



From Epi to Policy: Prescription Drug Overdose

State Health Department Training and Technical Assistance Meeting

Atlanta, Georgia
April 22 and 23, 2013

National Center for Injury Prevention and Control
Division of Unintentional Injury Prevention



From Epi to Policy: Prescription Drug Overdose

State Health Department Training and Technical Assistance Meeting



The challenges of the prescription drug overdose epidemic are apparent from simply looking at a map of the US. Some regions of the country have been devastated by prescription drug deaths, while others have been only lightly affected. In 2010, the state with the highest drug overdose death rate had a rate eight times higher than the lowest state.

But that same map also captures the greatest opportunities for reversing this epidemic. Justice Louis Brandeis once wrote that “It is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.” States control the levers to prevent prescription drug abuse and overdose, and each has adopted a different approach to addressing this crisis. It is among these 50 state “laboratories,” each working to reverse the epidemic, where public health will find the best way forward for preventing more overdose deaths.

With this in mind, on April 22 and 23, 2013, CDC’s National Center for Injury Prevention and Control convened health officials from 15 states funded through the Core Violence and Injury Prevention Program (VIIPP) to receive intensive training on how to translate what we know about the epidemic into effective action. The meeting sought to combine CDC’s research and epidemiology on prescription drug overdose with real-world discussions of the challenges and successes states have faced in confronting the epidemic.

This report summarizes that meeting. It is organized based on the attendees’ discussions around five major interventions or practices that hold the greatest promise for turning the tide on this epidemic:

- I. Development and use of reports based on Prescription Drug Monitoring Programs (PDMP)
- II. Policies related to use of PDMP data
- III. Guidelines for prescribing prescription opioids
- IV. Pain management clinics
- V. Implementing a prescription drug poisoning prevention program

CDC Disclaimer

The findings and recommendations in this report are based on promising practices or interventions and expert opinion. Additional research is needed to understand the impact of these practices and interventions on reducing prescription drug abuse, diversion, and overdose. The conclusions of this report do not necessarily represent the official position of the HHS/Centers for Disease Control and Prevention.

I. Development and use of reports based on prescription drug monitoring programs (PDMP)

Accurate, timely data is the bedrock of prevention. As the prescription drug overdose epidemic has worsened, more and more states have created prescription drug monitoring programs (PDMPs), which use databases to track controlled substance prescribing and dispensing. By helping providers and dispensers better understand their patients' prescription history, PDMPs can help inform prescribing decisions for individual patients. On a population level, PDMP data can provide invaluable information on the behavior of the epidemic within a state's borders and the patient and provider behaviors that fuel it. Now virtually all states have PDMPs, but they vary in the ways they use PDMP data for surveillance and to inform policy decisions and the development and use of these programs was a key subject at the meeting.

i. PDMP use to inform policy and improve education efforts

Among meeting attendees, several states said that aggregate reports from the PDMP were central in getting relevant legislation (e.g. banning "pill mills") passed. One participant said that their "legislature seems more receptive to proposals if they are driven by PDMP data." Another panelist said that the PDMP data was a big factor in developing legislation to develop physician guidelines and restrictions on pain management clinics.

Another way some states have used PDMP data is to develop educational materials, directed at both the general public and specific audiences, such as physician prescribers. For example, Ohio presented PDMP data in an attractive, clearly written 8-page brochure to raise community awareness. Charts and graphs helped delineate the scope of the state's prescription drug overdose epidemic. Data on mortality, costs of the epidemic, and the role of prescription pain medications show the impact on the state. The brochure ends with a concrete list of actions that can be taken to address the problem, both at the local and state level.

ii. Other potential issues and uses

States also discussed some components of PDMP reports that are most important in bringing about change. One state said that providing data at the local level was useful. Another state said that it was important to link PDMP data and vital statistics data with Medicaid information. One commented that linking prescription drug overdose deaths with prescription data was important in publicizing the issue. Several states said they collaborated with other agencies, such as drug enforcement and law enforcement, in work groups to develop the most useful components of the PDMP reports.

II. Policies related to use of PDMPs

The utility of PDMP data is twofold. It can be used by providers to give them insight into a patient's history of controlled substance prescribing and inform individual-level decision making. PDMP data can also be used by state officials to understand prescribing trends on a broader scale and to identify troubling patterns of prescribing that might otherwise go undetected. Participants at the meeting had insights into ways to increase both types of use.

i. Use by Providers

Making data available about patients' use of controlled substances is one of the major benefits of PDMPs for many states. For example, Oregon's October 2012 statewide data report on prescription controlled substance dispensing emphasized that the state's mission is "to improve healthcare by offering health care providers and pharmacists information about prescription controlled substances... The PDMP is a useful tool for health care providers who prescribe controlled substances as part of a patient treatment plan." Oregon's system allows authenticated users around-the-clock access to information about medicines dispensed to his or her patients. Viewing the patient's purchasing history allows the physician a way to explore potential misuse or abuse of a controlled substance, like opioids. In addition, pharmacists in the state can access information on their customers to help prevent problems associated with controlled substances, according to the quarterly report.

States discussed both sides of the question of provider access to PDMP data. Barriers to access were noted. Some panelists said, for example, that it was difficult for behavioral health providers who did not prescribe controlled substances to a patient to get access to data that might help inform care of that patient. In some cases, doctors are not permitted to provide PDMP data to the patients themselves as part of a clinical encounter. Other comments expressed concern that broad access to PDMP data could lead to identity theft or inappropriate use of information about, say, people who were acquaintances or relatives rather than patients of a provider. Ideally, states thought, the system should have built-in checks to prevent inappropriate access. The question of mandating PDMP registration by prescribers elicited varied responses from the state representatives at the meeting. Some require it, whereas others emphasize ease of use and providing incentives to encourage providers to participate.

ii. Use by State Officials

Using data to identify providers with high prescribing patterns is another way some states use PDMP information. For example, Oregon focuses on outreach to high-volume prescribers by sending them "report cards" to alert them to their patterns of prescribing drugs with the potential for overdose and abuse. Identifying and working with high-volume prescribers has the potential to encourage improved prescribing behavior.

All states participating in the panel discussion related to providers said that data from state PDMPs were an important tool for state government in generating partnerships among relevant professional groups (physicians, pharmacists) and other agencies. The Tennessee panelist spoke for many when he stressed how important it was to "break down the silos," that is, to work across agencies and private groups, like physicians' associations. A Colorado representative said that state's injury program worked well with the workers' compensation program, other state agencies like Medicaid, and the state employers' group. Other states mentioned collaboration with law enforcement and drug enforcement agencies, as well as with a state's attorney general and/or specific legislators.

III. Guidelines/rules for prescribing opioids

In response to a concern about the rise of opioid-related overdoses and deaths, a number of states have generated guidelines for opioid prescribing. Guidelines were a subject of much discussion at the meeting, focused especially around the experiences of Washington and Utah.

i. Washington's Experience

The state of Washington developed a set of rules to curb opioid overuse and abuse. The legislature passed a set of rules that require consultation with a pain management specialist if a provider prescribes an adult a daily dosage exceeding 120 milligrams morphine equivalent dose (MED).

Washington also developed guidelines for prescribing pain medication in emergency departments (EDs). A collaborative effort spearheaded by ED physicians, the guidelines limit prescribing of long-acting pain medications such as OxyContin for chronic, noncancer pain. They also ask for photo identification from patients, as well as a history of pain medication misuse. Provider and patient education are important aspects of the guidelines. A poster and related information brochure are available for EDs.

An important part of the Washington guideline approach is exchanging information among EDs in the state, with the goal of sharing information about frequent visitors to the ED who request pain medications. The Washington representative said that plans are to connect the PDMP to the ED information exchange in 2014. She also reported that efforts to reduce ED use among Medicaid patients, which included opioid prescribing guidelines, were showing initial success.

ii. Utah's Experience

Utah developed a thorough, comprehensive approach to creating guidelines for opioid prescribing. The two-year process received state funding and included a media campaign to raise awareness about the issue. The process involved a steering committee, an advisory committee open to all interested parties and stakeholders; work groups that focused on patient and community education; policy, insurance, and incentives; and data, research, and evaluation.

The cornerstone of Utah's plan was the process of identifying and scoring guidelines deemed effective in improving provider prescribing. The result was "six practices" for safe opioid prescribing. A campaign to disseminate this information targeted physicians via online CME and large-group presentations to physician groups. The Utah representative described this approach as "start low, go slow"—that is, a modest approach to win over physicians to adopt the guidelines.

IV. Pain Management Clinics

Pain management clinics, and laws designed to shut down rogue clinics, were a subject of major interest to the participants.

i. State Experiences

After a law closed down pain management clinics ("pill mills") in Florida, some states in the region began to see an increase in such clinics; the clinics effectively relocated from Florida to neighboring states. Tennessee anticipated such an eventuality and passed a law requiring registration of all pain management clinics in October 2012. The definition of a pain clinic in Tennessee is that more than half the patients are treated for pain. More than 300 clinics registered, about double the expected number. The state has the authority to inspect these clinics, but currently lacks the resources, so hasn't launched that effort yet.

In Ohio, a "health emergency" was declared in 2009 after it was found that many pain management clinics in the southern part of the state were owned by people with criminal records. A coalition was formed, fueled by family groups whose children had died as a result of obtaining prescription drugs from the "pill mills." A task force involving state medical and pharmacy boards looked at the issue statewide; as a result, a law was passed, and 19 of the clinics were shut down.

Kentucky passed legislation requiring that at least 50% of clinic staff be physicians, and they must have certification as pain specialists.

ii. Necessity of Partners

Several states agreed that numerous partners are essential in passing legislation to shut down “pill mills.” In Ohio, the governor kept the momentum going, and the family advocates also kept the issue alive. In Kentucky, key partners were the governor, the attorney general, and citizens who supported the cause. Doctors were influential in Tennessee—in fact, the Tennessee Medical Association drafted the bill.

V. Implementing a prescription drug overdose prevention program

The goal of the meeting’s final exercise was to identify all the disparate elements that make up a prescription drug overdose prevention program, prioritize them, and suggest resources to accomplish the implementation steps. Participants broke into six groups to discuss the most important steps in implementing such a program. Details of their deliberations were compiled by topic and follow this summary (Table 1).

Although each group approached the exercise in a slightly different way and emphasized different aspects of implementation, nine key elements emerged as common to all the discussions. The following elements were considered by state health department attendees to be vital to implementing a prescription drug poisoning prevention program within a state injury program.

1. Develop a surveillance system. This should draw on information from various data sources within the state, e.g., death certificates, hospital and ED discharge data.
2. Assure leadership and strong stakeholder commitment. The commitment to develop a strong prevention program is essential, as is the involvement of major stakeholders in the state. Building stakeholder groups and task forces will strengthen program growth. Work groups, e.g., on data or policy, can broaden involvement of different sectors.
3. Support and strengthen PDMPs. The ongoing involvement of key professionals like pharmacists and physicians is needed to keep the PDMPs effective and relevant.
4. Forge linkages with other agencies and private groups. Numerous states commented on the need to “break down the silos,” that is, to work across agencies and groups to accomplish the goal of preventing prescription drug overdose deaths.
5. Do not neglect harm reduction and preventing fatal outcomes of overdoses. It is important to raise public awareness about options for secondary prevention.
6. Provide education to the general public and targeted groups. The general public needs to understand the severity of the problem, and professional groups can benefit from education and training efforts to improve their prescribing practices and use of state data.
7. Develop guidelines for opioid prescribing. Utah’s process is a model to consider, and Washington has a well-developed set of guidelines for EDs to use.
8. Use data to inform laws/regulations that prevent pill mills.
9. Assure evaluation of implementation efforts. As efforts to establish poisoning prevention programs develop, it is vital to determine what really works to reduce prescription drug poisoning deaths.

Conclusion

The pressing and complex problem of prescription drug overdoses cannot be solved by a single policy, approach, or player. Opportunities for states to share their experiences—to learn from the successes and challenges in other state “laboratories”—are crucial to advancing the multi-sector, collaborative approach necessary to reverse this epidemic.

Table 1: State suggestions for key elements for successful implementation of state drug poisoning prevention programs, CDC State Health Department Training and Technical Assistance Meeting, Atlanta, Georgia, April 22–23, 2013

Develop Surveillance Systems
<ul style="list-style-type: none"> ● Convene data working group to identify important potential sources of data, such as the following: <ul style="list-style-type: none"> ▪ Hospital and ED discharge data ▪ Mortality data from death certificates ▪ Substance abuse and mental health data ▪ Medicaid data ▪ Relevant state reports ▪ Trauma registry data ▪ National Survey on Drug Use and Health ▪ News media investigative reports ▪ Qualitative data, e.g., stories from patients, parents of overdose victims ● Use standardized metrics ● Conduct continuing analysis, monitoring over time ● Evaluate data quality ● Provide training, technical assistance ● Share data at local state, and national level ● Include diagnostic codes
Assure Leadership and Strong Stakeholder Commitment
<ul style="list-style-type: none"> ● Build relationships with key local/state groups <ul style="list-style-type: none"> ▪ Medical associations ▪ Professional boards ▪ Local health department ▪ Local substance abuse authority ▪ Law enforcement ▪ Medical examiners/coroners ▪ Insurers/Medicaid ● Involve key stakeholders in work groups, task forces ● Assure good communication among all partners ● Examine climate to determine what will work best in your state/locality ● Forge connections with relevant national groups like ASTHO, National Governors’ Association, CSTE, NCSL ● Involve state advisory groups, as appropriate
Support and Strengthen PDMPs
<ul style="list-style-type: none"> ● Assure ongoing involvement of physician and pharmacy groups ● Maintain political will to sustain and fund PDMPs and to expand linkages (e.g., to substance abuse programs) ● Learn about best practices from Brandeis Center for Excellence in PMPs program ● Develop funding sources (e.g., private endowments/foundations, CDC) ● Develop guidelines for registration and use of PDMPs

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Forge Linkages with Other Agencies and Private Groups

- Create linkages with helping agencies, law enforcement, licensing boards (“break down the silos”)
- Forge linkages with relevant private groups and associations

Do Not Neglect Harm Reduction and Preventing Overdose Deaths

- Educate physicians about the value of providing naloxone to prevent overdose deaths
- Learn from the experience of North Carolina’s “Project Lazarus” and other, similar state initiatives
- Reduce the quantity of opioids in circulation via various means:
 - Medicaid “lock-in” program
 - Pharmacy “take back” programs
 - Drop boxes at pharmacies for disposal of drugs
- Assure access to substance abuse treatment programs for patients identified as high-risk for overdoses
- Increase the number of non-opioid pain management approaches (yoga, physical therapy) by increasing reimbursement for these therapies
- Consider “Good Samaritan” laws
- Promote participation at all levels, including
 - Governor’s office
 - Injury control programs
 - DEA
 - Pharmacists
 - Behavioral health specialists
 - Public safety and law enforcement agencies
 - Substance abuse prevention community

Provide Education to General Public and Targeted Groups

- Raise awareness among the general public about severity of opioid problem— using such tools as PSAs, brochures, fact sheets, posters
- Borrow ideas from other states, e.g., Utah campaign
- Develop toolkit to help professionals interpret PDMP data
- Provide education (seminars, continuing education) for providers on pain management issues
- Develop toolkit to help physicians talk to patients about dangers of opioid overuse, “doctor shopping”

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Develop Guidelines for Opioid Prescribing

- Develop guidelines for prescribing pain management drug (like opioids) for physicians in general practice and in EDs
- Look to experience of other states (e.g., Utah, Washington) as examples

Use Data to Inform Laws/Regulations that Prevent “Pill Mills”

- Inform laws that define/limit “pill mills”
- Learn from experience of other states; review sample laws
- Form partnerships with physicians, pharmacy groups and their licensing boards
- Engage key legislators in the issue
- Ensure enforcement role
- Forge alliances with compliance/enforcement agencies like DEA, local law enforcement, others

Assure Evaluation of Implementation Efforts

Plan evaluation component

Consider resources such as APHA policy training, NCSL policy evaluation, CDC training and technical assistance

Appendix A

Additional resources referenced in the report:

- Oregon PDMP reports and fact sheets: <http://www.orpdmp.com/reports/>
- Washington state materials on pain medication prescribing and PDMPs: <http://here.doh.wa.gov/ed-materials/subjects/alcohol-and-drugs>
- Utah Clinical Guidelines on Prescribing Opioids: http://health.utah.gov/prescription/pdf/Utah_guidelines_pdfs.pdf.



Appendix B

Meeting Attendees

From Epi to Policy: Prescription Drug Overdose Meeting

April 22–23, 2013

Atlanta, GA

The participating states were funded Core VIPP states and had identified prescription drug overdose or poisoning as a priority area for 2013. Each state was asked to designate one staff person working in epidemiology or surveillance and one staff person with the lead responsibility for policy in this priority area to attend the meeting.

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Appendix C

Formal Presentations

From Epi to Policy: Prescription Drug Overdose, April 22 and 23, 2013 Atlanta, Georgia

Epidemiologic Basis for Pain Clinic Laws

Noah Aleshire, JD
NCIPC, CDC

Prescription Drug Monitoring Programs: Analysis of State Level Usage

Carla Chen, JD
Director, Public Health Law Program, CDC

Prescription Drug Overdose Data & Statistics:

Guide to ICD-9-CM and ICD-10 Codes Related to
Poisoning and Pain

Origin and Process of Utah Guidelines

Anna Fondario, MPH
Utah Department of Health
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Considerations on the Use of Prescription Monitoring Programs

By Prescribers, Pharmacists, and Public Health
Departments
Traci C. Green, PhD, MSc
Director, Public Health Research and Methodology
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State of the States: Prescription Drug Abuse and Overdose Policy

Christopher M. Jones, PharmD, MPH
NCIPC, CDC

Epidemiology of Practice Interventions

Meelee Kim
PDMP Center of Excellence
Brandeis University
Heller School for Social Policy and Management

State of the States in Outcomes

Karin Mack
Behavioral Scientist
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Pain Management Clinic Laws

Akshara Menon, JD, MPH
Public Health Law Program, CDC

Prescription Drug Overdose: Mortality Surveillance Review

Len Paulozzi, MD, MPH
NCIPC, CDC

Prescription Behavior Surveillance Using PDMP Data

Len Paulozzi, MD, MPH
NCIPC, CDC

Prescribing Pain Medication— Guidelines for the Emergency Department

Jennifer Sabel, PhD
Injury and Violence Prevention
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Washington's Pain Management Rules

Kristi Weeks
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