

CDC *Vital Signs* Town Hall Teleconference

Success Stories: States Take Action to Combat Overprescribing

July 8, 2014

2:00 pm EDT

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen only mode until the question and answer session of today's call. At that time if you would like to ask a question please press star 1.

Today's conference is being recorded, if you have any objections please disconnect at this time. I would now like to turn the meeting over to your host Dr. Dan Baden, you may begin.

Dr. Dan Baden: Good afternoon everyone I'm Dr. Dan Baden. I'm the Associate Director for External Partner Outreach and Connectivity in CDC's Office for State, Tribal, Local and Territorial Support. Welcome, I'm glad you could join us today.

We're going to be discussing the latest *Vital Signs* report on opioid painkiller prescribing. Before we get started let's 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](http://www.cdc.gov/stltpublichealth). Again, that's S-T-L-T, public health. There's a link directly to the *Vital Signs* Town Hall web page under highlighted products and resources on the lower right side of the page.

On this town hall web page you can also view bios for each of the presenters and this is where we'll host the audio recording and transcript from today's teleconference. They should be available sometime next week, back to our topic.

Opioid prescribing painkillers is an important public health issue because 46 people die in the US every day from overdose of prescription painkiller - drugs. Healthcare providers wrote 259 million prescriptions for painkillers in 2012—that's enough for every American adult to have a bottle of pills and an increase in painkiller prescribing is a key driver in the increase in prescription overdoses.

The Federal government is supporting states that want to develop programs and policies to prevent prescription painkiller overdose and it's increasing access to mental health and substance abuse treatment through the Affordable Care Act.

One action states can take is to increase the use of prescription drug monitoring programs, which are state run databases that track prescriptions for painkillers and can help find problems in over prescribing.

On today's call we're going to hear from three colleagues. First we'll hear from Dr. Len Paulozzi who is a medical epidemiologist in the Division of Unintentional Injury Prevention in the National Center for Injury Prevention and Control at CDC. He will provide a summary of this month's *Vital Signs* report. He will hand the call over to Dr. Andy Holt the director of the Tennessee Controlled Substance Monitoring Database at the Tennessee Department of Health.

Dr. Holt will discuss recent actions taken in Tennessee to address problems and prescription of opioid pain relievers and benzodiazepines. He will then hand the call over to Terry O'Leary, JD the director of the Bureau of Narcotic Enforcement at the New York State Department of Health.

Mr. O'Leary will talk about New York State's recent legislative reforms.

There will be time for questions after our presentations but you can get in queue to ask a question at any time during the teleconference. Just press star 1 and record your name when prompted. And now I turn the call over to Dr. Paulozzi.

Dr. Len Paulozzi: Thank you Dan, again I'm Dr. Len Paulozzi I'm a medical epidemiologist in CDC's Injury Center. My topic today is going to be the MMWR released last week on inter-state variation in prescribing of opioid pain relievers and benzodiazepines.

Please turn to slide number 5. In brief, the latest data from 2011 just released shows that opioid pain relievers were involved in 16,917 overdose deaths in the United States.

Benzodiazepine sedatives were involved in about 1/3 of those opioid deaths. Use of these drugs that have contributed to these overdoses varies greatly among the states and in 2012 as I'm going to show you and the general pattern is that the highest prescribing rates were found in the southern region for the opioids and benzos.

Slide 6, this is the map in the MMWR of opioid pain reliever prescriptions per 100 people. As you can see the highest rates in the darkest color are concentrated in this southern region.

The southern region ranges from Texas in the west through to Kentucky, West Virginia, Maryland, and Delaware. Overall there were 82 per 100 people, 82 prescriptions for opioids per 100 people in 2012.

Please turn to slide number 7. Benzodiazepine prescriptions show a similar map, benzodiazepines were about 38 prescriptions were prescribed per 100 people nationwide but there is a wide variation again with concentration in the southeastern United States.

And slide number 8 a few more details about the patterns and prescribing. The south as I mentioned have the highest rates for the OPR and the benzodiazepines.

The highest rate in the country was in Alabama for the opioids and in West Virginia for the benzodiazepines. In general, opioid prescribing rates correlated strongly with benzodiazepine prescribing rates.

We also looked at rates for long-acting or extended release opioids and high dose opioids and both have the highest rates in the northeastern region of the United States.

Maine, which is in that region had the highest rates for long-acting opioids and Delaware, which is actually in the southern region, had the highest rates for high-dose opioid pain reliever formulation.

These regional patterns but you can see some striking contrasts in adjacent states. For example in New York they were - had prescribed 2/3 of the rate of opioids and benzo compared with its neighbor Pennsylvania and Illinois had 60% of the opioid rate seen in Indiana.

Slide 9, why do we see this inter-state prescribing variation? Well I think the initial explanation people offer is that their states vary in the prevalence of pain but in fact that prevalence of pain doesn't vary that much between regions of the country.

And earlier studies have shown that there is - it does not account for the variability when you look at prevalence of morbidity, disability, hospitalization rates and so on.

In fact the - if you think about opioids being more commonly prescribed to older people as they are we see that the oldest region of the country is the northeast with the midwest having the second oldest percent of the population over age 65.

And the south has the highest rates of opioids but is not the oldest part of the country in terms of its residents. There may be socioeconomic factors like poverty rates that affect these rates.

The south does have the highest rates of poverty and the exact relationship between poverty and prescribing is unclear. Variations exist across states in terms of proportion to minorities of course.

Minorities do represent larger proportions in the south and in the western region of the country but it doesn't appear that that explains the higher rates. Prescribing rates for these drugs are actually lower among African Americans and Hispanics.

And even though the south region has a greater prevalence of minorities they have higher rates. There are other reasons that we can propose to explain this variation but improving it is a task for the future.

There may be differences in prescribing norms, we see that in the south also has the highest rates for prescribing a stimulant to children with ADHD, it has

the highest rates for prescribing of antibiotics, and also for prescribing of drugs that are high-risk for the elderly.

So there may be some factors there that dictate how prescribers or how physicians use prescription drugs in that region of the country. The variation may also relate to differences in rates of misuse and abuse states that with a large population and abusing the drug may have higher rates and there may be some impact of individual state policies on their rates.

Slide 10, so why is this variation in prescribing a problem? Well we know that from past work that high prescribing rates on the state level and on the county level within states correlate with risk of overdose.

So we think there's potentially unnecessary prescribing going on in some areas of the country and that - those high rates of prescribing might be driving the epidemic of prescription drug overdoses and its geographic variation in this country.

What is a problem is that we don't have a national consensus on when opioid pain relievers should be used. So doctors are going mostly on their preferences.

We don't have a strong evidence base for use, we do have guidelines for standard prescribing but in general adherence to those prescribing guidelines that have been published it is not high. This is a problem also because it may reflect high rates of abuse in individual states that they need to address.

Slide 11, to work with their providers states can make it easier for the providers, the prescribers to use the state prescription drug monitoring

programs. They can make those programs better by using unsolicited reports and trying to make data from PDMPs available in real time for prescribers.

The states can use PDMPs to identify prescribers that are out of step and contact them to try to explore the reasons for that and within their own insured population such as Medicaid, states can require adherence to safe prescribing by any of the providers who treat those patients.

Slide 12, specific policies for states to consider would include things like pain clinic laws, universal prescriber use of prescription monitoring programs when prescribing controlled substances, enhanced coverage for non-drug treatments for chronic pain, and of course increased access to substance abuse treatment.

Slide 13 shows a few links that may be helpful to states on the topic of policy, we have a document called policy impact prescription painkiller overdoses at the link shown and there are now at several web sites that show surveys of state legislative strategies related to prescription drug use and overdose prevention, our own web site that the national alliance and at the laws Atlas.

Finally slide 14, thank you, you can see my email address shown there. I'd like to now hand over the microphone to Dr. Andrew Holt from Tennessee.

Dr. Andrew Holt: Thank you Len, I'd like to begin by thanking everyone at the CDC for organizing this meeting and giving us the opportunity to describe the initiatives that we have undertaken in Tennessee to address over prescribing.

My name is Andy Holt I'm the director of the Controlled Substance Monitoring Database in Tennessee, which is housed in the Board of Pharmacy under the Department of Health's leadership.

Under the leadership of Governor Haslam and his Cabinet along with the legislature and various stakeholder groups there have been numerous initiatives enacted in Tennessee to affect various aspects of the prescription drug abuse epidemic.

Next slide please. Governor Haslam convened a public safety sub-Cabinet to address several issues including prescription drug abuse. This sub-Cabinet is led by the Department of Safety and Homeland Security with Commissioner director level participation from numerous departments of government.

This is intended to afford us a multi-disciplinary approach to addressing prescription drug abuse and diversion of controlled substances. One of the major work products of this group was the Prescription Safety Act of 2012, which was introduced as an administrative bill to address the prescription drug abuse epidemic.

The legislation was amended during the legislative process through collaboration with the legislature and other stakeholder groups, it was passed ultimately by unanimous vote of both chambers of the legislature.

Next slide please. The major features of the Prescription Safety Act include mandatory PDMP registration by January 1, 2013. Prescribers of controlled substances required to begin using the database on April 1, upon initial prescribing of an opioid or benzodiazepine and at least yearly thereafter.

Our PDMP reporting window of pharmacy's was shortened from twice monthly to weekly, our practitioners with actual knowledge of doctor shopping behavior are required to report to law enforcement as a result of the bill.

Inter-state data sharing was authorized for the first time in this bill. We established delegate accounts to facilitate practitioner use of the database in the mandated checking requirement.

We also increased our staffing of the prescription monitoring program significantly to accommodate the increased volume. There is also funding built into the note on the bill to allow increased enhancements to increase the ability to handle the increased volume to the prescription monitoring program.

Next slide please. An additional initiative is our state team neonatal abstinence syndrome sub-Cabinet workgroup, which is again is a multi-disciplinary approach to dealing with neonatal abstinence syndrome (NAS), which is a side effect noticed frequently with over prescribing.

This group is bringing attention to the NAS problem and has various work products associated with this group as well. They apply to the FDA for a black box warning for narcotics in use in pregnancy and that was enacted.

Neonatal abstinence syndrome is now a reportable condition to the Department of Health as of January 1, 2013. They've also created a multi-institutional, multi-disciplinary research consortium dedicated to the understanding and prevention and treatment of neonatal abstinence syndrome.

Next slide please. This is one example of data, which is reported weekly by the Department of Health showing the number of cases of neonatal abstinence syndrome reported, the distribution, and reported causes of

neonatal abstinence syndrome. This again is reported weekly from the data that is reported to the state as a result of the mandate.

Next slide please. Also with all of this activity we began to try and look for indicators of change within the state. One indicator that we looked at was the number of high utilization patients in the state and this graph is representative of that.

We used for this analysis the number of patients who obtained prescriptions from five or more prescribers in five or more pharmacies in a 90-day period. And you'll notice from the graph declines from 2012 to the first quarter of 2014.

And it's believed that mandatory registration and use of the prescription monitoring program as well as the heightened awareness surrounding prescription drug abuse with all of the legislation and efforts within the state has all ultimately contributed to this decline and it's been a significant decline at that.

Next slide please. This graphic shows a possible correlation with the increased number of prescription monitoring program queries, PMP queries and a decreased utilization decreasing the number of high utilization patients, which there is an intersection if you'll notice in early 2013, which happens to correspond with mandatory registration and mandatory use of the prescription monitoring program.

Possible correlation we have not definitely attributed to that but many studies show that increased use of prescription monitoring programs do decrease the doctor shoppers behavior within the state and I think we can at least draw a conclusion that it does contribute to that. Also further

affirmation of this came with a survey of prescribers that was done in 2013 within the prescription monitoring program in Tennessee.

We gathered some results, the following were just a sampling of that, 71% of the respondents changed a treatment plan after reviewing a PDMP report, 73% were more likely to discuss substance abuse issues or concerns with their patient, 57% were more likely to refer patient for substance abuse treatment, and 79% felt that the PDMP was useful for decreasing doctor shopping.

Next slide please. In addition to the Prescription Safety Act of 2012 this slide shows the number of initiatives that were pursued in 2013. We had chronic pain treatment guidelines, which have been drafted to this point and presented to the boards for their consideration.

Those boards decide how the guidelines are incorporated into the standard of care at that time. We also had a bill passed to require ARCOS-level reporting to the board of pharmacy so we can facilitate analysis of controlled substance distributions to licensee's and compare that to report submitted to the prescription monitoring program.

We also had a bill to require identification of the top 50 prescribers in the state, which has led to numerous complaints and disciplinary action against prescribers and an increased awareness of over prescribing.

And initial analysis of this bill does show a decline in the total morphine equivalence prescribed by those top 50 and also the new top 50 that have replaced them.

Also a Safe Harbor Law was passed for pregnant women to seek treatment assistance and a bill was passed that prohibited dispensing from pain management clinics.

Next slide please. In 2014 legislative initiatives were passed to shorten the prescription monitoring program reporting window to daily, which will be done by 2016 but many are already doing that.

We also have a pilot ongoing of near real time reporting, which pharmacies are reporting every five minutes. There was a naloxone bill passed in 2014, which granted immunity to those who prescribe and administer in a naloxone and they're acting in good faith.

A further bill was passed to prohibit dispensing of opioids and benzodiazepines by prescribers. This is in addition to the 2013 ban on pain clinic prescribing. Additionally a bill was passed requiring identification of those who pick up controlled substance prescriptions at pharmacies.

Next slide please. For 2014 and beyond we're currently evaluating the effects of these initiatives in the state relative to prescription drug abuse and diversion. Additionally, Governor Haslam recently announced the set of initiatives outlined in the *Prescription for Success* document, which is published by the Tennessee Department of Mental Health and Substance Abuse Services.

This document was developed with the cooperation of numerous of state agencies and is a coordinated multi-disciplinary approach to reducing prescription drug abuse in Tennessee and is a further affirmation of the Governor's dedication to these efforts.

The Governor's goals for this effort are shown on the slide with a particular emphasis focused on intervention and access to treatment and recovery services and we hope to be able to report additional positive results in the future.

And the next slide is my contact information and I'd like to again thank you for the opportunity to speak. I am one small part of a large state effort to reduce over prescribing.

Certainly if you have any questions you can send them to me and I will forward them to the appropriate person within our state to answer them, thank you. I would like to now turn it over to Mr. Terence O'Leary in New York.

Terence O'Leary: Thank you very much Andy and again thank you to the CDC for the opportunity to talk about a little bit of what New York has done in the area of opioid abuse.

So if you go to slide 27, in 2013 a law called I-STOP took effect in New York. This was a bill introduced by Governor Andrew Cuomo along with the Attorney General.

And it actually stands for Internet System to Stop Over Prescribing but while it didn't create a new system what it did do was overhaul New York's existing prescription monitoring program.

New York is one of the first states to have a PMP, we've had one since the 1970's and as an attorney I'll point out that New York State actually litigated the right of the state to collect this data over patient pharmacists and patient

objection all the way to the US Supreme Court in 1977 in a case entitled Whalen v. Roe.

And that case really set the groundwork for PMPs in every other state. So we updated our PMP, which we've been collecting all schedule controlled substances for over a decade and we've had an online program since 2010 but we made it much more user friendly.

Similar to Tennessee we allowed non-prescribers delegates access if they were delegated by a practitioner and we just increased the ease of use and decreased the number of clicks it takes to get to the answer that the prescribers are looking for.

We did require that practitioners consult the PMP before prescribing and this took effect on August 27, 2013 and it's for all prescriptions for schedules II, III, or IV with only certain exceptions including patient safety.

If the patient - if it's being prescribed for use within an institutional dispenser like a hospital but for the most part this covers the majority of the prescriptions dispensed in New York.

In 2013 there were about 23.5 million prescriptions dispensed and 22 million of them were for schedules II, III, and IV controlled substances. We required pharmacies and other dispensers to report their dispensing data to us within 24 hours.

New York's original regulations were written back when we received paper reports of dispensing and so it required that reports be made monthly. We closed that window down to 24 hours.

One of the big changes that we made was New York is moving to mandatory electronic prescribing of all substances both controlled and non-controlled. All prescription drugs will have to be prescribed.

Currently my bureau issues forge proof forms from a single vendor to every prescriber in New York State. Last year we issued about 145 million forms free of charge to practitioners in institutions throughout New York.

We'll still be issuing those forms but electronic prescribing with certain exceptions including if the power goes out will become mandatory starting on March 27, 2015.

The final big change we made was we placed hydrocodone on schedule II effectively eliminating refills here in New York State for hydrocodone products and we also scheduled tramadol on schedule IV and I'll talk a little bit later about the effect that that had.

So if you go to slide 28, the duty to consult the PMP as I mentioned was before prescribing or dispensing any controlled substance in schedules two, three, or four.

Practitioner dispensing in New York State is pretty rare, we didn't have the traditional pain clinics like you would see in Florida, years ago in Florida where you would have prescribing and dispensing occurring from the same location.

The majority of practitioner dispensing in New York is actually veterinarians and one of the reasons is New York has long had a ban on practitioners dispensing for a profit so it becomes a money losing proposition with all of the overhead and record keeping that's required.

The practitioners must consult the PMP data no more than 24 hours before they issue the prescription. So assuming that the prescription is reported within 24 hours it takes the Department of Health between one to two hours to spin the information into the PMP registry.

And then the doctor checks no more than 24 hours beforehand, the data they're looking at will be no more than 50 hours old at the time they decide to prescribe.

If you go to slide 29, this shows you the use of New York's PMP registry. You can see we started in January 2010 and up until June of 2013 we had less than 5,100 users and they did approximately 465,000 searches over those 3 1/2 years.

We rolled out the new PMP 2 1/2 months before its mandated use and with the easier system we immediately saw an increase up to 14,000 users in one month.

Once the mandate kicked in and I-STOP's effective date of August 27 we now see anywhere between 42 and 46,000 users in a given month. Since the law went into effect in August 27 we've actually had a total of 76,000 users and they've performed over 14 million searches over the course of those 9 1/2 months.

Now if you go to slide 30, you'll see the PMP registry activity by month and again it was relatively flat for the first three years and the main complaint we heard was it was not a user friendly system.

And it was limited to only the practitioners they couldn't have a HIPAA compliant administrative staff employee look for them and that's something we changed.

So now we see between 1.3 and 1.5 million searches in a given month for around a million different patients every month. Since August 27 we've actually had searches performed for over 5.3 million unique patients.

If you go to the next slide this shows you who is actually performing the searches here in New York State and the overwhelming majority are being performed by those with a medical license either an MD or a DO.

They're performing almost 70% of all searches and the practitioners actually perform about 60% of the searches themselves with 40% of the searches being done by designees.

Next is nurse practitioners with about 12% of the searches, pharmacists who never had access in New York before August of 2013 are now doing about 10% of all of our searches.

You'll see that PA's are about 8%, dentists are about 1%, and we also created a tool. We have about 15% of the country's residents and interns here in New York State and so what we did since they don't have DEA numbers and it can be cumbersome for an attending to designate somebody. We allow the institutions to designate their residents so that they can still prescribe in accordance with our law.

If you go to slide 32, similar to what Andy was saying before we've seen real results from the implementation of mandatory PMP use. You'll notice that in any given month New York never had less than 300 individuals who were

going to five or more prescribers and cashing their prescription to five or more pharmacies.

That is until the PMP, new PMP went into effect and actually in the past month we were down to about 65 people who meet that criteria, which gives my investigators time to actually go through and review each and every record.

And we find that over half of the people who meet these criteria on its face actually appears to be legitimate activity. People with co-morbidity seeing multiple providers and usually people in rural areas who go to medical centers will hit a number of pharmacies along the way between their house and where they actually see some of their practitioners.

If you go to slide 33, this will show you the effect that we've seen in opioid prescribing and I included pregabalin here in green at the bottom. So hydrocodone was always the most prescribed controlled substance in New York State until it was placed on schedule II when it was surpassed by oxycodone.

You'll notice that tramadol, which we just scheduled is actually the third most prescribed painkiller in New York State. We didn't know where it was and it's third.

Our mandate only affects schedules II, III, and IV but you'll see there is no increase in pregabalin, which some people thought might happen since it's schedule V it's been relatively flat. The only large fluctuation was in codeine V and it mirrors pretty nasty flu season.

If you go to slide 34, you'll see for benzodiazepine we've had a slight increase over the last five years but it's flattened out a bit since August 2013. One thing that Dr. Paulozzi pointed out was that New York has a relatively low rate of benzodiazepine prescribing.

And I think that's in part because although it's a schedule four New York has for over a decade not allowed refills of benzodiazepine so it's been treated as a schedule II drug for prescribing purposes.

If you go to slide 35, you'll see stimulant prescribing. This is the one class of controlled substances that seems unaffected by our prescriber mandate even though these are schedule - these are within the mandated schedules.

You'll see that adderall amphetamine has increased almost doubled over the last five years as has vyvanse and we've also seen increases in ritalin as well as phentermine over the past few years. We're not exactly sure why it's something that we're actively looking at but it's interesting that this is the sole class of drugs that's been unaffected.

If you go to slide 36, New York has taken some recent steps. They include expanding, availability of naloxone including upon patient specific prescription.

New York has been very proactive in the area of naloxone. We have opioid overdose programs, Department of Health has licensed over 130 of them since 2006 that have resulted in over 10,000 registered naloxone administrators as well as over 1,000 confirmed reversals.

We also expanded recently the use of naloxone to basic life service EMTs as well in late 2013. Our goal - recent law also requires expanded coverage for

addicted treatment services including covering inpatient addiction treatment during a rejection of benefits coverage while the appeals process is continuing.

And finally we created an increased penalty for practitioners and pharmacists who illegally dispense controlled substances under their license so it's not treated as the sale of any other prescription controlled substance.

This also builds on a few of Governor Cuomo's other initiatives, which include having all first responders in New York State giving them the opportunity to participate in naloxone training as well as expanding law enforcements approach in using data to combat prescription drug abuse as well as the resulting heroin addiction abuse problem.

So at this point the next slide 37 is my contact information. I'd like to thank everybody for their time and I'll turn it back over to Dr. Baden.

Dr. Dan Baden: Thank you very much, those were great presentations. At this point I want to remind everyone that you can get in queue to ask a question by pressing star 1, say your name when prompted, and you'll be announced into the conference by the operator when it's your turn to ask your question.