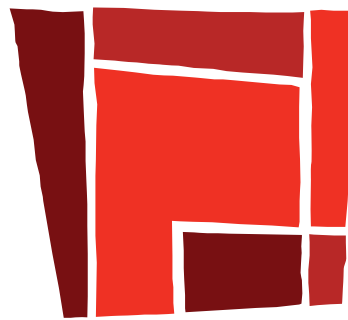


# 50 State Review on Opioid Related Policy



ARIZONA DEPARTMENT  
OF HEALTH SERVICES

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[azhealth.gov/opioid](http://azhealth.gov/opioid)



# ARIZONA DEPARTMENT OF HEALTH SERVICES

August 18, 2017

Dear Fellow Arizonan,

In the United States, the opioid crisis has been firmly established as a national epidemic. Every day across our country lives are being lost and torn apart as a result of the deleterious effects caused by opioid misuse, abuse, overdose, and death.

Calls to action are being declared by individuals, communities, states, and national stakeholders. Collaboration and alignment among stakeholders has resulted in the implementation of numerous policy recommendations, statutory actions, public health interventions, and various other initiatives to address the opioid crisis.

Arizona has joined in this effort by establishing itself as a catalyst for change in developing and implementing a comprehensive public health approach to successfully tackle the complexities present within the opioid epidemic landscape.

Governor Doug Ducey's June 5, 2017 *Declaration of Emergency and Notification of Enhanced Surveillance Advisory* further solidified Arizona's resolve in enhancing and strengthening Arizona's opioid response activities so that we can effectively halt and begin to reverse the impact the opioid epidemic is having in our state.

Very shortly after the Governor's *Declaration*, the Arizona Department of Health Services initiated its Health Emergency Operations Center to establish an agency-wide response to implement Governor Ducey's requirements. One of the requirements was to "*provide a report on findings and recommendations, including additional needs and response activities, and preliminary recommendations that require legislative action to the Governor by September 5, 2017.*"

The *Arizona 50 State Review on Opioid Related Policy* is intended to assist partners and decision-makers in determining what additional programmatic and policy actions may be necessary as Arizona moves forward with its opioid initiatives.

We hope that the *Arizona 50 State Review on Opioid Related Policy* is a helpful resource and adds value to the conversation on how best to address, and hopefully solve, the opioid crisis in Arizona and the United States.

Sincerely,

A handwritten signature in black ink that reads "Cara M. Christ MD".

Cara M. Christ, MD, MS  
Director

Douglas A. Ducey | Governor    Cara M. Christ, MD, MS | Director

## **Methodology**

The development of the *Arizona 50 State Review on Opioid Related Policy* was a group effort. A team of Arizona Department of Health Services staff representing the Bureau of Epidemiology and Disease Control, Office of Injury Prevention, and Bureau of Tobacco and Chronic Disease worked collaboratively to produce the document and reference materials.

An exhaustive literature review was conducted to gather relevant and meaningful information to support discussion of each of the sixteen indicators included in the *Arizona 50 State Review on Opioid Related Policy*. Over 3,000 pages of text representing federal and state guidance documents, state task force publications, academic articles, federal, state, and local laws, administrative rules, and stakeholder contributions were reviewed. Information was then categorized by topic to provide a high level picture of what opioid intervention initiatives were taking place across the country.

Each topic was allowed 1-2 pages of text to provide readers with a quick glance of what the current national landscape looks like, what strategies and initiatives may have shown positive impacts on reducing opioid morbidity and mortality, and what strategies and activities Arizona is currently engaged in compared to other states.

## **Utilization of the Arizona 50 State Review**

Due to the volume of documents that were available for review and the timeline in which the *Arizona 50 State Review on Opioid Related Policy* was developed, the authors were only able to provide the reader with a very high-level representation of the vast amount of effort taking place across the country to address the opioid epidemic.

Determining associative or causal relationships between interventions and the impact they are having on improving outcomes falls beyond the scope of this document. Furthermore, the large majority of work being done on a national scale to address this issue has been developed and implemented very recently. As a result, research and subsequent findings investigating the relationship between resources allocated to the crisis and outcomes produced are likely not going to be observed for some time.

However, the *Arizona 50 State Review on Opioid Related Policy* does represent an open door for stakeholders to walk through to explore more broadly and deeply the nuance, complexity, and opportunity there is to work together to create, implement, and sustain impactful policies and interventions to defeat the opioid epidemic we now face.

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## SUMMARY OF ARIZONA INDICATORS

MEDICAL PRACTICE INDICATORS	
	Does Arizona Currently Have in Place?
Are there laws in place that target pill mills?	No
Are there laws in place to regulate pain clinics?	No
Are there laws in place supporting informed consent, including pain management agreements?	No
Does the state have any best practices or guidelines in place that encourage the use of non-opioid alternatives for the treatment of chronic pain?	Yes
PRESCRIPTION INDICATORS	
	Does Arizona Currently Have in Place?
Was a state Task Force created in response to the opioid epidemic?	Yes
Has the Task Force developed a list of recommendations to help guide future initiatives related to the state's response to the opioid epidemic?	Yes, <a href="#">See Appendix A</a>
Has the state developed opioid prescribing guidelines?	Yes
Are there laws in place that limit initial opioid prescriptions?	No
Does the state have an operational Prescription Drug Monitoring Program (PDMP)?	Yes
Are there laws in place to require use of state PDMP?	Yes, effective October 16, 2017

**PRESCRIPTION INDICATORS (cont.)**

Are there laws in place that permit access to the PDMP to assigned delegates?	Yes
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**EMERGENCY INDICATORS**

EMERGENCY INDICATORS	
	Does Arizona Currently Have in Place?
Are there laws in place to expand Naloxone access?	Yes
Does the state have a Naloxone Good Samaritan Law in place?	No
Has your jurisdiction issued any executive or administrative orders or declarations that provide emergency powers needed for response to the opioid epidemic?	Yes
Has your jurisdiction/agency officially activated its Emergency Operations Center for the Opioid Crisis?	Yes

**REPORTING INDICATORS**

REPORTING INDICATORS	
	Does Arizona Currently Have in Place?
Are there laws in place to require the reporting of drug overdose cases?	No
Are there laws in place that require the reporting of Neonatal Abstinence Syndrome (NAS) cases?	No



<b>PREVENTION, TREATMENT &amp; EDUCATION INDICATORS</b>	
Does the state fund or require substance abuse prevention programs for children and youth?	Does Arizona Currently Have in Place?  Yes, but not required
Are there laws in place to support referral to treatment including utilization of SBIRT and MAT?	No
Are there laws in place that require opioid abuse prevention curriculum be developed and incorporated into academic programs for medical, dental, and nursing students?	No
Are there laws in place that require all medical providers to complete continuing education coursework related to opioid prescribing/ chronic pain management?	No

# **MEDICAL PRACTICE INDICATORS**

## **Pill Mills**

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3 states, Florida, Texas, and Kentucky have implemented opioid misuse, abuse, and overdose laws, policies, or initiatives labeled “pill mill” laws. Regulations of pill mills are similar to regulations of pain clinics, but these three states have adopted greater regulatory and punitive policies to eliminate pain clinics that operate outside of medical and ethical boundaries.

A pill mill is 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” (CDC, 2012).

### **Practices from Other States**

In 2011, Florida governor signed into law an anti-pill mill bill (HB 7095), championed by Attorney General Pam Bondi. This bill specifically toughened criminal and administrative penalties targeting doctors and clinics engaged in prescription drug trafficking. The bill also established standards of care for physicians prescribing narcotics, required physicians making narcotic prescriptions to register with the Department of Health, and banned physicians from dispensing the most abused narcotics. Lastly, the bill also strengthened oversight of pharmacies and wholesale distributors and strengthened the effectiveness of the prescription drug database by speeding up the time data must be entered.<sup>1</sup>

In 2009, Texas’s pill mill legislation required all pain management clinics to be certified by the state medical board on a biennial basis and to be owned or operated by a licensed physician. Furthermore, clinic owners must be physically present at least one-third of operating hours and must personally review at least one-third of all patient files. Lastly, pain management clinic owners must regularly verify qualifications and licensure of all employees.<sup>2</sup> Failure to comply with the law may result in revoking physicians’ licensure.

In 2012, Kentucky passed a pill mill law that introduced “restrictions on pain management clinics, strict new limits on prescribing controlled substances, and increased reporting requirements for practitioners using Kentucky’s ‘KASPER’ electronic controlled substances monitoring system.”<sup>3</sup> HB 1 also requires each pain management facility to be owned only by licensed physicians and to be operated by a certified pain management specialist (whether the owner or his or her designee).

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<sup>1</sup> <http://www.myfloridalegal.com/newsrel.nsf/newsreleases/9AD68A6580FA8DFD852578A400499E5E>

<sup>2</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4976392/>

<sup>3</sup> <http://www.taftlaw.com/news/publications/detail/941-new-kentucky-pill-mill-bill-places-new-restrictions-on-pain-management-facilities-and-controlled-substances-prescribing>

**Impact: How has law, policy, or initiative improved outcomes in other states?**

A 2016 article published in *Drug and Alcohol Dependence* presented an observational cohort study of Texans' (1) average morphine equivalent dose (MED) per transaction; (2) aggregate opioid volume; (3) number of opioid prescriptions; and (4) quantity of opioid pills dispensed before versus after the passage of Texas's pill mill legislation. This study found Texas's pill mill law was associated with modest declines (8.1-24.3%) in average MED per transaction, monthly opioid volume, monthly number of opioid prescriptions, and monthly quantity of opioid pills dispensed.<sup>4</sup>

A 2015 *JAMA* study of Florida's Prescription Drug Monitoring Program (PDMP) and pill mill laws (jointly) found they were associated with modest decreases in opioid prescribing and use. Specifically, "Florida's laws were associated with statistically significant declines in opioid volume (2.5 kg/mo,  $P < .05$ , > equivalent to approximately 500 000 5-mg tablets of hydrocodone bitartrate per month) and morphine milligram equivalent (MME) per transaction (0.45 mg/mo,  $P < .05$ , > without any change in days' supply. Twelve months after implementation, the policies were associated with approximately a 1.4% decrease in opioid prescriptions, 2.5% decrease in opioid volume, and 5.6% decrease in MME per transaction. Reductions were limited to prescribers and patients with the highest baseline opioid prescribing and use."<sup>5</sup>

**Arizona: Current State and Recommendations**

To date, Arizona does not have any laws or specific guidance on the regulation of pill mills.

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<sup>4</sup> <https://stacks.cdc.gov/view/cdc/40739/Email>

<sup>5</sup> <http://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2429105>

## **Regulation of Pain Clinics**

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**10** states, Alabama, Florida, Georgia, Kentucky, Louisiana, Mississippi, Ohio, Tennessee, Texas, and West Virginia have implemented laws that regulate pain management clinics. All ten states require that every pain management clinic/facility have an owner or medical director to oversee its operations, and most states mandate that the owner or medical director meet certain requirements.

**5** of these states, Florida, Kentucky, Louisiana, Tennessee, and West Virginia restrict prescribing and dispensing of controlled substances in pain management clinics/facilities.<sup>6</sup>

### **Practices from Other States<sup>7</sup>**

Florida prohibits anyone except physicians from dispensing any medications on the premises of a pain management clinic. “Physicians, physician assistants, and advanced practice nurses are required to perform a physical examination of the patient on the same day that the physician prescribes a controlled substance and, if the physician prescribes more than a 72-hour dose of a controlled substance, the physician must document in the record the reason for prescribing that quantity.” (NAMSDL, 2016).

Kentucky law requires that each physician who will prescribe or dispense controlled substances to patients at a pain management facility shall successfully complete a minimum of ten hours of Category I continuing medical education in pain management during each registration period throughout the employment agreement with the facility.

In Louisiana, clinics must verify the identity of each patient who is seen and treated for chronic pain management and who is prescribed a controlled substance. Prescriptions for controlled substances may have a maximum quantity of a 30-day supply and shall not be refillable. On each visit to a pain clinic which results in a prescription for a controlled substance, the patient shall be personally examined by a pain specialist.

No pain management clinic or practitioner working at a pain management clinic in Tennessee shall be permitted to dispense controlled substances. The clinic or practitioner may provide, without charge, a sample of a Schedule IV or V controlled substance in a quantity limited to an amount that is adequate to treat the patient for a maximum of 72 hours or a sample of a non-narcotic Schedule V substance in a quantity limited to an amount adequate to treat the patient for a maximum of 14 days. If any practitioner

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<sup>6</sup> <http://www.namsdl.org/library/74A8658B-E297-9B03-E9AE6218FA0F05B0/>

<sup>7</sup> <http://www.namsdl.org/library/74A8658B-E297-9B03-E9AE6218FA0F05B0/>

prescribes controlled substances for the treatment of chronic non-malignant pain, the practitioner must document in the patient's record the reason for prescribing that quantity.

Finally, in West Virginia a person may not dispense any medication, including a controlled substance, on the premises of a pain management clinic unless he or she is a physician or pharmacist licensed in West Virginia. Prior to dispensing, the physician must check the prescription monitoring program and at every patient examination thereafter or a minimum of every 90 days. Clinics may not dispense to any patient more than a 72-hour supply of a controlled substance. A physician, physician assistant, certified registered nurse anesthetist, or advanced nurse practitioner shall perform a physical examination of the patient on the same day the physician initially prescribes, dispenses, or administers a controlled substance to the patient and at least four times a year thereafter.<sup>8</sup>

**Impact: How has a law, policy, or initiative improved outcomes in other states?**

With only a handful of states having specific laws regulating pain management clinics there is little confirmatory evidence of the impact these laws have on reducing opioid misuse, abuse, and death. However, there are a few examples that suggest pain clinic regulatory laws are effective (Haegerich et al., 2014) but that in order to determine effectiveness more states will need to enact and enforce pain clinic laws and conduct research to measure the extent to which legislation improves outcomes (Rutkow, Vernick, & Alexander, 2017).

**Arizona: Current State and Recommendations**

To date, Arizona does not have any laws or specific guidance on the regulation of pain clinics.

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<sup>8</sup> <http://www.namsdl.org/library/74A8658B-E297-9B03-E9AE6218FA0F05B0/>

# Informed Consent, Patient Pain Management Agreements

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26 states have implemented informed consent agreement laws, recommendations, or guidelines.

## Practices from Other States

Alabama, Arizona, Delaware, Florida, Georgia, Kansas, Kentucky, Maine, Michigan, Minnesota, Missouri, Montana, Nebraska, New Hampshire, North Carolina, Ohio, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Wisconsin, and Wyoming all have laws, quasi-regulatory requirements, or prescribing guidelines that mandates or includes informed consent for opioid treatment.

Informed consent consists of obtaining from a patient their acknowledgement of the potential risks and benefits associated with taking opioid medications and the responsibility of the patient when taking opioid prescription medications.

[Appendix B](#) (Davis, 2017) provides additional detail for all states that currently have informed consent laws, recommendations, or guidelines in place.

## Practice Impact: How has law, policy, or initiative improved outcomes in other states?

Currently, there is a dearth of published evidence demonstrating the relationship between laws that require informed consent and individual health outcomes.

## Arizona: Current State and Recommendations

Arizona currently includes informed consent within the Arizona Opioid Prescribing Guidelines and in the recently issued emergency rules for health care institutions.

In response to the Governor's Declaration of Emergency and after obtaining an exception from the rulemaking moratorium established by Executive Order 2017-02, the Department has amended the rules in 9 A.A.C. 10, Article 1 for licensed health care institutions through emergency rulemaking. The new rules require licensed health care institutions to:

- Establish, document, and implement policies and procedures for prescribing, ordering, or administering opioids as part of treatment;
- Include specific processes related to opioids in a health care institution's quality management program; and
- Notify the Department of the death of a patient from an opioid overdose.

Specifically, the new rules require that healthcare institutions obtain informed consent from the patient or the patient's representative prior to prescribing an opioid. The consent must include potential risks, adverse reactions, complications, and medication interactions associated with the use of opioids, including risks associated with concurrent use of an opioid and a benzodiazepine. The consent must also include information on alternatives to a prescribed opioid.

## **Non-Opioid Chronic Pain Management**

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11 states have laws or guidelines in place that encourage the use of non-opioid alternatives for the treatment of chronic pain.

### **Practices from Other States**

The Centers for Disease Control and Prevention *Chronic Pain Guidelines*<sup>9</sup> and National Safety Council recommendations<sup>10</sup> highlight and underscore the need to utilize alternative non opioid pharmacologic therapies to treat chronic pain. Physical therapy, occupational therapy, water therapy, acupuncture, yoga, T'ai Chi and massage have all been recognized as effective interventions to reduce the effects of and to effectively treat chronic pain. NSAID combination therapy (200 mg of ibuprofen combined with 500 mg of acetaminophen) is also recommended as a preferred alternative to prescribing an opioid<sup>11</sup> for treating chronic pain.

### **Impact: How has law improved outcomes in other states?**

Arizona, California, Alaska, Colorado, Arkansas, Alabama, Connecticut, and Delaware have developed chronic pain guidelines that include providing alternatives to opioids for treating chronic pain. Ohio, Oregon, and Vermont have implemented laws allowing Medicaid recipients access to acupuncture, a non-pharmacotherapy form of pain management<sup>12</sup>. Other states' task forces have also recommended employing a variety of alternative approaches to treating chronic pain.

Frank et al. (2017), "systematically reviewed the evidence on the effectiveness of strategies to reduce or discontinue long-term opioid therapy prescribed for chronic pain and the effect of dose reduction or discontinuation of long-term opioid therapy on important patient outcomes." Frank found that alternatives for treating chronic pain with non-pharmacologic and self-management strategies are effective and consistent with current best practice for management of chronic pain. Frank also recommended a need for higher quality research to continue if the relationship between implementing alternative methodologies for treating chronic pain and improvement in patient outcomes is to be realized.

### **Arizona: Current State and Recommendations**

In 2016, the Arizona Substance Abuse Taskforce provided Recommendation Number 18 providing specific guidance regarding alternatives to opioids: "*Educate providers, health plans, and the general public about effective alternative pain management modalities for acute and chronic pain in order to decrease the use of opioids and unintended addiction.*" (p. 8).

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<sup>9</sup> [https://www.cdc.gov/drugoverdose/pdf/nonopioid\\_treatments-a.pdf](https://www.cdc.gov/drugoverdose/pdf/nonopioid_treatments-a.pdf)

<sup>10</sup> National Safety Council. (2016) Prescription Nation 2016: Addressing America's Drug Epidemic.

<sup>11</sup> <https://www.colorado.gov/pacific/hcpf/pain-management-resources-and-opioid-use>

<sup>12</sup> <https://www.integrativepractitioner.com/whats-new/news-and-commentary/evidence-opens-medicaid-oregon-acupuncture/>



In May 2017, the Arizona Department of Health Services held a chronic pain summit to launch a public health initiative focused on promoting awareness of self-management strategies and non-opioid alternatives to treating chronic pain.

## **PRESCRIPTION INDICATORS**

## **Opioid/Prescription Drug Task Force**

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**37** states have created a state Task Force in response to the opioid epidemic.

**30** states have a Task Force which developed a list of recommendations to help guide future initiatives.

### **Practices from Other States**

As of 2017, 37 states have created multi-agency task force groups to assess the current state of the opioid epidemic and to establish a coordinated statewide response to reducing death and injury caused by opioid misuse and abuse. Of these states, 30 task force groups have also developed recommendations to guide next steps for combating prescription drug misuse and abuse. While most of these recommendations were developed within the past two years, some states have recommendations that were established as early as 2013. While specific task force recommendations tend to vary based on the needs of the state; there are similarities that exist as well. A review of existing task force documents revealed that many states recommend the following actions:

- Expanding prevention efforts to continue raising public awareness regarding the dangers of prescription drug misuse and abuse.
- Establishing new education and training requirements for healthcare providers related to safe opioid prescribing practices, pain management, and addiction.
- Improving the functionality of state Prescription Monitoring Programs
- Increasing access to naloxone
- Enhancing access to substance abuse treatment services, including the continued expansion of medication assisted treatment services

[Appendix C](#) provides links to state-specific detail regarding task force actions.

### **Impact: How has law improved outcomes in other states?**

With the majority of state task forces being implemented very recently, empirical evidence suggests that the initiatives states are employing to address the opioid crisis are effective. However, given the very short existence of the task forces that have been implemented, very little scientific evidence has been collected to measure the impact task forces and their subsequent activities are having on reducing maladies caused by opioid misuse, abuse, overdose, and death.

### **Arizona: Current State and Recommendations**

In 2016, the Arizona Substance Abuse Taskforce provided 104 separate recommendations ([see Appendix A](#)) to address various components of substance abuse in Arizona, including the opioid epidemic.

In addition to the Arizona Substance Abuse Taskforce, the Arizona Substance Abuse Partnership (ASAP)<sup>13</sup> has played a central role in supporting initiatives targeting substance abuse, misuse, and overdose. Authorized by Executive Order 2013-05, amending and superseding Executive Order 2007-12, ASAP serves as the single statewide council on substance abuse prevention, enforcement, treatment, and recovery efforts. The Arizona Substance Abuse Partnership is chaired by the Maricopa County Attorney and vice-chaired by the Director of the Governor’s Office of Youth, Faith and Family and is composed of representatives from state governmental bodies, federal entities, and community organizations.

The Prescription Drug Core Group, a subcommittee of the Arizona Substance Abuse Partnership, convened in 2012 and created the Arizona Misuse & Abuse Prescription Drug Initiative with a set of five strategies and a toolkit for action at the state and community levels.

In the fall of 2016, the Governor’s Goal Council 3 on Health chose reducing opioid overdose deaths as its breakthrough project. Starting June 2017, sub-groups were convened to make recommendations and work on improvement actions targeting illicit opioid supply, prescription opioid supply, demand, youth prevention, treatment, and death.

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<sup>13</sup> <http://substanceabuse.az.gov/substance-abuse/arizona-substance-abuse-partnership>

## **Opioid Prescribing Regulations and Guidelines**

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**33** states have prescribing requirements enforceable by law.

**23** states have developed opioid prescribing guidelines.

**18** states have developed guidelines by exercising their rule-making or quasi-regulatory<sup>14</sup> authority.

### **Current Status across the US**

The majority of US states have prescribing laws in place. Review of examples from a handful of states finds that, in general, most state laws provide guidance on prescribing within an emergency department or office setting that includes: outlining specific limits on number of prescriptions a prescriber can write for any patient, number of pills prescribed per patient, MME limits, and number of days a prescription can be written before a refill is required. Some states also include requirements for checking a prescription drug monitoring database and laws specific to Medicaid recipients.

For example, Alabama's Administrative Code § 540-X-4-.08 (2013), includes performing a patient evaluation before prescribing opioids, obtaining informed consent from the patient for opioid treatment, conducting a periodic review of the opioid treatment, and maintaining a complete medical record of the patient's treatment. Physicians are not to fear disciplinary action if opioids are prescribed for legitimate purposes and within accepted medical knowledge and practice. Alabama's Administrative Code § 560-X-16-.20 (2014) limits the number of outpatient pharmacy prescriptions to four brand names and five total drugs per month per adult recipient for all Medicaid recipients. In no case can total prescriptions exceed ten per month per recipient.

[Appendix B](#) (Davis, 2017) provides a state-by-state overview of current laws, regulations, and guidelines.

### **Impact: How has law improved outcomes in other states?**

A review of 13 opioid prescribing guidelines for chronic pain by Teryl K. Nuckols and her colleagues (2014) found that all of the guidelines contained the following opioid risk mitigation strategies: "upper dosing thresholds; cautions with certain medications; attention to drug–drug and drug–disease interactions; and use of risk assessment tools, treatment agreements, and urine drug testing. Frank et al. (2017), "systematically reviewed the evidence on the effectiveness of strategies to reduce or discontinue long-term opioid therapy prescribed for chronic pain and the effect of dose reduction or discontinuation of long-term opioid therapy on important patient outcomes." Frank found that alternatives for treating chronic pain with non- pharmacologic and self-management strategies are

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<sup>14</sup> *Quasi-regulatory* refers to situations where agencies may develop or enact guidance, rules, or regulations that may not be supported by statute.

effective and consistent with current best practice for management of chronic pain. Frank also recommended a need for higher quality research to continue if the relationship between implementing alternative methodologies for treating chronic pain and improvement in patient outcomes is to be realized.

### **Arizona: Current State and Recommendations**

Arizona has developed and made widely available the *Arizona Opioid Prescribing Guidelines*<sup>15</sup>, *Arizona's Emergency Department Prescribing Guidelines*<sup>16</sup>, *Arizona Guidelines for Dispensing Controlled Substances*<sup>17</sup>; all of which are embedded and disseminated through the *Rx Drug Misuse and Abuse Initiative Toolkit (Strategy 2)*<sup>18</sup>.

In addition, in response to the Governor's Declaration of Emergency, ADHS has amended the rules for licensed health care institutions through emergency rulemaking. The new rules require licensed health care institutions to:

- Establish, document, and implement policies and procedures for prescribing, ordering, or administering opioids as part of treatment consistent with the Arizona Opioid Prescribing Guidelines or national opioid prescribing guidelines, such as those issued by the Centers for Disease Control and Prevention;
- Include specific processes related to opioids in a health care institution's quality management program; and
- Notify the Department of the death of a patient from an opioid overdose.

The new rules include conducting a physical exam of the patient; checking the state's Controlled Substances Prescription Monitoring Program; conducting a substance abuse risk assessment; explaining alternatives to an opioid; and obtaining informed consent.

Finally, Recommendations 23 through 31 provided by the Arizona Substance Abuse Task Force acknowledge and support the need for continued development and implementation of prescribing and education guidance for practitioners and the public.

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<sup>15</sup> [www.azhealth.gov/opioidprescribing](http://www.azhealth.gov/opioidprescribing)

<sup>16</sup> [www.azhealth.gov/opioidprescribing](http://www.azhealth.gov/opioidprescribing)

<sup>17</sup> [www.azhealth.gov/opioidprescribing](http://www.azhealth.gov/opioidprescribing)

<sup>18</sup> [www.RethinkRxabuse.org](http://www.RethinkRxabuse.org)

## Prescribing Limits

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**12** states have laws in place that limit the initial amount of opioids medical professionals can prescribe.

### Current Status of US States

Over the past year, 12 states have passed laws or agency rules limiting the initial amount of opioids practitioners can prescribe. These states are Connecticut, Delaware, Indiana, Kentucky, Maine, Massachusetts, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, and Vermont. Of these states, New Jersey limited first fill prescriptions to 5 days while 10 states limited first fill prescriptions to 7 days. Kentucky recently passed a 3 day limit for controlled substances prescribed for acute pain. Maryland, Rhode Island, and Vermont enacted laws or adopted rules to limit morphine milligram equivalents (MME) below 100 MME within 30 days. Ohio is adopting administrative rules to limit MME to no more than 30 MME per day for acute pain. The Virginia Board of Medicine adopted several regulations in 2017, including requiring a prescriber treating acute pain with opioids to begin with short-acting opioids. Some states also require physicians to enter into a pain management agreement with a patient, prescribe non-opioid medications for chronic pain, and limiting daily pill counts<sup>19</sup>.

In addition, several states introduced legislation in 2017 limiting initial opioid prescription limits. States include Georgia, Hawaii, Montana, Oregon, and Washington.

### Impact: How has law improved outcomes in other states?

In 2016, CDC published their *Guideline for Prescribing Opioids for Chronic Pain – United States, 2016*<sup>20</sup>. To date, there is a dearth of state-level literature that presents evidence demonstrating associations between the development and implementation of prescribing guidelines and reductions in opioid misuse, abuse, and overdose. However, Dowell, Haegerich, and Chou (2016) and others demonstrate the need to determine the relationship between prescribing limits, prescribing behavior, and patient outcomes.

### Arizona: Current State and Recommendations

Governor Doug Ducey issued an executive order limiting initial opioid prescriptions to 7 days for AHCCCS members and state employees and their families on the state's health insurance plan. The order went into effect in April 2017.

Arizona published *Arizona Opioid Prescribing Guidelines* in 2014<sup>21</sup> and is currently revising this edition to reflect recent evidence and feedback from Arizona practitioners and public health professionals. This initiative aligns with Recommendation Number 26 provided by the Arizona Substance Abuse Taskforce.

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<sup>19</sup> <http://www.astho.org/StatePublicHealth/A-Look-at-State-Legislation-Limiting-Opioid-Prescriptions/2-23-17/>

<sup>20</sup> <https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6501e1er.pdf>

<sup>21</sup> <http://www.azhealth.gov/opioidprescribing>

## **Prescription Drug Monitoring Program (PDMP)**

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**49** states have an operational PDMP.

**36** states have laws in place to require use of state PDMP.

**44** states have laws in place that allow delegates to use the PDMP.

### **Practices from Other States**

Prescription Drug Monitoring Programs (PDMP) have emerged as a leading intervention adopted by states to address the opioid epidemic. Up until July, 2017, all states, with the exception of Missouri had an operational PDMP system in place. However, a recent executive order issued by Missouri Governor, Eric Greitens now directs the Missouri Department of Health and Senior Services to create a PDMP for this state as well<sup>22</sup>.

Despite evidence showing the effectiveness of PDMPs in reducing prescription drug related death and injury (Patrick, Fry, Jones, & Buntin, 2014). PDMPs remain underutilized leaving states unable to reap the full benefits of this system. A national survey conducted in 2014 found that while 72% of primary care physicians were aware of the state's PDMP system, only 53% of those surveyed reported using it, with the two main barriers to use being that it was too time consuming, and lacked ease of access (Rutkow et al., 2015).

While several states have put legislation in place that requires the use of the state PDMP system by prescribers, the integration of PDMPs with Electronic Health Records (EHR) and Health Information Exchange (HIE) systems has also been identified as a best practice for increasing PDMP utilization by minimizing technical challenges and making access to prescribing information more readily available to healthcare professionals<sup>23</sup>.

### **Impact: How has law improved outcomes in other states?**

Past research has shown PDMPs to be an effective tool to monitor prescribing behavior (Katz et al., 2010). CDC highlights examples from Florida, New York, and Tennessee to illustrate the association between the enactment of state-level PDMP policy enactments and changes in prescribing behavior<sup>24</sup>.

Florida<sup>25</sup>

- 2010 Action: Regulated pain clinics and stopped health care providers from dispensing prescription opioid pain relievers from their offices, in combination with establishing a PDMP.
- 2012 Result: Saw more than 50% decrease in oxycodone overdose deaths.

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<sup>22</sup> <http://www.astho.org/StatePublicHealth/Prescription-Drug-Monitoring-Program-Legislation-Update/7-20-17/>

<sup>23</sup> <http://www.astho.org/Rx/Brandeis-PDMP-Report/>

<sup>24</sup> <https://www.cdc.gov/drugoverdose/policy/successes.html>

<sup>25</sup> <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6326a3.htm>



- These changes might represent the first documented substantial decline in drug overdose mortality in any state during the previous ten years.

#### New York<sup>26</sup>

- 2012 Action: Required prescribers to check the state's PDMP before prescribing opioids.
- 2013 Result: Saw a 75% drop in patients' seeing multiple prescribers for the same drugs.

#### Tennessee<sup>27</sup>

- 2012 Action: Required prescribers to check the state's PDMP before prescribing painkillers.
- 2013 Result: Saw a 36% decline in patients' seeing multiple prescribers for the same drugs.

### **Arizona: Current State and Recommendations**

In 2007, Arizona established its Controlled Substances Monitoring Program (CSPMP)<sup>28</sup>. Every medical practitioner who is issued a medical license pursuant to title 32 and who possesses an Arizona registration under the controlled substances act (21 United States Code sections 801 through 904) must have a current controlled substances prescription monitoring program registration issued by the board and be granted access to the program's central database tracking system.

Following the passage of S.B. 1023, beginning the later of October 1, 2017, or 60 days after the statewide health information exchange has integrated the CSPMP into the exchange, a medical practitioner, before prescribing an opioid analgesic or benzodiazepine controlled substance listed in schedule II, III or IV for a patient, shall obtain a patient utilization report regarding the patient for the preceding twelve months from the controlled substances prescription monitoring program's central database tracking system at the beginning of each new course of treatment and at least quarterly while that prescription remains a part of the treatment.

Medical practitioners are not required to obtain a patient utilization report from the central database tracking system pursuant to subsection H of this section if any of the following applies:

- The patient is receiving hospice care or palliative care for a serious or chronic illness.
- The patient is receiving care for cancer, a cancer-related illness or condition or dialysis treatment.
- A medical practitioner will administer the controlled substance.

<sup>26</sup>[http://www.pdmpassist.org/pdf/COE\\_documents/Add\\_to\\_TTAC/Briefing%20on%20PDMP%20Effectiveness%203rd%20revision.pdf](http://www.pdmpassist.org/pdf/COE_documents/Add_to_TTAC/Briefing%20on%20PDMP%20Effectiveness%203rd%20revision.pdf)

<sup>27</sup>[http://www.pdmpassist.org/pdf/COE\\_documents/Add\\_to\\_TTAC/Briefing%20on%20PDMP%20Effectiveness%203rd%20revision.pdf](http://www.pdmpassist.org/pdf/COE_documents/Add_to_TTAC/Briefing%20on%20PDMP%20Effectiveness%203rd%20revision.pdf)

<sup>28</sup> <http://www.azleg.gov/viewDocument/?docName=http://www.azleg.gov/ars/36/02606.htm>

- The patient is receiving the controlled substance during the course of inpatient or residential treatment in a hospital, nursing care facility, assisted living facility, correctional facility or mental health facility.
- The medical practitioner is prescribing the controlled substance to the patient for no more than a ten-day period for an invasive medical or dental procedure or a medical or dental procedure that results in acute pain to the patient.
- The medical practitioner is prescribing the controlled substance to the patient for no more than a ten-day period for a patient who has suffered an acute injury or a medical or dental disease process that is diagnosed in an emergency department setting and that results in acute pain to the patient. An acute injury or medical disease process does not include back pain.
- The medical practitioner is prescribing no more than a five-day prescription and has reviewed the program's central database tracking system for that patient within the last thirty days, and the system shows that no other prescriber has prescribed a controlled substance in the preceding thirty-day period.

By complying with S.B. 1023, Section J, a medical practitioner acting in good faith, or the medical practitioner's employer, is not subject to liability or disciplinary action arising solely from either:

- Requesting or receiving, or failing to request or receive, prescription monitoring data from the program's central database tracking system.
- Acting or failing to act on the basis of the prescription monitoring data provided by the program's central database tracking system.

The Arizona Substance Abuse Task Force Recommendation Number 25 calls for the continued enhancement of the PDMP to become more robust and user- friendly. This should be accomplished through continued efforts to integrate the PDMP into existing Electronic Health Records and Health Information Exchange systems across the state.

# **EMERGENCY INDICATORS**

## Naloxone Access

50 states have laws in place to expand naloxone access.

### Practices from Other States

Every state in the Union has laws in place to expand access to naloxone. However, there is variation among states regarding the extent to which immunity is provided to prescribers, dispensers and lay administrators. Differences among states are also observed with respect to whether or not friends, family, and other community members can distribute and possess naloxone and if prescribing naloxone by a third party with or without a standing order is permitted<sup>29</sup>.

### Impact: How has law improved outcomes in other states?

Evidence has shown that communities with higher access to naloxone and overdose training have significantly lower opioid overdose rates than those that do not (Walley et al., 2013).

### Arizona: Current State and Recommendations

As of May 17, 2017, Arizona has a number of laws providing expanded access to naloxone as reflected in Table 1 and the text below.

**Table 1. Characteristics of Arizona’s Naloxone Access Laws<sup>30</sup>**

Immunity: Prescribers			Immunity: Dispensers			Immunity: Lay Administrators	
Civil	Criminal	Disciplinary	Civil	Criminal	Disciplinary	Civil	Criminal
-	Yes	Yes	-	Yes	Yes	Yes	-
Lay Distribution and Possession				Prescribing Permitted			
Lay Distribution	Possession without prescription		3 <sup>rd</sup> Party		Standing Order		
*	-		Yes		Yes		

*Note:* Citations: Ariz. Rev. Stat. Ann. § 32-1979; Ariz. Rev. Stat. Ann § 36-2266; Ariz. Rev. Stat. Ann. § 36-22667. \* State law permits naloxone to be prescribed to “a community organization that provides services to persons who are at risk of an opioid-related overdose” but does not permit those organizations to further distribute the medication. Ariz. Rev. Stat. Ann. § 36-2266(A).

[AZ Rev Stat § 32-1979 \(2016\)](#) allows a pharmacist to dispense without a prescription, according to protocols adopted by the board, to a person who is at risk of experiencing an opioid-related overdose or to a family member or community member who is in a position to assist that person. Arizona Department of Health Services Director Dr. Cara Christ issued a standing order on June 9, 2017 for dispensing naloxone.

<sup>29</sup> [https://www.networkforphl.org/\\_asset/qz5pvn/legal-interventions-to-reduce-overdose.pdf](https://www.networkforphl.org/_asset/qz5pvn/legal-interventions-to-reduce-overdose.pdf)

<sup>30</sup> [https://www.networkforphl.org/\\_asset/qz5pvn/legal-interventions-to-reduce-overdose.pdf](https://www.networkforphl.org/_asset/qz5pvn/legal-interventions-to-reduce-overdose.pdf)

[AZ Rev Stat § 36-2266 \(2016\)](#) allows health care providers with prescribing authority to prescribe or dispense, directly or by a standing order, naloxone to a person who is at risk of experiencing an opioid-related overdose, to a family member of that person, to a community organization that provides services to persons who are at risk of an opioid-related overdose or to any other person who is in a position to assist a person who is at risk of experiencing an opioid-related overdose.

[AZ Rev Stat § 36-2228 \(2015\)](#) allows law enforcement officers or Emergency Medical Care Technician (EMTs) to administer naloxone to a person if they believe the person is suffering from an opioid-related overdose. The law requires a standing order for naloxone be issued by a physician or nurse practitioner, and requires training on proper administration of naloxone prior to being able to administer naloxone.

Currently, AHCCCS and ADHS are funding naloxone education and distribution throughout Arizona.

Recommendation Number 37 provided by the Arizona Substance Abuse Task Force states:

1. Increase[ing] access to the overdose antidote naloxone (Narcan™).
2. Conduct a needs assessment regarding the distribution of naloxone kits in Arizona and create strategies to support harm reduction.
3. Conduct community overdose education and prevention programs and distribute naloxone overdose prevention kits. Distribution must be accompanied with appropriate training on how to recognize the signs of an overdose, when and how to administer naloxone, the importance of calling 911, and how to administer rescue breathing until 911 first responders arrive.

Recommendation Number 38 provided by the Arizona Substance Abuse Task Force states:

1. Promote greater use of naloxone, especially in populations that are prone to fatal overdose such as people getting out of jail or prison, veterans, and individuals leaving the emergency department or a treatment program.

## Good Samaritan Law

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40 states have a Naloxone Good Samaritan Law.

### **Current Status across the United States**

As of May, 2017, 40 states and the District of Columbia have passed an overdose Good Samaritan law that provides some protection from arrest or prosecution for individuals who report an overdose in good faith<sup>31</sup> (Davis, Chang, Carr, & Hernandez-Delgado, 2017).

For states with Good Samaritan laws, legal protections may provide immunity (arrest, charge, prosecution<sup>32</sup>.) for controlled substance possession, paraphernalia, and other violations (protective or restraining order; pretrial, probation, or parole conditions). Other legal protections may include considering reporting as a mitigating factor and if reporting could result in civil forfeiture.

### **Impact: How has law improved outcomes in other states?**

An evaluation of Washington State's 911 Good Samaritan law by Caleb J. Banta and his colleagues (2011) revealed, "88% of opiate users indicated that now that they were aware of the law they would be more likely to call 911 during future overdoses. 62% of police surveyed said the law would not change their behavior during a future overdose because they would not have made an arrest for possession anyway, 20% were unsure what they would do, and 14% said they would be less likely to make such an arrest." Banta and his colleagues (2013) also reported in their assessment of the implementation of the Good Samaritan law in Washington State that, "Most police and paramedics surveyed believed it was important for police to be at the scene of an overdose to help ensure the safety of medical personnel. This finding is important in light of concerns expressed locally and in the research literature about the presence of police at the scene of an overdose. Importantly, just a third of police felt it was important to be at the scene of an overdose to enforce laws."

Measuring the long-term effects of Good Samaritan law on reductions in opioid-related deaths has yet to occur. It is recommended that research efforts continue in order to pair anecdotal, qualitative reports with rigorous evidence-based analysis to become better able to assess the impact Good Samaritan laws have on reducing opioid overdose and death.

### **Arizona: Current State and Recommendations**

Along with Iowa, Idaho, Kansas, Maine, Missouri, Oklahoma, South Carolina, Texas, and Wyoming, Arizona does not have any Good Samaritan laws. A next logical step for Arizona would be to review laws currently on the books in other states to identify which laws, or components of laws might be best applied in Arizona and the extent to which the benefits of enacting Good Samaritan laws in Arizona outweigh possible risks.

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<sup>31</sup> <http://pdaps.org/dataset/overview/good-samaritan-overdose-laws/58caa647d42e073a0b9ab804>

<sup>32</sup> [https://www.networkforphl.org/\\_asset/qz5pvn/legal-interventions-to-reduce-overdose.pdf](https://www.networkforphl.org/_asset/qz5pvn/legal-interventions-to-reduce-overdose.pdf)

## Emergency Response Activities

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6 states have issued any executive or administrative orders or declarations that provide emergency powers needed to respond to the opioid epidemic.

3 states have activated their Emergency Operations Center for the Opioid Crisis.

### Current State Status

Alaska, Arizona, Colorado, Florida, Georgia, Louisiana, Maryland, New Hampshire, Utah, and Virginia have issued an executive or administrative order or declaration that provides emergency powers needed to respond to the opioid crisis. The majority of executive and administrative powers included standing orders to allow entities, with or without medical direction, to distribute naloxone and implementing training for first responders and community to safely administer naloxone<sup>33</sup>.

### Practice Impact: How has law improved outcomes in other states?

Since the majority of emergency declarations have occurred within the past few years (Massachusetts, 2014; Arizona, 2017), it will very likely take a number of years to be able to determine the extent to which the provision of emergency powers impacted opioid outcomes.

### Arizona: Current State and Recommendations

On June 5, Governor Doug Ducey issued a Declaration of Emergency and Notification of Enhanced Surveillance Advisory<sup>34</sup> that included 5 deliverables:

1. Within seven days of the order, provide consultation to the Governor on identifying and recommending the necessary elements for an Enhanced Surveillance Advisory
2. Initiate emergency rule making with the Arizona Attorney General's Office in order to develop rules for opioid prescribing and treatment within health care institutions
3. Develop guidelines to educate healthcare providers on reasonable prescribing practices
4. Develop and provide training to local law enforcement agencies on proper protocols for carrying, handling, and administering naloxone in overdose situations
5. Provide a report on findings and recommendations, including additional needs and response activities, and preliminary recommendations that require legislative action to the Governor by September 5, 2017.

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<sup>33</sup> <http://www.astho.org/StatePublicHealth/Emergency-Declarations-and-Opioid-Overdose-Prevention/6-8-17/>

<sup>34</sup> <http://www.azdhs.gov/documents/prevention/womens-childrens-health/injury-prevention/opioid-prevention/opioid-emergency-declaration.pdf>

## **REPORTING INDICATORS**



## Opioid Overdose Reporting

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3 states have laws or regulations in place to require the reporting of drug overdose.

### Practices from Other States

Currently, New Mexico, Rhode Island, and Texas have laws or regulations in place that require drug overdoses to be reported.

New Mexico requires all drug overdoses to be reported within 24 hours to the Department of Health (N.M. Code R. § 7.4.3<sup>35</sup>). Rhode Island utilized its Department of Health's rulemaking authority to require, "*health care professionals and hospitals...to report all opioid overdoses or suspected overdoses to the Department within a forty-eight (48) hour time period.*<sup>36</sup>"

Texas requires mandatory reporting under § 97.3 of the Texas Administrative Code and § 161.042 of the Health and Safety Code. Reporting entities and individuals who report in good faith are provided civil and criminal liability protections.

### Impact: How has law improved outcomes in other states?

Very little is yet known regarding the relationship between required overdose reporting and lowering of the incidence and prevalence of opioid overdose and overdose deaths. However, collecting and tracking overdose data can guide public policy, prevention, and intervention efforts.

### Arizona: Current State and Recommendations

Governor Ducey's Executive Order Enhanced Surveillance Advisory includes a requirement to report within 24 business hours to the Arizona Department of Health Services<sup>37</sup>:

- suspected opioid overdoses;
- suspected opioid deaths;
- naloxone doses administered in response to suspected overdoses;
- naloxone doses dispensed by pharmacists; and
- Neonatal Abstinence Syndrome.

In addition, new emergency rules for licensed health care institutions require reporting of a patient's death within one working day if the death may be related to an opioid prescribed, ordered, or administered as part of treatment.

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<sup>35</sup> <http://164.64.110.239/nmac/parts/title07/07.004.0003.htm>

<sup>36</sup> <http://www.sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/7738.pdf>

<sup>37</sup> <http://www.azdhs.gov/documents/prevention/womens-childrens-health/injury-prevention/opioid-prevention/opioid-faqs-reporting.pdf>

## Neonatal Abstinence Syndrome (NAS)

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9 states have laws in place that require the reporting of Neonatal Abstinence Syndrome.

### Practices from Other States

Georgia, Indiana, Kentucky, Louisiana, Ohio, South Carolina, Tennessee, Texas, and Virginia currently have laws in place requiring NAS to be reported. Montana supports voluntary reporting and New Hampshire allows their Child Protection Services agency to require anyone suspected of child abuse or neglect to undergo drug testing.

In Georgia, reports are required to be provided to the Department of Health within 7 days of identification<sup>38</sup> whereas in Kentucky, reporting is required at the time of diagnosis. In Louisiana, notification of NAS to the Department of Child and Family Services, “*shall not constitute a report of child abuse or parental neglect, nor shall it require prosecution for any illegal action.*” Many states, including Alaska, Connecticut<sup>39</sup>, Florida<sup>40</sup>, Massachusetts, and Illinois<sup>41</sup> have utilized their opioid and Neonatal Abstinence Syndrome task forces and advisory committees to recommend NAS as a reportable incident.

### Impact: How has law improved outcomes in other states?

Long-term developmental outcomes related to NAS are limited<sup>42</sup>. However, including NAS as a reportable condition greatly improves the timeliness of providing in utero and postnatal treatment to affected neonates. Reporting is also very likely to assist public health officials in identifying if specific populations or geographic areas are disproportionately affected by conditions that may contribute to higher incidence and prevalence of NAS.

### Arizona: Current State and Recommendations

Governor Ducey’s enhanced surveillance declaration includes NAS as a reportable condition<sup>43</sup>. Referrals of NAS to the Department of Child Safety continue to be required as directed by A.R.S. 13-3620. On September 12, 2016, the Arizona Statewide Task Force on Preventing Prenatal Exposure to Alcohol and Other Drugs published their *Guidelines for Identifying Substance-Exposed Newborns*<sup>44</sup>. The Arizona Substance Abuse Taskforce dedicated Recommendations 87 through 104 to address and expand NAS initiatives in Arizona.

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<sup>38</sup> <https://dph.georgia.gov/NAS>

<sup>39</sup> [http://www.ct.gov/dph/lib/dph/publications/family\\_health/nas\\_fact\\_sheet\\_2016.pdf](http://www.ct.gov/dph/lib/dph/publications/family_health/nas_fact_sheet_2016.pdf)

<sup>40</sup> [http://myfloridalegal.com/webfiles.nsf/WF/RMAS94LJPF/\\$file/Statewide\\_Task\\_Force\\_on\\_Prescription\\_Drug\\_Abuse\\_and\\_Newborns\\_Final\\_Report.pdf](http://myfloridalegal.com/webfiles.nsf/WF/RMAS94LJPF/$file/Statewide_Task_Force_on_Prescription_Drug_Abuse_and_Newborns_Final_Report.pdf)

<sup>41</sup> <http://www.dph.illinois.gov/sites/default/files/publications/publications-owh-nas-report-ga-042816.pdf>

<sup>42</sup> <https://www.cdc.gov/cdcgrandrounds/pdf/archives/2016/august2016.pdf>

<sup>43</sup> <http://www.azdhs.gov/documents/prevention/womens-childrens-health/injury-prevention/opioid-prevention/faqs-neonatal-abstinence-syndrome.pdf>

<sup>44</sup> [http://www.azdhs.gov/documents/prevention/womens-childrens-health/reports-fact-sheets/high-risk/sen\\_guidelines.pdf](http://www.azdhs.gov/documents/prevention/womens-childrens-health/reports-fact-sheets/high-risk/sen_guidelines.pdf)

**EDUCATION, PREVENTION & TREATMENT INDICATORS**

## Programs for Children and Youth

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States support the implementation of substance use disorder interventions among children and youth. However, specific strategies and initiatives being implemented among states vary widely.

### **Current status of Interventions across the US**

States support the implementation of a variety of substance use disorder interventions among children and youth. However, determining the exact number of states and number and type of programs states are implementing is challenging due to the sheer number of programs that are available to states.

Within the school-setting, we know that the majority of schools across the U.S. require instruction on substance abuse prevention. The Centers for Disease Control and Prevention conducted the National School Health Policies and Practices Study in 2014, and found that 66.7 percent of middle schools and 86.9 percent of high schools require that students receive instruction on alcohol or other drug use prevention.

Longitudinal research has demonstrated that there are individual, family, school and community risk and protective factors that influence an individual's likelihood to use drugs and/or alcohol. Risk and protect factors have implications for the types of policies and prevention program that are likely to be effective in differing age, ethnic and socio-economic demographics. Prevention interventions are often classified into three categories: universal, selective and indicated depending on the risk of substance use the target population presents. While more research is need to determine the most effective mix of these interventions, it is often encouraged for communities to provide multiple levels of prevention programs.

There are multiple repositories of evidence-based prevention programs. One such repository is SAMHSA's National Registry of Evidence-based Programs and Practices<sup>45</sup>(NREPP). According to this registry, there are 132 interventions specific to providing children and youth with substance use disorder prevention and substance use disorder treatment education. In 2016, the U.S. Surgeon General released *Facing Addiction In America*, in which, 600 programs were reviewed and the top 42 prevention programs were categorized based on the target population's age.<sup>46</sup>

At the state level, there have been several federal and state grant opportunities that support the work of community organizations. Such programs include but are not limited to Drug Free Communities and the Strategic Prevention Framework, which have been implemented across multiple states with varying levels of success. These programs have historically received support from federal and state-level grant funding and technical

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<sup>45</sup> <https://www.samhsa.gov/nrepp>

<sup>46</sup> <https://addiction.surgeongeneral.gov/surgeon-generals-report.pdf>

assistance. Most of these programs are designed to empower community coalitions and non-profits to assess the community need, identify appropriate community and school-based interventions, and measure the outcome of the prevention intervention.

Outside of the U.S., a promising model has emerged out of Iceland where they saw significant decreases in past 30-day use among 16-year olds in alcohol consumption (from 42% to 7%), smoking (from 23% to 3%) and marijuana consumption (from 17% to 5%) use over a ten year period. The program worked by engaging communities, government and providers to provide youth alternative activities to drug use from 3- 6 p.m. The program has expanded into multiple European countries.

### **Arizona: Current State and Recommendations**

ARS 15-712 permits, but doesn't require, the instruction on the harmful effects of narcotic drugs, marijuana, date rape drugs, and other dangerous drugs in grades 4-12. The statute also allows instruction to include the harmful effects of drugs on a human fetus in grades 6-12.

Currently, federal Substance Abuse Block Grant funds are being utilized by the Governor's Office of Youth, Faith and Family to implement school-based programs targeting middle and high school youth. Additional prevention programming is funded through sources such as the SAMHSA's Partnership for Success grant, CDC Prescription for States, federal Drug Free Communities grant, and the Arizona Parent's Commission on Drug Education and Prevention, and implemented by a variety of community-based coalitions, non-profits, and county health departments.

The Arizona Substance Abuse Task Force provided several recommendations specific to children and youth.

- Recommendation Number 2  
*Increase funding to support prevention and early intervention activities. Investing in evidence-based prevention and early intervention improves public safety and decreases dollars spent on incarceration and long-term treatment.*
- Recommendation Number 6  
*Engage children and adolescents in building social skills, character, and coping skills, so they have the tools needed to decline when offered substances.*
- Recommendation Number 7  
*Engage youth to take the lead in educating their peers about the consequences of drug use by connecting them with education and supportive resources such as "Safe Talk for Teens."*

- Recommendation Number 8  
*Thoroughly train teens to deliver peer-to-peer prevention and early intervention messages through evidence-based programs. Address vaping (inhaling substances through e-cigarettes and other devices) as part of these programs.*
- Recommendation Number 9  
*Encourage use of the websites [substanceabuse.az.gov](http://substanceabuse.az.gov), [overcomeawkward.org](http://overcomeawkward.org), and [ivegotsomethingbetter.org](http://ivegotsomethingbetter.org) and [ReThinkRxAbuse.org](http://ReThinkRxAbuse.org)*
- Recommendation Number 10  
*Scale prevention programs throughout Arizona in schools to develop drug-free school cultures.*
- Recommendation Number 11  
*Investigate if the Adolescent ASAM (American Society of Addictive Medicine) Screening & Assessment Tool is the most efficacious tool for use in adolescents as well as the most cost effective option for the State.*
- Recommendation Number 12  
*Support the GOYFF's plan to build a Youth Treatment Locator.*
- Recommendation Number 13  
*Disseminate drug abuse prevention/resource toolkits to schools, primary care providers, faith based groups, parent groups, and others who interact with young people.*
- Recommendation Number 16  
*Support efforts to improve the screening and treatment of mental illness, and to screen and treat mental illness at earlier ages.*
- Recommendation Number 33  
*Scale the "Healthy Families – Healthy Youth" substance abuse prevention pilot and ensure its availability to all 7th grade students, parents, and faculty in the state.*
- Recommendation Number 34  
*Engage the Arizona Board of Education to consider a mandate that substance abuse be a part of the required health curriculum.*
  - a. *Utilize specialists and peers to assist in the delivery of evidence-based curricula.*
  - b. *Develop school-based drug prevention programming that builds drug-free culture.*
  - c. *As a part of the required health curriculum, prescreen for potential substance use precursors using the Adverse Childhood Experiences (ACEs) questionnaire and screen for substance abuse using the adolescent Screening, Brief Intervention, and Referral to Treatment (SBIRT) process.*

## **Referral and Access to Substance Abuse Treatment**

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Nearly all states have implemented laws, policies, or initiatives specific to improve referral and access to pain specialists and, or substance abuse treatment. Few states have specific guidance on providing SBIRT and MAT.

Furthermore, as of 2005, 29 states required state-funded providers to use the American Society of Addiction Medicine (ASAM) comprehensive treatment criteria to create personalized plans of care for individuals. The ASAM criteria uses a multi-dimensional assessment to guide the selection of services, which include early intervention, outpatient services, intensive outpatient/partial hospitalization services, residential/inpatient service, and medically-managed intensive inpatient services. Several states have created SAMSHA-grant funded initiatives to create SBIRT programs. Since 2003 SAMHSA has funded 15 State Cooperative Agreement grants for SBIRT programs.<sup>49</sup>

### **Practices from Other States**

State regulatory and purchasing policies may create barriers to MAT. A 2013 Medicaid report found while agencies in every state covered buprenorphine and at least 28 states covered all three MAT medications, many states have implemented policies that restrict their availability. “Between 2011 and 2013, at least 48 states required prior authorization for buprenorphine; at least 34 states imposed quantity limits on buprenorphine and at least 11 states imposed lifetime limits. Comparatively, only 13 states required prior authorization for methadone and 12 states required prior authorization for naltrexone. No state set a lifetime limit on either methadone or naltrexone.<sup>140</sup> Restricting access to legitimate buprenorphine treatment may increase illicit use; difficulty accessing buprenorphine treatment was found to be the most common risk factor associated with diversion.”<sup>50</sup>

In Massachusetts, the Gloucester Police Department developed a voluntary, no-arrest program that provides direct referral for drug detoxification and rehabilitation treatment. This program was featured recently featured in the New England Journal of Medicine for its successful outcomes. Police officers in the program collect demographic information from the participant, call treatment centers to identify a facility for placement, ensure participant’s transportation to the treatment center, and assign a volunteer Samaritan for emotional support if the process takes over a few hours.<sup>51</sup>

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<sup>49</sup> <https://www.integration.samhsa.gov/clinical-practice/sbirt>

<sup>50</sup> <http://nashp.org/wp-content/uploads/2016/09/Rural-Opioid-Primer.pdf>

<sup>51</sup> <http://www.nejm.org/doi/full/10.1056/NEJMc1611640>

In Griswold, Connecticut, state police teamed with the state department to begin the CRISIS Initiative (Connection to Recovery through Intervention, Support and Initiating Services) in June 2017. The project includes a full-time clinical social worker attached to an officer troop in Griswold and a mobile outreach team that can provide round-the-clock intervention services.<sup>52</sup>

In Kentucky, the state department runs a toll-free treatment referral line, called Operation UNITE, for anyone seeking assistance with drug addiction as well as family members in need of support. Staff is available 8-5 M-F to help callers learn about available treatment programs in the region and next steps to enter such programs.<sup>53</sup>

In New Mexico, the state health department works with the University of New Mexico's School of Medicine to run a teleconsultation program, Project ECHO (Extension for Community Healthcare Outcomes) to increase provider training and build treatment capacity for substance use disorders in rural areas. The program connects healthcare providers in rural areas with specialists at a central hub via teleconferencing technology to provide support in patients' care management. The model has spread to other states, including one multi-state collaborative that supports addiction treatment at federally qualified health centers."<sup>54</sup>

**Impact: How has law, policy, or initiative improved outcomes in other states?**

While evidence-based medicine strongly supports the efficacy of MAT in treating opioid use disorder, there is less evidence supporting SBIRT and MAT state-wide initiatives. According to SAMHSA, MAT services are most effective when combined with other behavioral therapies such as counseling to address both the behavioral and physiological components of substance use disorders. "Patient advocates and academics argue that state policies limiting the use MAT may do more harm than good, especially when accounting for the societal cost of untreated addiction. Studies suggest states can strike a balance between rigid utilization." management policies that make it more difficult to receive care and unfettered access.

In 2008, the Massachusetts Medicaid Agency implemented a targeted prior authorization policy that required increasingly frequent prior authorization for prescribing higher doses of buprenorphine, ranging from no prior authorization requirement for doses of 16 mg/day or less up to monthly prior authorization for doses of 32 mg/day or more. As a result, the percentage of individuals receiving dosages beyond the FDA's recommended dose fell from 16.5 to 4.1 percent. Cost savings to the state were minimal, as decreased dosages may have increased the rate of relapse for individuals already receiving buprenorphine, but lowering the availability of higher doses did not negatively affect individuals beginning MAT and may have reduced diversion."<sup>55</sup>

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<sup>52</sup> <http://www.courant.com/community/griswold/>

<sup>53</sup> <http://odcp.ky.gov/Pages/Treatment-Resources.aspx>

<sup>54</sup> <http://nashp.org/wp-content/uploads/2016/09/Rural-Opioid-Primer.pdf>

<sup>55</sup> <http://nashp.org/wp-content/uploads/2016/09/Rural-Opioid-Primer.pdf>



## **Arizona: Current State and Recommendations**

AHCCCS reimburses three FDA approved medications for MAT: methadone, buprenorphine, and naltrexone. No prior authorization is required for use of these medications for opioid replacement therapy, and there are no restrictions on the duration of treatment for MAT for AHCCCS members.

The Arizona Substance Abuse Task Force's 2016 report strongly supports the implementation of Recommendation 77 through 86 to provide education, training, and capacity to provide necessary treatment, referral, SBIRT, and MAT services in Arizona.

Examples of Arizona Substance Abuse Task Force Recommendations:

*77. Increase the number of providers who are trained and licensed to provide MAT in Arizona.*

*79. Create a system of needs assessments for detoxification services, identify gaps, and increase capacity as needed so that appropriate levels of residential detox, inpatient detox, and outpatient detox services are readily available throughout Arizona.*

*80. Encourage the use of evidence-based tools to help determine whether residential, inpatient, or outpatient detoxification is the best choice for a given individual, followed by appropriate assessment and treatment.*

*83. Create targeted strategies for MAT for special populations, for example, individuals involved with the Department of Corrections, pregnant women, Native American communities, and rural communities.*

*85. Support the efforts of the Industrial Commission of Arizona to prevent future opioid addiction among Worker's Compensation beneficiaries and to obtain treatment for individuals who already have SUD.*

*86. Continue to seek federal grant monies to support prevention, early intervention, and treatment efforts in Arizona.*

## **Continuing Medical Education & Medical Training**

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**5** states have laws in place that *require* all medical providers to complete continuing education coursework related to opioid prescribing and chronic pain management.

**0** states have a laws in place that require opioid abuse prevention curriculum be developed and incorporated into academic programs for medical, dental, and nursing students.

### **The National Perspective**

Forty-six states and the District of Columbia require physicians to obtain periodic CME as a condition of maintaining their license to practice medicine<sup>56</sup>. As of December 2015, 23 states require at least some physicians to receive training in pain management or controlled substance prescribing as a condition of obtaining or renewing their license to practice medicine or to specialize in pain management (Davis & Carr, 2016).

The characteristics of these laws vary across states in such attributes as the types of physicians who are required to receive training, the duration and frequency of the training, and the subjects covered. Only five states (CT, IA, MD, SC, and TN) require all or nearly all physicians to obtain periodic CME on such topics as pain management, controlled substance prescribing, or substance use disorders.

In all states with such requirements, they represent a small fraction of the total required CME hours. For example, Connecticut requires that physicians obtain 50 CME hours every two years, but only one CME hour in pain management and controlled substance prescribing every six years. Similarly, Maryland requires all physicians to obtain 50 CME hours every two years, of which only one must be relevant to pain management, proper prescribing, or substance use disorders (Davis & Carr, 2016).

Regarding providing required education on pain and pain management in medical and health profession curricula, Mezei and Murinson (2011) found that of the 104 medical schools they surveyed, only 4 reported having a required pain course and only 16 offered a designated pain elective. Following recent pressure placed on the medical school community as a result of the opioid crisis, medical schools across the United States are beginning to revise their curricula to reflect a need for pain and pain management training in the undergraduate medical school environment<sup>57</sup>. The literature is very unclear what changes, if any, have been made to revise training in other medical and veterinary education training programs. However, a recent offering by John Loeser and Michael Schatman (2017) underscores and highlights the need to include pain and pain management as an absolute requirement for undergraduate and post-medical school training.

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<sup>56</sup> <http://www.medscape.org/public/staterequirements>

<sup>57</sup> <https://www.medpagetoday.com/publichealthpolicy/medicaleducation/56025>

**Impact: How has law improved outcomes in other states?**

In 2012, New Mexico passed SB 215<sup>58</sup> requiring all health care licensing boards to mandate CME training in the treatment of chronic pain. Shortly thereafter, the New Mexico Medical Board (NMMB) developed Rule 16.10.14, requiring physicians and physician assistants to complete 5 hours of CME in pain and addiction between November 1, 2012, and June 30, 2014. Additionally, the NMMB mandated that all physicians and physician assistants sign up with the New Mexico Board of Pharmacy PMP and check the PMP each time a new prescription for chronic opioids is written and every 6 months thereafter (Katzman et al., 2014).

From 2012-2013, a reduction in the quantity of opioid medications prescribed was observed following passage of legislation and rule. Total MME decreased as did MME per prescription. High-dose prescriptions decreased, low-dose prescriptions increased. Prescribing limits were not included in the statutory or rulemaking text.

**Arizona: Current State and Recommendations**

Currently, Arizona does not statutorily require CME. However, several professional licensing boards are currently updating rules to require CME at the request of Governor Doug Ducey. Free CME about opioid prescribing is available online.

Recommendation Number 24, from The Arizona Substance Abuse Task Force Substance Abuse Recommendations report (2016) states, “Require and expand prescriber education regarding opioid use for pain management. Standardized resources for Arizona providers should include information on the dangers of prescribing opioids, SB 1283, and the CSPMP database, and recent federal legislation. These resources should be available online.”

Recommendation Number 28 states, “Engage medical schools, dental schools, veterinarian schools, and higher education programs for nurse practitioners and physician assistants to increase required curricula on substance abuse prevention and treatment.”

**Arizona CME Recommendation:** Consider statutorily requiring 5 hours of CME that reflects guidance provided in Recommendation Number 24. Consider including New Mexico’s SB 215<sup>59</sup> language that includes: a basic awareness of the epidemic of chronic pain as well as opioid abuse, addiction, and diversion; management of pain with non-opioid medications; safer opioid prescribing; identification and management of patients at risk for addiction; and, current state and federal rules and regulations including rules regarding use of the prescription monitoring program.<sup>60</sup>

**Arizona Medical and Health Professions Recommendation:** Follow guidance provided in Recommendation 28 to increase pain management content in medical and nursing schools.

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<sup>58</sup> Relating to Pain Management; Amending the Pain Relief Act; Changing the Name and Composition of the Pain Management Advisory Council; Requiring Continuing Education for Non-Cancer Pain Management, SB 215. 50th Leg., 2nd Sess., N.M. (2012).

<sup>59</sup> <https://www.nmlegis.gov/sessions/12%20Regular/bills/senate/SB0215.html>

<sup>60</sup> New Mexico Prescription Monitoring Program. Available at: <http://www.nmpmp.org>.

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## Resources by Topic

### ***Naloxone***

[https://www.networkforphl.org/\\_asset/qz5pvn/legal-interventions-to-reduce-overdose.pdf](https://www.networkforphl.org/_asset/qz5pvn/legal-interventions-to-reduce-overdose.pdf)

### ***Good Samaritan Laws***

<http://pdaps.org/dataset/overview/good-samaritan-overdose-laws/58caa647d42e073a0b9ab804>

[https://www.networkforphl.org/\\_asset/qz5pvn/legal-interventions-to-reduce-overdose.pdf](https://www.networkforphl.org/_asset/qz5pvn/legal-interventions-to-reduce-overdose.pdf)

### ***Neonatal Abstinence Syndrome (NAS)***

<https://dph.georgia.gov/NAS>

[http://www.azdhs.gov/documents/prevention/womens-childrens-health/reports-fact-sheets/high-risk/sen\\_guidelines.pdf](http://www.azdhs.gov/documents/prevention/womens-childrens-health/reports-fact-sheets/high-risk/sen_guidelines.pdf)

[http://www.ct.gov/dph/lib/dph/publications/family\\_health/nas\\_fact\\_sheet\\_2016.pdf](http://www.ct.gov/dph/lib/dph/publications/family_health/nas_fact_sheet_2016.pdf)

[http://myfloridalegal.com/webfiles.nsf/WF/RMAS94LJPF/\\$file/Statewide\\_Task\\_Force\\_on\\_Prescription\\_Drug\\_Abuse\\_and\\_Newborns\\_Final\\_Report.pdf](http://myfloridalegal.com/webfiles.nsf/WF/RMAS94LJPF/$file/Statewide_Task_Force_on_Prescription_Drug_Abuse_and_Newborns_Final_Report.pdf)

<http://www.dph.illinois.gov/sites/default/files/publications/publications-owh-nas-report-ga-042816.pdf>

<https://www.cdc.gov/cdcgrandrounds/pdf/archives/2016/august2016.pdf>

<http://www.azdhs.gov/documents/prevention/womens-childrens-health/injury-prevention/opioid-prevention/faqs-neonatal-abstinence-syndrome.pdf>

### ***Prescribing Monitoring Program (PDMP)***

<http://www.astho.org/StatePublicHealth/Prescription-Drug-Monitoring-Program-Legislation-Update/7-20-17/>

<http://www.astho.org/Rx/Brandeis-PDMP-Report/>

<https://www.cdc.gov/drugoverdose/policy/successes.html>

### ***Emergency Response***

<http://www.astho.org/StatePublicHealth/Emergency-Declarations-and-Opioid-Overdose-Prevention/6-8-17/>

<http://www.azdhs.gov/documents/prevention/womens-childrens-health/injury-prevention/opioid-prevention/opioid-emergency-declaration.pdf>

### ***Non-Opioid Pain Management***

[https://www.cdc.gov/drugoverdose/pdf/nonopioid\\_treatments-a.pdf](https://www.cdc.gov/drugoverdose/pdf/nonopioid_treatments-a.pdf)

National Safety Council. (2016) Prescription Nation 2016: Addressing America's Drug Epidemic.

<https://www.colorado.gov/pacific/hcpf/pain-management-resources-and-opioid-use>

<https://www.integrativepractitioner.com/whats-new/news-and-commentary/evidence-opens-medicaid-oregon-acupuncture/>

### ***Prescribing Guidelines***

[www.azhealth.gov/opioidprescribing](http://www.azhealth.gov/opioidprescribing)

<http://www.namsdl.org/library/74A8658B-E297-9B03-E9AE6218FA0F05B0/>

### ***Informed Consent***

<http://preventopioidabuse.org/>

Please see [Appendix B](#).

### ***Medical Education and Continuing Education***

<http://www.medscape.org/public/staterequirements>

<https://www.medpagetoday.com/publichealthpolicy/medicaleducation/56025>

Relating to Pain Management; Amending the Pain Relief Act; Changing the Name and Composition of the Pain Management Advisory Council; Requiring Continuing Education for Non-Cancer Pain Management, SB 215. 50th Leg., 2nd Sess., N.M. (2012).

<https://www.nmlegis.gov/sessions/12%20Regular/bills/senate/SB0215.html>

New Mexico Prescription Monitoring Program. Available at: <http://www.nmpmp.org>.



## ***Treatment***

<https://www.integration.samhsa.gov/clinical-practice/sbirt>

<http://nashp.org/wp-content/uploads/2016/09/Rural-Opioid-Primer.pdf>

<http://www.nejm.org/doi/full/10.1056/NEJMc1611640>

<http://www.courant.com/community/griswold/>

<http://odcp.ky.gov/Pages/Treatment-Resources.aspx>

<http://nashp.org/wp-content/uploads/2016/09/Rural-Opioid-Primer.pdf>

<http://nashp.org/wp-content/uploads/2016/09/Rural-Opioid-Primer.pdf>

## ***Practice Management***

<http://www.myfloridalegal.com/newsrel.nsf/newsreleases/9AD68A6580FA8DFD852578A400499E5E>

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4976392/>

<http://www.taftlaw.com/news/publications/detail/941-new-kentucky-pill-mill-bill-places-new-restrictions-on-pain-management-facilities-and-controlled-substances-prescribing>

<https://stacks.cdc.gov/view/cdc/40739/Email>

<http://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2429105>

<http://www.namsdl.org/library/74A8658B-E297-9B03-E9AE6218FA0F05B0/>

## ***Programs for Children and Youth***

<http://legacy.nreppadmin.net/SearchResultsNew.aspx?s=b&q=early+childhood+intervention>

<http://legacy.nreppadmin.net/ViewIntervention.aspx?id=201>

<http://substanceabuse.az.gov/substance-abuse/meeting-body/arizona-substance-abuse-task-force-coalition-leading-substance-abuse>

[http://substanceabuse.az.gov/sites/default/files/files/substance abuse task force final 0.pdf](http://substanceabuse.az.gov/sites/default/files/files/substance%20abuse%20task%20force%20final%200.pdf)

<https://www.samhsa.gov/nrepp>

<https://addiction.surgeongeneral.gov/surgeon-generals-report.pdf>