

CDC *Vital Signs* Town Hall Teleconference

Prescription Painkiller Overdoses Among Women

July 09, 2013

2:00–3:00 pm EDT

Coordinator: Welcome and thank you for standing by. At this time, all participants are on a listen-only mode. Questions will be taken throughout today's presentation. If you do have a question at any time today, please press star 1 on your touchtone phone.

Today's conference is being recorded, if you have any objections, you may disconnect. Now I'd like to turn the meeting over to Dr. Brandy Peaker, coordinator of the Medical and Business Outreach Program. You may begin.

Brandy Peaker: Thank you, Fran. Good afternoon, all, my name is Brandy Peaker and I am the coordinator of the *Vital Signs* Medical and Business Outreach Program. I work very closely with Dr. Schieber, the *Vital Signs* coordinator, but I'll be moderating today's Town Hall Meeting. We welcome you and we're glad that you could join us today.

Today we will discuss the latest *Vital Signs* report on prescription painkiller overdoses among women. Before we get started, I would like to go over some housekeeping details. You can go online and download today's PowerPoint presentation so you can follow along with the presenters. The web address is www.cdc.gov/stltpublichealth. That's S-T-L-T, public health.

There is a link directly to the *Vital Signs* Town Hall website under Highlighted Products and Resources on the lower-right side of the page. On this town hall page, you can also view bios for each of the presenters. This is where we will add the audio recording and today's transcript for the teleconference.

They should be available by next week. Prescription painkiller overdoses among women is an under recognized epidemic. Approximately 18 women die every day of a prescription painkiller overdose in the US. That's more than 6,600 deaths in 2010. For women, 7 in 10 prescription drug deaths include painkillers and deaths from prescription painkiller overdoses have increased more than 400% among women since 1999.

For every woman who dies of a prescription painkiller overdose, 30 go to the emergency department for painkiller misuse or abuse. That's every three minutes that a woman is going to the emergency department for painkiller misuse or abuse. Our STLT partners are critical in helping to raise awareness about prescription painkiller overdoses and prevention strategies.

On today's call, we're going to hear from three colleagues. First we will hear from Dr. Karin Mack, senior behavioral scientist on the Prescription Drug Overdose Team at the Division of Unintentional Injury Prevention in the National Center for Injury Prevention and Control at CDC. She will provide a summary of this month's *Vital Signs* report.

Dr. Mack will then hand the call over to Ms. Anne Rogers, a data and research manager at the Maine Office of Substance Abuse and Mental Health Services within the Department of Health and Human Services in Maine. Ms. Rogers will share data on prescription drug use and abuse among women in the state of Maine and their efforts to prevent further misuse.

Ms. Rogers will then turn the call over to Mr. Hal Johnson, a behavioral epidemiologist in the Substance Abuse Program Office at the Florida Department of Children and Families. Mr. Johnson will discuss gender differences and prescription drug epidemiology that they see in Florida, as well as effects from Florida's legislative action regarding prescription

medications. Please note that there will be time for questions after the presentations today.

You can get in the queue to ask a question at any time during the teleconference. Simply press star 1 and record your name when prompted. I will now turn the call over to Dr. Mack.

Karin Mack: This is Karin Mack, welcome, everyone. Today I will be discussing prescription painkiller overdose deaths and emergency department visits for painkiller misuse or abuse among women. Go to slide 5, please. This information is from the *Vital Signs* report that was released on Tuesday, July 2.

The report shows that the epidemic of drug overdoses in the United States has continued to worsen. Starting in 2007 drug overdose deaths among women were higher than the number of deaths from motor vehicle crashes. I'll discuss our study's findings and our recommendations for addressing this growing public health problem.

Among our findings, the following stood out. In 2010, drug overdoses in the United States caused 15,323 deaths among women. Of those deaths prescription pain killer overdoses killed over 6,600 women. The percentage increase from prescription painkiller overdose deaths among women was more than 400% since 1999, compared to 265% among men.

Slide 6, please. These two charts are in the MMWR. They show overdose deaths on the left and emergency department (ED) visits from misuse or abuse on the right. For women, for selected drugs for the years 2004 to 2010. These are the rates per 100,000 population and each line represents a different drug. Prescription painkiller or opioid overdose deaths and ED visits are represented by the solid line.

Prescription painkiller deaths and emergency department visits for misuse or abuse increased in parallel. Death rates for opioid overdoses went from 2.5 per 100,000 women in 2004 to 4.2 in 2010. The rate of emergency department visits for opioid misuse or abuse went from 56.1 per 100,000 women in 2004 to 129.6 in 2010.

It is also important to note the changes in the benzodiazepine rates—that's the long dashed line. Emergency department visits for benzodiazepine misuse or abuse increased along with opioid misuse and abuse, and is higher in some years than opioids. The rate of benzodiazepine related overdose deaths for women doubled between 2004 and 2010.

Slide 7, please. About 18 women died every day in 2010 of a prescription painkiller overdose. And every 3 minutes, a woman went to the emergency department for prescription painkiller misuse or abuse. For every woman who died of a prescription painkiller overdose 30 went to the emergency department for painkiller misuse or abuse.

Certain demographic groups are at greater risk for misuse and its consequences. Women ages 45 to 54 are at the highest risk compared to other age groups of dying of a prescription painkiller overdose. For emergency department visits women between the ages of 25 to 54 were more likely than younger or older women to go because of prescription painkiller misuse or abuse.

Non-Hispanic white and American Indian or Alaskan Native women had the highest rate of prescription painkiller overdose death. Slide 8. Some states have a bigger problem than others. This map shows age adjusted death rates for drug overdoses by state for women in the years 2009 and 2010.

The overall US rate for these years was 9.4 per 100,000 for women and 15.1 for men. Age adjusted drug overdose death rates ranged from 3.9 per 100 thousand women in North Dakota to 18.5 in Nevada. The female drug overdose death rate was greater than the male rate in Idaho, Nebraska, and North Dakota.

The male rate was at least double the rate for females in Connecticut, Hawaii, Illinois, Massachusetts, Maryland, New York, Vermont, and Washington DC. Increased use of prescription painkillers has likely contributed to the overall increases in rates of overdose death as well as misuse and abuse.

Variation among states and sales of these drugs then probably contributes to state variation in these outcomes. One study found that a small percentage of physicians accounted for a large percentage of the opioid painkillers prescribed.

The proliferation of high volume prescribers and legitimate pain clinics, or pill mills, can have a large impact on state use of prescription painkillers and overdose death rates.

Next slide please, slide 9. The *Vital Signs* report includes steps that states, healthcare providers, and women can take. First, I'll focus on state recommendations. States play a central role in protecting public health and regulating healthcare and the practice of health professions. As such, states are especially critical to reversing the prescription drug overdose epidemic. States might consider improving prescription-drug monitoring programs.

State-run electronic databases are used to track the prescribing and dispensing of controlled prescription drugs to patients. They are designed to monitor this information for suspected abuse or diversion—that is the channeling of the

drugs into an illegal use and can give critical information about both patients and prescribers.

States can use PDMP data, Medicaid data, and worker's compensation data to identify patients at highest risk and providers who clearly deviate from accepted medical practice.

States can improve PDMPs by enhancing real-time data reporting and access, integrating electronic health records, using proactive unsolicited reporting, and considering interoperability with other states.

Special programs often known as Patient Review and Restriction Programs can be setup for Medicaid and other state-run health plans to restrict patients who might be using painkillers inappropriately to a single designated prescriber and pharmacy.

Slide 10, please. Other steps CDC recommends include consideration of laws to prevent the operation of pain clinics or pill mills, doctor shopping, as well as other laws to reduce prescription painkiller diversion and abuse, while safeguarding legitimate access to pain management services.

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

Finally, states can enhance substance abuse treatment programs, including ensuring immediate access to treatment for pregnant women and reducing barriers to substance abuse treatment for women, such as having adequate

child care programs. Slide 11. Here are two resources that might be useful. First is an issue brief on promising state policies.

The second is a site where you can search based on the type of law. There's information about seven law types.

They include laws that require a physical examination before prescribing, use of tamper-resistant prescription forms, pain clinic regulations, prescription drug limits, laws prohibiting doctor shopping, patient identification before dispensing, and finally immunity from prosecution at sentencing for individuals seeking assistance during an overdose.

I would also like to take a little time here to discuss steps that women can take to keep themselves safe from prescription painkiller overdoses. Women can discuss all medications they are taking, including any over-the-counter medications with their healthcare provider.

They can use prescription drugs only as directed by a healthcare provider and store them in a secure place. Disposing of medications properly is important.

As soon as the course of treatment is done, do not keep prescription medications around just in case. Women can prevent misuse and abuse by not selling or sharing prescription drugs. Women can discuss pregnancy plans with their healthcare provider before taking prescription painkillers. Finally it is important to get help for substance abuse problems.

Slide 12, please. While the statistics in the rapid rise in deaths and emergency department visits are grim, there are things we can do to make a difference and keep our mothers, sisters, and daughters safe. Together we can reduce the risk of overdoses among women while making certain patients have access to

safe, effective pain treatment. Thank you, and I'll turn the presentation over to Anne Rogers.

Anne Rogers: Good afternoon. My name is Anne Rogers and I'm the data and research manager in the Maine Office Substance Abuse and Mental Health Services. We're going to start with slide 14. This is a few pictures of how lovely Maine is. Maine's a fairly rural state.

We have a few small cities, and in the entire state there's about 1.3 million people and they are dispersed in an area which is larger than New Hampshire, Vermont, Massachusetts, Rhode Island, and Connecticut put together. Most of the population lives in the southern half of this state. Moving on to slide 15. While Maine may be a state of beautiful scenery, we also have problems with prescription drug abuse, just like all other states.

This slide shows that per 1,000 Maine residents by gender and year who filled a prescription opioid, stimulant, and/or benzodiazepine, females were higher than males each year for opioids and benzodiazepines, but with stimulants males were higher than females each year. But most of this is due primarily to ADHD drugs during the first 20 years of a male's life. Move on to the next slide, please, slide 16.

Maine residents under 25 years of age who are male show higher rates of stimulant prescriptions, primarily due to the ADHD drugs in both 2010 and in 2012. Shown in the graphs for under the age of 18 and then 18 to 24, you still see this as males being higher, but if you look at the 2012 year, females start to catch up a little bit within the 18 to 24 year old age group. But for the other remaining age groups, females are higher. The transition seems to appear when you look at it on a year-by-year basis at the age of 20.

Next slide, slide 17. Using Maine's prescription monitoring program data, you can see the trend in the number of dispense prescriptions for opioids in persons 20 and older from 2008 through 2012 has Maine fairly stagnant and their both following along the same lines, but it has gone down in the past couple years slightly.

Maine is still making a considered effort over the past few years to educated prescribers on responsible opioid prescribing, and it appears that with the numbers going down that the efforts may be working. On slide 18, over 50% of drug medication overdoses that Maine emergency medical services received and responded to were from females in both calendar years 2011 and 2012.

And you'll notice that there was a dramatic rise in 2012 in the calls. Moving on to slide 19. When looking at poisonings from opioids, it is important to look at the type of drug. From this graph, you can see there have been more inpatient than outpatient hospital visits, which includes emergency rooms from males than from females due to poisonings from methadone.

Whereas when looking at all other opioid poisonings, more females than males were treated in an inpatient and/or outpatient basis in three out of the four years that are shown. Outpatient data for 2011 was not available at the time of this data extract, but inpatient data from 2011 was available and while not shown on this, it is showing that the trend appears to be continuing and that females appear to be catching up to males in the number of methadone related poisonings, 34 females to 40 males.

I'll be interested to see if once 2011 inpatient and outpatient, and then 2012 inpatient and outpatient hospital data is available, if we'll begin to see maybe a decrease in opioid poisonings that might possibly correspond to a decrease in

the actual opioid prescriptions that are filled each year. But that remains to be seen. Moving on to slide 20.

Since 2001 total drugs related overdose deaths have risen, peaking a 173 in 2009. While both males and females have seen an increase in the number of drug related deaths per 100,000, the rate for females increased by 97.5%, this is an average increase of 13% per year between 2001 and 2010.

Whereas males increased by 32.2%, which is an average increase of 4% per year, still also unacceptable, but not as high as females. By 2010, 90% of all overdose deaths involved pharmaceuticals. From the Maine Substance Abuse Cost Report for 2010, deaths in females due to drugs was estimated to be \$51.2 million.

Not shown in this slide, there's data from Maine's Chief Medical Examiner's office. And it shows that opioids have been involved in 10% of drug-induced deaths, and benzodiazepines were involved in 26% of drug-induced deaths. When we say drug-induced, we mean a death that's indirectly caused by use of drugs.

Moving on to Slide 21. This shows the number of inpatient and outpatient discharges where there was a diagnosis of Newborn Drug Withdrawal Syndrome and the number of diagnosis of Maternal Drug Dependence. The type of drug withdrawal and dependence were not identified in the ICD-9 coding so I couldn't quite pull that out.

But you can see that each year the number has gone up from 2007 through 2010. And then on the very far right, you'll see that 2011 inpatient data only, which is why it's not as high as the other numbers, is already quite high. The inpatient data shows an increase in both Newborn Drug Withdrawal and Drug Dependence in each year. And hopefully we'll get this to go down.

The next slide, 22, contains data from Maine's treatment data system, which is all licensed treatment agencies are supposed to report up into every day. The number of clients whose primary, secondary, and/or tertiary reason for a treatment that listed a benzodiazepine showed that females in three out of the four years were most likely to receive treatment for benzodiazepine.

The graph to the right shows the number of clients whose primary, secondary, and/or tertiary reason for a treatment listed as a pharmaceutical stimulant. And more females, again, than males have received treatment for stimulant addiction in the past three out of four years. More males than females continue to receive treatment for opioid addiction, although the gap there appears to be closing.

In state fiscal year 2011, there were 502 more males than females. In state fiscal year 2012, the gap was 485. And so far in the state fiscal year 2013 there is only a difference of 246. So, the gap has more than halved in just two years. The next slide, 23. Prescription drug misuse, abuse, and diversion is a serious problem in Maine. To work on the problem, Maine is trying to do a few things.

One, we're encouraging more medical providers to make and check the PMP a part of their standard practice of patient care. We're providing education around responsible opioid prescribing and we're encouraging them to register. We're using the Scott Fishman book to help prescribers learn about responsible opioid prescribing.

Two, we're reviewing the data to identify any particular problem areas in this state. Three, we're trying to increase our treatment, focusing on women who are pregnant and substance using, or women who are parenting and substance using with children ages birth to five years.

We're also focusing on developing a strategic plan on prevention, intervention and treatment of Fetal Alcohol Spectrum Disorders and Drug Addicted Babies (FASDDAB). The work so far has included creating a task for and providing education on FASDDAB. Our hope is that we can reverse the trend of prescription abuse and misuse and allay the consequences associated with it.

And we'll skip slide 24 which is just some added information. On slide 25 there's a link to Maine's Prescription Monitoring Program and my contact information should you have any further questions. And we'll move on to our next presenter.

Hal Johnson: All right, thank you, Anne, this is Hal Johnson. Welcome, everyone. I'm the behavioral epidemiologist at the Florida Department of Children and Families Substance Abuse and Mental Health Program. Slide 27. Florida's prescription drug monitoring program is known as E-FORCSE. Electronic Florida Online Reporting of Controlled Substances Evaluation program.

It requires prescriptions for all schedule II, III, and IV drugs to be entered into the system. In 2012, there were a total of 34.5 million prescriptions filled in that data set. The rate of prescriptions filled by women is higher for opiates, it's 22% higher than it is for men. For stimulants, 21% and for benzodiazepine is 80% higher for women. Slide 28. Across the age groups, women fill more prescriptions than men.

The peak for both men and women is in the 45 to 64 range. In that range, the rate is over 1,000 per 1000 population or more than one prescription per person. Slide 29. For stimulants, there's a different pattern. Men peak at the youngest age group, as Anne pointed out before, primarily due to ADHD drugs, then they decline steadily over the years. Whereas women are higher than men in stimulant prescriptions for all ages, except for the youngest age.

And they peak in the 35 to 44 range. In fact, in the four age groups between 25 and 64 in this slide, the rate is more than two times higher for women than it is for men. As far as benzodiazepine, Slide 30, both genders have increasing rates of benzodiazepine across age groups. But the gender gap increases as the age gets older.

Women aged 65 and older in fact fill 1.4 benzodiazepine prescriptions per person. Next slide, 31, we're switching to mortality data from the Florida Medical Examiner's data set. The blue lines on this chart are men and the red lines are women. The solid lines are deaths caused by opioids, not merely present but caused by opioids.

The dashed lines are deaths caused by benzodiazepine. You see more men die from both opioids and benzodiazepines than women. Interestingly, though the increase seen from 2006 to 2010 appears to have leveled off for both genders and both substances, and we're hoping that that continues when the 2012 data comes out. Slide 32. As far as looking at opioids by age, more men die from opioids at all age levels, except for the oldest group where there's not a difference.

Male deaths have a wider peak, from 25 to 54 it appears, whereas women opioid deaths peak between 45 and 54. Next slide, 33, please. The benzodiazepine pattern is very similar to what we saw in the opioids, although there are fewer deaths from benzodiazepines than there are from the opioids.

The patterns are virtually identical as far as peak age of deaths and males are more likely to die from it. Slide 34. Now we'll switch from looking at mortality to morbidity and this data is from emergency department and inpatient hospital records combined in Florida from 2006 to 2011. Like the

medical examiner's data, the increase seems to possibly have leveled off. We'll wait and see again when the 2012 data comes.

Again the blue lines are male, red are female, solid are opioids and dashed are benzodiazepines. And although there's little gender difference in most of the trend on this chart, there's a slightly higher rate of hospitalization for benzodiazepines for women in 2010 and 2011.

But I think it's also important I point out because I work with the substance abuse program, that our main interest is in unintentional overdoses, and that's what these charts show. If I include suicide attempts and unknown intent, women have a substantially higher rate than men across all of these years.

Slide 35, please. Now if we look at the hospitalization and emergency department visits by age group for the opioids, there's really not much meaningful difference. There's a higher hospitalization rate for men up to about the first two age categories, about 34. And then higher for women in the 35 to 44 and 65 plus, and in-between, they're pretty even from 45 to 64.

The men's rate appears to be bimodal, peaking at like 25 to 34 and then again at 45 to 64. When all intentions are included here, suicide and the unknown intent, the numbers generally about double, but there's virtually no change in the pattern. Slide 36. If we look at the similar age groups for benzodiazepine as with the opioids, the men's rate is slightly higher at 34 but the women are higher for every age group after that.

Both men and women both seem to be bimodal as far as peak ages with 25 to 34 and 45 to 54 being the peaks. And for benzodiazepines when suicide and unknown intent are included, their rates are two to four times higher with men being generally near the bottom of that range and women being toward the

top. So the women rates, especially in the 25 to 54 rate are substantially higher than the men's.

Slide 37. This is similar to some of the data that Anne had shown earlier too on fetal substance exposure. This is per 1,000 live births. The red line is the rate of Neonatal Abstinence Syndrome, which is where the infant is in withdrawal, a specific drug is not indicated. And the blue line indicates a fetus affected by narcotics.

And unfortunately in this measure, there doesn't seem to be any leveling off. I do think it's important to at least consider that at least since 2009, the awareness has greatly increased among healthcare professionals of this problem. That could partially, at least, be a part of the reason for the continuing increase.

Slide 38. So what has Florida done to address these issues? A 2011 legislature passed a slew of laws and essentially they banned the dispensing of schedule I and II drugs directly by physicians, creating a standard of care for chronic pain management practitioners.

They mandated electronic prescribing for counterfeit-proof prescription pads; require wholesale distributors to report on the distribution of schedule drugs in the state; require pharmacies disturbing schedules II and III to be re-permitted; created and funded seven regional drug strike forces; and added a number of new criminal penalties for violations.

And in 2012, the legislature followed up with the creation of a statewide task force on prescription drug abuse in newborns, and it was chaired by the Attorney General and co-chaired by the Surgeon General of Florida. Slide 39. The results are so far look pretty positive. We've had a 60% reduction in the

number of pain clinics since 2010, \$9 million in general revenue was appropriated specifically for substance abuse services to pregnant women.

From March 2011 to the end of 2012, the strike forces that were created in 2011 made about 3,800 arrests including 67 doctors, seized about 850,000 pills and over \$10 million in cash. What that all comes down to mean, the jury is still out on this, but we're hoping it's progress. Also back to Prescription Drug Monitoring Program data (PDMP).

It's a five quarter trend from the last quarter of 2011 to the fourth quarter of 2012. You can see opioid prescriptions filled are down by 6% and benzodiazepines are down 4.3%. So hopefully this trend will continue on and maybe get a little steeper, but only time will tell.

There was no meaningful difference by gender in this decrease. Slide 41. I would like to thank Rebecca Poston, Gail Strickler, and Peter Kreiner for providing the PDMP data so I could complete this presentation. And that does it for me.

Brandy Peaker: Okay great, thank you all for the excellent presentations. I'd like to remind everyone that you can get in the queue to ask a question by pressing star 1. Record your name when prompted, and you will be announced into the conference by the operator when it's your turn to ask your question.

I encourage you to take advantage of this opportunity to share strategies, lessons learned, challenges, and success stories. Okay, we'll go ahead, operator and start with our first question, please.