



City of Long Beach

Working Together to Serve

Memorandum

Date: March 19, 2018
To: Patrick H. West, City Manager *T.M.*
From: Kelly Colopy, Director of Health and Human Services *KC*
For: Mayor and Members of the City Council

Subject: Opioid Prescribing Public Health Detailing Campaign

On October 10, 2017, the City Council directed the City Manager and Department of Health and Human Services (DHHS) to report back on the feasibility, strategy, and potential benefits of conducting a public health detailing campaign on promoting judicious opioid prescribing among Long Beach doctors, and other applicable healthcare staff.

Discussion of Strategies and Potential Benefits

Background and Scope of the Problem

Opioids are a class of drugs that include the illicit drug heroin, as well as the licit prescription pain relievers, oxycodone, codeine, morphine, fentanyl, and others¹. Drug overdoses are the leading cause of accidental death nationwide².

In 2015, in the United States alone, 20,101 overdose deaths were attributed to prescription pain relievers, and 12,990 overdose deaths were attributed to heroin³. In California, in 2016, there were 1,925 deaths attributed specifically to opioids, including at least 234 fentanyl deaths⁴.

Long Beach

Irregularities with the way the data points are defined, and the way these data are reported, make it challenging to determine the exact number of opioid deaths in Long Beach. Sources include or exclude different drugs in their definition of opioids, some use age adjusted rates, and most do not contain denominators to aid in comparison across regions.

Data provided by the Los Angeles County Coroner's Office show 51 Long Beach deaths attributed to opioid overdose in 2016⁵. Tables 1 and 2 show these deaths by zip code and race. According to these data, the zip codes with the highest number of deaths were 90802 and 90813. Caucasians were, by far, the racial group with the highest number of opioid overdose deaths.

¹ National Institute of Drug Abuse. (2015) *Drugs of Abuse: Opioids*. Bethesda, MD.

² Paulozzi MD, Jones PharmD, Mack PhD, Rudd MSPH. *Vital Signs: Overdoses of Prescription Opioid Pain Relievers – United States, 1999-2008*. Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. 2011:60:5.

³ Rudd, RA, Seth P, David F, Scholl L. Increases in Drug and Opioid-Involved Overdose Deaths – United States, 2010-2015. *MMWR Morb Mortal Wkly Rep* 2016;65:1445-1452.

⁴ California Opioid Overdose Surveillance Dashboard. Accessed at https://pdop.shinyapps.io/ODdash_v1/.

⁵ Los Angeles County Coroner's Office data provided to DHHS, January 2017.

Table 1

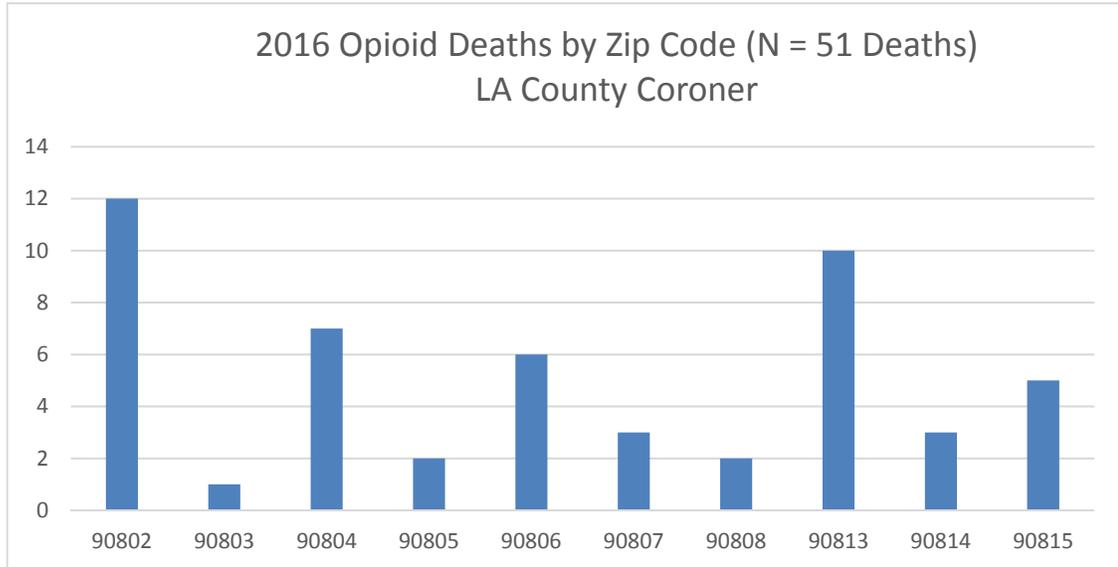
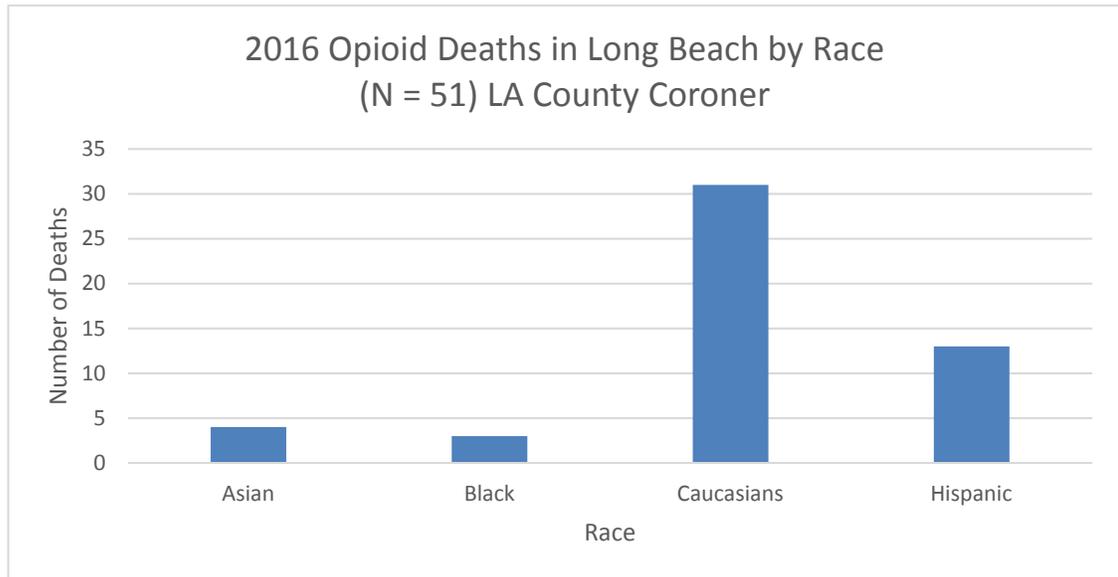


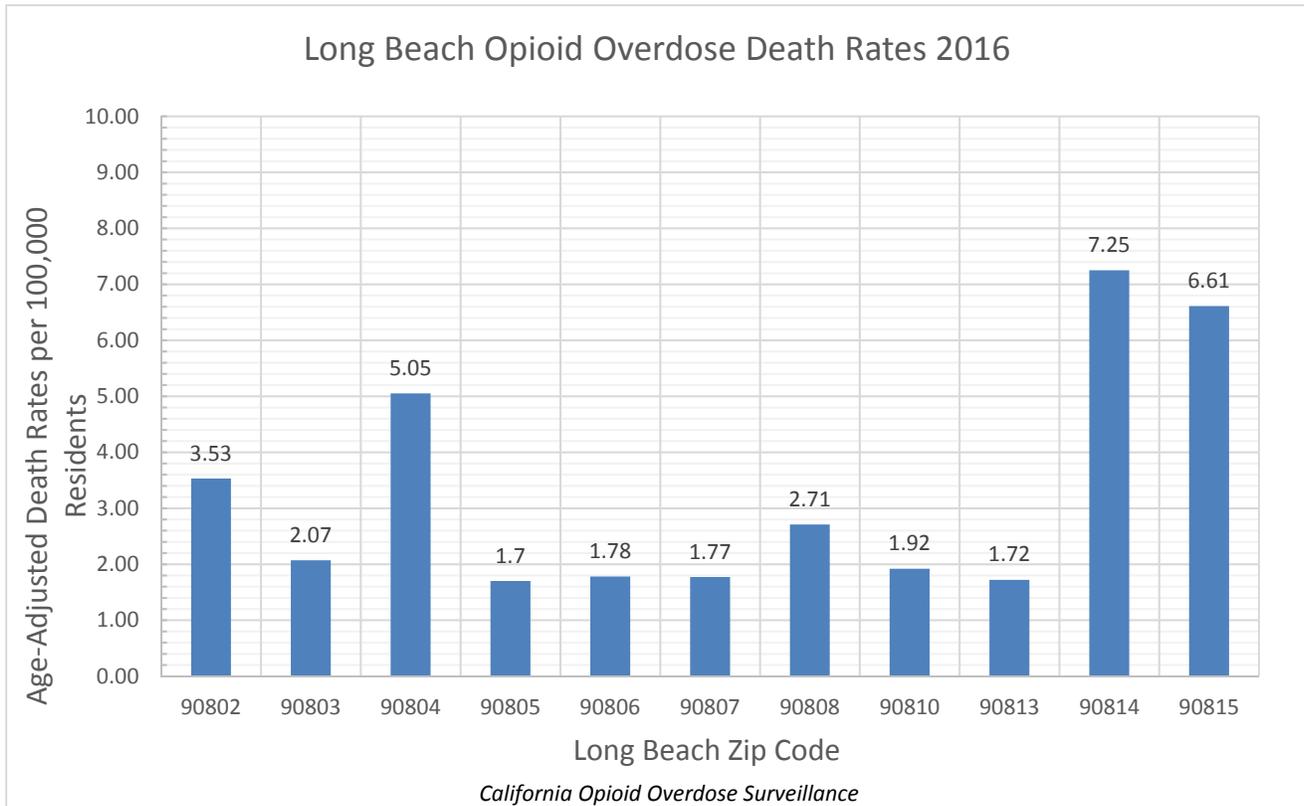
Table 2



The California Opioid Overdose Surveillance Dashboard shows a slightly different picture for the same year. Table 3 shows 2016 opioid attributed age-adjusted death rates in Long Beach by zip code⁶. These are not actual deaths, but rather rates per 100,000 residents. The zip codes with the highest age-adjusted rates were 90814 and 90815.

⁶ California Opioid Overdose Surveillance Dashboard. Accessed at https://pdop.shinyapps.io/ODdash_v1/.

Table 3



Prescription Opioids

According to the Substance Abuse and Mental Health Services Administration, one in five individuals in L.A. County started illicit drug use with prescription drugs according to 2013 data⁷; four out of five new heroin users had previously misused prescription opioids⁸; and, 28 percent of L.A. County opioid misusers and abusers received their opioids in the past year from a doctor⁹. Risk of long-term opioid use significantly increases after only five consecutive days of use.¹⁰

Data provided by Councilmember Price on October 10, 2017, show that prescription opioid death rates per 100,000 were higher in Long Beach when compared to L.A. County (Table 4).

These data further show that prescription-related opioid total deaths in Long Beach declined in 2014 when compared to 2013 (Table 5).

⁷ Substance Abuse and Mental Health Services Administration. National Surveys on Drug Use and Health in 2013. Results from the 2013 NSDUH. Summary of National Findings.

⁸ Substance Abuse and Mental Health Services Administration. Center for Behavioral Health Statistics and Quality Data Review. August, 2013.

⁹ *Substance Abuse Prevention and Control. Medical Director's Brief.* County of Los Angeles Public Health. March 2015. No. 2

¹⁰ SAMHSA, 2016.

Table 4

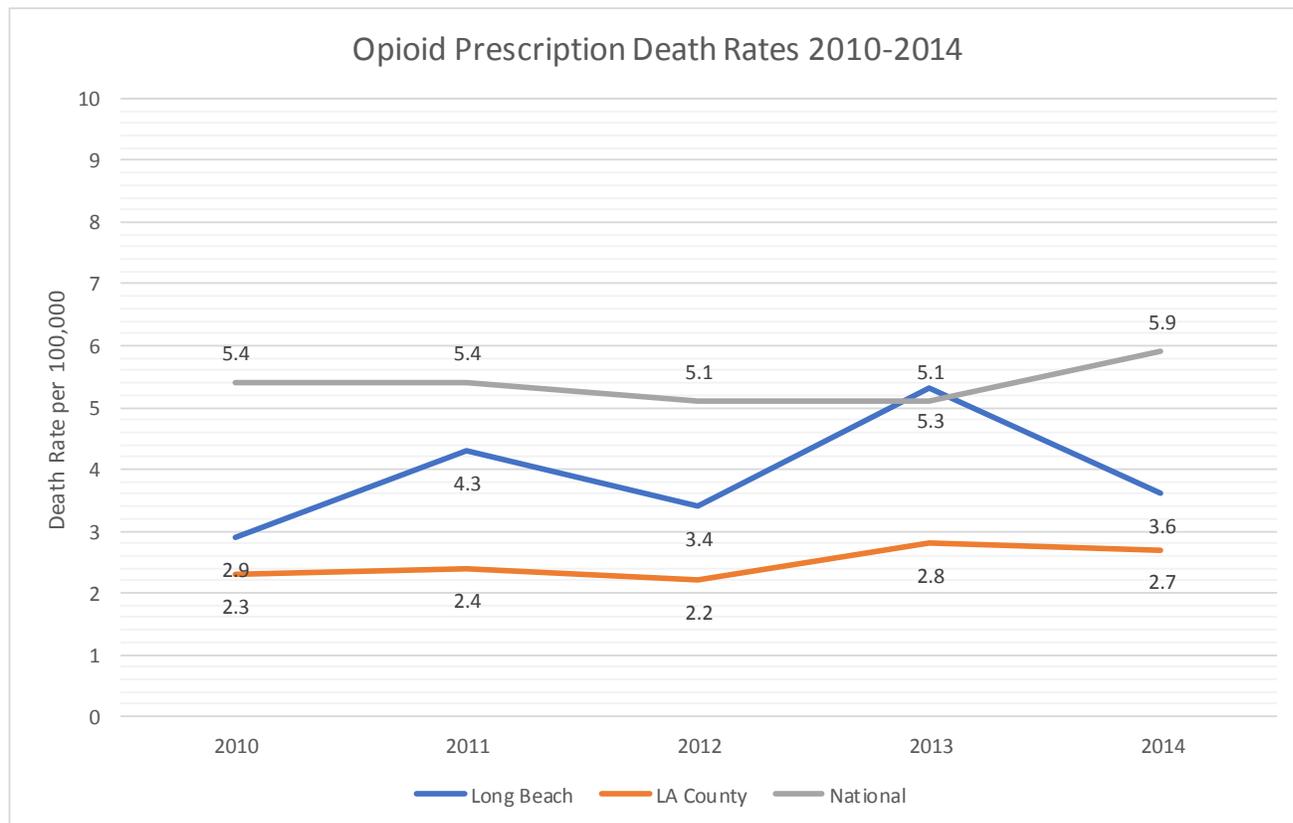
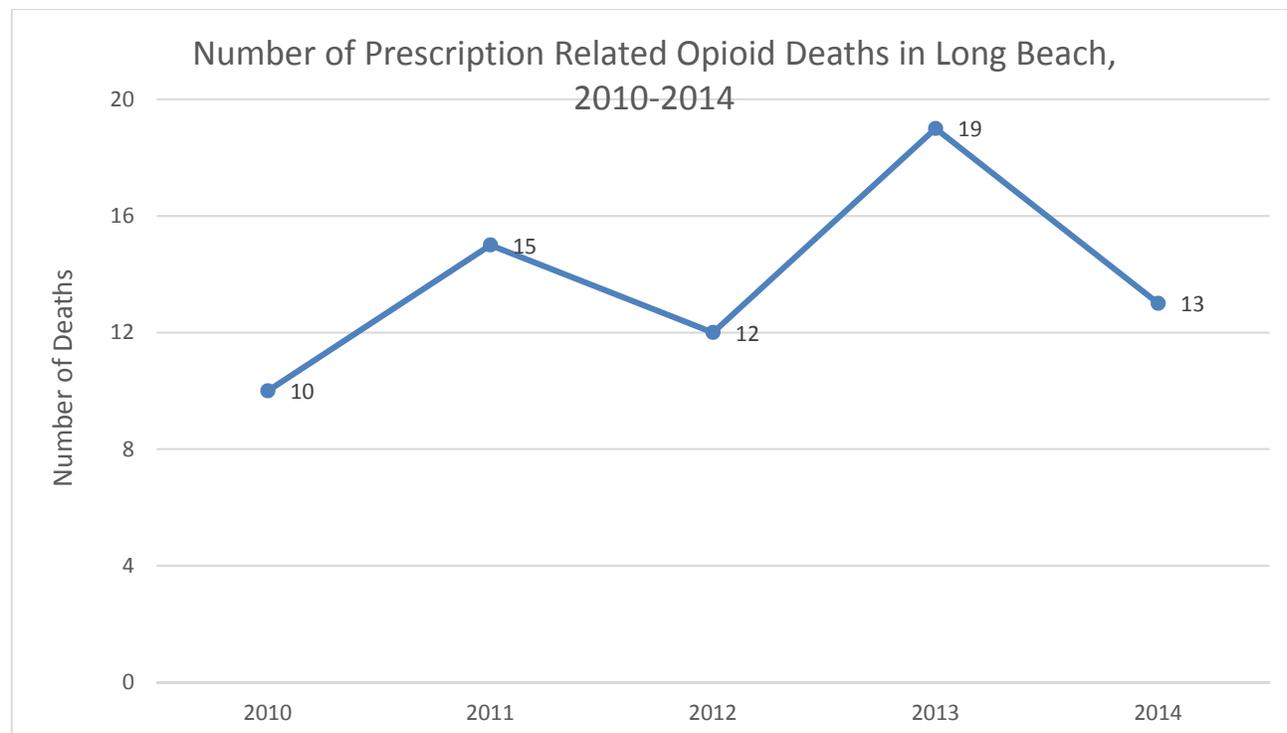


Table 5



The increase in opioid use disorder and opioid overdose deaths is largely due to the dramatic rise in the rate and number of opioids prescribed for pain over the past decades. Since 1999, the amount of prescription opioids sold in the U.S has nearly quadrupled¹¹. This increase has been attributed to regulatory pressures and pharmaceutical company campaigns that minimized the risks of opioid misuse and encouraged health care providers to prescribe more opioids to treat their patients' pain^{12, 13}. In response, providers began prescribing opioids at greater rates and doses. In 2013, providers wrote nearly a quarter billion prescriptions for opioids – enough for one bottle of pills per adult in the U.S.¹⁴

Providers often lack training in appropriate prescribing of opioid medications. They may write opioid prescriptions for people who have, or are at risk of, opioid use disorder and, without adequate medical justification or oversight, may contribute to opioid misuse and abuse. In addition, providers may not be checking patients' opioid prescription history.

CURES Database

In jurisdictions where there has been a substantial decrease in prescribing of opioids, the reduction is attributed to the passage of state laws requiring providers to check the state's Prescription Drug Monitoring Program (PDMP) database before prescribing.

Legislative mandates to check the PDMP have shown the greatest effectiveness in reducing the number and dosage of prescriptions. For instance, within months of passing the mandate, doctor shopping, defined as a patient going to seven or more prescribers and seven or more pharmacies within a 90-day period, was reduced by 74.8 percent in New York, and by 36 percent in Tennessee¹⁵.

California's PDMP is called CURES, or the Controlled Substance Utilization Review and Evaluation System. It stores controlled substance prescription information reported as dispensed in California. CURES contains patient name, patient date of birth, patient address, prescriber name, prescriber DEA number, pharmacy name, pharmacy license number, date prescription was dispensed, prescription number, drug name, drug quantity and strength, and number of refills remaining¹⁶.

Though prescribers are legally required to register for CURES, California law does not require prescribers to check the database before prescribing. The dispensing entity, the pharmacy or clinic, enters the data. Access to CURES is limited to licensed prescribers and licensed pharmacists strictly for patients in their direct care, and for regulatory board staff and law enforcement personnel for official oversight or investigatory purposes.

¹¹ Centers for Disease Control and Prevention, National Center for Health Statistics. (2016). *Wide-ranging Online Data for Epidemiologic Research (WONDER)*. Atlanta, GA: Author. Retrieved from <http://wonder.cdc.gov>.

¹² Kolodny, A., Courtwright, D. T., Hwang, C. S., Kreiner, P., Eadie, J. L., Clark, T. W., & Alexander, G. C. (2015). The prescription opioid and heroin crisis: A public health approach to an epidemic of addiction. *Annual Review of Public Health*, 36, 559-574.

¹³ Government Accounting Office. (2004). OxyContin abuse and diversion and efforts to address the problem: Highlights of a government report. *Journal of Pain & Palliative Care Pharmacotherapy*, 18(3), 109.

¹⁴ U.S. Department of Health and Human Services. (2016). *The Opioid Epidemic: By the Numbers*. Retrieved from <https://www.hhs.gov/sites/default/files/Factsheet-opioids-061516.pdf>

¹⁵ *Briefing on PDMP Effectiveness*, September 2014, Brandis University Center of Excellence.

¹⁶ *Controlled Substance Utilization Review and Evaluation System*, <https://oag.ca.gov/cures>, accessed January 3, 2018.

CURES patient safety alerts provide post-prescription updates of patient medicinal therapy levels. These messages alert clinicians when their patient's aggregate prescription level exceeds certain thresholds and sends a message to the patient's other prescribers.

Public health officials say CURES is key to preventing opioid-related deaths in California and has had success. California Department of Public Health data show that deaths peaked in 2009 and had dropped 15 percent by 2016. California had 10.8 drug overdose-related deaths per 100,000 people in 2016, below the national average of 19.8 deaths per 100,000.

Early this month, a legislative hearing was held on opioids and the CURES system. In 2016, Senator Ricardo Lara, wrote legislation requiring doctors to check CURES before prescribing opioids and other controlled substances to a patient for the first time, and at least once every four months if drugs remain part of the treatment. The law, Senate Bill 482 which was signed into law on September 27, 2016, takes effect six months after the State certifies the database. The exact date the mandate will take effect is unclear, but will depend on the Department of Justice (DOJ) making a certification about the system's readiness. At that time, the CURES system did not have the capacity to handle the increase in usage, so it has not yet been certified. At the recent hearing, the State Attorney General's Office said they hoped to finish certifying the prescription drug monitoring database for Statewide use by July, which would mean doctors will be required to check the system before prescribing by early 2019.

Provider Education Programs

Provider educational programs show modest levels of effectiveness. For example, the most publicized of the public health detailing campaigns was a two-month campaign that included one-on-one educational visits with providers in Staten Island, NY in 2013. This project improved provider knowledge; however, after the campaign, overall opioid prescribing rates decreased similarly across other areas of N.Y. that did not participate in the campaign. In the second three-month post campaign period, high dose prescribing (a subset of overall opioid prescribing) decreased 12.4 percent in Staten Island and 7.3 percent in surrounding areas that did not receive the intervention.

Feasibility and Recommendations

Resourcing

Research captured a number of different programs. We report on the Staten Island project as an example because it is similar in size to Long Beach, and is the only opioid prescription detailing campaign our research uncovered that was conducted by a health department and the only one that isolated a physician prescribing detailing campaign to evaluate the effectiveness of this approach. Other programs conducted by state health departments, were much larger in scale and included passing laws requiring use of their statewide prescribing database. Other programs were conducted by non-profit organizations that solely focus on, and exist to, address opioid addiction, where the prescribing practices were a small focus compared to other components such as support groups for pain patients, education in schools and increasing treatment availability. These comprehensive programs have not published results that isolate the effectiveness of the prescribing detailing campaign, making it difficult, if not impossible, to attribute outcomes specific to the detailing program itself.

¹⁷ <http://www.sacbee.com/news/politics-government/capitol-alert/article199444229.html>

Staten Island, N.Y. has an estimated population of 475,000, making it comparable to Long Beach. The Staten Island public health detailing program described operated with a one-year budget of \$250,000 for subcontracts, plus additional City support that would cost \$265,362 at Long Beach rates, for a total project cost of \$515,362 for 12 months of planning and an eight-week educational and outreach campaign.

The total project cost for Staten Islands' program is detailed below:

- \$200,000
 - Subcontract with an organization that trained, coordinated and oversaw eight “detailers,” or educators for every 1,000 providers.
 - These detailers all had master’s degrees and were former pharmaceutical representatives who had experience visiting physicians to talk about drugs.
 - They completed two in-person visits per individual provider during the eight-week campaign.
- \$50,000
 - Action Kits for providers, subcontracted out. Action Kits were print material tools for medical providers to aid them in implementing the recommendation. This cost is for English only. Additional languages would require additional funds.
- \$265,362 for 12 months
 - .5 FTE Medical Doctor for project direction
 - .1 FTE Master of Public Health for project coordination
 - .01 Communications support
 - .01 Policy support
 - .10 Epidemiology support
- \$515,362 = Total Projected Cost to Replicate the Staten Island Detailing Campaign

The City of Long Beach does not receive funding for substance use prevention or treatment. These funds are provided to the LA County Public Health Substance Abuse Prevention and Control Division (SAPC). Utilizing these funds, they are developing an opioid prevention campaign. In addition, the funds for treatment services are contracted to treatment service providers across the County, including in the City of Long Beach and surrounding jurisdictions. The DHHS is working to partner with SAPC to increase access to prevention and treatment services.

Proposed Action

Research indicates the most effective interventions are those that require providers to consult the statewide CURES database before prescribing. Further, to replicate the Staten Island project, which showed modest results, would cost the City more than \$500,000. Because of the cost and limited effectiveness, we do not recommend following the Staten Island model.

Recognizing that opioid prescribing is an area where the DHHS could have a positive influence, the DHHS proposes the following, without additional cost, but within our capacity to do so:

1. Develop messaging to convey the published recommendations of the New York City Department of Health and Mental Hygiene (DOHMH), which are: (1) a three-day supply of opioids is usually sufficient for acute pain; (2) avoid prescribing opioids for chronic non-cancer pain; and, (3) avoid high-dose opioid prescriptions. The DHHS will add a fourth message focused on the importance of checking the CURES database before prescribing.
2. Promote the use of CURES within health systems that operate in Long Beach. As meetings occur between the DHHS and health systems such as St. Mary's Hospital, Memorial Care, and Kaiser, the DHHS Director and Health Officer will discuss and promote policies and practices that require providers to check CURES as part of their prescribing protocol.
3. Add resources to the DHHS website including links to webinars, continuing medical education (CME) opportunities, the California Department of Public Health, and applicable Federal websites (e.g., CDC, SAMHSA), patient handouts, applicable laws, and Narcan information.
4. Develop a media release containing these messages and referring providers to the DHHS website.
5. Send a Health Alert from the City's Health Officer to Long Beach providers and pharmacists reinforcing these messages and referring providers to the DHHS website.
6. Post similar information on social media outlets.
7. Continue the current practice of providing Narcan (when received from the State) and appropriate training to first responders who work primarily with high-risk populations.
8. Utilize L.A. County Substance Abuse Prevention and Control (SAPC) developed prevention materials, and when possible, assist individuals to connect to substance use treatment opportunities funded by SAPC in the City of Long Beach and surrounding cities.
9. Provide consultation with other City officials on the feasibility of instituting a needle exchange program, or a safe injection site, to minimize harm, such as the spread of HIV and Hepatitis C, as well as providing additional opportunities to engage injecting drug users with needed programs, services and treatment opportunities.

For additional information, please contact me at (562) 570-4016 or Ginger Lee, Collective Impact and Operations Bureau Manager, at (562) 570-4018.

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