



Pain Standards Task Force
PacificSource Community Solutions – Boardroom
2965 NE Conners Ave, Bend OR 97701

Agenda: January 6, 2016 from 7:00am-8:00am

Call-In Number: 866-740-1260
7-Digit Access Code: 3063523

1. **7:00-7:05** **Introductions—All**

2. **7:05-7:25** **2015 Year In Review and COHC Board Presentation Input—Dr. Swanson**

3. **7:25-7:35** **PDMP Update—Rebeckah Berry**

5. **7:35-8:00** **2016 Aims and Objectives Initial Brainstorm—Dr. Swanson**
 - **Pain Society of Oregon Collaboration Opportunities**
 - a. **Pain 101 Conference for PCPs in April?**
 - b. **Aligning four OPS events with Grand Rounds?**
 - **PDMP sign-up?**
 - **Needle Exchange?**
 - **Naloxone Training?**
 - **Suboxone/Buprenorphine?**
 - **Trainings on evidence-based alternatives for PC settings (CBT, ACT, etc.)?**
 - **Remaining Money from Summit to Reduce Rx Abuse Donations**
 - **2016 Grand Rounds Topics and Speakers**

Action: Please email Rebeckah any aims or objectives to bring in front of the group for February's meeting no later than January 22, 2016.

Consent Agenda:

- **Approval of the draft minutes dated December 2, 2015 subject to corrections/legal review**

Increases in Drug and Opioid Overdose Deaths — United States, 2000–2014

Rose A. Rudd, MSPH¹; Noah Aleshire, JD¹; Jon E. Zibbell, PhD¹; R. Matthew Gladden, PhD¹

The United States is experiencing an epidemic of drug overdose (poisoning) deaths. Since 2000, the rate of deaths from drug overdoses has increased 137%, including a 200% increase in the rate of overdose deaths involving opioids (opioid pain relievers and heroin). CDC analyzed recent multiple cause-of-death mortality data to examine current trends and characteristics of drug overdose deaths, including the types of opioids associated with drug overdose deaths. During 2014, a total of 47,055 drug overdose deaths occurred in the United States, representing a 1-year increase of 6.5%, from 13.8 per 100,000 persons in 2013 to 14.7 per 100,000 persons in 2014. The rate of drug overdose deaths increased significantly for both sexes, persons aged 25–44 years and ≥55 years, non-Hispanic whites and non-Hispanic blacks, and in the Northeastern, Midwestern, and Southern regions of the United States. Rates of opioid overdose deaths also increased significantly, from 7.9 per 100,000 in 2013 to 9.0 per 100,000 in 2014, a 14% increase. Historically, CDC has programmatically characterized all opioid pain reliever deaths (natural and semisynthetic opioids, methadone, and other synthetic opioids) as “prescription” opioid overdoses (1). Between 2013 and 2014, the age-adjusted rate of death involving methadone remained unchanged; however, the age-adjusted rate of death involving natural and semisynthetic opioid pain relievers, heroin, and synthetic opioids, other than methadone (e.g., fentanyl) increased 9%, 26%, and 80%, respectively. The sharp increase in deaths involving synthetic opioids, other than methadone, in 2014 coincided with law enforcement reports of increased availability of illicitly manufactured fentanyl, a synthetic opioid; however, illicitly manufactured fentanyl cannot be distinguished from prescription fentanyl in death certificate data. These findings indicate that the opioid overdose epidemic is worsening. There is a need for continued action to prevent opioid abuse, dependence, and death, improve treatment capacity for

opioid use disorders, and reduce the supply of illicit opioids, particularly heroin and illicit fentanyl.

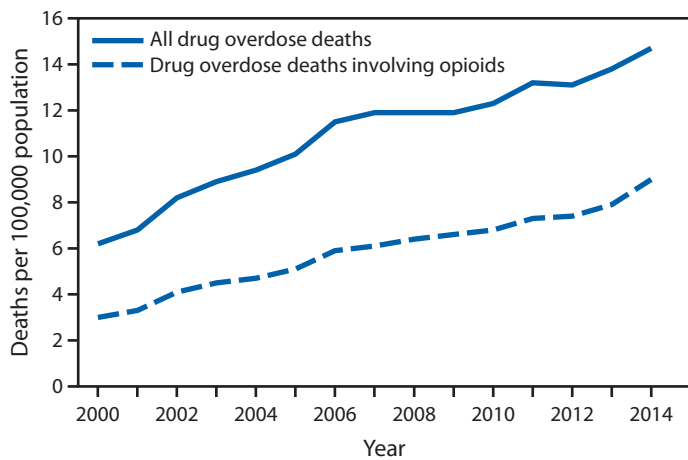
The National Vital Statistics System multiple cause-of-death mortality files were used to identify drug overdose deaths.* Drug overdose deaths were classified using the *International Classification of Disease, Tenth Revision* (ICD-10), based on the ICD-10 underlying cause-of-death codes X40–44 (unintentional), X60–64 (suicide), X85 (homicide), or Y10–Y14 (undetermined intent) (2). Among the deaths with drug overdose as the underlying cause, the type of opioid involved is indicated by the following ICD-10 multiple cause-of-death codes: opioids (T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6); natural and semisynthetic opioids (T40.2); methadone (T40.3); synthetic opioids, other than methadone (T40.4); and heroin (T40.1). Some deaths involve more than one type of opioid; these deaths were included in the rates for each category (e.g., a death involving both a synthetic opioid and heroin would be included in the rates for synthetic opioid deaths and in the rates for heroin deaths). Age-adjusted death rates were calculated by applying age-specific death rates to the 2000 U.S standard population age distribution (3). Significance testing was based on the z-test at a significance level of 0.05.

During 2014, 47,055 drug overdose deaths occurred in the United States. Since 2000, the age-adjusted drug overdose death rate has more than doubled, from 6.2 per 100,000 persons in 2000 to 14.7 per 100,000 in 2014 (Figure 1). The overall number and rate of drug overdose deaths increased significantly from 2013 to 2014, with an additional 3,073 deaths occurring in 2014 (Table), resulting in a 6.5% increase in the age-adjusted rate. From 2013 to 2014, statistically significant increases in drug overdose death rates were seen for both males and females, persons aged 25–34 years, 35–44 years,

* Additional information available at http://www.cdc.gov/nchs/nvss/mortality_public_use_data.htm.



FIGURE 1. Age-adjusted rate* of drug overdose deaths† and drug overdose deaths involving opioids§,¶ — United States, 2000–2014



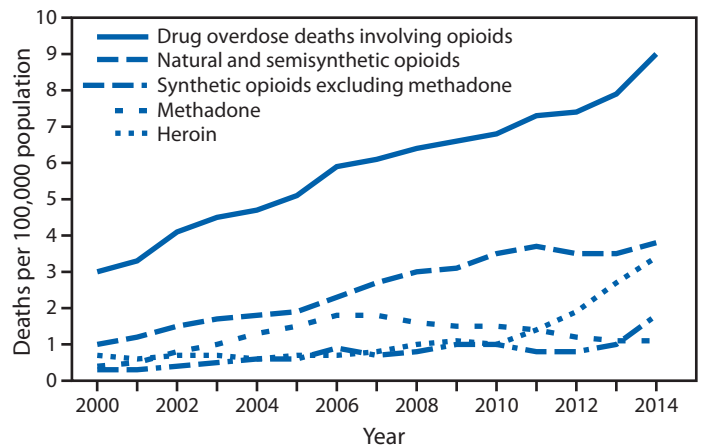
Source: National Vital Statistics System, Mortality file.
 * Age-adjusted death rates were calculated by applying age-specific death rates to the 2000 U.S. standard population age distribution.
 † Drug overdose deaths are identified using *International Classification of Diseases, Tenth Revision* underlying cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14.
 § Drug overdose deaths involving opioids are drug overdose deaths with a multiple cause-of-death code of T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6. Approximately one fifth of drug overdose deaths lack information on the specific drugs involved. Some of these deaths might involve opioids.
 ¶ Opioids include drugs such as morphine, oxycodone, hydrocodone, heroin, methadone, fentanyl, and tramadol.

55–64 years, and ≥65 years; non-Hispanic whites and non-Hispanic blacks; and residents in the Northeast, Midwest and South Census Regions (Table). In 2014, the five states with the highest rates of drug overdose deaths were West Virginia (35.5 deaths per 100,000), New Mexico (27.3), New Hampshire (26.2), Kentucky (24.7) and Ohio (24.6).† States with statistically significant increases in the rate of drug overdose deaths from 2013 to 2014 included Alabama, Georgia, Illinois, Indiana, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Mexico, North Dakota, Ohio, Pennsylvania, and Virginia.

In 2014, 61% (28,647, data not shown) of drug overdose deaths involved some type of opioid, including heroin. The age-adjusted rate of drug overdose deaths involving opioids increased significantly from 2000 to 2014, increasing 14% from 2013 (7.9 per 100,000) to 2014 (9.0) (Figure 1). From 2013 to 2014, the largest increase in the rate of drug overdose deaths involved synthetic opioids, other than methadone (e.g., fentanyl and tramadol), which nearly doubled from 1.0 per 100,000 to 1.8 per 100,000 (Figure 2). Heroin overdose death rates increased by 26% from 2013 to 2014 and have more than tripled since 2010, from 1.0 per 100,000 in 2010 to 3.4 per 100,000 in 2014 (Figure 2). In 2014, the rate of drug overdose

† Additional information available at <http://www.cdc.gov/drugoverdose/data/statedeaths.html>.

FIGURE 2. Drug overdose deaths* involving opioids,†,§ by type of opioid¶ — United States, 2000–2014



Source: National Vital Statistics System, Mortality file.
 * Age-adjusted death rates were calculated by applying age-specific death rates to the 2000 U.S. standard population age distribution.
 † Drug overdose deaths involving opioids are identified using *International Classification of Diseases, Tenth Revision* underlying cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14 with a multiple cause code of T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6.
 § Opioids include drugs such as morphine, oxycodone, hydrocodone, heroin, methadone, fentanyl, and tramadol.
 ¶ For each type of opioid, the multiple cause-of-death code was T40.1 for heroin, T40.2 for natural and semisynthetic opioids (e.g., oxycodone and hydrocodone), T40.3 for methadone, and T40.4 for synthetic opioids excluding methadone (e.g., fentanyl and tramadol). Deaths might involve more than one drug thus categories are not exclusive.

deaths involving natural and semisynthetic opioids (e.g., morphine, oxycodone, and hydrocodone), 3.8 per 100,000, was the highest among opioid overdose deaths, and increased 9% from 3.5 per 100,000 in 2013. The rate of drug overdose deaths involving methadone, a synthetic opioid classified separately from other synthetic opioids, was similar in 2013 and 2014.

Discussion

More persons died from drug overdoses in the United States in 2014 than during any previous year on record. From 2000 to 2014 nearly half a million persons in the United States have died from drug overdoses. In 2014, there were approximately one and a half times more drug overdose deaths in the United States than deaths from motor vehicle crashes (4). Opioids, primarily prescription pain relievers and heroin, are the main drugs associated with overdose deaths. In 2014, opioids were involved in 28,647 deaths, or 61% of all drug overdose deaths; the rate of opioid overdoses has tripled since 2000. The 2014 data demonstrate that the United States’ opioid overdose epidemic includes two distinct but interrelated trends: a 15-year increase in overdose deaths involving prescription opioid pain relievers and a recent surge in illicit opioid overdose deaths, driven largely by heroin.

TABLE. Number and age-adjusted rates of drug overdose deaths,* by sex, age, race and Hispanic origin,† Census region, and state — United States, 2013 and 2014

| Decedent characteristic | 2013 | | 2014 | | % change from 2013 to 2014 |
|-----------------------------------|---------------|-------------------|---------------|-------------------|----------------------------|
| | No. | Age-adjusted rate | No. | Age-adjusted rate | |
| All | 43,982 | 13.8 | 47,055 | 14.7 | 6.5[§] |
| Sex | | | | | |
| Male | 26,799 | 17.0 | 28,812 | 18.3 | 7.6 [§] |
| Female | 17,183 | 10.6 | 18,243 | 11.1 | 4.7 [§] |
| Age group (yrs) | | | | | |
| 0–14 | 105 | 0.2 | 109 | 0.2 | 0.0 |
| 15–24 | 3,664 | 8.3 | 3,798 | 8.6 | 3.6 |
| 25–34 | 8,947 | 20.9 | 10,055 | 23.1 | 10.5 [§] |
| 35–44 | 9,320 | 23.0 | 10,134 | 25.0 | 8.7 [§] |
| 45–54 | 12,045 | 27.5 | 12,263 | 28.2 | 2.5 |
| 55–64 | 7,551 | 19.2 | 8,122 | 20.3 | 5.7 [§] |
| ≥65 | 2,344 | 5.2 | 2,568 | 5.6 | 7.7 [§] |
| Race and Hispanic origin† | | | | | |
| White, non-Hispanic | 35,581 | 17.6 | 37,945 | 19.0 | 8.0 [§] |
| Black, non-Hispanic | 3,928 | 9.7 | 4,323 | 10.5 | 8.2 [§] |
| Hispanic | 3,345 | 6.7 | 3,504 | 6.7 | 0.0 |
| Census region of residence | | | | | |
| Northeast | 8,403 | 14.8 | 9,077 | 16.1 | 8.8 [§] |
| Midwest | 9,745 | 14.6 | 10,647 | 16.0 | 9.6 [§] |
| South | 15,519 | 13.1 | 16,777 | 14.0 | 6.9 [§] |
| West | 10,315 | 13.6 | 10,554 | 13.7 | 0.7 |
| State of residence | | | | | |
| Alabama | 598 | 12.7 | 723 | 15.2 | 19.7 [§] |
| Alaska | 105 | 14.4 | 124 | 16.8 | 16.7 |
| Arizona | 1,222 | 18.7 | 1,211 | 18.2 | -2.7 |
| Arkansas | 319 | 11.1 | 356 | 12.6 | 13.5 |
| California | 4,452 | 11.1 | 4,521 | 11.1 | 0.0 |
| Colorado | 846 | 15.5 | 899 | 16.3 | 5.2 |
| Connecticut | 582 | 16.0 | 623 | 17.6 | 10.0 |
| Delaware | 166 | 18.7 | 189 | 20.9 | 11.8 |
| District of Columbia | 102 | 15.0 | 96 | 14.2 | -5.3 |
| Florida | 2,474 | 12.6 | 2,634 | 13.2 | 4.8 |
| Georgia | 1,098 | 10.8 | 1,206 | 11.9 | 10.2 [§] |
| Hawaii | 158 | 11.0 | 157 | 10.9 | -0.9 |
| Idaho | 207 | 13.4 | 212 | 13.7 | 2.2 |
| Illinois | 1,579 | 12.1 | 1,705 | 13.1 | 8.3 [§] |
| Indiana | 1,064 | 16.6 | 1,172 | 18.2 | 9.6 [§] |
| Iowa | 275 | 9.3 | 264 | 8.8 | -5.4 |
| Kansas | 331 | 12.0 | 332 | 11.7 | -2.5 |
| Kentucky | 1,019 | 23.7 | 1,077 | 24.7 | 4.2 |
| Louisiana | 809 | 17.8 | 777 | 16.9 | -5.1 |
| Maine | 174 | 13.2 | 216 | 16.8 | 27.3 [§] |
| Maryland | 892 | 14.6 | 1,070 | 17.4 | 19.2 [§] |
| Massachusetts | 1,081 | 16.0 | 1,289 | 19.0 | 18.8 [§] |
| Michigan | 1,553 | 15.9 | 1,762 | 18.0 | 13.2 [§] |
| Minnesota | 523 | 9.6 | 517 | 9.6 | 0.0 |
| Mississippi | 316 | 10.8 | 336 | 11.6 | 7.4 |
| Missouri | 1,025 | 17.5 | 1,067 | 18.2 | 4.0 |
| Montana | 137 | 14.5 | 125 | 12.4 | -14.5 |
| Nebraska | 117 | 6.5 | 125 | 7.2 | 10.8 |
| Nevada | 614 | 21.1 | 545 | 18.4 | -12.8 |
| New Hampshire | 203 | 15.1 | 334 | 26.2 | 73.5 [§] |
| New Jersey | 1,294 | 14.5 | 1,253 | 14.0 | -3.4 |
| New Mexico | 458 | 22.6 | 547 | 27.3 | 20.8 [§] |
| New York | 2,309 | 11.3 | 2,300 | 11.3 | 0.0 |
| North Carolina | 1,259 | 12.9 | 1,358 | 13.8 | 7.0 |
| North Dakota | 20 | 2.8 | 43 | 6.3 | 125.0 [§] |
| Ohio | 2,347 | 20.8 | 2,744 | 24.6 | 18.3 [§] |
| Oklahoma | 790 | 20.6 | 777 | 20.3 | -1.5 |
| Oregon | 455 | 11.3 | 522 | 12.8 | 13.3 |

See table footnotes on the next page.

TABLE. (Continued) Number and age-adjusted rates of drug overdose deaths,* by sex, age, race and Hispanic origin,† Census region, and state — United States, 2013 and 2014

| Decedent characteristic | 2013 | | 2014 | | % change from 2013 to 2014 |
|-------------------------|-------|-------------------|-------|-------------------|----------------------------|
| | No. | Age-adjusted rate | No. | Age-adjusted rate | |
| Pennsylvania | 2,426 | 19.4 | 2,732 | 21.9 | 12.9 [§] |
| Rhode Island | 241 | 22.4 | 247 | 23.4 | 4.5 |
| South Carolina | 620 | 13.0 | 701 | 14.4 | 10.8 |
| South Dakota | 55 | 6.9 | 63 | 7.8 | 13.0 |
| Tennessee | 1,187 | 18.1 | 1,269 | 19.5 | 7.7 |
| Texas | 2,446 | 9.3 | 2,601 | 9.7 | 4.3 |
| Utah | 594 | 22.1 | 603 | 22.4 | 1.4 |
| Vermont | 93 | 15.1 | 83 | 13.9 | -7.9 |
| Virginia | 854 | 10.2 | 980 | 11.7 | 14.7 [§] |
| Washington | 969 | 13.4 | 979 | 13.3 | -0.7 |
| West Virginia | 570 | 32.2 | 627 | 35.5 | 10.2 |
| Wisconsin | 856 | 15.0 | 853 | 15.1 | 0.7 |
| Wyoming | 98 | 17.2 | 109 | 19.4 | 12.8 |

Source: National Vital Statistics System, Mortality file.

* Deaths are classified using the *International Classification of Diseases, Tenth Revision* (ICD-10). Drug overdose deaths are identified using underlying cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14. Age-adjusted death rates were calculated by applying age-specific death rates to the 2000 U.S. standard population age distribution.

† Data for Hispanic origin should be interpreted with caution; studies comparing Hispanic origin on death certificates and on census surveys have shown inconsistent reporting on Hispanic ethnicity.

§ Statistically significant change from 2013 to 2014.

Natural and semisynthetic opioids, which include the most commonly prescribed opioid pain relievers, oxycodone and hydrocodone, continue to be involved in more overdose deaths than any other opioid type. Although this category of opioid drug overdose death had declined in 2012 compared with 2011, and had held steady in 2013, there was a 9% increase in 2014.

Drug overdose deaths involving heroin continued to climb sharply, with heroin overdoses more than tripling in 4 years. This increase mirrors large increases in heroin use across the country (5) and has been shown to be closely tied to opioid pain reliever misuse and dependence. Past misuse of prescription opioids is the strongest risk factor for heroin initiation and use, specifically among persons who report past-year dependence or abuse (5). The increased availability of heroin, combined with its relatively low price (compared with diverted prescription opioids) and high purity appear to be major drivers of the upward trend in heroin use and overdose (6).

The rate of drug overdose deaths involving synthetic opioids nearly doubled between 2013 and 2014. This category includes both prescription synthetic opioids (e.g., fentanyl and tramadol) and non-pharmaceutical fentanyl manufactured in illegal laboratories (illicit fentanyl). Toxicology tests used by coroners and medical examiners are unable to distinguish between prescription and illicit fentanyl. Based on reports from states and drug seizure data, however, a substantial portion of the increase in synthetic opioid deaths appears to be related to increased availability of illicit fentanyl (7), although this cannot be confirmed with mortality data. For example, five jurisdictions (Florida, Maryland, Maine, Ohio, and Philadelphia, Pennsylvania) that reported sharp increases in

illicit fentanyl seizures, and screened persons who died from a suspected drug overdose for fentanyl, detected similarly sharp increases in fentanyl-related deaths (7).[§] Finally, illicit fentanyl is often combined with heroin or sold as heroin. Illicit fentanyl might be contributing to recent increases in drug overdose deaths involving heroin. Therefore, increases in illicit fentanyl-associated deaths might represent an emerging and troubling feature of the rise in illicit opioid overdoses that has been driven by heroin.

The findings in this report are subject to at least three limitations. First, several factors related to death investigation might affect estimates of death rates involving specific drugs. At autopsy, toxicological laboratory tests might be performed to determine the type of drugs present; however, the substances tested for and circumstances under which the tests are performed vary by jurisdiction. Second, in 2013 and 2014, 22% and 19% of drug overdose deaths, respectively, did not include information on the death certificate about the specific types of drugs involved. The percent of overdose deaths with specific drugs identified on the death certificate varies widely by state. Some of these deaths might have involved opioids. This increase in the reporting of specific drugs in 2014 might have contributed to some of the observed increases in drug overdose death rates involving different types of opioids from 2013 to 2014. Finally, some heroin deaths might be misclassified as morphine because morphine and heroin are metabolized similarly (8), which might result in an underreporting of heroin overdose deaths.

[§] Additional information available at <http://pub.lucidpress.com/NDEWSFentanyl/>.

Summary

What is already known on this topic?

The rate for drug overdose deaths has increased approximately 140% since 2000, driven largely by opioid overdose deaths. After increasing since the 1990s, deaths involving the most commonly prescribed opioid pain relievers (i.e., natural and semisynthetic opioids) declined slightly in 2012 and remained steady in 2013, showing some signs of progress. Heroin overdose deaths have been sharply increasing since 2010.

What is added by this report?

Drug overdose deaths increased significantly from 2013 to 2014. Increases in opioid overdose deaths were the main factor in the increase in drug overdose deaths. The death rate from the most commonly prescribed opioid pain relievers (natural and semisynthetic opioids) increased 9%, the death rate from heroin increased 26%, and the death rate from synthetic opioids, a category that includes illicitly manufactured fentanyl and synthetic opioid pain relievers other than methadone, increased 80%. Nearly every aspect of the opioid overdose death epidemic worsened in 2014.

What are the implications for public health practice?

Efforts to encourage safer prescribing of opioid pain relievers should be strengthened. Other key prevention strategies include expanding availability and access to naloxone (an antidote for all opioid-related overdoses), increasing access to medication-assisted treatment in combination with behavioral therapies, and increasing access to syringe service programs to prevent the spread of hepatitis C virus infection and human immunodeficiency virus infections. Public health agencies, medical examiners and coroners, and law enforcement agencies can work collaboratively to improve detection of and response to outbreaks associated with drug overdoses related to illicit opioids.

To reverse the epidemic of opioid drug overdose deaths and prevent opioid-related morbidity, efforts to improve safer prescribing of prescription opioids must be intensified. Opioid pain reliever prescribing has quadrupled since 1999 and has increased in parallel with overdoses involving the most commonly used opioid pain relievers (1). CDC has developed a draft guideline for the prescribing of opioids for chronic pain to address this need.[†]

In addition, efforts are needed to protect persons already dependent on opioids from overdose and other harms. This includes expanding access to and use of naloxone (a safe and effective antidote for all opioid-related overdoses)** and

increasing access to medication-assisted treatment, in combination with behavioral therapies (9). Efforts to ensure access to integrated prevention services, including access to syringe service programs when available, is also an important consideration to prevent the spread of hepatitis C virus and human immunodeficiency virus infections from injection drug use.

Public health agencies, medical examiners and coroners, and law enforcement agencies can work collaboratively to improve detection of outbreaks of drug overdose deaths involving illicit opioids (including heroin and illicit fentanyl) through improved investigation and testing as well as reporting and monitoring of specific drugs, and facilitate a rapid and effective response that can address this emerging threat to public health and safety (7). Efforts are needed to distinguish the drugs contributing to overdoses to better understand this trend.

[†]Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, CDC.

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References

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[†] Additional information available at <http://www.cdc.gov/drugoverdose/prescribing/guideline.html>.

** Additional information available at https://store.samhsa.gov/shin/content/SMA13-4742/Overdose_Toolkit_2014_Jan.pdf.

Number and age-adjusted rates of drug-poisoning deaths involving opioid analgesics and heroin: United States, 2000-2014

| Year | Drug poisoning | | | | | |
|------|----------------|--------------------|-------------------|--------------------|--------|--------------------|
| | All | | Opioid analgesics | | Heroin | |
| | Number | Deaths per 100,000 | Number | Deaths per 100,000 | Number | Deaths per 100,000 |
| 1999 | 16,849 | 6.1 | 4,030 | 1.4 | 1,960 | 0.7 |
| 2000 | 17,415 | 6.2 | 4,400 | 1.5 | 1,842 | 0.7 |
| 2001 | 19,394 | 6.8 | 5,528 | 1.9 | 1,779 | 0.6 |
| 2002 | 23,518 | 8.2 | 7,456 | 2.6 | 2,089 | 0.7 |
| 2003 | 25,785 | 8.9 | 8,517 | 2.9 | 2,080 | 0.7 |
| 2004 | 27,424 | 9.4 | 9,857 | 3.4 | 1,878 | 0.6 |
| 2005 | 29,813 | 10.1 | 10,928 | 3.7 | 2,009 | 0.7 |
| 2006 | 34,425 | 11.5 | 13,723 | 4.6 | 2,088 | 0.7 |
| 2007 | 36,010 | 11.9 | 14,408 | 4.8 | 2,399 | 0.8 |
| 2008 | 36,450 | 11.9 | 14,800 | 4.8 | 3,041 | 1.0 |
| 2009 | 37,004 | 11.9 | 15,597 | 5.0 | 3,278 | 1.1 |
| 2010 | 38,329 | 12.3 | 16,651 | 5.4 | 3,036 | 1.0 |
| 2011 | 41,340 | 13.2 | 16,917 | 5.4 | 4,397 | 1.4 |
| 2012 | 41,502 | 13.1 | 16,007 | 5.1 | 5,925 | 1.9 |
| 2013 | 43,982 | 13.8 | 16,235 | 5.1 | 8,257 | 2.7 |
| 2014 | 47,055 | 14.7 | 18,893 | 5.9 | 10,574 | 3.4 |

NOTES: Deaths are classified using the *International Classification of Diseases, Tenth Revision* (ICD-10). Drug-poisoning deaths are identified using underlying cause-of-death codes X40-X44, X60-X64, X85, and Y10-Y14. Drug-poisoning deaths involving opioid analgesics are drug-poisoning deaths with a multiple cause code of T40.2, T40.3, or T40.4. Drug-poisoning deaths involving heroin are drug-poisoning deaths with a multiple cause code of T40.1. Each year a small subset of drug-poisoning deaths involved both opioid analgesics and heroin. For example, in 2013, 1,342 deaths involved both opioid analgesics and heroin. Deaths involving both opioid analgesics and heroin are included in both the rate of deaths involving opioid analgesics and the rate of deaths involving heroin. Approximately one-fifth of drug-poisoning deaths lack information on the specific drugs involved. Some of these deaths may involve opioid analgesics or heroin.

SOURCE: CDC/NCHS, National Vital Statistics System, Mortality File.



**MINUTES OF A MEETING OF
THE PAIN STANDARDS TASK FORCE
CENTRAL OREGON HEALTH COUNCIL
THIS WAS A CALL-IN MEETING DUE TO INCLEMENT WEATHER
December 2, 2015 from 7-8:00am**

Task Force Members Present (Call-In Only)

Kim Swanson, Chair (St. Charles Medical Group)
Gary Allen (Advantage Dental)
Rebeckah Berry (COHC)
Wil Berry (Deschutes County Behavioral Health)
Patty Buehler, MD (InFocus Eyecare)
Muriel DeLaVergne-Brown (Crook County Health Department)
Maria Hatcliffe (PacificSource)
Janet Kadlecik, OTR (Work Capacities)
Steve Mann (COIPA and High Lakes Healthcare)
Donna Mills (COHC)
Kyle Mills (Mosaic Medical)
Laura Pennavaria (La Pine Community Health Center)
Christine Pierson (Mosaic Medical)
Marie Rudback, DC (Endeavor Chiropractic, LLC)
Kerie Raymond, ND (Hawthorne Center)
Scott Safford (St. Charles Family Care)
Divya Sharma (Mosaic Medical and COIPA)
Pam Tornay (Central Oregon Emergency Physicians)
Sharity Ludwig (Advantage Dental)
Tina Patel (PacificSource)

Absent

Robert Andrews (Desert Orthopedics)
David Holloway (Bend Memorial Clinic)
Jessica LeBlanc (Mosaic Medical)
Alison Little (PacificSource)
Rob Ross (St. Charles Medical Group)
Rick Treleaven (BestCare Treatment Services)
Tom Watson (Rebound Physical Therapy)

1. Introductions & Opening Remarks

- Team members introduced themselves and their respective organizations.

2. PDMP Data Update

- Dr. Swanson explained that Sarah Kingston has done extensive work analyzing and organizing the PDMP data into the dashboard. The group reviewed the information and formatting.
 - Dr. Swanson confirmed that cancer or acute pain patients cannot be removed from the data
 - She pointed out that the number of opiate prescription refills peaked in 2014 in each county in Central Oregon.
 - Dr. Berry mentioned that it would be reasonable to make some assumptions about the rate of cancer and acute pain patients based on comparable data, given that there are 58,000+ unique individuals.
 - **ACTION:** Rebeckah will look into options for estimating cancer patients within the data.
 - Hydrocodone-acetaminophen is the most frequently prescribed.
 - The group discussed how the distribution compares in Central Oregon to the rest of the state, specifically related to an older age bracket due to back pain and chronic conditions.
 - Dr. Swanson stated that opiates and benzodiazepine are highest in co-prescribing and a top priority for the Task Force (keeping in mind that chronic opiate use includes cancer diagnoses).
 - The group agreed that the death rate data from overdose would be useful information.
 - Ms. Hatcliffe noted that the Medical Examiner website has illicit drugs such as heroin, cocaine, etc., overdose data for the state through 2012, and suggested looking into more specific information on each county. Dr. Buehler noted that death rates for both opioids and heroin are needed. It was suggested that the Medical Examiner data could be weak, as they do not always drug test in unexplained deaths. Ms. DeLaVergne-Brown explained that counties will not provide individual data and that the information is fed to State Public Health and included in vital statistics.
 - **ACTION:** Rebeckah and Maria will research further with the Medical Examiner's office and Muriel will check with her Public Health partners.
 - Dr. Allen noted that dentists would not think this information applies to them and requested that the provider type be included on the dashboard.
 - Dr. Berry referenced the Chronic Opiate Use box, stating that it was redundant and suggested placing death rates in that spot.
 - Dr. Buehler noted that more information about provider type would be helpful, as in the case of oncologists where some assumptions could be made about patients being treated.
 - Dr. Mann suggested a chart for MED to look for a hopeful downward trend moving forward.
 - **ACTION:** Rebeckah will work on seeing if they can add the provider type to the data, remove the Chronic Opiate Use table, and insert hospitalization and death rate table (opiod and heroin).
 - **ACTION:** Rebeckah will follow up with Sarah regarding percent of cancer patients in original PSCS data.

3. Pain Contracts and the Emergency Department

- Options were discussed and the group determined PreManage is a good source for ED's to pull from.
 - Dr. Tornay explained that messaging to primary clinics about the importance of sending these in will be important.
 - Ms. Hatcliffe noted that she checked at PacificSource about the use of PreManage for uploading contracts by clinics and confirmed it would be useful and would also potentially be

available to other providers. She noted that some clinics are already enrolled and a rollout plan is being developed for other clinics, however the timing has not been determined.

- The issue of access by dental clinics was discussed but it was unclear how that would play out.
- Ms. Ludwig noted the potential for admin-level access. Dr. Tornay stated that confidentiality would need to be scrutinized.
- Dr. Sharma mentioned the shared risk and quality measures data is being reviewed related to opioid prescriptions from EDs for chronic conditions. They are looking into how to treat this measure for next year.
 - **ACTION:** Dr. Swanson and Maria will follow up on PreManage clinic access. Dr. Tornay will draft a letter to PCPs about the importance of sharing contracts.

4. Updates on Internal Communication Plans for Endorsement Letter

- Dr. Mann has had a number of one-on-one meetings with providers at High Lakes. He reported that there has been no resistance but his group is anticipating how it may affect patients.
- Dr. Sharma noted that there were no issues with the endorsement letter at Mosaic. However, there is frustration with the changes in back pain coverage.
- Dr. Pierson also reported mostly positive feedback at Mosaic.
- Dr. Tornay mentioned that the ED at St. Charles wanted to know if the letter was legally binding in any way, to which the response from the group was no. Outside of that, she reported that at least half of the providers have signed the letter.
- Dr. Pennavaria noted that there is a uniform acceptance of the standards at La Pine Community Health and the clinic has changed policies and procedures to reflect it.
- Dr. Swanson reported that The Center has been very supportive. She indicated that Dr. Ross at St. Charles has received several endorsements and there is no resistance from St. Charles as a system. She added that she would be working with Dr. Salton in the E.D. to facilitate medical staff meetings. She also explained that Dr. Barrett is willing to help speak with psychiatrists in the community.

6. Task Force Updates & Key Information

December 7th Regional Press Release

- Dr. Swanson confirmed that the press release was going out today and she would be the main contact. She added that Portland is also released their tri-county press release and had good coverage.
- Dr. Mann noted that he has an OPB interview about the delay regarding new low back pain guidelines.
- **ACTION:** Dr. Swanson and Rebeckah will work together prepare talking points and email to the group today.
- **ACTION:** Rebeckah will send the OPB interview out to the group.

December 10th Endorsement Dinner

- Dr. Swanson confirmed that there are just fewer than 100 providers registered for the dinner to date. She encouraged the group to make a final push with registration closing on December 7th.
- An informal breakfast invite with Dr. Loeser after Friday Grand Rounds also went out to PSTF members.

Final 2015 Grand Rounds is December 11 from 7:00 am – 8:00 am

HERC Low Back Pain Guidelines Updates

- Dr. Little was not able to attend the meeting but provided a link from a recent Bend Bulletin article on the guidelines.

http://www.bendbulletin.com/exports/newsletters/main/3730007-151/oregon-delays-change-in-back-pain-treatment?utm_source=%7CLIST_LIST_NAME%7C*&utm_medium=email&utm_campaign=BendBulletin

- Dr. Mann noted that there is some indication that therapies may be rolled out in a limited fashion in stages.

Recap of November 19th Oregon Pain Society Event

- Dr. Swanson shared that this event was sold out with 60 in attendance and thanked all of the PSTF members that were able to attend.
- Dr. Swanson also encouraged the group to use the content in the slides available in the PSTF packet.

7. **Consent Agenda:** Minutes dated November 4, 2015 were approved, subject to corrections and legal review.