate stakeholders) for individuals who meet certain criteria. It requires periodic updates on the progress of individuals placed in alternative settings.

Sec. 202 – First Responder Training for the Use of Drugs and Devices that Rapidly Reverse the Effects of Opioids: This section authorizes HHS, in coordination with the Attorney General, to make grants to state, local, and tribal law enforcement agencies for training in the use of naloxone and for the purchase of naloxone.

Sec. 203 – Prescription Drug Take Back Expansion: This section authorizes the Attorney General, in coordination with the Administrator of the Drug Enforcement Administration (DEA), the Secretary of HHS, and the Director of ONDCP, to coordinate with State, local, or tribal law enforcement agencies, as well as pharmacies and others, to develop or expand disposal sites for unwanted prescription medications.

Sec. 204 – Heroin and Methamphetamine Task Forces: This section authorizes the Attorney General to make grants to State law enforcement agencies to locate or investigate illicit activities related to the distribution of heroin or fentanyl, or the unlawful distribution of prescription opioids.

Title III: Treatment and Recovery

Sec. 301 – Evidence-Based Prescription Opioid and Heroin Treatment and Interventions Demonstration: This section authorizes the Director of the Center for Substance Abuse Treatment to award grants to State substance abuse agencies, units of local government, Indian tribes or tribal organizations, or nonprofit organizations in geographic areas that have a high rate of—or have had rapid increases in—heroin or other opioids to expand activities (including those making available medication-assisted treatment) in the relevant areas.

Sec. 302 – Criminal Justice medication-assisted treatment and Interventions Demonstration: This section authorizes HHS, in coordination with the Attorney General, to make grants to eligible entities for the administration of medication-assisted treatment programs through criminal justice agencies.

Sec. 303– National Youth Recovery Initiative: This section authorizes the Secretary of Health and Human Services, in coordination with the Secretary of Education, to make grants to eligible entities (including high schools, institutions of higher learning, nonprofit organizations, and others) to provide support for recovery from substance use disorders to individuals in high school or enrolled in institutions of higher learning.

Sec. 304 – Building Communities of Recovery: This section authorizes HHS to award grants to certain independent nonprofit organizations for the development and expansion of recovery services.

Title IV: Addressing Collateral Consequences

Sec. 401 – Correctional Education Demonstration Grant Programs: This section authorizes the Attorney General to award grants to states, local governments, nonprofit organizations, or Indian tribes to design, implement, and expand educational opportunities for people in jails, prisons, and juvenile detention facilities. Grants under this section may be used to pay for basic education, secondary level education, high school equivalency examination preparation, career technical education, and English as a second language education. They may also be used for instructor hiring and teaching and the screening and assessment of individuals to determine educational and other needs, risk, and aptitude.

Sec. 402 – National Task Force on Recovery and Collateral Consequences: This section creates a task force made up of representatives from the health care, housing, employment, substance use disorder, law enforcement, and legal communities to identify the collateral consequences faced by individuals with state or federal drug convictions and to recommend ways of reducing and, where possible, eliminating them.

Title V: Addiction and Recovery Services for Women, Families, and Veterans

Sec. 501 – Improving Treatment for Pregnant and Postpartum Women: This section authorizes the

creation of grants for the purpose of expanding a State›s services for women offenders who are pregnant and women offenders with dependent children who are suffering from substance use disorder.

Sec. 502 – Report on Grants for Family-Based Substance Abuse Treatment: This section directs the Attorney General to submit to Congress an annual report that describes the number of grants awarded under section 2921(1) of the Omnibus Crime Control Bill that are used for family-based substance use treatment programs that serve as alternatives to incarceration for custodial parents to receive treatment and services as a family.

Sec. 503 – Veterans' Treatment Courts: This section amends the Omnibus Crime Control and Safe Streets Act of 1968 to allow for veterans who were discharged or released from service under dishonorable conditions, if the reason for that discharge was attributable to a substance use disorder.

Title VI: Incentivizing State Comprehensive Initiatives to Address Prescription Opioid and Heroin Abuse

Sec. 601 – State Demonstration Grants for Comprehensive Opioid Abuse Response: This section authorizes the Attorney General, in coordination with the Secretary of Health and Human Services and the Director of the Office of National Drug Control Policy, to award planning and implementation grants to eligible state, units of local government, territories, or Indian Tribes, or combination thereof, to prepare a comprehensive plan for, and implement, an integrated opioid abuse response initiative. The comprehensive response must include specific improvements to state prescription drug monitoring programs, as well as prevention/education efforts, expanded treatment programs, and plans for reversing opioid overdoses.

Title VII: Miscellaneous

Sec. 701 – GAO Report on IMD Exclusion: This section requires GAO to publish a report, within 365 days, on the impact that the Medicaid Institutions for Mental Disease exclusion has on access to treatment for individuals with substance use disorders.

Sec. 702 – Funding: This section authorizes $62 million for each FY 2016 through FY 2020 in funding for the Attorney General and HHS to carry out the provisions of the bill.

Sec. 703 – Conforming Amendments: This section amends the Omnibus Crime Control and Safe Streets Act to include the heading "Comprehensive Addiction and Recovery".

Sec. 704 – Grant Accountability: This section requires all grants awarded under the provisions of the bill to be subject to audits and other accountability measures.

Sec. 705 – Programs to Prevent Prescription Drug Abuse under the Medicare Program: This section authorizes amendments to the Social Security Act to ensure the prevention of prescription drug abuse within Medicare among at-risk individuals.

Title VIII: Transnational Drug Trafficking Act

Sec. 801 – Short Title: This section names the Title of the bill as the "Transnational Drug Trafficking Act of 2015".

Sec. 802 – Possession, Manufacture, or Distribution for Purposes of Unlawful Importations: This section makes it illegal to manufacture or distribute a Schedule I or Schedule II controlled substance with the knowledge that this will be imported into the U.S.

Sec. 803 – Trafficking in Counterfeit Goods or Services: This section adds trafficking in a drug to the U.S. while knowingly using a counterfeit mark with the drug as a crime to be punished by fine or imprisonment. (CARA, October 2016)

II. Key Georgia Issues

Georgia prevention programs

1. The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) and its Office of Behavioral Health Prevention (OBHP) is the state agency charged with providing prevention leadership, strategic planning and services to improve the mental/emotional well-being of communities, families and individuals in Georgia. DBHDD also provides support and funding for organizations involved in treatment and recovery. (See Section 2 – Treatment and Recovery).

With substantial funding from SAMHSA, the OBHP develops and contracts for prevention services across the state specifically designed to reduce the risks and increase protective factors linked to substance abuse related problem behaviors, suicide, and mental health promotion.

OBHP adheres to the prevention priorities set by SAMHSA, so most of its programming focuses on the prevention of underage drinking and prescription drugs misuse and abuse. OBHP created and manages three key programs that are funded by SAMHSA: 1) Alcohol Prevention Project (APP), 2) Generation Rx Project (GEN Rx), and 3) the Georgia Prescription Drug Abuse Prevention Collaborative (GADAPC).

APP is a public awareness program designed to address underage drinking in Georgia.

The objective of GEN Rx is to implement evidence based strategies to reduce prescription abuse among 12–25 years old within the targeted areas of Catoosa, Early and Gwinnett counties. The primary strategies implemented by GEN Rx are education, proper medication disposal and enforcement.

2. GADAPC is a statewide initiative focused on four priority areas to prevent and reduce prescription drug abuse in Georgia. The four areas addressed are those that have been identified by the Office of National Drug Control Policy (ONDCP): education, monitoring, proper medication disposal, and enforcement.

The collaborative is designed to include public and private sectors working collectively in Georgia to address the four priority areas. Collaborative members network with community and political leaders to raise awareness and provide education around prescription drug abuse prevention.

The collaborative monitors policy, law enforcement and legislative efforts around these issues and shares that information with the collaborative members at its quarterly meetings.

Statewide Non-profit Providers

Though DBHDD funds dozens of local prevention providers throughout the state, there are only two organizations it funds that provide statewide prevention programs: The Georgia Prevention Project (GPP) and The Council on Alcohol and Drugs (TCAD).

1. The Georgia Prevention Project (GPP) is a statewide prevention program aimed at reducing the use of dangerous drugs among youth and youth adults. It accomplishes its work through awareness campaigns, educational programming and strategic partnerships with national and community-based organizations.

GPP evolved from the Georgia Meth Project, which launched in March 2010. After the successful implementation of the "Not Even Once" meth prevention campaign, the name of the project changed in 2014 when it expanded its scope of services to include prescription drugs.

GPP partners with community members, schools and prevention professionals to develop strategy, build coalitions, and provide drug education and resources to prevent substance abuse among teens and young adults.

With its proven success of achieving sustainable outcomes from its prevention programs, GPP is on track to become the leading authority for substance abuse, drug education, and advocacy in Georgia.

GPP has made tremendous inroads within middle and high schools throughout the state by implementing its meth prevention lesson in health and PE classes. Over the last couple of years, GPP has provided training to health and PE teachers so they can teach the lesson.

In 2015, GPP launched a pilot program, the College Prevention Partnership, on six college campuses to prevent the misuse and abuse of prescription drugs, especially Adderall and Ritalin. The program utilizes a coalition approach to enlist and empower students to advocate for the prevention of prescription drug misuse and abuse among their peers. The pilot was funded through a grant by the Cardinal Health Foundation.

Midway through the pilot program, GPP was awarded additional funding by the DBHDD to expand the program and improve upon its preliminary results. GPP is now in its second year of funding from DBHDD to continue the program.

With the exception of the funding received for the college initiative, GPP is solely funded by private donations from corporations, foundations, and individuals.

2. The Council on Alcohol and Drugs (TCAD) is a 47-year-old nonprofit substance abuse prevention and education agency that develops programs and materials based on the most current research on drug use and its impact on community. Its programs target youth, young adults, and the business community.

TCAD provides substance abuse prevention services throughout the state. Most of its programs primarily focus on underage drinking and prescription drugs. Its major initiatives include fulfilling grant obligations in support of the Alcohol Prevention Project (APP), the Georgia Prescription Drug Abuse Prevention Collaborative (GADAPC) and GEN Rx. TCAD is the sole grantee manager of GADAPC.

Additionally, the council is an affiliate of the Georgia Chamber of Commerce and a partnership program of the South Carolina State Chamber of Commerce. The council's Drugs Don't Work (DDW) program has been the official drug-free workplace provider for the state of Georgia since 1993.

3. The Georgia Teen Institute (GTI), a program of county-funded Gwinnett United in Drug Education, Inc. (GUIDE), focuses on youth leadership across several regions of Georgia. The institute begins with a summer training program and continues with year-round support. GTI is dedicated to providing young people in middle and high schools with opportunities to become strong leaders.

The goal of GTI is to provide education training and motivation to middle and high school students and adult advisors in an effort to assist them in:

- Developing or enhancing sound habilitation concepts and life skills.
- Designing and implementing effective prevention initiatives which will have a positive impact on alcohol, tobacco, and other drug use and other health and safety problems within their communities.
- Promoting peer-led prevention in school and community activities.

GTI seeks to reduce the frequency of underage alcohol use, tobacco and other drug use and other self-destructive behaviors by guiding students to realize their leadership potential, learn new skills and become empowered to create change in their schools and communities.

National Primary Prevention Programs

The Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

Congress established SAMHSA in 1992 to make substance use and mental health information, services, and research more accessible. Consequently, SAMHSA is the governmental authority and leading provider of funds for substance abuse prevention services both nationally and locally.

Furthermore, SAMHSA sets the priorities for what types of substance abuse prevention programs are funded. Depending on national trends at any particular time, the priority focus shifts from underage drinking to marijuana to prescription drugs.

Alcohol continues to be the most widely misused substance among America's youth. Consumption of alcohol by anyone under the age of 21 remains a considerable public health challenge.

In recent years, all federal agencies have been tasked with addressing the opioid epidemic through their respective programs, and each agency has a unique role in the effort. In that light and despite continuing its substantial attention to underage drinking, SAMHSA has in the last couple of years shifted significant resources and attention to address the growing misuse of prescription drugs and, more specifically, illicit opioid use among 12 to 25-year-olds.

Office of National Drug Control Policy (ONDCP)

A component of the Executive Office of the President, ONDCP was created by the Anti-Drug Abuse Act of 1988. ONDCP advises the President on drug-control issues, coordinates drug-control activities and related funding across the Federal government, and produces the annual National Drug Control Strategy that outlines Administration efforts to reduce illicit drug use, manufacturing and trafficking, drug-related crime and violence, and drug-related health consequences. ONDCP now also contains the Office of Recovery.

The Drug-Free Communities (DFC) Support Program, created by the Drug-Free Communities Act of 1997, is the Nation's leading effort to mobilize communities to prevent youth substance use. Directed by ONDCP, in partnership with SAMHSA, the DFC Program provides grants to community coalitions to strengthen the infrastructure among local partners to create and sustain a reduction in local youth substance use.

In FY 2016, $85.9 million was awarded to fund 92 new DFC grants, 585 continuation grants for coalitions already in a five-year cycle, 3 new DFC Mentoring (DFC-M) grants and 18 continuation DFC-M grants.

ONDCP awarded two new DFC grants in Georgia in FY 2016. Those grantees are in Quitman and Fayetteville. Those add to the 14 grants previously awarded to the cities of Lawrenceville, Gainesville, Atlanta, Lagrange, Blakely, Richmond Hill, Grovetown, Conyers, Cumming, Rome, Holly Springs, and Statesboro. These grants include two grants for the city of Atlanta, and one DFC-M (mentor) grant for Lawrenceville.

To date, only a small percentage of DFC grantee programs, nationally or in Georgia, are focused on opioid misuse prevention programs.

Community Anti-Drug Coalitions of America (CADCA)

The mission of CADCA is to strengthen the capacity of community coalitions to create and maintain safe, healthy and drug-free communities globally.

CADCA represents more than 5,000 community coalitions nationwide working together to create a

world of safe, healthy and drug-free communities. CADCA leads this vision by providing cutting-edge services in training, communications, youth empowerment, veteran's programs, public policy and advocacy and the latest scientific research.

For the past several years CADCA has set its focus on the prevention of alcohol abuse and prescription drug misuse.

CADCA urges coalitions to help raise awareness about the dangers of prescription and over-the-counter medicine abuse by taking part in National Medicine Abuse Awareness Month (NMAAM).

The campaign serves as an ideal launching pad for medicine abuse prevention efforts. A cornerstone of the NMAAM campaign is the CADCA 50 Challenge, an initiative designed to challenge coalitions to get medicine abuse on the radar screens of parents and others by holding an educational event or activity in their communities.

Through a partnership with the National Institute on Alcohol Abuse and Alcoholism (NIAAA), CADCA encourages advocates to demonstrate their social media acumen and inform on the topic of alcohol abuse.

They teamed up for a new communications challenge to share NIAAA's scholarly facts with the masses by keeping information bite-sized to quickly understand and share with others. This is already a widely accepted marketing and communications strategy.

Partnership for Drug-Free Kids

The Partnership for Drug-Free Kids is a national nonprofit committed to helping families struggling with their child's substance use. Founded in 1986 as the Partnership for a Drug Free America, it is the longest running national nonprofit that focuses on substance abuse prevention.

One important way it helps families find answers is by translating the science of substance use and addiction into support and tools for parents.

Another way the Partnership helps families find answers is through timely responses to emerging drug threats. With funding and support from the High Intensity Drug Trafficking Areas (HIDTAs) in the eastern United States, in May 2016 it launched a comprehensive resource to help families and communities address the country's growing heroin and prescription drug abuse crisis. Titled "Heroin and Other Opioids: From Understanding to Action", it provides parents with information, support for their family and treatment resources for their loved one.

Particularly helpful to parents is the Partnership's Parent Support Network which provides an evidence-informed service available free of charge to parents through the Partnership helpline at (855)-378-4373.

The opioid epidemic is also the principal target of its multi-year national action campaign, The Medicine Abuse Project. The Partnership works with federal partners, numerous nonprofit and association partners, and both public and private sector funders to help educate parents and the public at large about what they can do to end adolescent medicine abuse.

Other organizations participating with the Partnership include: federal partners such as the National Institute on Drug Abuse, the Drug Enforcement Administration, the Centers for Disease Control and Prevention and the Office of National Drug Control Policy; a large number of strategic partners including the American Academy of Pediatrics and the American Academy of Family Physicians; and private sector partners, including a number of pharmaceutical companies.

The most visible initiatives include its "Mind Your Meds" campaign, a teen-made documentary, "Out of Reach", and website at www.medicineabuseproject.org, which offers an array of best-in-class resources for parents, educators, healthcare providers and community leaders/law enforcement.

In addition, the Partnership is engaged in a five-year prescriber education effort, underwritten by the

Food and Drug Administration, aimed at driving greater prescriber use of state-based Prescription Drug Monitoring Programs (PDMPs), which has been shown to significantly reduce doctor shopping when consistently applied.

The National Safety Council and National Governors Association recommendations for state PDMPs (NSC, 2016; NGA, 2016):

1. Require providers to check the PDMP before prescribing Schedule II, III and IV controlled substances
2. Require providers to report to the PDMP within 24 hours
3. Simplify the PDMP registration process, integrating and automating when possible with other licensing processes
4. Make PDMPs easier to use by integrating PDMP data into electronic health records and health information systems
5. Improve reporting response times and upgrade PDMP technology to facilitate data transfer into clinical workflows
6. Allow prescribers to establish delegate accounts
7. Allow the creation of institutional accounts
8. Use PDMP data to provide proactive analyses and reporting to professional licensing boards and law enforcement
9. Ensure PDMP interoperability with other states

The National Safety Council and National Governors Association recommendations for pill mill legislation (NSC, 2016; NGA, 2016):

1. Define what constitutes a pain management clinic based on the volume and types of services provided
2. Enforce prescription guidelines based on set standards and best practices of medical care by state licensing authorities and prevailing best practice standards
3. Define ownership requirements so owners of pill mills can be identified and held accountable if in violation of state policy
4. Require pain management clinics to register with the state or obtain a license or certificate from the state
5. Give the state health agency or licensing board authority to inspect pain management clinics and mandate unannounced inspections when receiving complaints of violations
6. Require pain management clinic owners and medical directors to meet training requirements
7. Prohibit non-law-abiding or restricted licensees from becoming owners or employees
8. Restrict the prescribing of controlled substances
9. Require PDMP utilization
10. Require a medical evaluation including adequate patient history and physical examination prior to prescribing medication
11. Conduct an appropriate patient risk assessment at each visit

National Governors Association Recommendations

1. Develop and update guidelines for all opioid prescribers
2. Limit new opioid prescriptions for acute pain, with exceptions for certain patients
3. Develop and adopt a comprehensive opioid management program in Medicaid and other state-run health programs
4. Remove methadone for managing pain from Medicaid preferred drug lists
5. Expand access to non-opioid therapies for pain management
6. Enhance education and training for all opioid prescribers
7. Maximize the use and effectiveness of state PDMPs
8. Use public health and law enforcement data to monitor trends and strengthen prevention efforts
9. Enact legislation that increases oversight of pain management clinics to reduce "pill mills"
10. Raise public awareness about the dangers of prescription opioids and heroin
11. Establish a collaborative information sharing environment that breaks down silos across state agencies to better understand trends, target interventions and support a comprehensive state response
12. Leverage assets from partner entities to improve data collection and intelligence sharing to restrict the supply of illicit opioids
13. Expand statutory tools for prosecuting major distributors
14. Expand law enforcement partnerships and data access to better target over-prescribers
15. In narcotics investigations, implement best practices and ensure intergovernmental cooperation
16. Establish and enhance stakeholder coalitions
17. Change payment policies to expand access to evidence-based MAT and recovery services
18. Increase access to naloxone
19. Expand and strengthen the workforce and infrastructure for providing evidence-based MAT and recovery services
20. Create new linkages to evidence-based MAT and recovery services
21. Consider authorizing and providing support to syringe service programs
22. Reduce stigma by changing the public's understanding of substance use disorder
23. Empower, education and equip law enforcement personnel to prevent overdose deaths and facilitate access to treatment
24. Reinforce use of best practices in drug treatment courts
25. Ensure access to MAT in correctional facilities and upon reentry into the community
26. Strengthen pre-trial drug diversion programs to offer individuals the opportunity to enter into substance use treatment
27. Ensure compliance with Good Samaritan laws

(NGA, 2016)

National Safety Council Recommendations:

1. Establish State requirements for medical education on effective pain management
2. Require CME for prescribers who apply for a new or renewed registration under the Controlled Substances Act of 1970. CME should be pertinent to the classes of controlled substances prescribed by the provider.
3. Adopt state opioid prescribing guideline.
4. Develop or strengthen state policy that stops the establishment and/or operation of pill mills that function outside prescribing standards for licensed, qualified physicians and whose primary treatment is prescribing opioids.
5. Make PDMPs easy to use:
    - Require the collection of prescription data within 24 hours
    - Simplify the PDMP registration process, integrating and automating when possible with other medical professional licensing processes
    - Improve reporting response times and facilitate data transfer into clinical workflows
6. Improve reporting of drugs involved in drug overdose fatalities
7. Expand access to naloxone and remove barriers to its purchase and use
8. Increase patient caseload caps for buprenorphine waivered physicians
9. Allow advanced practice nurses to obtain waivers to prescribe buprenorphine. Expand use of medication-assisted treatment, ensure it is offered and available at state-funded treatment providers.
10. Require public and private health insurers to cover medication-assisted treatment
11. Remove caps on the duration of medication-assisted treatment

(NSC, 2016)

The National Safety Council and National Governors Association recommendations for increasing access to naloxone (NSC, 2016; NGA, 2016):

- Review and remove Medicaid barriers to naloxone, such as prior authorization, and consider placing naloxone on the preferred drug list
- Work to ensure that naloxone is covered by all insurance plans
- Pass "Good Samaritan" laws to protect prescribers, first responders and bystanders from liability when prescribing or administering naloxone
- Enact legislation allowing naloxone dispensing via standing orders, collaborative practice agreements, statewide protocols or pharmacist authority
- Train first responders to recognize the signs of opioid overdose and administer naloxone
- Partner with professional associations to promote co-prescribing of naloxone when clinically appropriate
- Permit third party prescribing of naloxone
- Create a centralized naloxone procurement and distribution process at the state level and consider negotiating with manufacturers to obtain a competitive pricing agreement

The National Safety Council and National Governors Association recommendations for expanding state capacity to treat opioid use disorder (NSC, 2016; NGA, 2016):

- Change payment policies to expand access to evidence-based MAT and recovery services
- Ensure that Medicaid and other state health programs adequately cover all FDA-approved MAT (methadone, buprenorphine, oral and extended-release injectable naltrexone) and evidence-based behavioral interventions. Encourage or require commercial health plans to adopt similar policies.
- Provide reimbursement for components of comprehensive evidence-based treatment and recovery, including medication, office visits, behavioral interventions and wrap-around services.
- Review and remove barriers to MAT, such as fail first and inappropriate prior authorization protocols, and encourage generic substitution when appropriate.
- Work with the department of insurance to enforce federal parity laws designed to ensure equal access to behavioral health care and medical/surgical care.
- Use payment strategies (e.g., pay for performance, quality metrics and separating behavioral health from payment bundles) to increase access to evidence-based MAT and behavioral interventions and promote integration of behavioral health and primary care.
- Require buprenorphine waiver training in primary care and other select medical residency programs.
- Establish a coordinated treatment system in which specialty treatment centers stabilize patients and refer to community providers for ongoing care (e.g., hub and spoke model).
- Provide ongoing education and support to primary care providers and other buprenorphine prescribers to expand MAT capacity (e.g., Project ECHO telehealth model).
- Increase the number of office- and community-based opioid treatment programs through collaboration with community health centers and new state funding.
- Expand the reach of peer and family support organizations (e.g., Learn to Cope) through Medicaid and other state funding.
- Begin MAT in emergency departments following an opioid overdose or related drug event, and ensure immediate linkages to behavioral services and community supports.
- Establish peer-based recovery programs in emergency departments to support individuals following an opioid overdose or related drug event.
- Train first responders to refer patients to high-quality MAT and harm reduction services following an overdose reversal.
- Provide information and assistance to help health care providers and the public identify treatment and recovery options in their communities (e.g., a call line).

Georgia Medication-assisted Treatment Programs

The National Institute of Drug Abuse and state of Georgia resources on medication-assisted treatment:. drugabuse.gov/publications/research-reports/prescription-drugs/treating-prescription-drug-addiction/treating-addiction-to-prescription-opio and drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/pharmacotherapies). More specifically, the Substance Abuse and Mental Health Administration issued updated guidelines for opioid treatment programs in 2015 (store.samhsa.gov/shin/content/PEP15-FEDGUIDEOTP/PEP15-FEDGUIDEOTP.pdf). The American Society of Addiciton Medicine (ASAM) also released a national practice guideline for the use of medications in the treatment of addiction involbing opioid use in 2015 (http://www.asam.org/docs/default-source/

practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf).

The Opioid Treatment Providers of Georgia (OTPG) is a non-profit organization of medication-assisted treatment providers, counselors, and others interested in treatment, recovery, and traditional and alternative options for heroin and other opioid addiction (otpgeorgia.org/otpg-member-treatment-facility-map).

Table XX. Opioid Treatment Program (OTP) and non-OTP services and coverage in Georgia in 2014 (NSSATS, 2014).

	OTP (n=56) N (%)	Non-OTP (n=297) N (%)	All SUD treatment programs (n=353) N (%)
Ownership			
Private for-profit	52 (92.86)	123 (41.41)	175 (49.58)
Private non-profit	1 (1.79)	94 (31.65)	95 (26.91)
State government	--	46 (15.49)	46 (13.03)
Local, county, community government	2 (3.57)	26 (8.75)	28 (7.93)
Federal government	1 (1.79)	8 (2.69)	9 (2.55)
Methadone			67 (18.98)
Buprenorphine with naloxone	19 (33.93)	34 (11.45)	53 (15.01)
Buprenorphine without naloxone	15 (26.79)	17 (5.74)	32 (9.09)
Extended-release injectable naltrexone	2 (3.57)	25 (8.42)	27 (7.65)
Oral Naltrexone	3 (5.36)	39 (13.13)	42 (11.9)
Cash/self-pay	56 (100)	250 (84.46)	306 (86.93)
Medicare	2 (3.57)	113 (38.57)	115 (32.95)
Medicaid	4 (7.14)	197 (66.78)	201 (57.26)
State financed health insurance	1 (1.85)	139 (49.47)	140 (41.79)
Military	8 (14.55)	127 (45.68)	135 (40.54)
Private	6 (10.91)	167 (57.59)	173 (50.14)
Free to all (no payment accepted)	0	12 (4.07)	12 (3.42)
Uses sliding fee scale	7 (12.5)	180 (60.61)	187 (52.97)
Offers treatment at no charge for those that cannot afford to pay	5 (8.93)	148 (49.83)	153 (43.34)

Research on the effectiveness of pill mill legislation

Four studies have examined the effectiveness of pill mill legislation in Florida and Texas (Lyapustina et al., 2015; Rutkow et al., 2015; Chang et al., 2016; Kennedy-Hendricks et al., 2016). Rutkow and colleagues (2015) found that Florida's pill mill legislation was associated with modest decreases in opioid prescribing (decrease in opioid prescriptions, opioid volume, and MME per transaction).

These decreases were concentrated among prescribers and patients with the highest baseline opioid prescribing and use (Rutkow et al., 2015). A second study of the Florida legislature showed similar findings and indicated that high-risk prescribers were disproportionately responsive to state policies than low-risk prescribers (Chang et al., 2016). A third study of Florida state laws and law enforcement operations targeting pill mills found reductions in opioid overdose deaths (Kennedy-Hendricks et al., 2016).

A study of Texas's pill mill legislation showed decreases in average MED per transaction, monthly opioid volume, monthly number of opioid prescriptions and monthly quantity of opioid pills dispensed following implementation (Lyapustina et al., 2015). Consistent with the Florida studies, these decreases were greater among prescribers and patients with the highest opioid prescribing and utilization at baseline (Lyapustina et al., 2015).

Kentucky's pill mill legislation

The major components of Kentucky's pill mill legislation (HB1) include defining pain management facilities, licensure and regulation of pain management facilities, CME requirements prior to licensure, ownership requirements, licensing standards, interagency reporting requirements, reporting requirements for drug overdose deaths, and insurance/payment requirements. More specifically, this legislation requires practitioners of pain management clinics to register with the KY PDMP (KASPER) and requires that illegal prescribing and dispensing of controlled substance be reported within 3 days. The legislation also includes requirements for the reporting of drug related deaths.

Following the implementation of HB1, several pain clinics closed (Freeman et al., 2015). The closure of pain management clinics in KY may have resulted in decreases in the number of CS prescribers in the top decile, which decreased by over 14% from FY2012 to FY2013 (Freeman et al., 2015).

Results also suggest that strengthened regulations of pain management clinics in HB1 had a significant impact on inappropriate prescribing including a decrease in patients receiving concurrent prescriptions for an opioid, alprazolam and carisoprodol (OAC), decreases in the number of patients receiving high dose oxycodone, decreases in the number of patients and mean daily MME for patients receiving oxycodone, and decreases in doctor shopping (Freeman et al., 2015).

Recurring Blue-Ribbon Commission on Substance Abuse and Recovery - Notes.

The Georgia Legislature, in collaboration with the Governor's Office, should create a recurring commission that convenes every 5-7 years to establish strategy and statewide goals, recommend appropriations, and review progress on reducing substance use and expanding local systems of recovery supports and treatment services in Georgia.

Over the past 50 years, Georgia has had some experience with creating recurring commissions, particularly in the public education arena. These types of commissions can have great value when setting long term strategies and gathering collaborative support among legislators, agencies, the Office of the Governor, and the public.

Moreover, a recurring commission structure gives everyone a chance to review progress against goals, plan appropriations over multiple years, and continually re-educate the participants about the issues associated with the subject matter.

A recurring commission structure would work well in addressing the current opioid and heroin problem – and provide a forum for addressing other similar substance abuse problems that are likely to occur over any five or seven year period.

SARA believes that the current State Senate Study Committee has been a valuable and well-managed process for addressing many substance abuse issues, and the recurring commission structure could be implemented as a simple extension and expansion of the current committee's work – with new agenda items and expanded participation. Alternatively, the recurring commission could take the form of 1) a joint Senate-House Study Committee, 2) a Governor's commission, or 3) a privately run and funded commission.

We believe that while any of the above scenarios can be successful, the best structure would include maximum participation from key lawmakers, the Governor's Office, and the heads of certain state agencies. Non-profit organizations, for-profit companies, and private individuals can also add great value to the work of such a commission.

REFERENCES

Prescription Opioids and Heroin Epidemic in Georgia

I. Opioids overview

https://www.whitehouse.gov/the-press-office/2016/12/08/continued-rise-opioid-overdose-deaths-2015-shows-urgent-need-treatment

National Center for Health Statistics

References for Economic costs of opioid misuse and abuse in GA and the U.S.

Centers for Disease Control and Prevention, (2016, January 1). Increases in Drug and Opioid Overdose Deaths – United States, 2000-2014. Morbidity and Mortality Weekly Report (MMWR), Retrieved from: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6450a3.htm?s_cid=mm6450a3_w)

Link between prescription opioids and heroin:

Kolodny, A. Courtwright, D. T., Hwang,, C. S., Kreiner, P., Eadie, J. L., Clark, T. W., & Alexander, C. A. (2015). The prescription opioid and heroin crisis: A public health approach to an epidemic of addiction. Annual Review of Public Health, 36, 559-74.

Peavy, K. M., Banta-Green, C. J., Kingston, S., Hanrahan, M., Merrill, J. O., & Coffin, P. O. (2012). "Hooked on" prescription-type opiates prior to using Heroin: Results from a survey of syringe exchange clients. Journal of Psychoactive Drugs, 44(3) 259-265.

II. Key Georgia Issues

PDMP and Pill Mills

Bao, Y., Pan, Y., Taylor, A., Radakrishnan, S., Luo, F., Pincus, H.A., Schackman, B.R. (2016). Prescription Drug Monitoring Programs Are Associated With Sustained Reductions in Opioid Prescribing by Physicians. ***Health Affairs, 25(6),*** 1045-1051. DOI: 10.1377/hlthaff.2015.1673

Clark, T., Eadie, J., Knue, P., Kreiner, P., & Strickler, G. (2012). Prescription Drug Monitoring Program Center of Excellence at Brandeis. Prescription Drug Monitoring Programs: An Assessment of the Evidence for Best Practices.

Freeman, P.R., Goodin, A., Troske, S., & Talbert, J. (2015). ***Kentucky House Bill 1 Impact Evaluation.*** Institute for Pharmaceutical Outcomes and Policy Department of Pharmacy Practice and Science. National Criminal Justice Reference Service. Retrieved September 2, 2016. https://www.ncjrs.gov/App/Publications/abstract.aspx?ID=271254

Kennedy-Hendricks, A., Richey, M., McGinty, E.E., Stuart, E.A., Barry, C.L., & Webster, D.W. (2016). Opioid Overdose Deaths and Florida's Crackdown on Pill Mills. ***American Journal of Public Health, 106(2),*** 291-297. Retrieved September 2, 2016. DOI: 10.2105/AJPH.2015.302953

Kentucky House Bill 1. 2012 Special Session of the Kentucky General Assembly. Retrieved September 2, 2016 from http://kbml.ky.gov/Pages/default.aspx.

Leitman, R. (2013). ***Georgia's Fight against Prescription Drug Abuse***. Senate Research Office: At Issue.

Lyapustina, T., Rutkow, L., Chang, H., Daubresse, M., Ramji, A.F., Faul, M., Stuart, E.A., & Alexander, G.C. (2016). Effect of a "Pill Mill" Law on Opioid Prescribing and Utilization: The Case of Texas. ***Drug and Alcohol Dependence, 159,*** 190-197. Retrieved September 2, 2016. DOI: http://dx.doi.org/10.1016/j.drugalcdep.2015.12.025

National Association of Boards of Pharmacy. (2016). NABP PMP INterConnect. Retrieved September 9, 2016 from http://www.nabp.net/programs/pmp-interconnect/nabp-pmp-interconnect

Patrick, S.W., Fry, C.E., Jones, T.F., & Buntin, M.B. (2016). Implementation of Prescription Drug Monitoring Programs Associated with Reductions in Opioid-Related Death Rates. ***Health Affairs, 35(7),*** 1324-32. Retrieved September 2, 2016. DOI: 10.1377/hlthaff.2015.1496

Paulozzi LJ, Kilbourne EM, Desai HA. (2011). Prescription drug monitoring programs and death rates from drug overdose. ***Pain Medicine, 12(5),*** 747– 54.

Rutkow L, Chang H, Daubresse M, Webster D, Stuart EA, Alexander GC. (2015). Effect of Florida's prescription drug monitoring program and pill mill laws on opioid prescribing and use. ***JAMA Internal Medicine, 175(10),*** 1642–9. DOI: 10.1001/jamainternmd.2015.3931

Prevention Education

NIDA - Diagnosis and Treatment of Drug Abuse in Family Practice - Prevention. (n.d.). Retrieved June 27, 2016, from http://archives.drugabuse.gov/diagnosis-treatment/diagnosis7.html

Prescription Drug Monitoring Programs (PDMPs). (2016). Retrieved June 27, 2016, from

White House, ***Office of National Drug Control Policy***, https://www.whitehouse.gov/ondcp/federally-funded-prevention-programs; (accessed Oct. 7, 2016)

SAMHSA, ***Substance Abuse Mental Health Services Administration***, http://www.samhsa.gov/prevention/samhsas-efforts, (accessed October 7, 2016)

CADCA, ***Community Anti-Drug Coalitions of America***, http://www.cadca.org/campaigns/drug-free-kids-campaign, (accessed October10, 2016)

Department of Behavioral Health and Developmental Disabilities, ***Georgia.gov,*** http://dbhdd.georgia.gov/bh-prevention, (accessed October 11, 2016)

The Council on Alcohol and Drugs, ***livedrugfree.org,*** http://www.livedrugfree.org/Prevention-Services-Programs.551.0.html, (accessed October 12, 2016)

The Partnership for Drug Free Kids, ***Drugfree.org***, http://www.drugfree.org/newsroom/statement-partnership-drug-free-kids-funding-operations/, (accessed October 12, 2016)

Prevention Education and Medications

Amass L, Ling W, Freese TE, et al. Bringing buprenorphine-naloxone detoxification to community treatment providers: The NIDA Clinical Trials Network field experience. ***American Journal on Addictions.*** 2004;13:S42-S66.

Barnett PG, Rodgers JH, Bloch DA. A meta-analysis comparing buprenorphine to methadone for treatment of opiate dependence. ***Addiction.*** 2001;96(5):683-690.

Bell JR, Butler B, Lawrance A, Batey R, Salmelainen P. Comparing overdose mortality associated with methadone and buprenorphine treatment. ***Drug & Alcohol Dependence.*** 2009;104(1-2):73-77.

Center for Substance Abuse Treatment. ***Medication-assisted treatment for opioid addiction in opioid treatment programs.*** Rockville, MD: Substance Abuse and Mental Health Services Administration (SAMHSA);2005.

Fiellin DA, Pantalon MV, Pakes JP, O'Connor PG, Chawarski M, Schottenfeld RS. Treatment of Heroin Dependence with Buprenorphine in Primary Care. ***American Journal of Drug and Alcohol Abuse.*** 2002;28(2):231.

Gastfriend DR. Intramuscular extended-release naltrexone: Current evidence. ***Annals of the New York Academy of Sciences***.2011;1216:144–166

Gueorguieva R, Wu R, Krystal JH, Donovan D, O'Malley SS. Temporal patterns of adherence to medications and behavioral treatment and their relationship to patient characteristics and treatment response. ***Addictive Behaviors***. 2013;38:2119–2127.

Kranzler HR, Stephenson JJ, Montejano L, Wang S, Gastfriend DR. Persistence with oral naltrexone for alcohol treatment: Implications for health-care utilization. ***Addiction***.2008;103:1801–1808

Schwartz RP, Kelly SM, O'Grady KE, et al. Attitudes Toward Buprenorphine and Methadone Among Opioid-Dependent Individuals. ***American Journal on Addictions.*** 2008;17(5):396-401.

Swift R, Oslin DW, Alexander M, Forman R. Adherence monitoring in naltrexone pharmacotherapy trials: A systematic review. Journal of Studies on Alcohol and Drugs.2011;72:1012–1018

Syed YY, Keating GM. Extended-release intramuscular naltrexone (VIVITROL®): A review of its use in the prevention of relapse to opioid dependence in detoxified patients. CNS Drugs.2013;27:851–861

Volpicelli JR, Rhines KC, Rhines JS, Volpicelli LA, Alterman AI, O'Brien CP. Naltrexone and alcohol dependence. Role of subject compliance. ***Archives of General Psychiatry***.1997;54:737–742.

The ASAM National Practice Guideline For the Use of Medications in the Treatment of Addiction Involving Opioid Use.

National Safety Council Report on Opioid Epidemic Indicators

Indicator	Number of states meeting indicator	States meeting indicator
Requires mandatory prescriber education for prescribers on pain management	**17**	California, Connecticut, Delaware, Iowa, Kentucky, Massachusetts, Nevada, New Hampshire, New Mexico, North Carolina, Oregon, Rhode Island, South Carolina, Tennessee, Vermont, West Virginia and Wisconsin
State or state medical board has issued an opioid prescribing guideline	**22**	Alabama, Arizona, Arkansas, California, Colorado, Hawaii, Indiana, Kentucky, Massachusetts, Minnesota, New Hampshire, New Mexico, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, Tennessee, Utah, Vermont, Washington and West Virginia
The State has a law or laws regulating pain clinics or pain management services	**12**	Alabama, Florida, **Georgia**, Indiana, Kentucky, Louisiana, Mississippi, Ohio, Tennessee, Texas, West Virginia and Wisconsin
State PDMP allows prescriber and dispenser delegates	**40**	Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Minnesota, Montana, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming
State allows a standing order for naloxone*	**35**	Alabama, Alaska, Arkansas, California, Colorado, Delaware, Florida, **Georgia**, Illinois, Indiana, Kentucky, Louisiana, Maine, Maryland, Minnesota, Mississippi, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington and Wisconsin
State has sufficient buprenorphine treatment capacity to treat residents with opioid dependence	**3**	Maine, New Mexico, and Vermont (only these states have enough of the drug to meet the need)

*Thirty-four (34) states and the District of Columbia have enacted Good Samaritan laws.