OHIO INJURY PREVENTION PARTNERSHIP

Prescription Drug Abuse Action Group

Recommendations

Prevention of Misuse and Abuse of Prescription Drugs
Prevention of Deaths from Unintentional Prescription Drug Overdoses
Developed by the
Prescription Drug Abuse Action Group
April 5, 2010

Introduction

These recommendations are from a statewide work group, the Prescription Drug Abuse Action Group (PDAAG), which consists of representatives from local health departments, mental health centers, health care professions, alcohol and drug addiction treatment and prevention centers, law enforcement agencies, health professional and provider associations, state medical boards, coroners, hospitals, pain and palliative care programs, prosecutors and more. A list of members is attached. The work group began meeting in August 2009 and formed three subcommittees to develop recommendations: Consumer/Public, Prescriber/Provider and Policy/Legislative/Data/Surveillance. These recommendations reflect a consensus of a majority of the members. For some recommendations, there was a diversity of opinion and no clear consensus. In those cases the dissenting opinion is reflected in a note following the recommendation.

The PDAAG is presenting these recommendations to Angela Cornelius Dawson, Director of the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) and to Alvin Jackson, MD, Director of the Ohio Department of Health (ODH), to assist these departments in their efforts to reduce and prevent the misuse and abuse of prescription drugs and prevent unintentional deaths from

prescription drug overdose and heroin use in Ohio. As these recommendations are prioritized by the Directors of ODADAS and ODH, an implementation plan will be developed that will include specific responsibility for various actions, a timeline, potential funding sources as necessary and focus areas for additional subcommittees that may be needed for implementation. The Directors may also share these recommendations with the Governor, other state agencies and Ohio legislators to ensure a collaborative and comprehensive approach to addressing this problem.

Consumer and Public Committee Recommendations

Recommendation: Increase Public Awareness of the Problem

1. **Establish Local/Regional Task Forces:** Encourage and provide support for the development of local multidisciplinary coalitions or task forces to address the problems in their county or region. These coalitions should bring together a wide range of local agencies and organizations to identify priorities and provide education to the public and local service providers about this problem. Links should be made with existing coalitions with similar goals (such as drug-free coalitions and Family and Children First Councils) when possible to maximize resources and reduce any possible duplication of effort.
   Implementation: Local coalitions should be established with leadership from local agencies and support from ODH, ODADAS and other state agencies as appropriate. Coalitions already in existence as noted above should expand their membership and focus to incorporate activities related to prevention of prescription drug overdose. Local leadership should be provided by health departments, coroners, health care professionals, alcohol and drug addiction treatment and prevention centers, law enforcement agencies, health professional and provider associations, mental health agencies, Poison Control Centers, hospitals, pharmacists, private citizens, businesses, media and other interested and relevant organizations or agencies.

2. **Fund Social Marketing Campaigns:** Implement state and local multi-faceted social marketing campaigns (including use of social networking sites, development of PSAs, newspaper articles, videos/DVDs and ads in movie theaters) to educate the public about prescription drug abuse and misuse i.e. potential for addiction, dangers of sharing prescriptions, proper storage, diversion concerns and proper disposal. Models from other states such as Utah and New Jersey should be reviewed for potential adaptation for use in Ohio. A consistent message should be used throughout the state. Consider the use of a well-known and respected spokesperson for the campaigns. Materials developed should always include information on how to access local, state and national resources for treatment and more information.
   Implementation: Many agencies and organizations should make public education on this topic a priority. State agencies such as ODADAS, ODH, the Ohio Department of Mental Health (ODMH), the Ohio Department of Aging (ODA) and the Ohio

Department of Education (ODE) should work together to fund and implement a social marketing campaign for the state. Health care professional and provider associations should work with state agencies on these campaigns and make it a priority to educate their members on this topic. Partnerships should be formed at the state and local level with corporations, marketing firms, the insurance industry, colleges/universities and the media for development and funding of these campaigns.

3. **Promote Population Specific Education:** Identify and/or develop educational campaigns specifically for populations particularly at risk for prescription drug abuse and/or unintentional overdose, i.e. males 35-54 who have the highest death rates; women ages 35-54 who are the fastest growing population at risk for dying from unintentional prescription drug overdose; and, individuals ages 18-25 who have the highest prevalence of abuse of prescription drugs. Educational campaigns/programs should also be developed for high school and college students for primary prevention. Identify and develop programs specifically for individuals at high risk for overdose (e.g., those in detox/treatment facilities, jail and drug courts) and those who have already suffered a non-fatal overdose in emergency departments. Provide specific overdose prevention information and resources to these individuals in an effort to prevent fatal overdoses (also see Data, Surveillance, Research Needs section). Develop a message that can be marketed to peers, parents and grandparents of adolescents. Research and use existing toolkits e.g. Teen Influence from the National Council on Patient Information and Education and Generation Rx from the Ohio State University College of Pharmacy.
   Implementation: PDAAG Consumer/Public subcommittee members should work in conjunction with state agencies such as The Ohio Board of Regents (OBR), ODADAS, ODH, the ODMH, ODA, ODE and the Ohio Department of Rehabilitation and Correction (ODRC) to engage health care professional and provider associations, the Ohio Poison Control Centers, teachers' professional associations, business organizations, schools, colleges/universities, pharmaceutical manufacturers, the media and others in providing this education. Existing networks and events should be used to market these programs. For example, for reaching teens, connect with Teen Institute, Youth to Youth, PRIDE, school nurses conference, Ohio Education Association conferences and meetings, 4-H events, school sporting events, etc.

4. **Develop and Promote Multiple and Widespread Training Programs:** Develop (or adopt) education and training programs and materials for use in reaching adults in a variety of settings including places of employment, professional conferences and meetings, doctors' offices, dentists' offices, civic and community organizations, emergency departments (show a video/DVD in the waiting room), nursing homes, and their own homes through home health and hospice agencies. Identify and review existing models in Ohio and other states to recommend for adoption, i.e. the Cardinal Health employee education effort.
   Implementation: The Consumer/Public subcommittee of the PDAAG in partnership with local and state associations and organizations should take the lead and work with existing networks to market these educational programs e.g. Ohio State Medical Association annual meeting, Ohio Pharmacists Association conference, School Health conference, Health Educator's Institute, Ohio Hospital Association meetings, law enforcement conferences and business association meetings and conferences.

5. **Conduct Proper Prescription Drug Storage and Disposal Programs:** Promote proper storage and disposal of prescription drugs to the public and health care providers/prescribers throughout the state through Drug Take Back programs and other similar initiatives.
   Implementation: Local hospitals, health departments, ADAMHS/ADAS Boards, pharmacies and/or treatment and prevention providers should collaborate with law enforcement agencies and environmental protection agencies to promote and conduct these programs on a regular basis.

Provider/Prescriber/Health Care Professionals Committee Recommendations

Recommendation: Provide Health Care Professionals with information, training and materials to address the prevention of misuse/abuse of and unintentional deaths from prescription drugs

1. **Engage health care and allied medical professional organizations and state boards to initiate educational campaigns (A Call to Action) for their members regarding the problem of unintentional overdose deaths due to misuse/abuse of prescription drugs, particularly prescription opioids, including the issues of addiction in and diversion by health care providers:** Develop (or adopt) training programs to present to health care and allied professionals in a variety of formats (webinars, videos, newsletters) and settings, including professional conferences/meetings, in-services, Grand Rounds and training tutorials. The audience for these trainings should be broad and include physicians (including those in specialty areas), nurses, nurse practitioners, LPNs, dentists, pharmacists, EMS, firefighters, medical social workers and alcohol and drug addiction treatment specialists. These trainings should address all aspects of the problem, including extent of the problem, pain management guidelines, how to assess for addiction, doctor shopping and diversion, options for prescribing non-opioid analgesics and adjuvants, as well as pain management options other than medication and resources for treatment.
   Implementation: The PDAAG Providers/Prescribers subcommittee should take the lead to identify and recommend appropriate curricula addressing the topics noted above. With the assistance of state agencies such as ODADAS, ODH and ODMH, these curricula should be promoted to state and local health care professional associations, local health departments, local health care providers and prescribers, substance abuse treatment agencies, hospitals, mental health centers and other appropriate health care entities to encourage them to implement these programs for their staff and members.

2. **Develop (or adopt/adapt) a tool kit for use by health care providers to educate all patients being prescribed pain medication:** This education should be provided and repeated at each step in the process including: prior to prescribing before surgery, after surgery, with discharge instructions and by the pharmacist dispensing the pain medication

Implementation: The PDAAG Providers/Prescribers subcommittee should take the lead to identify and recommend an appropriate tool kit(s) for distribution and use in health care settings. Health care systems (hospitals, clinics, physicians, dentists, pharmacies, etc.) should implement a protocol for the use of such a tool kit. Pharmaceutical companies and other health related corporations should be contacted to ask for their support in providing educational information and funding and distribution of the tool kit.

3. **Adopt a Screening Brief Intervention and Referral for Treatment (SBIRT) protocol within health care (hospital, clinics, physician's offices, etc.) and workplace (EAP and wellness programs) settings:** The SBIRT can be used to screen for misuse and/or abuse of prescribed medications and can indicate possible pain management challenges. The SBIRT is now being used in many settings as a screen for current or past alcohol abuse and/or addiction. SBIRT screenings are brief and can be used to alert the health care professional to possible prescription drug misuse/abuse so that intervention, in the form of a referral or other actions, can take place. This has the potential of preventing or mitigating more serious problems and saving money (related to addiction treatment and/or overdose death) in the long term.
   Implementation: The PDAAG Providers/Prescribers subcommittee should work with health care professional boards and associations to encourage them to implement SBIRT protocols in all health care settings. The Centers for Disease Control and Prevention (CDC), National Center for Injury Prevention and Control (NCIPC) has produced a guide for implementing such screenings that includes a comprehensive listing of online SBIRT Training Resources at the end: ***Screening and Brief Interventions (SBI) for Unhealthy Alcohol Use: A Step-by-Step Implementation Guide for Trauma Centers.*** Although this guide is focused on unhealthy alcohol use, it can easily be adapted to screen for potential prescription misuse/abuse problems. Many of the online trainings listed are approved for CME credit. The National Institute of Drug Abuse has also developed an online Modified Alcohol, Smoking and Substance Involvement Screening Test (NMASSIST) adapted from the World Health Organization that includes screening for street opioids and prescription opioids.

4. **Require course work in substance use disorders, prevention and treatment in the college curriculum for any medical professional or allied health care degree:** Ohio colleges and universities should integrate education on this topic into health care professional curricula and student orientation programs. This training should be integrated into the medical specialty areas including Family Practice and should address all aspects of the problem, including extent of the problem, pain management guidelines, how to assess for addiction, doctor shopping and diversion, options for prescribing non-opioid analgesics and adjuvants, as well as pain management options other than controlled substances and resources for treatment.

Implementation: Health care professionals and their professional organizations should encourage the inclusion of such course work as part of the degree program. ODADAS and ODH should work with the OBR to reach out to the University System in Ohio.

5. **Convene a state forum and/or task force to identify evidence based approaches to support and improve treatment for opioid addiction including medication assisted treatment such as Buprenorphine (Suboxone®)*:** Engage treatment providers from around the state to identify and assess promising practices, develop a plan for implementation in Ohio and consider overdose prevention strategies such as use of intranasal Naloxone (Narcan®)* prescriptions for high-risk individuals. **Implementation:** ODADAS should convene a forum to bring together alcohol and drug addiction treatment and prevention centers, mental health treatment providers and professional and provider associations such as the Association of County Behavioral Health Authorities and the Ohio Council of Behavioral Health Care Providers to address this issue. Continue to include promising practices in this area as an agenda item for the Governor's Council on Alcohol and Drug Addiction Services.

Policy and Legislative Committee Recommendations

Recommendation: Implement policy and legislative changes designed to prevent misuse/abuse and unintentional deaths from prescription drugs

1. **Initiate and support efforts to increase the capacity for treatment for opioid addiction including medication assisted treatment:** Treatment centers across the state are seeing an unprecedented increase in the number of people seeking treatment for addiction to prescription opioids and other pain medication. While the treatment need has increased, resources remain the same or are shrinking. The results of this addiction are extremely negative and affect the social, emotional, health and financial circumstances of the addicted individual, their family members, associates, workplaces and their entire community. When developing plans for the expansion of treatment services, the needs of unique populations should be taken into consideration such as pregnant women who are taking Buprenorphine (Suboxone®)* whose babies are then born addicted to Suboxone and must be treated for that addiction.
   Implementation: ODADAS should collaborate with Alcohol and Drug Addiction (AOD) treatment programs and PDAAG members to provide information to state legislators, federal agencies and Congressional representatives documenting the need for increased funding for treatment for those addicted to prescription opioids and other pain medication. PDAAG members should engage with physicians and their professional organizations to determine the availability of medication assisted treatment (such as the use of Buprenorphine (Suboxone®)* in Ohio. The issue of reimbursement by Medicaid for

Suboxone and other medication assisted treatment (beyond reimbursement as a physician service) should be researched and considered as part of this effort to document treatment needs.
Note: Although this recommendation is focused on the need to increase capacity for treatment for opioid addiction, many organizations and programs in Ohio that provide valuable services related to the prevention of prescription opioid misuse/abuse and overdose have lost funding or seen a substantial decrease in funding, e.g. the Ohio Poison Control Centers. The committee urges state policy makers to review these reductions and implement funding that will provide a comprehensive approach to prevention, intervention and treatment of this problem.

2. **Enact legislation for licensing standards for pain management clinics:** Pain management clinics are facilities operated by a physician or with the assistance of a physician whose primary service is the treatment of pain by prescribing narcotic and opioid medications. The purpose of the legislation would be to define what constitutes a pain management clinic and develop standards of care to ensure access to medically necessary health care services and quality care at pain management clinics. Louisiana recently passed this type of legislation which could be used as a model for Ohio. This legislation is being implemented under the Louisiana Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing: Pain Management Clinics: Rule: LAC 48:I.Chapter 78.
Implementation: Stakeholders including advocacy groups, state medical and health care professional and provider organizations, law enforcement associations, PDAAG members, ODADAS, the Bureau of Workers Compensation (BWC) and ODH should collaborate to develop legislative language to propose to state legislators. One approach could be to make an Ohio Automated Rx Reporting System (OARRS) check mandatory for each prescription written for any place that desires to dispense or prescribe scheduled substances whether or not they are a pharmacy.

3. **Institute mandatory continuing education credits in pain medication management for health care professionals for licensure renewal:** Education should focus on all aspects of the pain medication problem including extent of the problem, pain management guidelines, how to assess for addiction, doctor shopping and diversion, options for prescribing non-opioid analgesics and adjuvants, as well as pain management options other than medication and resources for treatment.
Implementation: The Ohio State Medical Board (OSMB), the Ohio Board of Nursing (OBN), the Ohio State Dental Board (OSDB), the Ohio State Board of Pharmacy (BOP) and other related state boards should establish a requirement for at least one hour of continuing education addressing prescription drug misuse/abuse and overdose in addition to education in pain management.
Note: Many physicians, medical associations, such as the Ohio State Medical Association and pharmacists associations in Ohio and nationwide oppose a mandatory requirement for topic specific continuing education credits. Once concern, among others, is that a medical license is broad in terms of the scope of practice and thus medical professionals should not be required to obtain continuing education on specific topics that may not be relevant to a particular practice. In addition,

multiple topics are being suggested by various groups for mandatory continuing education credit so it becomes a concern of which topic to select and how to accommodate all requests. Representatives from these organizations have suggested that those interested in educating health care professionals on this topic work with the professional associations to provide speakers at conferences and meetings.

4. **Enact legislation to require all physicians and other prescribers to register with and use the OARRS (see #2 above-Implementation) administered by the BOP:** The BOP operates OARRS which is a prescription monitoring program. As of January 1, 2006, all pharmacies licensed with the Ohio BOP must report dispensing information for all controlled substances, carisoprodol products, and tramadol products that are dispensed to outpatients. Non-resident pharmacies must report dispensing information listed above for all patients located in Ohio. At present controlled substances dispensed by physicians are not required to be entered into OARRS. As part of the effort to reduce/eliminate doctor shopping and other practices that can lead to prescription drug abuse/misuse and ultimately deaths from overdoses, it is recommended that all drug dispensers, not just pharmacists, be required to register with OARRS and conduct an OARRS check prior to prescribing controlled substances. At the very least this check should be conducted for certain patients such as new patients, patients frequently returning for opioid prescriptions and patients not seen for over a year. The OARRS check would inform the physician or other prescriber of previous prescriptions received by the patient that are in the above categories. According to the BOP currently only 13% (about 5,500) of the approximately 42,022 licensed Ohio physicians and dentists have voluntarily registered with OARRS.
   Implementation: The members of organizations supporting this type of legislation should work with state agencies, Ohio legislators, the BOP, the OSMB, the Ohio Chapter of the American College of Emergency Physicians (OHACEP), the OSDB, other relevant state boards and state medical associations to develop language appropriate to accomplish this recommendation. Consideration should be given to which physicians and other prescribers should be required to register for OARRS based on their scope of practice. Another suggestion for consideration is require the OARRS check only for prescribing one of the top 10 abused drugs.
   Note: The Ohio State Medical Association, the OHACEP and the Ohio Pharmacists Association have stated opposition to requiring all physicians or pharmacists to register with and request an OARRS report prior to dispensing or prescribing a controlled substance. They cite time constraints, some concerns with the OARRS registration process, the level of detail needed to request an OARRS report as well as concerns with multiple mandates as part of their opposition to such a requirement.

5. **Enact legislation to implement E-prescribing in Ohio:** Integrate an E-prescribing system with OARRS so that when a physician/prescriber is prescribing an opioid or other controlled medication for chronic non-malignant pain, they must review the patient's prescription history via OARRS prior to completing the prescription.

Implementation: Advocacy organizations and state agencies supporting this type of legislation should work with Ohio legislators, the BOP, the OSMB, the OSDB, ODMH, other relevant boards and state medical associations to develop language appropriate to accomplish this recommendation.

6. **Enact rules changes at the Ohio Department of Job and Family Services (ODJFS) that would allow for reimbursement of SBIRT interventions from Medicaid:** Ohio regulations for reimbursement should be made comparable to the Federal standards for reimbursement. These changes in the rules would help to reduce health care costs as it would provide an incentive for health care providers to screen patients regularly. This would allow for earlier intervention and referral for potential addiction problems. See #3 in the Provider/Prescriber recommendations above for more information on SBIRT resources. The federal government allows for Medicaid reimbursement for SBIRT but it has to be included in Ohio's Medicaid plan for Medicaid reimbursement of this service to occur in Ohio.
   Implementation: ODJFS should be encouraged by all stakeholders to include SBIRT in the state's Medicaid plan of covered services. In addition, at a minimum, ODJFS should implement a physician awareness program regarding the value of SBIRT as a routine screening practice and the voluntary reporting of SBIRT activities through activation of the SBIRT Medicaid codes. The Joint Commission standards should be taken into consideration when considering these rule changes. In addition, private insurers should be encourages to include reimbursement for this service in their plans.

7. **Ensure the development, adoption and implementation of pain management guidelines in all health care systems:** Identify model policies that are already in place in some health care facilities, review for best practices and distribute the recommended policy across the state. Pain management guidelines should be provided that are specific to various health care settings including private medical practices, hospital emergency departments, hospice and home care programs, dental practices, EMS units, clinics, etc.
   Implementation: The PDAAG Policy/Legislative subcommittee should identify and recommend a model policy working in conjunction with state health care professional and provider associations, state medical/health care-related boards, the Ohio Hospital Association and state health care administrator associations. Such associations should then promote this policy to their members and ensure adoption in all health care settings in Ohio.

8. **Enact 911 Good Samaritan Immunity Laws that legalize the use of Naloxone (Narcan®)* by lay persons when someone has overdosed and protects the lay person from prosecution:** Such laws are in effect in other states including North Carolina. They are intended to reduce the hesitation on the part of friends, associates or bystanders to assist when someone overdoses. The purpose of Good Samaritan Laws is to help save lives and provide intervention. This time of crisis is often an opportune time to refer the person whose life has been saved to treatment which has humanitarian, social and economic benefits.

Implementation: The PDAAG Policy/Legislative subcommittee should review such laws in other states and recommend wording for Ohio legislation. Local and state law enforcement agencies, treatment centers, first responders and community advocates should then collaborate to propose specific language for legislation and enactment.

9. **Increase the use of "Drug Courts" as an alternative to incarceration for illegal use/abuse of prescription drugs:** Drug courts are specialized courts that, based on a description from the Butler County drug court website, "are designed to reduce substance abuse, crime and recidivism by utilizing treatment and community control alternatives." According to an ODADAS report, there are currently 82 drug courts in Ohio: 32 for adults; 27 for juvenile, 17 for families (parents charged with drug related offenses) and six for OVI/DUI. ODADAS funds 24 of these. The rest are funded through a mix of local, state and federal sources, including the Ohio Supreme Court and the U.S. Department of Justice. An evaluation funded by the Ohio Supreme Court in 1998 found that drug courts are effective in reducing criminal activity and retaining offenders in treatment. The Akron drug court web site states their study of the effectiveness of their drug courts found that drug courts also save money. The cost for a person going through their drug court system was $2,500 per year vs. $20,000 per year for incarceration.
   Implementation: Local coalitions addressing prescription drug abuse/misuse/overdose and other stakeholders should educate the public and policy makers regarding the success and cost effectiveness of drug courts and request increased funding for drug courts from the Ohio legislature and Ohio Supreme Court.

10. **Other state level policy recommendations for consideration:**
    - Implement state and/or local ordinances to require photo ID when picking up prescriptions for controlled substances
    - Implement laws to reduce/eliminate doctor shopping;
    - Require emergency departments to report drug-related visits to a state database in order to get Medicaid reimbursement;
    - Promote collaborative efforts among law enforcement agencies to enforce prescription drug fraud statues currently in effect in Ohio: ORC 2925.22; and,
    - Promote the coordination of investigations of fraud committed by individuals or pain clinics among local law enforcement, state regulating agencies and state and federal investigative agencies.

11. **Federal Government:**
    - Implement regulations to impose limits on direct-to-consumer marketing of opioids by pharmaceutical companies; and,
    - Support proposed Food and Drug Administration (FDA) rule changes:

- Require pharmaceutical manufacturers to provide educational information for patients on proper use of medication; and,
- Require certification of any health care provider who wishes to dispense pain medication.

Note: At least two physicians who are members of the PDAAG believe such certification is beyond the scope of the FDA and should be addressed at the state level.

Data, Surveillance and Research Committee Recommendations

Recommendation: Increase, improve and coordinate data collection related to the prevention of unintentional deaths from prescription drug overdoses

1. **Improve linkage of data systems among state agencies:** Change laws as needed to eliminate/reduce barriers to data sharing among state entities for the purposes of public health and safety surveillance, research and program planning. Establish protocols for such information sharing between and among the state data owners such as ODH, BOP, Medicaid/ODJFS, ODADAS, Ohio Department of Insurance, etc. This information could be used for a variety of purposes such as more accurate and expanded documentation of the increasing numbers of deaths and comparing availability of the pain medications to levels of abuse.
   Implementation: State agencies such as those noted above that have data related to drug poisoning should collaborate to identify legislative changes needed to facilitate data sharing and communicate the recommended changes to agency administrators for potential action by state legislators.

2. **Establish collaboration with other states in regards to drug monitoring systems:** This collaboration would allow tracking of doctor shopping and other diversion methods across state lines.
   Implementation: The BOP is currently exploring options for such collaboration between Ohio and Kentucky.

3. **Establish Poison Death Review (PDR) Committees:** County or multi-county poison death review committees (based on the Child Fatality Review model) should be established to identify the circumstances surrounding drug poisoning/overdose

deaths to provide insight into prevention. A data base should be developed based on PDR data from death certificates, coroner reports, autopsy, toxicology and other data as available (e.g., prescription and medical records, law enforcement/criminal records, substance abuse or mental health information). Reviews should be conducted by representatives from the local drug poisoning/drug abuse coalition or task force according to guidelines provided by ODH. **Implementation:** The local drug poisoning coalition or task force should assess the feasibility of implementing a county PDR with guidance from staff in the Injury Prevention Program at ODH. ODH is currently funding two pilot projects to implement a PDR; one in Scioto County and one in Montgomery County.

4. **Increase the capacity of coroners for data collection:** Provide funding to coroners for electronic record keeping and toxicology screening to document more accurately the number of deaths due to prescription drug overdose and the types of medications involved. Provide funding for a statewide coroner reporting system to be maintained by the Ohio State Coroner's Association (OSCA) that is able to compile electronic records/data from coroners statewide. **Implementation:** The OSCA, local coroners and ODH should collaborate on this effort to explore potential funding sources and determine the most reasonable and effective repository for the data collected i.e. OSCA or ODH Vital Statistics.

5. **Conduct a study to assess treatment access throughout Ohio:** Conduct a survey of mental health and substance abuse treatment providers and individuals with substance abuse issues to identify areas of greatest need. This information should then be used to request state and federal funding to supplement areas in greatest need of increased treatment options. **Implementation:** ODADAS should initiate this survey working in collaboration with relevant state associations and local alcohol, drug addiction and mental health boards and providers. The location of access needs can be established from the ADAMH/ADA Boards' current community plans that are submitted to ODADAS. Additionally, the new Ohio Behavioral Health Module (OHBH) system which tracks admissions and discharges in all ODADAS funded agencies is collecting information that can assist with this assessment.

6. **Create an action group of the PDAAG to review current surveys and data collection methods and identify gaps in knowledge and develop specific questions to address these needs:**
    - Behavioral Risk Factor Surveillance Survey (BRFSS) – Questions are included related to this topic. Review the questions related to prescription drug abuse, the data obtained and determine if changes are needed.
    - Youth Risk Behavior Survey (YRBS) – Questions regarding non-medical use of medications are included. Review the questions and data obtained and determine if changes are needed.
    - Family Health Survey – Explore the feasibility of adding questions relevant to non-medical use of medications ad prescription drug abuse/misuse/overdose

Implementation: ODH and ODADAS staff should contact PDAAG members to ask for volunteers to become part of this action group.

*Naloxone (Narcan®): Naloxone is an opioid antagonist that helps reverse the respiratory depression affects associated with an opioid overdose. In other states, (e.g., North Carolina, Massachusetts), intranasal naloxone prescriptions coupled with education programs have been effective in preventing fatal opioid overdoses among high risk individuals.
*Buprenorphine (Suboxone®): Buprenorphine is a prescription opioid medication indicated for the treatment of opioid dependence. Studies have shown that it is effective in helping opioid addicts manage their addictions.

For more information contact:

- Ohio Violence and Injury Prevention Program, 614-466-2144