THE OPIOID EPIDEMIC

Nebraska's response to a national crisis

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A Legislative Research Office Backgrounder

Prepared by
Kate Gaul
Research Analyst

Designed by
Logan Seacrest
Research Analyst

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INTRODUCTION

On average, 115 Americans die every day after overdosing on opioids[1], a class of narcotics that includes the prescription painkillers oxycodone, hydrocodone, and morphine; the illegal drug heroin; and fentanyl, a powerful synthetic opioid intended to treat the intense pain of terminal cancer patients, but which can be illicitly manufactured and used to "cut" heroin or cocaine, to deadly effect.

Deaths from prescription opioids—the driving factor of this epidemic—have more than quadrupled since 1999.

At the direction of the President, the acting secretary of the U.S. Department of Health and Human Services declared opioid abuse a nationwide public health emergency in 2017. The declaration required federal agencies to temporarily shift portions of their existing budgets to focus on the public health emergency.

Six states—Alaska, Arizona, Florida, Maryland, Massachusetts, and Virginia—have declared their own states of emergency to better direct resources within their borders.

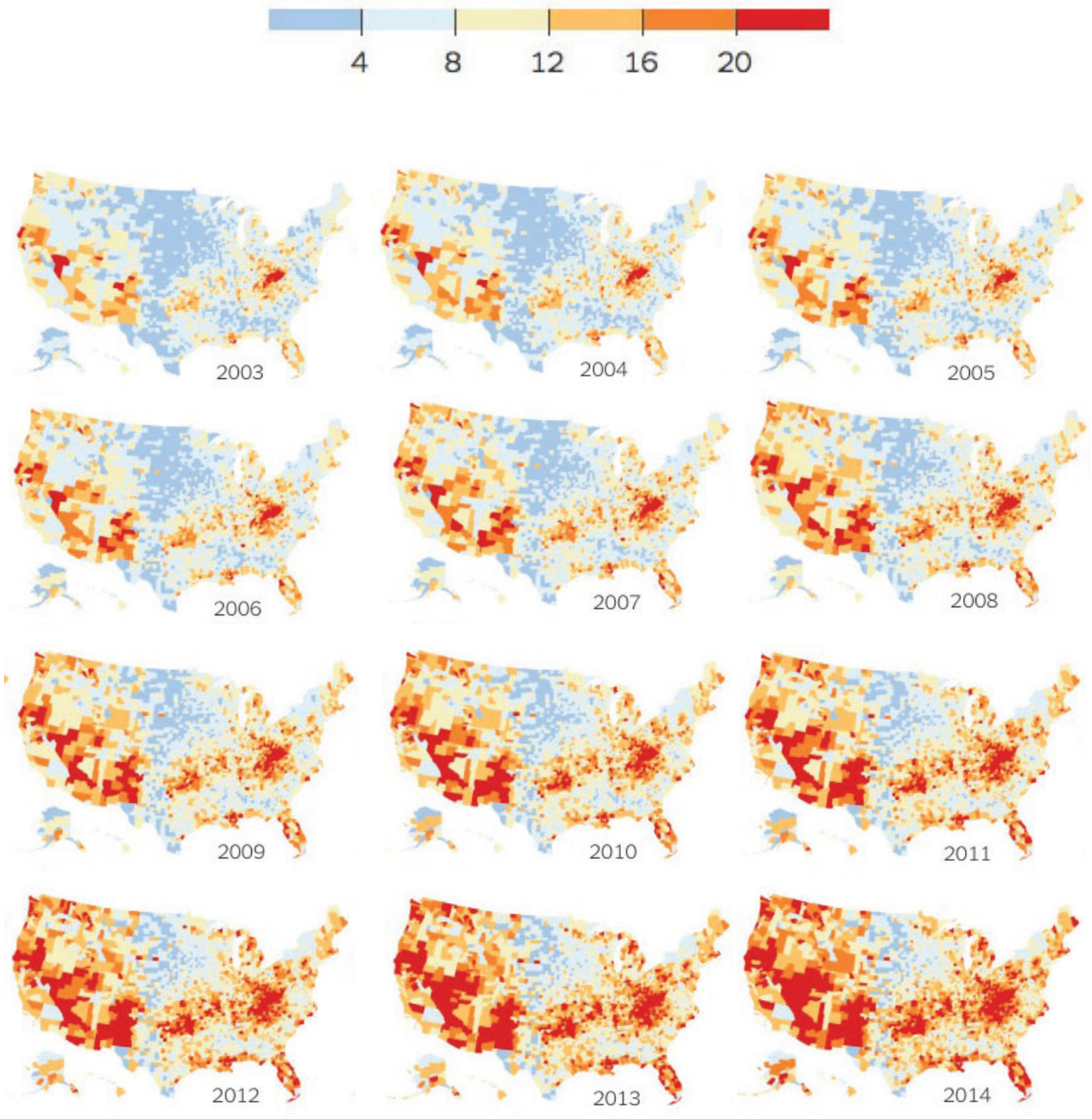
However, not all states are experiencing the opioid crisis to the same degree. Nebraska—where meth remains the chief concern of law enforcement and alcohol the primary drug of abuse—is fortunate to be among those states apparently less affected by opioids.

Data from the Nebraska Department of Health and Human Services (DHHS) shows a slight decrease in opioid-related deaths in Nebraska over the last decade, from 2.4 deaths per 100,000 residents in 2005 to 2.2 per 100,000 in 2016. The national average is 10.4, as reported by the Kaiser Family Foundation, which ranked Nebraska last in its state ranking of drug overdose deaths in 2015.[2]

Has Nebraska just been lucky? Or has the state taken steps to achieve this ranking and are we on a path to sidestep the epidemic? This Backgrounder reviews the policies adopted by the Legislature, state agencies, and private entities to address opioid misuse; discusses recommendations by experts for best practices; and provides a resource for individuals who may need help for themselves or another person struggling with opioid addiction.

Notably, this report does not discuss in any detail the opioid crisis facing so many states and the nation as a whole. Much has been written about this and information is readily available from many sources. However, this Backgrounder provides various graphics that illustrate the unparalleled depths of the opioid drug epidemic in America.

Opioid Overdose deaths per 100,000



SOURCE: Centers for Disease Control and Prevention (CDC)

Nebraska's Legislative Response

The Nebraska Legislature has addressed prescription opioid abuse by adopting and strengthening an electronic prescription drug monitoring program; relaxing rules for administering life-saving, overdose reversing drugs; and granting immunity from prosecution for drug crimes related to individuals who call for help during an apparent overdose.

Prescription Drug Monitoring

Former state Senator Gwen Howard called prescription drug abuse the "fastest growing drug problem in the country" in 2011 when she introduced LB 237, initiating a prescription drug monitoring program in Nebraska.[3]

Prescription drug monitoring programs are among the most widely adopted state responses to the opioid crisis. Every state except Missouri operates a statewide monitoring program. The design of the programs vary, but the essential element of each program is an electronic prescription drug database. The database collects information entered when pharmacists or their designees dispense an opioid prescription. That information is then available to physicians and other authorized users.

Nebraska was not the first state to enact a monitoring program. When Senator Howard introduced LB 237 in 2011, at least 37 states had some form of an operational monitoring program.[4] Since then, however, Nebraska has gone further than any state in creating a program that, beginning January 2018, tracks ***every*** prescription drug dispensed within the state in order to provide patients' complete medication histories.

LB 237 provided legislative intent to "establish a system of prescription drug monitoring for the purposes of (1) preventing the misuse of prescription drugs in an efficient and cost-effective manner and (2) allowing doctors and pharmacists to monitor the care and treatment of patients for whom a prescription drug is prescribed to ensure that prescription drugs are used for medically appropriate purposes and that the State of Nebraska remains on the cutting edge of medical information technology."[5]

The bill authorized DHHS to work collaboratively with the Nebraska Health Information Initiative (NeHII)[6] or any similar successor entity to establish a system enabling doctors and pharmacists to track prescriptions. LB 237 did not authorize any state funding and proposed using NeHII's already established technological infrastructure.

The limits of this initial legislation were quickly recognized. An early roadblock was the prohibition in LB 237 on the use of state funds, which also prevented the receipt of grant funds that flowed through a state agency. This prohibition was remedied with the passage of **Laws 2014, LB 1072**, which created the Prescription Drug Monitoring Fund and allowed DHHS to receive state funds, grants, and gifts to establish and operate a monitoring program.

How Drug Monitoring Works

Health Care Providers

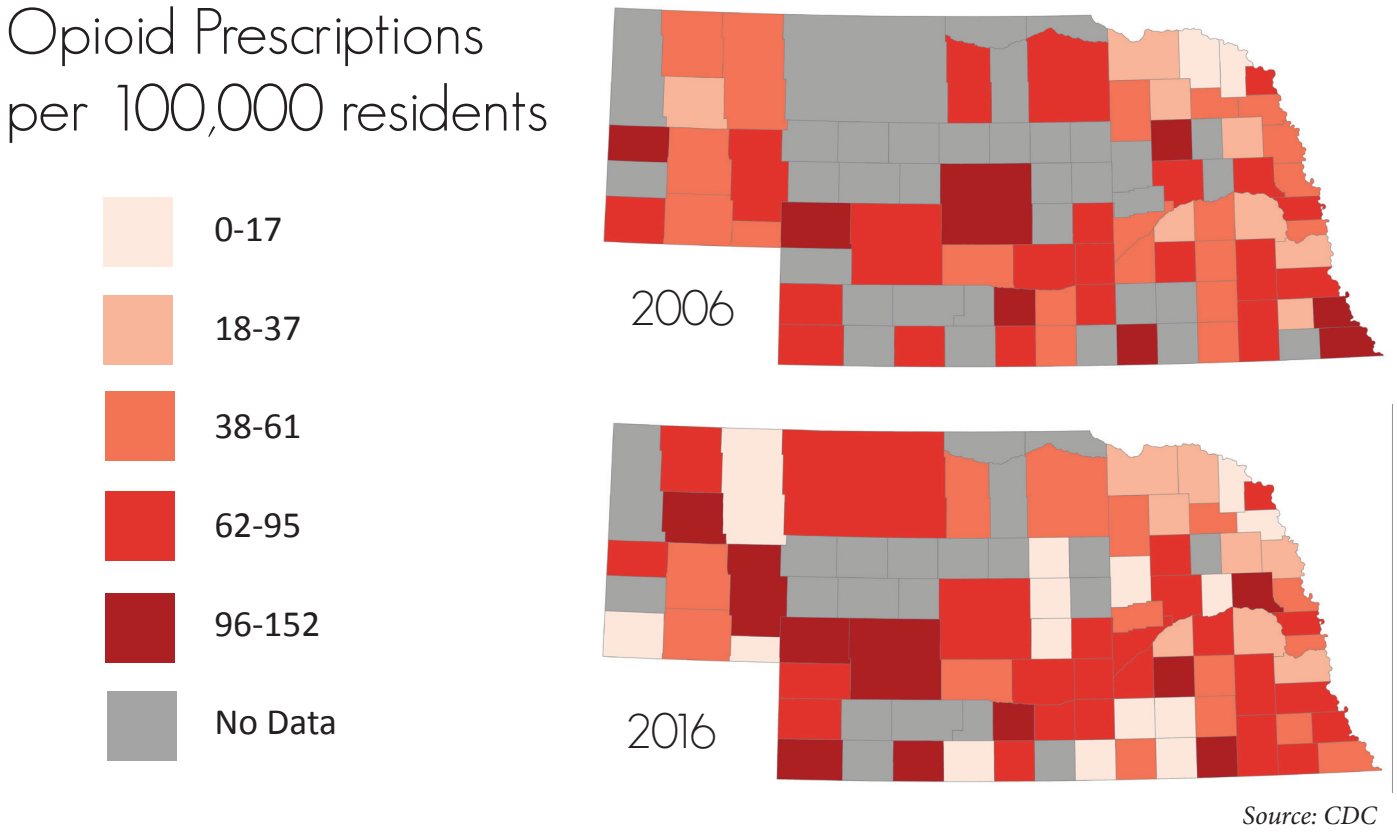
Prescription Drug Monitoring Programs

Pharmacies

Laws 2016, LB 471 provided structure for Nebraska's drug monitoring program. Beginning in January 2017, LB 471 requires every dispensed prescription for a controlled substance to be reported by the dispenser or the dispenser's designee to the drug monitoring program. Beginning January 2018, the bill requires all prescription information to be reported.[7]

Certain information must be included about each prescription reported to the monitoring program:

- The patient's name, address, and date of birth;
- The name and address of the pharmacy dispensing the prescription;
- The date the prescription is issued;
- The date the prescription is filled;
- The name or National Drug Code number of the dispensed drug;
- The strength of the drug prescribed;
- The quantity of the drug prescribed and the number of days' supply; and
- The prescriber's name and National Provider Identifier number or Drug Enforcement Administration number when reporting a controlled substance.



Source: CDC

LB 471 allowed for some exemptions to the prescription medication reporting requirements. They are:

- The delivery of prescription drugs for immediate use for purposes of inpatient hospital care or emergency department care;
- The administration of a prescription drug by an authorized person upon the lawful order of a prescriber;
- Wholesale drug distributors; or
- Licensed veterinarians when dispensing prescriptions for animals in the usual course of providing professional services, through December 31, 2017.

Importantly, LB 471 prohibited patients from opting out of having their prescription drug information entered into the monitoring system; required dispensers or their designees to enter the prescription information daily after dispensing each prescription; allowed prescribers and dispensers of prescription drugs or their designees to access the system at no cost; and assured that the information contained in the program was confidential. Patient-identifying data cannot be released or disclosed except to authorized users of the monitoring program.

Additionally, because persons seeking to conceal a narcotics habit often pay cash in the hopes their health insurance carriers will not track the doctor-shopping behavior, LB 471 requires pharmacists to enter prescriptions regardless of whether the drugs are paid by cash, private insurer, or Medicaid or Medicare.

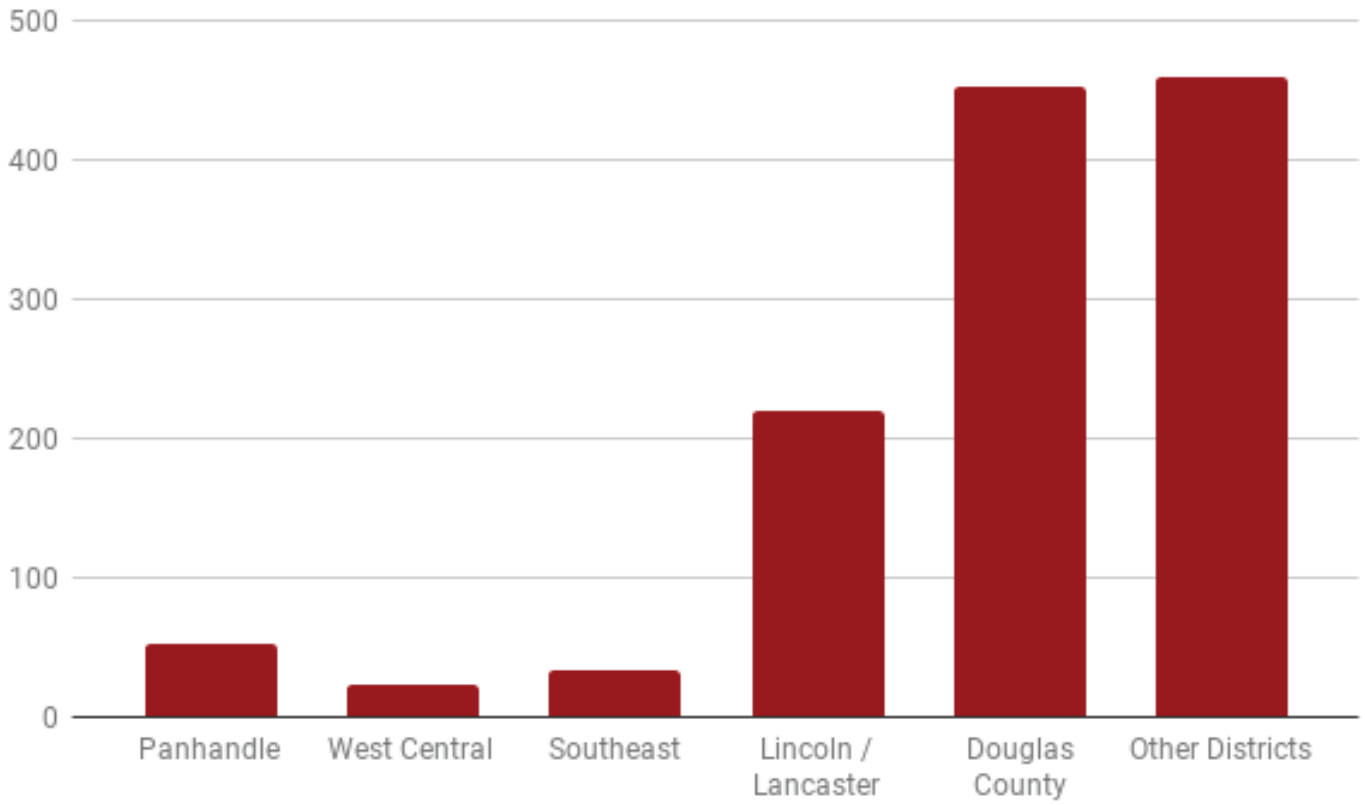
The Legislature did not appropriate funds to carry out LB 471. However, the bill's fiscal note indicated DHHS had secured two federal grants to help pay for implementing the program and for ongoing maintenance costs.

Finally, **Laws 2017, LB 223** establishes training requirements for users of the monitoring program and addressed how prescribing veterinarians would be brought into the program. Beginning July 1, 2018, prescribing veterinarians are required to enter controlled substance prescriptions dispensed from their offices.

LB 223 also contains technical changes, including assuring the program's confidentiality standards comply with the federal Health Insurance Portability and Accountability Act (HIPAA).

Opioid Drug Overdose Deaths by Nebraska Health District (2006-2015)

Source: DHHS



Common Prescription Opioids

- Oxycodone (Brand names: OxyContin, Percodan, Percocet)
- Hydrocodone (Brand names: Vicodin, Lortab, Lorcet, Norco)
- Diphenoxylate (Brand name: Lomotil)
- Morphine (Brand names: Kadian, Avinza, MS Contin)
- Codeine (Various brand names)
- Fentanyl (Brand name: Duragesic)
- Hydromorphone (Brand name: Dilaudid)
- Meperidine (Brand name: Demerol)
- Methadone (Various brand names)

Reversing drug overdoses and calling for help

With the passage of **Laws 2015, LB 390,** Nebraska took steps to help people survive opioid overdoses by making naloxone more widely available. Naloxone is an opioid antagonist that blocks or reverses the effects of opioids. Sold under the brand name Narcan, the medication operates much like an Epipen in reversing allergic reactions.[8]

LB 390 provides immunity from administrative and criminal liability for specific groups of persons using naloxone on individuals who are or appear to be overdosing on opioids, thereby allowing naloxone to be used by persons outside of a hospital, clinic, or other emergency setting.

LB 390 removes the threat of administrative action or criminal liability from health professionals[9] when prescribing, administering, or dispensing naloxone to (1) a person who is apparently experiencing or who is likely to experience an opioid-related overdose or (2) a family member, friend, or other person in a position to assist a person who is apparently experiencing or who is likely to experience an opioid-related overdose.

Further, the law protects family members, friends, or others who administer naloxone obtained from a health professional provided the person administering it acts in good faith. And, LB 390 exempts emergency responders and peace officers from administrative action and criminal prosecution, when acting in good faith, they obtain naloxone from their respective agencies and administer it to overdose victims.

Laws 2017, LB 487 extends limited legal immunity from prosecution under criminal drug laws to individuals who call for help when they or another person overdose. The call must be made in good faith and as soon as the drug overdose is apparent. When emergency medical assistance is requested for another, the caller must remain on the scene until help arrives and cooperate with the emergency medical responders and law enforcement personnel. The law mirrors legislation passed in 2015 that provides limited immunity to underage individuals seeking help for acute alcohol intoxication.

Nebraska's state agencies respond

The state's Attorney General and DHHS are among state agencies actively involved in efforts to prevent opioid misuse.

In 2016, under guidance from the Attorney General's Office, the Nebraska Coalition to Prevent Opioid Abuse formed after a summit at the University of Nebraska Medical Center drew participants from the fields of medicine, social services, government, and law enforcement. A year later, the coalition released its first Strategic Initiative Report,[10] detailing efforts in three broad areas:

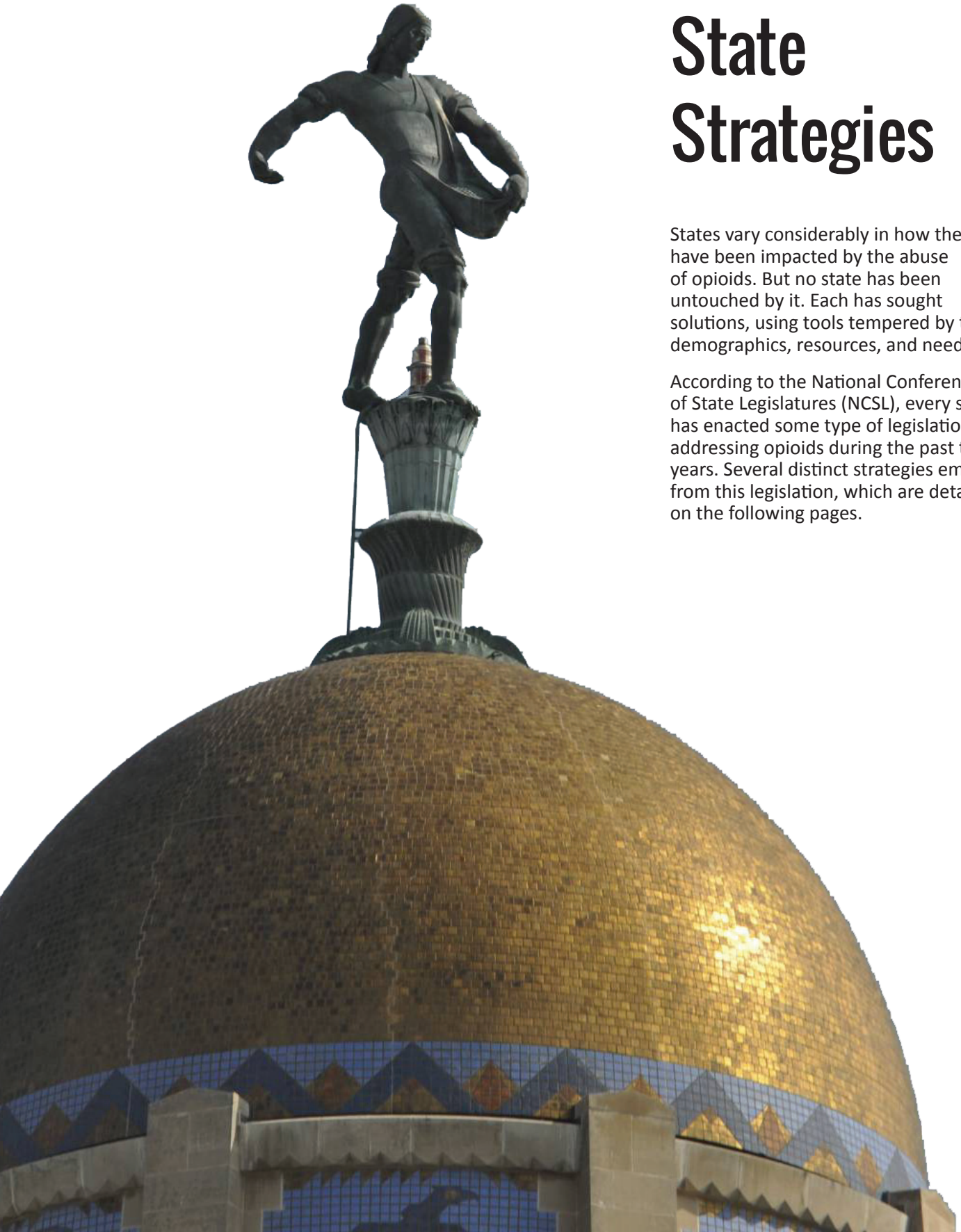
- Prevention
  - Prescription drug take back
  - Prescription drug overdose prevention
  - Dose of Reality educational campaign
  - Broader access to naloxone
- Treatment
  - Getting more health care professionals certified to prescribe buprenorphine in order to be able to help addicts get clean using medication-assisted treatment
  - Getting health professionals and students trained in the evidence-based diagnosis and treatment of opioid use disorder
- Law enforcement
  - Developing a collaborative approach to curtailing drug trafficking between local, state, and federal law enforcement[11]
  - Ensuring safety of front-line law enforcement with guidelines developed by the State Patrol Crime Laboratory on the safe handling of fentanyl and fentanyl-related compounds, which are highly dangerous to breathe or touch.

DHHS plays a key role in the state's drug abuse prevention strategies, particularly the divisions of Behavioral Health and Public Health. DHHS has received several federal grants[12] in support of the divisions' activities promoting prevention, expanding treatment, and supporting recovery from opioid addiction.

Activities include:

- Ongoing collaboration with NeHII to enhance and maximize Nebraska's drug monitoring program by increasing medical providers access to and use of the program and using the program data for public health surveillance;
- Training providers in pain management. DHHS partnered with the Nebraska Medical Association and practicing clinicians to produce the *Nebraska Pain Management Guidance Document*;[13]
- Publicizing the Dose of Reality educational material;
- Promoting and expanding safe prescription drug disposal initiatives. In particular, the Nebraska Meds Coalition, a private group, sponsors a statewide drug disposal network;
- Creating and promoting evidence-based opioid prevention strategies, especially geared to providers of drug abuse prevention services.

DHHS is also actively working to expand the number of prescribers of buprenorphine (medication-assisted treatment), naloxone (overdose remedy), and implementing the ECHO model in Nebraska. The ECHO model links primary care providers with an expert specialist team to increase competencies and best practice treatment statewide.



State Strategies

States vary considerably in how they have been impacted by the abuse of opioids. But no state has been untouched by it. Each has sought solutions, using tools tempered by their demographics, resources, and needs.

According to the National Conference of State Legislatures (NCSL), every state has enacted some type of legislation addressing opioids during the past two years. Several distinct strategies emerge from this legislation, which are detailed on the following pages.

Naloxone

All 50 states have modified their statutes to increase access to naloxone.

Historically, state practice laws prohibited prescribing medications to third parties or to someone with whom the prescriber does not have a doctor-patient relationship. But allowing "standing order" prescribing for naloxone is important to be able to use it in emergencies, whether by the drug user, a family member or friend, or first responders.

Increasingly, law enforcement agencies are issuing naloxone to officers for their use in cases of accidental exposures to highly toxic substances such as fentanyl, which can be absorbed through contact with the skin.

Doctors are also concerned about liability. In concert with laws liberalizing naloxone availability, states are expanding so-called Good Samaritan laws to grant civil and criminal immunity to persons administering naloxone in good faith and to persons who call 911 seeking medical help in cases of overdose.

Prescription Drug Monitoring Programs

Forty-nine states operate some form of a prescription drug monitoring program, so recent legislative activity has focused on mandatory check and reporting requirements for providers and dispensers and additional authority for other entities to access the databases. States are also looking at interoperability with other states' monitoring programs to strengthen prescription drug monitoring programs and prevent one state from pushing its problems across its borders.

The Centers for Disease Control and Prevention (CDC) describes a successful monitoring program as having four components: (1) Requiring prescribers to check the database before writing an opioid prescription; (2) having dispensers enter information about dispensed prescriptions within five minutes of dispensing them (called "real-time"); (3) actively managing the information in order to provide alerts to users of overprescribing and other trends[14]; and (4) making monitoring programs easy to sign up for, sign on to, and navigate.

In 2014, the Congressional Research Service reviewed monitoring programs and found such programs effective in (1) reducing the time required for drug diversion investigations by law enforcement, (2) changing prescribing behavior, (3) reducing doctor shopping, and (4) reducing prescription drug abuse. Unintended consequences, however, included limiting access to medications for legitimate use. There is also concern that the crackdown on prescription opioids has led users to heroin and illegally manufactured fentanyl.

Pending Legislation in Nebraska (2018)

LB 788 would require continuing education for certain health-care professionals to include information on prescribing opiates.

LB 923 would provide immunity for administering naloxone to law enforcement employees and contract employees who regularly handle evidence or property that may include or contain opioids.

LB 931 would set a seven-day limit on new prescriptions of opioids for patients who are younger than age 19 diagnosed with an acute (or temporary) condition.

LB 932 would require discharge planning for state inmates to include whether an inmate should receive medication-assisted treatment for opioid addiction.

LB 933 would require medical practitioners to discuss with their patients the dangers of addiction and overdose before prescribing opioids

LB 934 would require individuals to present identification before picking up an opioid prescription.

Provider training and pain clinic regulation

Such provisions set continuing education or medical education requirements for health care providers related to prescribing opioids. Some states have also included recognizing substance use disorders in educational requirements.

The National Alliance for Model State Drug laws reports that 23 states[19] and the District of Columbia have requirements, either in statute, regulation, or board guidelines, for practitioners to obtain a certain number of continuing education hours in one or more of the following: prescribing controlled substances, pain management, and identifying substance use disorders. Some states leave discretion to the state board whether to make such continuing education mandatory, while other states require the training by statute.

Pain clinics are facilities specializing in treating chronic pain. Such clinics are a valuable part of the medical landscape, but states are cracking down on the bad actors, known derisively as “pill mills.” Pill mills can be doctor’s offices, clinics or any health care facilities that routinely prescribe controlled substances outside the scope of standard medical practice and often in violation of state laws.

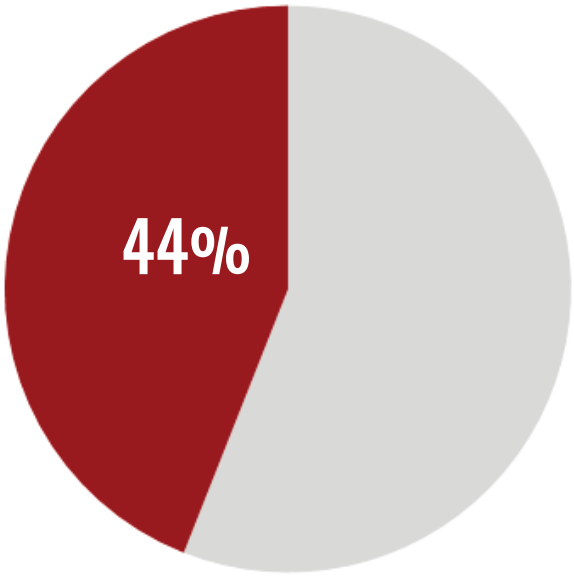
Legislation in this area seeks to assure sufficient state oversight through registration and licensure laws. Other legislative efforts regarding pain clinics or pain management practice include requiring they follow prescribing guidelines and use state prescription drug monitoring programs. At least 12 states have enacted laws addressing practices at pain clinics or for pain management services.[20]

Opioid prescribing guidelines or limits

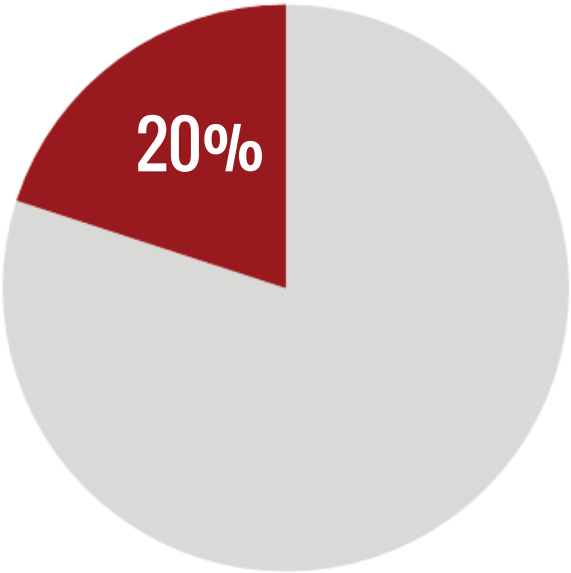
Such guidelines or limits typically set the number of days’ supply for an initial opioid prescription, with some exceptions (e.g., cancer treatment or palliative care). According to NCSL, 24 states[15] had enacted legislation setting some type of limit, guidance, or requirement pertaining to opioid prescriptions by 2017.

The CDC has issued opioid prescriber guidelines, which have been adopted, in whole or in part, by 24 states in their Medicaid programs. (Nebraska is one of those states, adopting the guidelines in its traditional fee-for-service Medicaid program and as a requirement for Medicaid managed care organizations to adopt.)[16]

Percent of Americans that know someone who has been addicted to Rx painkillers



Percent of Americans that know someone who has died from a Rx painkiller overdose



SOURCE: Kaiser Family Foundation

What to do and where to go when you need help

Given the prevalence of prescription opioid and illegal drug use, even in a "safe" state such as Nebraska, the unfortunate situation is that anyone can have a friend, a family member, or other loved one with a drug problem. Sometimes that friend looks back at you from the mirror.

In Nebraska, for those seeking or ready to receive help, what can you do? The information below is intended to provide some initial guidance.

Risk factors for opioid addiction

- ✓ Having depression, anxiety, or other mental illness
- ✓ A personal and/or family history of alcohol or substance abuse
- ✓ A history of physical, mental, or sexual abuse
- ✓ Obtaining overlapping prescriptions from multiple providers and pharmacies
- ✓ Taking high daily doses of prescription opioids
- ✓ Long-term use of prescription opioids
- ✓ Living in rural areas and having low income

Recognizing an opioid overdose

Recognizing an opioid overdose can be difficult. If you are unsure, it is best to treat the situation like an overdose: Call 911 and do not leave the person alone. Signs of an opioid overdose can include any of the following:

- ✓ Small, constricted "pinpoint pupils"
- ✓ Falling asleep or loss of consciousness
- ✓ Slow, shallow breathing
- ✓ Choking or gurgling sounds
- ✓ Limp body
- ✓ Pale, blue, or cold skin

Seeking treatment

A simple step to getting help can begin with a discussion with a primary care physician.

Individuals can also:

- Seek a drug and alcohol evaluation. In Nebraska, such evaluations can be conducted by licensed substance abuse counselors and mental health counselors. An evaluation can point the way to the proper treatment, which isn't necessarily the traditional 30-day inpatient stay.
- Talk to a peer in an anonymous call to Narcotics or Alcoholics Anonymous.
- Visit an informational website. DHHS has compiled a "Consumer Substance Misuse Quick Reference Sheet," available online at http://dhhs.ne.gov/publichealth/PDMP/Documents/Consumer%20Substance%20misuse%20quick%20reference_v4.pdf.

Additional resources

Coalition Rx is a private, nonprofit advocacy and education organization. In October 2017, the organization sponsored a daylong seminar on "The State of Prescription Drug Abuse in Nebraska." The group's strength is networking across disciplines, bringing together first responders, providers, law enforcement, academia, and government. Staff is also available to do presentations at schools, through its Dillon's House initiative, created because of the accidental opioid overdose death of an Omaha teen in the basement of the family home in 2010.

Coalition Rx can be reached at 402-552-2221.

Nebraska Regional Poison Center operates a 24-hour emergency phone service that is used by professionals and the general public alike. The poison center also provides educational information and professional training, conducts research in the field of clinical toxicology, and assists first responders during hazardous materials incidents.

The poison center's toll-free number is 800-222-1222.

Nebraska Meds Coalition sponsors the safe disposal of prescription and over-the-counter medication through a network of participating pharmacies. Because of the Nebraska MEDS Coalition, Nebraska is one of only two states in the nation to operate a statewide drug disposal program. (Iowa is the other one.)

For a list of participating pharmacies—there are nearly 300 across the state—or more information about proper disposal of medication, the Meds Coalition number is 800-222-1222.

END NOTES

1. *Increases in Drug and Opioid-Involved Overdose Deaths – United States 2010-2015,* Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, Dec. 2016.

2. For other states' overdose rankings, see the Legislative Research Office's 2017 *Nebraska At-A-Glance,* available online.

3. Neb. Rev. Stat. secs. 71-2454 to 71-2456.

4. According to the Alliance of States with Prescription Monitoring Programs, operational programs have the capacity to receive and distribute controlled substance prescription information to authorized users. In October 2011, Nebraska was included as one of 11 additional states to establish a prescription drug monitoring program that was not yet operational.

5. Laws 2011, LB 237, sec. 1.

6. Established in 2005 by health care providers and health insurers, NeHII is a statewide, internet-based 501(c)3 nonprofit health information exchange that allows providers and insurers to electronically access and share patient records.

7. The bill granted an exemption for controlled substances prescribed by veterinarians. The delay was intended to provide for a study to determine what controlled substances veterinarians should report and how they should be reported. To conduct the study and make recommendations, LB 471 created the Veterinary Prescription Monitoring Program Task Force.

8. Naloxone is a life-saver in its ability to temporarily reverse the effects of an opioid drug overdose, generally acting within two to five minutes when administered nasally or subcutaneously, and requires little to no training to administer. (Naloxone can also be administered intravenously, reacting within one to three minutes.) In clinical settings, naloxone has been used for more than 40 years to treat drug overdose. Naloxone is not a narcotic and, although it does have side effects, it is not addictive. Successive doses can be administered. However, naloxone's effects last 30 to 90 minutes, meaning most overdose victims should receive additional medical treatment.

9. Neb. Rev. Stat. sec. 28-470(d) defines "health professional" to mean a physician, physician assistant, nurse practitioner, or pharmacist licensed under the Uniform Credentialing Act.

10. The full report is available on the Nebraska Attorney General's website: Nebraska Coalition to Prevent Opioid Abuse Strategic Initiatives Report 2017

11. The U.S. Drug Enforcement Administration (DEA) developed its "360-degree strategy" for collaboration with local law enforcement and initiated the program in four pilot cities, none of which were in Nebraska. However, the collaborative model is being used, as evidenced by the giant fentanyl bust in Omaha in October 2017, according to the coalition report.

12. The awards include, a two-year $2 million State Targeted Response to the Opioid Crisis grant from the Substance Abuse and Mental Health Services Administration; a CDC Prescription Drug Overdose Prevention for States Grant, funding for September 2015 to August 2019 of $3,084,996; and a Department of Justice Comprehensive Opioid Abuse Site-based Program Grant, funding for

END NOTES

October 2017 to September 2020, total award $600,000.

13. The document is available online at http://dhhs.ne.gov/publichealth/PDMP/Documents/Nebraska%20Pain%20Management%20Guidance%20Document%20v3.2.pdf

14. Recently, Nebraska's drug monitoring program has begun to proactively alert physicians when a patient has received high dosages of opioids in the past seven to 30 days, signaling to the provider the patient may be at higher risk for adverse events such as a possible overdose.

15. Alaska, Connecticut, Hawaii, Indiana, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Nevada, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, Utah, Vermont, Virginia, Washington, and Wisconsin.

16. A Fact Sheet summarizing the guidelines can be found online at https://www.cdc.gov/drugoverdose/pdf/Guidelines_Factsheet-a.pdf.

17. Bachhuber, Marcus A., et al. "Medical Cannabis Laws and Opioid Analgesic Overdose Mortality in the United States, 1999-2010." JAMA Internal Medicine, vol. 174, no. 10, Jan. 2014, p. 1668., doi:10.1001/jamainternmed.2014.4005.

18. Powell, David, et al. "Do Medical Marijuana Laws Reduce Addictions and Deaths Related to Pain Killers?" July 2015, pp. 1-36., doi:10.3386/w21345.

19. Alabama, Arizona, California, Connecticut, Florida, Georgia, Idaho, Iowa, Kentucky, Massachusetts, Michigan, Mississippi, Nevada, New Mexico, North Carolina, Ohio, Oregon, Pennsylvania, South Carolina, Tennessee, Utah, Vermont, and West Virginia.

20. Alabama, Florida, Georgia, Indiana, Kentucky, Louisiana, Mississippi, Ohio, Tennessee, Texas, West Virginia, and Wisconsin.

IMAGE CREDITS

- Getty Images
- Nebraska Department of Health and Human Services
- Centers for Disease Control and Prevention
- Scientific American
- Reuters
- Wikimedia Commons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