6 ways states are fighting the opioid epidemic

By Gale Pryor | May 19, 2017

As the White House appears to step back from the opioid crisis — proposing a 95 percent cut in the budget of the Office of National Drug Control Policy —the states are in an all-hands offensive.

In July 2016, the National Governors Association released "A Compact to Fight Opioid Addiction" outlining key targets: Reducing inappropriate prescribing, raising awareness and understanding of addiction, and increasing access to treatment.

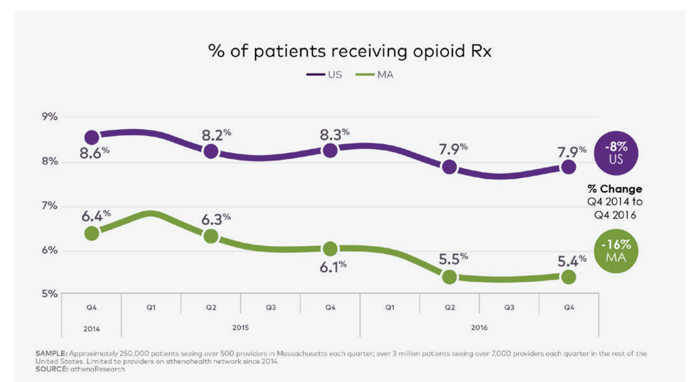
"When you're the governor of a state, you're responsible for four million people, their health, and their lives," former Kentucky Governor Steven L. Beshear said at a recent roundtable symposium at Harvard's T.H. Chan School of Public Health. "[When] you see this kind of thing going on, it is time to step up."

As states sift the evidence for tactics that work, here are the six most effective measures enacted to date. (And for more on the links between tactics and outcomes, see this infographic of state-by-state interventions.)

1. Prescribing limits and guidelines

Thirteen states have set limits on opioid prescribing based on quantities of pills or number of days prescribed. Data from the athenahealth network confirms that legislated limits have an impact on clinical practice.

In Massachusetts, where Governor Charlie Baker enacted a strict limitation law, opioid prescriptions took a sharp downward turn between 2014 and 2016.



But reducing the quantity of pills given to patients and in communities, Massachusetts soon

discovered, is a preliminary step that cannot be taken in isolation. Over the same period, opioid-related deaths rose just as sharply. When patients' access to opioids is cut off without support and treatment, they are at high risk of replacing their supply with lethal street drugs: heroin and fentanyl.

2. Mandatory prescription monitoring

At the Harvard roundtable, Beshear, who served as Kentucky's governor from 2007 to 2015, talked about how his state – among the hardest hit by the crisis — became the first in the nation to establish a mandatory prescription drug monitoring program.

Within a year after passing the 2012 legislation that established the program, Beshear said, Kentucky saw a 30 percent decrease in concurrent prescribing of opioids and sedatives and other potentially lethal combinations. Deaths from prescription opioid abuse dropped 25 percent, the first reduction in nearly a decade.

The program had previously been voluntary, Beshear noted. The Kentucky Medical Association opposed the switch to requiring all providers to check a database before prescribing pain medication, sedatives, or other addictive drugs.

But, Beshear said, "when you get into one of these kinds of crises, I think you have to go a little farther than just voluntary measures."

Other states followed suit and, as of 2017, 49 have established prescription monitoring programs operating under a range of regulations. Mandated monitoring to prevent "doctor shopping" and inadvertent prescribing of drugs in lethal combinations is "the single most effective thing states have done to curb opioid prescribing," according to public health researcher John Eadie, "and it seems to have an almost instantaneous effect."

3. Standards of care

Rhode Island leads the nation in reducing opioid prescribing for pain, with the volume of prescriptions dropping by 16 percent from 2013 to 2015, according to the Pew Charitable Trusts. That lead is set to grow thanks to comprehensive state-wide standards of care for opioid-use disorder in emergency and hospital settings, which the Rhode Island legislature passed in March 2017.

While the specifics of the regulations — from quantity limits to discharge planning — are each important, consistency and clarity for providers may be the initial benefit. James McDonald, M.D., chief administrative officer of Rhode Island's Board of Medical Licensure and Discipline, calls the new regulations "a real paradigm shift" in prescription practices.

"What was surprising to me was how many physicians wanted regulations," McDonald says. "In the absence of the state setting boundaries, they weren't sure where the limits were, so they had no real definition of what to do."

4. Prescriber education

With its new regulations, Rhode Island joins 23 other states that mandate or encourage continuing medical education for all providers who prescribe opioids. In Massachusetts, earning or renewing a medical license is predicated on completing training in pain management, identifying patients at high risk for substance abuse, and counseling patients on the use, side effects, and storage of pain medicine.

"Everyone wants to solve this problem yesterday," says Daniel Alford, M.D., director of Boston Medical Center's Clinical Addiction Research and Education Unit. "Education, in my mind, is the answer, because it allows individualized care — where we allow access for those who need it and not treat with opioids for those who don't."

Many providers in the state and from across the country earn their CME credits from SCOPE of Pain, a course Alford developed with Boston University.

Since its launch in 2013, SCOPE has issued more than 35,000 certificates. After completing the course, 87 percent of participants said they would be making changes in the way they manage pain patients.

5. Expanded access to Naloxone

Naloxone, or Narcan, blocks the effects of opioids to reverse overdoses within minutes. In 2014, the FDA approved the use of one Narcan delivery device for use by the general public. Narcan kits can be distributed, even without a prescription, to first responders, recovery services, needle exchanges, schools and families of patients with opioid abuse disorder in 36 states.

As of January 2017, CVS Pharmacies and other national chains sell the kits over the counter in 35 states.

6. Expanded access to treatment

The most urgent need — treatment — may be the knottiest to implement. Universal access to effective addiction treatment is hampered on many fronts: Insufficient coverage, long waits for behavioral counseling, few residential treatment beds, and a paucity of physicians certified in medication-assisted treatment, or MAT.

While treating opioid-use disorder with Suboxone or Methadone is proven to be effective, few primary care physicians do so, according to data from the athenahealth network. Just 5.7 percent of providers prescribed drugs for opioid dependence in the first quarter of 2017, compared to 4.5 percent of providers in 2014, a slight rise in three years despite relentless demand. To close that gap in Ohio, state officials have streamlined the certification process to become a MAT provider.

Ohio's most powerful action, however, may be establishing the Governor's Cabinet Opiate Action Team to align the work of all its state agencies to fight the epidemic. Its initiatives range from mental healthcare to stable housing and employment services that could reduce the risk of relapse.

Officials are also coordinating support for pregnant, opioid-dependent women to deliver healthy babies and lower NICU costs for Medicaid.

"Fragmentation does not promote good outcomes," says Mark Hurst, M.D., an addiction psychiatrist and medical director for the Ohio Department of Mental Health and Addiction Services. "The more integration you can have and the easier you make it for the patient, most importantly, the better chance you have of adherence to treatment, the better chance you have of good outcomes."

While the states are in the trenches, their impact is limited unless the federal government scales programs proven to work on the local level. Beshear compares their fight to preparing for World War II: "The government is going to have to declare a Manhattan Project, and put the funds in the states."

Gale Pryor is an associate editor of athenaInsight. David Levine contributed to this article.

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