

Tri-County Region Opioid Trends

Clackamas, Multnomah, and Washington, Oregon

2016



Executive Summary

"20.8 million people in the United States have a substance use disorder (not limited to opioids), equivalent to the number of Americans with diabetes.¹

We have to help the country see that addiction is a chronic disease like diabetes or heart disease. If we help people see that it will make it easier for folks to come forward. It will make it easier for communities to support treatment programs in their neighborhoods."

--Dr. Vivek Murthy, United States Surgeon General

Staff from the public health departments of Clackamas, Multnomah, and Washington counties produced the content of this special report in collaboration with the Oregon Public Health Division of the Oregon Health Authority and Health Share of Oregon.

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¹ <https://addiction.surgeongeneral.gov/surgeon-generals-report.pdf>

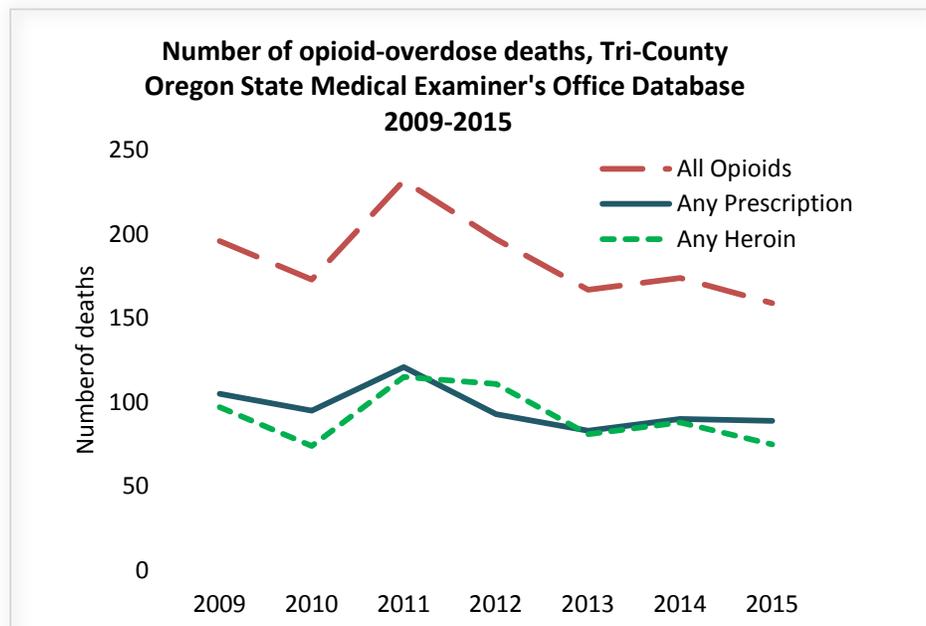
Executive Summary

The purpose of the [2016 Tri-County Region Opioid Trends](#)² report is to provide the public, community advocates, physical and behavioral health providers, and policy makers with accurate quantitative data about a pervasive problem. The report is organized in five chapters: fatal overdoses, 9-1-1 overdose responses (non-fatal overdoses), opioid prescribing trends, syringe exchange trends and client survey, and substance use treatment. This document presents the key points from each chapter of the report alongside considerations for future policy. More analysis, data gaps, and analytic challenges are discussed in the full report.

While deaths have diminished since the peak in 2011, we are disappointed to report there has been little decrease in fatal overdoses in the Tri-County region over the last three years. Although half of all opioid deaths are caused by prescription pain pills, legal opioid prescribing remains persistently high; more than one in five people in the region receives an opioid prescription every year. Although our efforts at harm reduction through syringe exchange prevent the spread of HIV and hepatitis C, the high demand for syringes suggests that injection drug use may be increasing. Finally, we are deeply concerned that many of those suffering from addiction want treatment to reach long-term recovery but do not receive it.

Fatal Overdose

Both Oregon Medical Examiner records and National Vital Statistics analysis show that total opioid deaths in the Tri-County peaked in 2011 but remain stubbornly elevated. In 2015, prescription opioids and heroin killed similar numbers of people in our region but, in contrast to national trends, heroin deaths here have not increased. Deaths from pain pills remain persistently elevated.



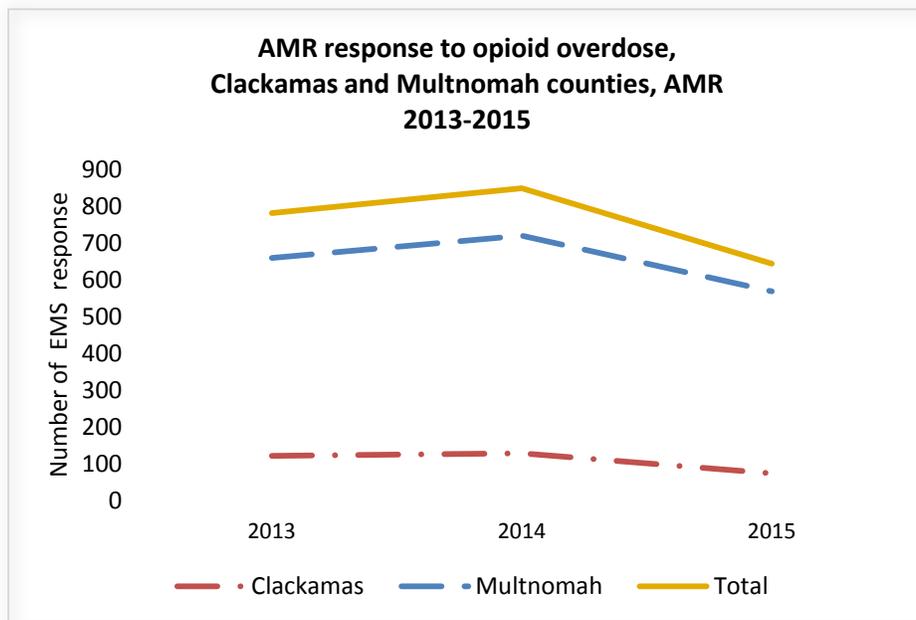
² <http://portlandprofessional.oregonpainguidance.org/wp-content/uploads/sites/8/2017/02/TRI-COUNTY-REGION-OPIOID-TRENDS-2016-REPORT.pdf>

Across the Tri-County region in 2015 there were:

- 159 fatal opioid overdoses; two thirds occurred in Multnomah County.
- Deaths occur at younger ages among males than females in all three counties.
- Deaths from heroin occur at younger ages than from prescription opioids in all three counties.
- Over 90% of opioid deaths occurred among those of white race.

9-1-1 Overdose Responses (Non-Fatal Overdose)

Naloxone is the antidote for opioid overdose and can prevent death if given early after respiratory depression begins. One measure of the frequency of non-fatal opioid overdose is how often paramedics successfully use naloxone to revive patients. From 2014 to 2015, we noted a substantial decline in such ambulance naloxone responses. The decreased need for naloxone after 9-1-1 response may reflect either fewer overdoses or more frequent bystander administration of naloxone.



American Medical Response ambulances provided service in Clackamas and Multnomah Counties; in 2015:

- There were over 600 overdose responses in Clackamas and Multnomah counties, with 88% of these occurring in Multnomah.
- In Multnomah County, over half of responses occurred in public places or businesses; most of the remainder occurred in private residences.
- In Clackamas County, two thirds overdose responses were to private residences.
- Data were available for Washington County but were not comparable to Clackamas and Multnomah because there is a different ambulance company operating in that county.

Overdose Policy Considerations

This report illustrates that opioid deaths in the region have declined from a peak in 2011-2012, but that progress in preventing fatal overdose has slowed. While we are pleased to report a trend toward slightly fewer EMS responses to opioid overdose, our optimism is tempered because more widespread use of naloxone by the public may cause EMS records to underestimate the true number.

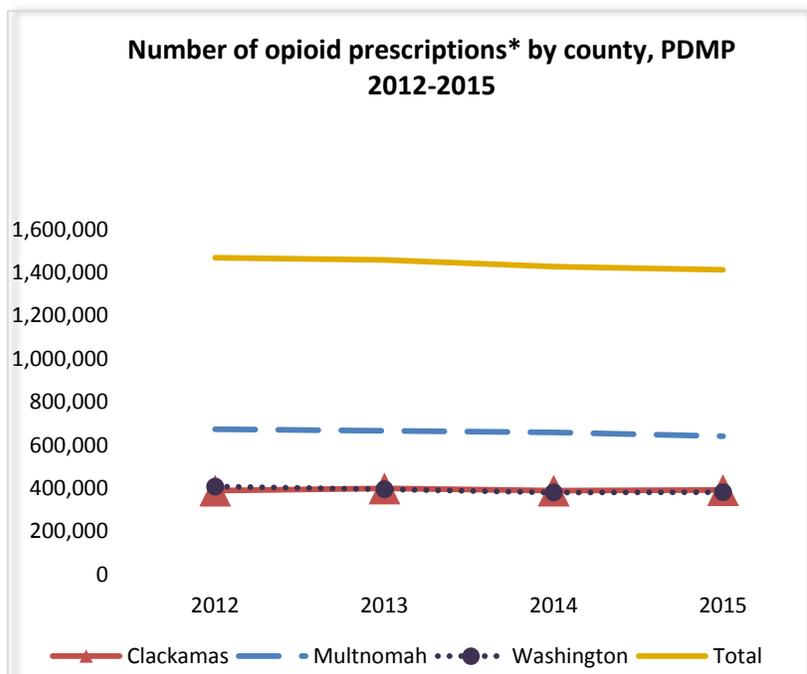
Decreasing the number of opioid users, providing better treatment for chronic pain, and providing more high quality addiction treatment will be needed to turn the tide on overdose fatalities. In the short run, better data and increased access to the antidote naloxone can prevent fatal overdose among opioid users. To do so, policy makers may wish to consider:

- Changing naloxone to over-the-counter status because it is not a drug of abuse.
- Adopting lessons learned from State and National evaluations of successful naloxone programs.
- Promoting state, local, and health-insurer policies that include naloxone prescription coverage for members, and encourage community pharmacies to stock naloxone.
- Providing incentives and support for law enforcement and other community first responders to understand, carry, and use naloxone.
- Linking naloxone administration to recovery treatment.
- Developing media campaigns for the public to learn about fatal overdose prevention with naloxone.
- Facilitating bulk purchasing of naloxone to decrease cost.
- Disseminating regular, detailed reporting of fatal and non-fatal overdoses by county.

Opioid Prescribing

Prescription opioids can be used appropriately for pain, misused by the intended patient, misused by others, or diverted for illegal sale. Excessive prescribing is likely to be an important driver of the opioid epidemic in Oregon for several reasons.

*Excludes tramadol which was added to PDMP in mid 2014.



First, the higher rates of opioid prescribing are tightly correlated with fatal overdose and substance use treatment admissions. Second, in national polls, 75% of current heroin users report first becoming addicted to prescription pain pills; a 2016 survey at our regional syringe exchanges found more than 50% of heroin users reported getting hooked on pain pills before switching to heroin. Finally, compared with other states, Oregon has consistently high rates of opioid prescribing, especially for long-acting versions of these drugs.

Analysis of de-identified data from the Oregon Prescription Drug Monitoring Program (PDMP) showed that:

- There has been little decrease in the number of total opioid *prescriptions* and total opioid prescription *recipients* from 2012 through 2015.
- In each county, more than 20 of every 100 residents received an opioid prescription in 2015.
- While Clackamas County has the highest prescribing rate in the region, residents of all three counties frequently receive opioids.
- In 2015, retail pharmacies dispensed over 1.4 million opioid prescriptions to residents of the region which has a total population of approximately 1.7 million.
- The rate of prescribing increases steeply after age 15 and is highest in those ages 65-74.
- The overall rate of prescribing is higher in Clackamas County and higher in younger age groups compared with Multnomah and Washington counties.
- Females are prescribed opioids at a higher rate than males in all three counties.

Prescribing Policy Considerations

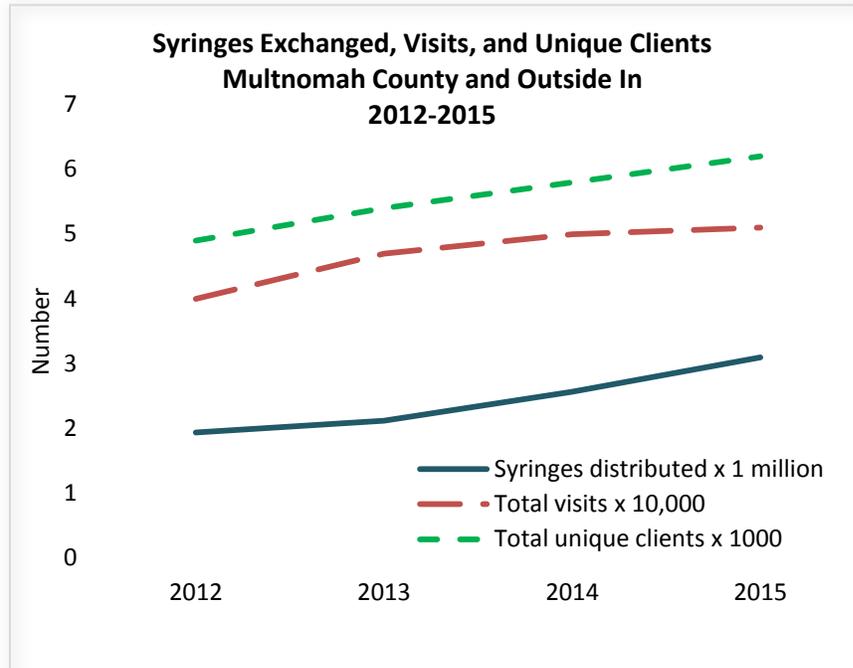
Although the misuse of prescription opioids has been widely publicized, this new analysis shows that through the end of 2015, the medical community in our region continues to dispense opioids at a high rate. In 2015, doctors, nurses, physician assistants, naturopaths, and dentists wrote nearly as many as many opioid prescriptions as there are people alive in the region. While there are many appropriate uses of opioids, our region's volume of prescribing per capita is beyond many other states and far in excess of the rate of prescribing in other countries. Policy options for addressing excess prescribing include:

- Encouraging Oregon licensing boards to include PDMP registration as part of licensure.
- Enhancing Oregon's PDMP to provide alerts to practitioners for possible unsafe prescribing.
- Allowing the PDMP program to partner with licensing boards to provide education to providers prescribing outside of the state-adopted CDC guidelines.
- Partnering of Oregon with neighboring states to provide cross border sharing of prescribing information.
- Developing metrics with insurers and health systems to monitor prescribing patterns.
- Enhancing links from the PDMP to electronic medical records to increase safety and decrease burden on providers.
- Providing incentives for free drug disposal to decrease the quantity of unused opioid pills
- Evaluating safe prescribing programs from other states.

Syringe Exchange

Syringe exchange is one part of a comprehensive public health approach to prevent the spread of HIV/AIDS, hepatitis C, and other blood-borne pathogens among injection drug users. Because most syringe exchange clients report using heroin, the clients of these programs can provide insight into the population suffering from opioid addiction and the need for substance use disorder treatment.

The syringe exchange programs run by Outside In and Multnomah County report:



- More than 3 million syringes exchanged in 2015, a 59% increase since 2012.
- More than 6,000 unique clients served in 2015; 70% were male, 78% white non-Hispanic race.
- 63% of first time clients in 2016 reported injecting heroin as the primary drug.
- Methamphetamine use among syringe exchange clients has increased from 38% in 2010 to 83% in 2016.
- In 2015, 40% of syringe exchange clients were homeless; an additional 27% reported an unstable housing situation.
- Among heroin users, 51% reported first being hooked on prescription pain pills.
- More than half of heroin users surveyed wanted to quit or cut down but report many barriers to treatment.

Substance Use Disorder Treatment

Comprehensive substance use disorder data are not available for the Tri-County region. In light of this limitation, Health Share of Oregon (Health Share), the state's largest Coordinated Care Organization serving 220,000 low income members, provided information as a proxy for the Tri-County; the Tri-County region also has Medicaid members served by FamilyCare. Analysis of Health Share of Oregon data shows:

- Opioid use disorder accounted for approximately 40% of all substance use disorder claims (other substance use disorders include alcohol, amphetamines, cocaine, marijuana, etc.).
- In 2015, nearly 5,000 Health Share members had a primary opioid substance use disorder claim.
- Comparison between the three metro area counties suggests possible gaps in the continuum of care, especially in Clackamas and Washington counties.

Opioid Substance Use Treatment Policy Considerations

Physical dependence and addiction to opioids is difficult to accurately measure. Our partnership Health Share provides some insight from medical claims into the magnitude of the problem, the services currently provided, and the characteristics of those in treatment. These data also suggest that there are geographic gaps in the availability of recovery services even in the most populated region in the state. This analysis also finds that among Medicaid clients, opioid drugs are the most frequent reason for substance use disorder treatment in our region. Between analysis of Health Share claims data and responses to the survey conducted at syringe exchange sites, we worry that treatment is not uniformly accessible and many receive no treatment at all in a given year. Despite the limitations of our methods, our local observations are broadly consistent with recent findings from the 2013 National Survey on Drug Use and Health that found that more than 75% of those with prescription opioid use disorders received no treatment in the previous year.³

Policy options to consider include:

- Updating and sharing a regional inventory of substance use disorder treatment options.
- Identifying gaps in substance use disorder treatment capacity.
- Eliminating or decreasing barriers to accessing opioid use disorder treatment.
- Requiring payers to use consistent criteria for level of addiction treatment.
- Eliminating payer policies that require clients to ‘fail first’ at one treatment before having access to other options.
- Requiring all payers and providers to support medication assisted opioid addiction treatments.
- Providing incentives for prompt treatment after overdose reversal by naloxone.
- Convening health care payers and treatment providers to collaborate on quality, metrics, and reimbursement for addiction treatment.
- Providing incentives for primary care office-based opioid use disorder treatment.

³ Center for Behavioral Health Statistics and Quality. (2014). *2013 National Survey on Drug Use and Health: Detailed Tables*. Rockville, MD: Substance Abuse and Mental Health Services Administration.