

CDC *Vital Signs* Town Hall Teleconference
Q&A

Success Stories: States Take Action to Combat Overprescribing
July 8, 2014
2:00 pm EDT

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.

I want to encourage you all to take advantage of this opportunity to share strategies, lessons learned, challenges, success stories and the like. And to start us off I'm reminded of when I used to moonlight and I would go out to rural areas of Wyoming and take over the ER.

And I would have several people come in looking for painkillers. I didn't know these people, they sometimes traveled and I really had no good way of knowing if they were seeking, just seeking drugs or if they really needed the drugs or what.

And I'm wondering how your databases could help me in that setting. Are they real time, are they able to get me the information I need to prescribe appropriately?

Dr. Andrew Holt: This is Andy in Tennessee.

Terence O'Leary: Go ahead Andy.

Dr. Andrew Holt: Sorry, okay I mean I - we allow real time access to our data. Real time prescriptions being reported to prescription monitoring programs in general is not the norm.

There are some states who are piloting initiatives, we're doing it in Tennessee with a very small number of pharmacy's to have near real time reporting of prescription data to Tennessee but it has not been widespread to this point.

But we do allow and I think most states allow real time access to their prescription monitoring program.

Dr. Dan Baden: Okay great. Another question I had is just along the line if this information is out there are you seeing tourism across state borders to areas of high regulation to low regulation - where people are crossing borders to try and seek drugs in areas that might have looser rules?

Terence O'Leary: So that is - this is Terry O'Leary. That is an issue that we deal with and here in New York we share a border with a number of different states, we have five separate states.

And some of those states - one thing New York is working on now after having overhauled our PMP is to share data with those states that are contiguous to us and then after that states further out.

But my bureau has investigators and we've actually had a couple of cases where prescribers who have been writing unlawfully have been encouraging their patients to go out of state to fill their prescriptions in hopes of staying off the states PMP and off of our radar.

Unfortunately even though practitioners currently within New York State cannot access other states' PMPs through our system we do share information and data with our surrounding states to try and combat diversion and abuse but that's currently one of the issues in sharing PMP data.

And it's something that the bureau of - there are two hubs out there that share data right now. NABP has one and the Bureau of Justice Administration runs another one and they're quickly addressing that problem and making it easier for states to do this.

Dr. Dan Baden: Okay thanks and you may have just hit it at the end there but is there a national PMP that tracks this information as well? I'm not sure maybe DEA or justice like you mentioned?

Terence O'Leary: No there's not all PMPs are actually run by the - by their states and it can create some issues in sharing. States have different privacy laws and what they're allowed to share and what they're not allowed to share. So in terms of sharing between the states there are usually two barriers. One is the technological barrier and the second one is the legal barrier about who can access the data and for what purposes.

And I know actually Tennessee and other states are ahead of New York on this one and this is something that we're actively working on and we're going to be able to share as well by the end of the year.

Dr. Dan Baden: Okay wonderful, Operator it looks like we might have a question in the queue.

Coordinator: Yes we do have a question from Michael Baker from Trinity Health, your line is open.

Michael Baker: Hi this is Michael Baker from Michigan College of Emergency Physicians. And one of the questions I have is, you know, so many states require mandatory look-up of prescription database information.

Why is there no mandate for electronic health record system vendors to display the prescription data at the time of prescribing? You know, there's significant time loss when a provider has to exit the EHR, log into a state database, enter the patient identifying information, and then wait for the retrieval of relevant data.

You know, a typical patient encounter might take 15 to 20 minutes, spending 5 minutes to query a state database surely represents a large unfunded expense for providers and this is especially true for patients that present to the emergency center.

So is there anything on the horizon or is there any reason why we're not looking towards the EHR vendors to make this data easily available to the providers?

Terence O'Leary: So speaking for New York we did not require vendors to have to present this information. It's part of prescribing under New York State law now to check. However with that being said we realize the barriers and the time constraints already placed on practitioners.

So one of the things we did was we allowed designees to look up for the practitioner. They can look up to 24 hours beforehand, we often encourage

people to print out your entire patient rosters information either the night before or the morning of so that it's already handy before you prescribe.

New York also applied for and received a grant from the Federal Government to help incorporate our PMP into existing electronic health records. It's something we've piloted, it's gone well and we hope using the states' health information network to be able to make it available to any practitioner who is using an EHR.

Dr. Andrew Holt: This is Andy from Tennessee, I echo that, I mean I think delegate access is key when you have a mandated checking requirement of the PDMP. There is also a National Standards and Interoperability Committee I believe that's organized through ONC and they're working on developing standards.

I think that's part of the problem has been PDMPs speak one language and then EHRs typically speak another language and trying to marry that - those two together has proven to be a challenge in the past.

There has been as Terry mentioned some very successful pilots. There are some systems that do right now automatically query a PDMP through some proprietary vendors. But there is a national standard being developed at this time.

Dr. Len Paulozzi: This is Len Paulozzi from CDC. I would just echo those comments and say that ultimately the goal is to have one click kind of access to all this information and the technical aspects of it are being worked out in a number of pilot projects and so on.

Whether or not at present given the situation I don't think anybody is mandating that those electronic medical record providers provide this utility but I think we're getting closer.

Dr. Dan Baden: All right, great question great discussion. Again if you have a question press star 1 and record your name and we'll get to you. Operator do we have another question?

Coordinator: Yes we do have a question from Amy Lahood, your line is open.

Amy Lahood: My name is Amy like she said and I am a family doctor here in Indianapolis and here in Indiana we have just recently passed legislation, which has a fairly aggressive requirement on the part of the providers that are treating patients with chronic opioids, which by the definition is more than 90 days of opioids.

One of the questions in going around and speaking to lots of physicians that seems to be a barrier for physicians and really appropriately prescribing is the two questions on the HCAHPS survey as well as the Jcaho pain assessment requirement.

And we have written, several people from Indiana have written to both Medicare in terms of the HCAHPS question and to the Jcaho folks in Chicago regarding their mandate and we've had less than an enthusiastic response from them.

And I don't know if others had thoughts about whether that really is affecting prescribers because that's what we continually hear when we go out and talk to doctors about how appropriate prescribing.

Dr. Len Paulozzi: Len Paulozzi, CDC, yes thank you for that comment. We hear that quite - from quite a few places that there is an impact on prescribing from Press Ganey scores, Joint Commission mandate, patient feedback, and so on and I think that we need to work further on that issue.

The Joint Commission particular is - we've talked to them about this they - their perspective on it is that they don't require the use of any particular class of drugs, their standards just require the assessment of pain.

But I think there is the perception out there that there is a requirement to actually treat pain from ecologically but I think that is a misunderstanding there.

But no I think this is a very real issue and right now I think it's something that the Joint Commission and others are working on trying to come up with a way to avoid having these standards lead to over use of controlled substances.

Amy Lahood: And I just had one more question if anyone had thoughts. Part of our new requirement has a requirement for compliance testing for folks on a certain amount of morphine equivalence daily, which is something that right now is being contested by the ACLU here in the state of Indiana.

And I didn't know if any other states had any kind of requirement for compliance testing for - with urine drug testing.

Terence O'Leary: This is Terry O'Leary from New York, New York does not require urine drug testing under any circumstances in terms of prescribing a certain amount of MEDs.

Dr. Len Paulozzi: This is Len I'm not aware of any states that require urine drug testing it's certainly a common part of many state guidelines.

Amy Lahood: Thank you.

Dr. Andrew Holt: This is Andy in Tennessee, they are listed in our guidelines currently that are being presented to our boards for consideration.

Dr. Dan Baden: Okay great, again star 1 if you have a question. Operator next question please.

Coordinator: Yes we do have a question from Tom Benzoni, your line is open.

Tom Benzoni: Thank you, this steps a little bit outside of the area you are discussing here today on the narcotics issue but I'm an ER doc of 30 years experience in practicing out in Iowa.

And we have a much larger issue that PDMP only partially address. When grandma shows up to my emergency department she takes a little white heart pill and then there's silence.

You know, PDMP is a small part of this with the narcotic use but I think you could get more traction and a larger piece of the pie by getting grandma and grandma's family as an advocate for us to have access in real time that there is this thing now called the Internet, in real time to all the medications that she's on and all the medications that anybody is on.

It would strike me that the people who are talking to me about the privacy rules about the only thing that they're interested in is protecting a drug

dealer. I have never met a family of grandma who is interested in me not knowing what was grandma's little white heart pill.

Dr. Len Paulozzi: Well that's an interesting proposal. I think that with all these things where we are collecting in a mandatory way identifying information there's always the discussion of balances in privacy against social utility and importance of the state having this information.

I think the case is made most strongly for a controlled substances in the need for the collection of that information and I'm not aware of efforts afoot right now to try to collect identified information for all drugs on all patients.

Perhaps because of this balance between access information, need-to-know, and benefit to society, and balanced against privacy rights.

Tom Benzoni: Because the cutter argument of course is how many people give me their HIV history, their sexual history, and everything else, this is an extremely small part of the entire picture.

The other ER doctors comment I thought was very interesting the PDMPs as I see them at the application level are very 1970s, you know, the Federal Government is funding all of these EHRs and putting forth the standards.

This should be just simply in my EHR, I'm an authorized user you've got my DEA number you know who I am. My computer should be querying this stuff in real time and reporting it to me as a national drug code not by some process where I get a picture of a printed document sent to me as a PDF into my email box.

I mean where we are with this stuff needs to get into the well probably early 21st Century at the application level.

Dr. Len Paulozzi: Well, yes agreed, there is a great variability among states on this but - and some are farther ahead than others but I think we all appreciate the need to make this easier for prescribers and pharmacists to access and are working on it.

And I think contacting the folks in your state and making clear the need would be a good idea and you could have a discussion about where they are in that process in Iowa.

Dr. Dan Baden: All right I think that is a - some good ideas and good opportunity for more discussion in the future. Again one final chance to do star 1 if you have any final questions.

One that we raised in here is it looks like this data is from 2012 that's included in the *Vital Signs*. Are there any hints of where this data is going since 2012?

Dr. Andrew Holt: This is Andy in Tennessee, we actually have noticed some very positive trends and again a lot of our initiatives began in 2012 with many of them only taking effect in 2013.

So I would say that the data doesn't necessarily represent the current trend that's going on. We've had some very initial data from IMS as well that we have decreased our oxycodone prescribing by about 4% from 2012 to 2013, which is favorable to the national average rate of change.

Our C3 prescribing has decreased by 5% from 2012 to 2013, which again is favorable to the national average. Our C4 prescribing has decreased by 3% from 2012 to 2013, which again is favorable to the national average.

I only mention that because we compared that to data from 2010 to 11 where we were all above the national average in those categories. And so we have seen some change, which has been reflected since this data set, this data year was used.

And certainly we're going to continue to get data in the future - our morphine equivalents has decreased over the last year, our number of benzodiazepine and opioid have also decreased from 2012 to 2013.

So I think as more data sets become available I hope to be able to report more success stories very similar to that in the future.

Dr. Dan Baden: Well that's very encouraging. All right we've got one final question in the queue and then we'll wrap up.

Coordinator: Yes we do have a question from Christine Connolly your line is open.

Frank Singleton: It's actually Frank Singleton and I'm with Chris I'm the health director of the City of Lowell in Massachusetts and my question is we've been working six years, seven years now on opioid overdoses through our Massachusetts grant but we've been frustrated with the Massachusetts PMP execution.

One question just struck me hearing this conversation is if every physician has to have a DEA number to prescribe why can't there be a federal database? What are the legal barriers to having a set of 50 states having 50 PMPs, having one database available linked to the DEA number?

Dr. Len Paulozzi: Well I would offer that, you know, the locus of control regulation of prescribing is at the state level currently rather than at the federal level and so that is the way it has been set up.

I don't know that there are technical limitations on what you are describing and I don't think anyone is actively pursuing a single system so far in the United States but I certainly can see the reason why that would be logical.

I don't know if anyone - any of the folks from New York or Tennessee have any comments on that.

Terence O'Leary: Well the right to - one thing that came out of the Supreme Court case that New York handled is that the right to collect this data is part of the states' inherent police power.

So the feds would have to find some type of affect on inter-state commerce or other federal question if they were going to take it over. I think Dr. Paulozzi hit the nail on the head though that states handle this very differently.

The schedules that are collected from who that data is collected varies widely state-by-state and then conversely who can access the system varies widely state-by-state.

In New York we do not allow law enforcement access to this data except upon a judicial subpoena or a court order and that's a privacy decision that New York State has made.

Other states have chosen either more strict or more lax standards and I think that is something that has to be taken into account here as well because this data is collected over the patients objection.

Frank Singleton: Okay, thank you.

Dr. Dan Baden: All right, good discussion, good questions, good presentations. Before we close here there is a little bit more information we can get. If you can just let us know how we can improve these teleconferences so they're more beneficial to you.

Please email your suggestions to ostltsfeedback@cdc.gov. That's O-S-T-L-T-S feedback, all one word at CDC. gov. We hope you'll be able to join us for next months call, which will be on August 12 and we'll focus on preventing obesity in children.

It's going to be entitled children are eating more fruit but not vegetables and how childcare in schools can help. We hope you're able to join us then. I want to thank everyone who attended the call and I want to thank our presenters and that's it for this presentation, thank you goodbye.

Coordinator: This now concludes today's conference all participants may disconnect at this time.