CDC *Vital Signs* Town Hall Teleconference

Prescription Drug Overdose
Transcript

November 8, 2011
2:00pm – 3:00pm EST

Coordinator: Welcome and thank you for standing by. At this time all participants are on a listen only mode for the duration of today's conference.

During the question and answer session please press star and 1 on your touch tone telephone.

You will be prompted to record your name in order to be introduced. Today's conference is being recorded, if you have any objections you may disconnect at this time. I would like to turn today's call over to Dr. Greg Holzman, sir you may begin.

Dr. Greg Holzman: Thank you operator. Good afternoon and welcome to CDC's November *Vital Signs* town hall teleconference. I'm glad you could join us today to discuss the growing issue of non-medical use of prescription pain killers which has created a record setting number of deaths in recent years.

Reading the *Vital Signs* report I was struck by the fact that while most people know drug abuse is a large problem in our society, many people are not aware of the huge toll prescription drug abuse has had on our communities.

Yet more people now die from overdosing on prescription painkillers than from heroin and cocaine combined. The national prevention strategy is another important resource that much like the *Vital Signs* focuses on the leading causes of preventable death and major illness.

Developed and released this past spring by the National Prevention Council, the national prevention strategy emphasizes a comprehensive approach to reducing inappropriate access to and use of prescription drugs.

This comprehensive approach couples prescription drug monitoring programs with laws that reduce inappropriate access and encourages consumers and prescribers education about safe medication use and disposal practices.

Today we will hear from New York State health official and colleagues in Washington State and New Mexico on how they have integrated many of the strategies identified in *Vital Signs* into their state activities to reduce and prevent prescription drug abuse.

So without further delay I will turn the conference over to Kim Wilson from our knowledge management branch here in the Office for State, Tribal, Local and Territorial Support who will introduce our speakers and facilitate the discussion portion of today's meeting. Kim?

Kim Wilson: Good afternoon everybody and thank you for joining us. Before we get started with the call I'd like to remind everybody that you can download today's PowerPoint presentation as well as see biographies for each of our presenters on our website.

The easiest way to get there is to go to http://www.cdc.gov/ostlts and that's O-S-T-L-T-S and then click twice on the town hall tab in the flash module at the top of the page.

This is also where we're going to add the recording and transcript of today's meeting. They should be available on the site by the end of the week so that you can download it and listen to it again.

If you have any problems viewing the PowerPoint presentation right click on the link to it and then select "Save As" to download the presentation to your computer and that should help out if your computer has any trouble opening a large file.

After the presentations today there will be a time for questions. I encourage you to take advantage of this opportunity to share strategies, lessons learned, challenges and success stories with you colleagues.

Now it is my pleasure to introduce our speakers for the afternoon. I'm going to introduce all of the speakers now and then each speaker will hand off to the next one.

Joining us today to provide a summary of this month's *Vital Signs* report is Dr. Len Paulozzi, a medical epidemiologist with the Division of Unintentional Injury Prevention within CDC's National Center for Injury Prevention and Control.

Then Dr. Nirav Shah, the New York State Commissioner of Health will discuss why prescription drug abuse is an important issue for the state health official perspective.

Our next speaker will be Dr. Jennifer Sabel, an epidemiologist with the Washington State Department of Health Injury and Violence Prevention program.

She will be followed by Dr. Michael Landen, the deputy state epidemiologist for the New Mexico Department of Health. Dr. Sabel and Landen will discuss many of the ongoing efforts in their states to preventing prescription drug abuse.

And now I will turn the call over to Dr. Paulozzi.

Dr. Len Paulozzi: Thank you Kim. My job is to hit some of the high points of the MMWR article entitled Prescription Painkiller Overdoses in the United States that was published last week.

You can follow me by slide numbers as I move through the slides. Slide 5, has some of the key findings from the MMWR article and basically we're highlighting two things. In 2008, drug overdoses in the United States caused 36,450 deaths which is getting very close actually to the number of deaths due to motor vehicle traffic crashes in the United States.

Opioid pain relievers which we call prescription painkillers in this presentation were involved in at least 14,800 of these deaths. Preliminary mortality and morbidity figures suggest that we probably have seen an increase in both morbidity and mortality related to opioid analgesics and overall drug overdoses in the United States in 2009.

In general states with higher prescription painkiller sales per person and more non-medical use of these kinds of drugs tended to have higher death rates from drug overdoses.

Slide 6, the opioid pain reliever death rate sales and substance abuse treatment admission rates all increased in parallel in the United States after 1999.

Sales of prescription pain killers shown on the top dotted line in this figure by 2010 were four times the sales in 1999 and in 2010 every opioid pain reliever, enough opioid pain relievers were sold to medicate every American adult with a typical dose of 5 milligrams of hydrocodone every four hours around the clock for a full month.

The overdose death rate which is the middle solid line in 2008 was nearly four times the rate in 1999 and the substance abuse treatment admission rate the bottom line, in 2009 was almost six times the rate in 1999.

Slide 7, certain demographic groups are at greater risk of misuse of these kind of drugs and its consequences. About one in ten non-Hispanic American Indian or Alaska Natives used prescription painkillers for non-medical reasons in the past year.

This is data from the Substance Abuse and Mental Health Services Administration, compared to 1 in 10 for non-Hispanic whites and 1 in 30 in non-Hispanic blacks.

For deaths involving prescription painkillers the rate among non-Hispanic whites and American Indians were three times higher than the rates in blacks and Hispanic whites.

All the death rates in the MMWR were highest among men and among persons age 35 to 54 years of age. And nationwide overdose rates in rural counties were about 50% higher than those in metropolitan counties based on other studies.

Slide 8, some states clearly have a bigger problem with this than others. Looking across sales, non-use and death rates, the painkiller sales per person

were more than three times higher in Florida for example which had the highest rate in the country than in Illinois which was lowest.

And in 2008 and ’09, non-medical use of painkillers ranged from 1 in 12 people or about 8% in Oklahoma to only 3% or 1 in 30 in Nebraska.

And as I said earlier, higher sales and more non-medical use were associated with higher rates of drug overdose deaths. Slide 9, this is a combination of the two maps in the MMWR.

The colors of the states in this Slide 9 indicate the quartiles of the age adjusted overdose death rate. The orange colored disk superimposed on each state indicated by their size, the volume of sales of opioid pain relievers in the state in 2010.

So the overdose death rates ranged from about 5.5 per 100,000 in Nebraska and other states in the upper Midwest to a high of 27 in New Mexico, high rates were also seen in states like West Virginia, Ohio, Florida and Louisiana.

Sales again represented by the sizes of the disk show that states like New York, Texas and Nebraska were in the lowest quartile for per capita sales.

New Mexico is in the second lowest quartile while Washington is in the highest quartile with other states such as Nevada and Oklahoma.

Slide 10, the *Vital Signs* includes recommendations for states healthcare providers, insurers and individuals and I’m going to focus on the state recommendations for the purposes of this call.

States play an important role in protecting the public health and regulating healthcare and the practice of health professionals. As such they are critical to reversing this problem.

CDC is recommending prescription drug monitoring programs. These are state run electronic databases that track the prescribing and dispensing of controlled prescription drugs.

They're designed to monitor this information for suspected abuse or diversion and they can give critical information about patients and prescribers. States can use PDMP data as well as Medicaid data and worker's compensation data to indentify patients at highest risk.

And providers who deviate from accepted medical practice. Special programs that are often known as patient review and restriction programs can also be set up by state Medicaid and other health plans in the state to restrict patients using painkillers in dangerous fashions to single designated prescribers and single designated pharmacies.

Slide 11, CDC also recommends that states enforce laws to prevent doctor shopping. The operation of rogue pain clinics, the so called "pill mills" and other laws to reduce prescription pain killer diversion and abuse while still safeguarding legitimate access to pain management services.

These laws all need to be rigorously evaluated for their effectiveness. States should ensure that providers follow evidence based guidelines for the safe and effective use of painkillers. State licensing boards can take action against providers acting outside the limits of accepted medical practice.

And finally states can provide better access to substance abuse treatment programs. Slide 12, I just direct you here to two additional resources that might be helpful, the policy impact document available on our website is a new document.

The State Health Agency responds document is a few years old. Slide 13, Albert Einstein says that the significant problems we face today cannot be solved at the same level of thinking we were at when we created them.

We indeed did create this problem for ourselves 20 years ago and we'll have to come up with new and better tools to address the abuse and overdoses with prescription drugs.

State policies are critical tools in solving this problem. Thank you. I now pass the proceedings on to Dr. Shah.

Dr. Nirav Shah: Thank you Len. I agree with Len's quote that solving this problem requires stepping back and developing a new approach.

In New York we believe that the battle against this crisis must be fought on many fronts and by a collaborative effort with numerous stakeholders.

As a state health agency we can be most effective by first focusing on our enforcement activities on the healthcare setting which is too often the source of the abused medications and second by strengthening our data analysis capacity and using the results to assist others in reining in inappropriate controlled substance use.

Slide 15, I've established an interagency workgroup to examine this issue. As you know too often at the state level accountability resides in silos.

In our case it's between state police, Office of Mental Health, the Office of Alcoholism and Substance Abuse and the Department of Health.

The work group that spans all these agencies has aggressively developed a strategic plan focusing specifically on the areas of prescriber education, prescription data monitoring, proper medication disposal, overdose prevention and treatment.

This workgroup has a special focus on increasing the sophistication of the data mining of our prescription monitoring program data.

We've begun to perform descriptive analyses of the dispensing of narcotics by county, age, prescriber type such as MD, dentist, PA, etcetera and payment type, cash, Medicaid, private insurance, etcetera.

We've also performed state wide mapping as well as detailed mappings of New York City neighborhoods using this data and I'll share some of those slides with you.

Our workgroup has also made recommendations to significantly improve our laws to allow for better sharing of this vital data with numerous stakeholders.

Our proposal is to allow practitioners to allow their nursing staff to view this data on their behalf as well as to give pharmacists full access.

The workgroup is also proposing that practitioners be specifically trained before they can prescribe these highly abused medication.

Slide 16, this is an example, I apologize for the font size of the descriptive analyses that we are now performing. This slide shows prescriptions dispensed for Oxycodone at a daily dosage of 100 milligrams per day or more of morphine equivalent dosing, MED, broken down by age, prescriber type as well as MED high which is 100 to 119 milligrams per day and very high, over 120 milligrams per day of dosing.

In 2010 there were over 2000 prescriptions written by dentists in New York for 100 milligrams per day or more of Oxycodone. Fully 16% of all the prescriptions dispensed for this dosage level were paid for by cash and not insurance.

This is much higher then the typical percentage of prescriptions that are paid for with cash and could be used as a flag for detecting diversion and the scope of the problem.

Over 500,000 total scripts for over 100 milligrams per day in 2010 is really a daunting and incredible number and we’re not a big part of the country’s problem.

And it’s actually a 52% increase over the last two years. Slide 17, this map shows the number of scripts per 1000 residents by county. If you look at the bottom right near New York City you’ll see the dark blue areas on this slide highlight a hotspot of Oxycodone dispensing.

Slide 18, this map shows the counties that are highest in dispensing high doses of Oxycodone per 1000 residents. Richmond County is a high outlier. Slide 19, here’s an even more detailed overview of the high dosage dispensing by New York City neighborhood.

Our next stop is to drill down further to evaluate prescribing and dispensing patterns in Richmond County which is in Staten Island on the left. More sophisticated data analysis such as this is allowing us to more effectively target investigations and educational activity.

We plan on enhancing our collaborations to allow us to continue to expand our data analysis capabilities, basically I plan to deputize almost any academic medical researcher who wants the data to permit the broadest use possible.

Slide 20, I wanted to end my presentation with a few thoughts on the most promising opportunities in this political and funding environment. With gridlock in Congress it's a time for states to take the lead in addressing the prescription drug abuse crisis.

There are important roles at the federal level however. What are the boundaries for data sharing that best balance privacy and security while still allowing collaboration and creativity?

And what are the most promising ideas that should be rigorously tested and then generalized? Thank you very much, now I'll hand it over to Dr. Sabel and Slide 21.

Dr. Jennifer Sabel: Okay thank you. It's a pleasure to be with you today to talk about Washington State's effort in preventing prescription drug abuse.

I'm going to talk about Washington's increased surveillance for opioid overdose deaths and interagency workgroup similar to that in New York, emergency department initiatives, chronic non-cancer pain management rules, and several Medicaid programs.

There are other ongoing efforts in Washington, for example a good Samaritan law and a prescription drug mentoring program that you may be interested in, but I won't have time to discuss those today.

Slide 22, in 2005 Washington State began a surveillance project looking specifically at the prescription opioid or painkiller overdose deaths.

Since our state does not have a centralized medical examiner system the project was limited to using death certificate data. The purpose of the project was to look at trends in overdose deaths involving prescription opioids and individual opioids.

These two graphs show the main results of our analysis with recently added 2010 data. The graph on the left shows the overall trend and a dramatic increase in the number of these deaths since 1995.

The blue portion of the bar represents deaths involving only prescription drugs. And the yellow portion represents those also involving alcohol or illicit drugs.

The number of these deaths peaked in 2008 and from 2008 to 2010 we observed a 19% decline. This decline is a small step in the right direction.

Simultaneously we have observed a small increase in heroin overdoses. The graph on the right shows the results of these deaths involving methadone, Oxycodone and hydrocodone, the three most commonly involved opioids.

Methadone is involved in the majority of these deaths with the range of 42% to 68%. Being able to create and share this type of data with partners was critical to gaining interest and prevention by state partners. A presentation of

this data to the Medicaid program prompted a linkage to determine the proportion of the deaths among Medicaid enrolled clients.

The analysis showed that 45% of the deaths occurred among Medicaid clients and that their age adjusted relative risk was almost six times higher compared to non-Medicaid population.

In addition to sharing these data with partners the Department of Health issued several news releases based on these data which stimulated media interest.

Slide 23, based on the findings on the previous slide the Washington State Department of Health began a quarterly work group similar to that that Dr. Shah mentioned in New York.

The purpose of the group was to coordinate prevention activities already underway, to set up a forum for continuing communication and to come up with some short term actions that we could work on together.

I’ve included examples of who was represented on the workgroup, basically the group includes state agency partners as well as external partners.

During the first few meetings we developed a charter which outlined our short term actions. The short term actions included increased education, surveillance and evaluation of several programs.

In addition to identified methods to reduce diversion through emergency departments. Slide 24, to accomplish the short term action focused on addressing the issue in emergency departments, a subgroup was set up.

This subgroup met monthly via conference call starting in April 2009. The goals of this subgroup included developing a state wide guideline for opioid prescribing in emergency departments.

And to spread the use of an information exchange data system to share patient visit data. Once the subgroup had finished drafting the guidelines we approached the board of the Washington chapter of the American College of Emergency Physicians to see if they would sponsor and disseminate the guidelines to their members.

After negotiations the board agreed provided that the workgroup develop patient education materials to accompany these guidelines.

The Washington chapter then worked with the state medical and hospital associations to gather their support.

The guidelines were disseminated this June followed in July by patient education materials mailed to every emergency department in the state.

The feedback we have received so far for both the guidelines and patient education materials has been overwhelmingly positive.

The second goal of this workgroup is to increase the sharing of patient visit data between emergency departments using a low cost HIPAA compliant system that has a focus on sharing data for patients who frequently visit emergency departments.

Right now about a quarter of the emergency departments are participating in this system and by early next year about half of all emergency department visits will be captured in the system.

Slide 24, the 2010 Washington State legislature passed the bill related to chronic non-cancer pain management in response to concerns about increasing painkiller overdose deaths and some high profile regulatory actions.

The law required the five boards and commissions that regulate the majority of prescribers to adopt new rules and repeal existing rules.

There were also some specific requirements for the new rules. The rules had to include a dosing threshold that required a pain management consultation before it could be exceeded.

Methods to increase consultation availability including the use of telemedicine, minimize the burden on practitioners and patients, guidance on the tracking of clinical progress to track pain interference, physical function and risk before outcome.

And lastly guidance on tracking the use of opioids. The final rule includes all of these elements and in addition to these elements the final rule encourages the use of best practices for treating chronic non-cancer pain with opioids.

The goal of the final rule is better treatment, not less treatment. There are also several exemptions built in, especially to the pain specialist requirement including if the provider has 12 hours of continuing education and pain management.

Or if the provider documents a good faith but unsuccessful effort to find an available pain specialist and for patients on a stable ongoing course of treatment.

Next slide, because the Medicaid program knew that its clients were at higher risk of overdose deaths, they developed several initiatives.

The first of these is the narcotic review program. This program focuses on clients receiving very high amounts of opioids, measured in milligrams morphine equivalents per day for a chronic condition.

These clients were receiving more than 1000 milligrams morphine equivalent per day. The program developed a multi-disciplinary team to review the clients' diagnoses, treatment and prescriptions.

In some cases a nurse case manager was assigned to the client. The nurses talked to the prescriber, shared prescription data with them, shared examples of paper plans and if necessary discussed the need for specialty referral or further work up.

If the provider was not comfortable with the team's recommendation of a decrease in the amount prescribed, then Medicaid requires a second opinion.

The second program is the patient review and coordination program. This program is for clients who are inappropriately using or misusing healthcare services.

Many of these clients are doctor shopping. The program restricts overusing clients to one provider, one pharmacy, one narcotic prescriber and one hospital for non-emergent issues.

The clients are case managed with the primary care provider and mental health and substance abuse referrals are integrated as needed.

So last program focuses on the top opioid prescribers. These prescribers were reviewed by the multi-disciplinary team, a letter of concern is being sent to these prescribers based on the dosages, frequency and diagnoses noted in the claims records.

Previous letters sent have been successful at reducing overprescribing. Next slide, in summary, Washington started its prevention work by increasing surveillance.

We then pulled together a group of interested parties to develop preventive actions, a subgroup focused on emergency department issues, developing some guidelines for prescribing opioids and emergency department and sharing patient information.

The legislature passed pain management rules for treating chronic non-cancer pain with opioids and the Medicaid program developed its own initiatives because its clients are at higher risk for dying of an overdose. Thank you and I'll pass it on to Michael Landen.

Dr. Michael Landen: Great, thanks Dr. Sabel. It's great to see such good work and good ideas coming out of New York and Washington. And hopefully I'll share a few too.

I'm going to present New Mexico drug overdose death data. New Mexico prescription drug monitoring program or PDMP data, information about the PDMP, information about a recent task force formed by our legislature and some recommendations to help prevent prescription drug overdose death.

So if you'll turn to the next slide, number 29, we'll look at some data. New Mexico's had the unfortunate distinction of leading the nation in poisoning

deaths every year since 1991 with the exception of 2004 and 2007 when West Virginia lead.

This slide shows drug overdose deaths in New Mexico from 1991 using data from the centralized New Mexico Office of the Medical Investigator.

Up until 2006, most New Mexico drug overdose deaths were caused by heroin primarily and then cocaine. In 2009 prescription drugs, primarily opioids caused the most deaths.

So in New Mexico the recent emergence of prescription drug overdose deaths has been overlaid on a chronic problem of heroin and cocaine overdose deaths.

Within New Mexico unlike some of the data Dr. Paulozzi presented, Hispanic males have the highest rate. So Hispanic males from the northern part of the state have had the highest rate of drug overdose death. And the New Mexico/Mexico border region has had a lower rate of drug overdose death.

If you'll turn to Slide 30, we'll look at some PDMP data from New Mexico. So here's some data from the - our prescription drug monitoring program or PDMP showing the proportion of residents by age group and sex who received an opioid prescription during a 26 month period.

And this is actually the period at which we just started getting good data, started January 2006.

You can see that the proportion of persons receiving opioids gradually increases with age the proportion higher for females in each age group and highest for females and males 85 years and older.

This actually - this fact may actually have some implications for the other significant emerging injury problem which is falls among the elderly. These exposure data were used in a recent case control study completed by CDC, New Mexico Department of Health, our Office of Medical Investigator, the Board of Pharmacy which showed that among persons who received a prescription for controlled substance in New Mexico drug overdose death was associated with male gender, older age, more prescriptions, one or more sedative prescriptions and prescriptions for (buprenorphine), Fentanyl, Hydromorphone, Methadone or Oxycodone.

Let's go to the next slide, that's number 31. The New Mexico PDMP was established in 2004 at the Board of Pharmacy by state regulation. By January 2006, New Mexico was receiving complete data for the state and we just looked at some data from the PDMP in the previous slide.

Initially dispensers, primarily pharmacies reported at least every month to the PDMP. This summer state regulation was changed to require reporting at least every week and we're exploring basically the ideal frequency of that reporting.

The PDMP in New Mexico is not real time currently. Providers and now their staff with this summer's regulation change must send a request to the board of pharmacy during 8 to 5 on weekdays.

This limited access has been a significant impediment to provider participation in the program. An upgrade planned for January 2012, where PDMP will become web accessible and hopefully will improve the access.

And we're also developing web based provider training in order to enhance the use of the PDMP. And I would just encourage you all if you have not read your state's PDMP enabling legislation or regulation I'd encourage you to do so.

Because that's - as was pointed out by Dr. Sabel too, PDMP is a very important part of our intervention here and it's important that people are familiar with basically the enabling legislation or regulation that allows the PDMP to function in your state.

So let's go to the next slide, number 32. In 2011, a legislative memorial created the New Mexico prescription drug abuse and overdose task force.

Sounds like somewhat similar to the efforts in New York and Washington with respect to these collaborative groups. Our task force here included representation from most of the healthcare provider licensing boards.

Many of these boards did not have regulations governing prescribing controlled substances for the treatment of pain.

So this task force has developed draft recommendations for licensing board regulations and these are generally similar to the ones Dr. Sabel mentioned for Washington.

New Mexico like many states has a law on the treatment of pain. It's called the New Mexico Pain Relief Act, task force recommendations have narrowed the definition of what an accepted pain management guideline is, broadened applicability of the law or the act to cover all pain, not just intractable pain.

And required licensing boards to notify providers of accepted guidelines. Draft recommendations were also made to encourage healthcare organizations to find ways to automate access to the PDMP and to encourage integrative approaches to pain management involving approaches other than opioid prescribing.

The task force also has modified Utah's clinical guidelines for pain treatment and will be disseminating a New Mexico version shortly.

And then our Office of Medical Investigator and the Department of Health were sending out joint letters to healthcare providers when one of their patients dies of prescription drug overdose death in order to inform them of that event.

If you'll turn to the next page, next slide and entitled Prescription Drug Overdose Prevention Recommendations, here are a few recommendations for preventing prescription drug overdoses.

Because of the almost linear relationship between deaths and opioid sales that Dr. Paulozzi showed earlier, we must find ways to reduce the consumption of opioids.

One approach could be to shift to alternatives for pain treatment. In addition better evidence is needed for ways to reduce prescription drug overdose and a community guide chapter on the subject would be helpful.

Since each state has a different profile of drugs causing overdose deaths, state based drug overdose death surveillance and opioid sales surveillance is needed.

I mean in New Mexico our leading drug causing death has changed often and it's very important that there be state surveillance. The Council of State and Territorial Epidemiologists has an overdose surveillance subcommittee which next meets by conference call Monday November 14 at 1:00 pm Eastern Time.

And so I'd encourage you all to consider joining that group. And then through real time and convenient access to PDMP data, we need to increase provider awareness of their patients' current controlled substance prescriptions and then PDMP data should be used by licensing boards to screen for providers who may have dangerous prescribing practices.

And we need to better define at what levels of opioids and sedative hypnotics does overdose risk truly increase. Thank you very much.