

Advisory Committee
Prescription Pain Medication Program
August 13, 2008
3:00-4:30, RM 114

Present:

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|---|---|
| 1. Bennion Buchanan, Utah ACEP | 19. Lynnette Wingert, DEA |
| 2. Kim Bateman, HealthInsight | 20. Roger Stuart, WCF |
| 3. Patrice Hirning, UMIA | 21. Jason Carlton, Vanguard Media |
| 4. Catherine Groseclose, UDOH VIPP | 22. Cindy Kindred, Vanguard Media |
| 5. Jaye Rieser, Jewish Family Services | 23. Ben Reaves, DSAMH |
| 6. Abbie Vianes, SLC Mayor's
Coalition | 24. Susannah Burt, DSAMH |
| 7. Erin Sexton, Medtronic | 25. Aubree Chesley, SLCO Substance
Abuse |
| 8. Marty Malheiro, Utah Poison
Control Center | 26. Tim Morley, UDOH Medicaid Drug
Program |
| 9. Dave Felt, DSAMH | 27. Connie Kitchens, U of U |
| 10. Barry Nangle, UDOH Center Health
Data | 28. Rodney Hopkins, U of U Social
Research Institute |
| 11. Charlotte Vincent, UT Division of
Aging | 29. Terry Russo, SLCO SA |
| 12. Julie Wald, U of U | 30. Pat Fleming, SLCO SA |
| 13. Jackie Lehman, Utah Medical
Association | 31. Brent Kelsey, DSAMH |
| 14. Joel Millard, Project Reality | 32. Lana Taylor, AG |
| 15. Raffaele Villella, Alparma
Pharmaceuticals | 33. Kevin Wyatt, Insurance Fraud
Division |
| 16. Chris Kottenstette, PAC, Alparma
Pharmaceuticals | 34. Ken Benson, Insurance Fraud
Division |
| 17. Robert Finnegan, UDOH-HCU | 35. Jeff Hawley, Utah Insurance Dept |
| 18. Arthur Lipman, U of U Pain Mgt.
Center | 36. Robert Rolfs, UDOH |
| | 37. Erin Johnson, UDOH |

Agenda:

Work Group Updates:

- Data, Research, Evaluation Work Group—Susannah Burt
- Policy, Insurance, Incentive Work Group—Erin Johnson
- Patient and Community Education Work Group—Abbie Vianes

Provider Education Overview: Kim Bateman, HealthInsight

Media Campaign Overview: Cindy Kindred & Jason Carlton, Vanguard Media

Guidelines Updates: Erin Johnson

Future of the Program: Bob Rolfs

Updates from the group

Work Group Updates

Data, Research, Evaluation Work Group Update by Susannah Burt

The Work Group brainstormed ways to evaluate the provider education: came up with the idea of measuring hits to the CSDB website to see if there is an increase after provider education (it is possible to tell where the people log on from so if it is from a specific hospital that received the intervention we would be able to track that).

Two reports were compiled and presented to the Work Group by Bill Stockdale. They are on:

[Drug Diversion Literature Review](#) by William Stockdale

[Literature Review of Prescription Analgesics In the Causal Path to Pain](#) by William Stockdale

They are a valuable resource and available on our website (health.utah.gov/prescription) under publications and under data work group.

Policy, Insurance, Incentives Work Group Update by Erin Johnson

Top 5 priority areas have been:

1. Require DOPL's CSDB to be up to date
2. Program to work with DOPL to promote appropriate use of the Controlled Substances Database among health care providers
3. Simple program for health plans to use to identify high opioid users tied with an educational and/or case management program.
4. Simple program that might educate providers
5. ER's only give 24 hr supply of narcotics

Explanation of how each is being accomplished:

1. With the passage of Rep Daw's bill, the pilot version of the Real-Time CSDB will be up by 2009. If all goes well with the pilot, the state should have a Real-Time Database by 2010.
2. We are currently working on a Provider Education training that will teach providers how to use the CSDB to their advantage. The pilot system will also use more user-friendly approaches to make the system easier for doctors to use.
3. Insurance organizations like Molina already have begun this case management of identified "high opioid users"
4. Our Provider Education training will sensitize physicians to the problem of prescription related deaths
5. Abbie Vianes conducted a survey of all Utah hospitals and found that nearly all of them had a policy of only giving 24 hr supply of narcotics to ER patients rather than giving a full prescription.

Ben Buchanan verified that most hospital refrain from giving out prescriptions for narcotics and urge patients to see their primary care physician if pain persists.

ER question: is it more an issue of the length of the prescription that is given or the number of pills being given?

This group met with representatives from Altius, Blue Cross Blue Shield, Medicaid, Molina, Lifesource, and Violence and Injury Prevention in order to discuss which current coverage and policies on opioids may be improved.

The group also supported Rep Daw's bill for real time reporting on CSDB. Individuals of the group drafted a letter that was circulated to doctors informing them of the upcoming bill and urging support.

Patient and Community Education Work Group Update by Abbie Vianes

Working with Vanguard to give feedback on posters, bookmarks, and website. Also, we've kept each other informed on different events and conferences relevant to our campaign or to prescription pain medication.

Arranged to have a pavilion at the Days of '47 Youth Parade. We worked on getting the booth and developing an informational survey (not intended for data collection, but rather, to be educational. For example: "did you know that more people died from...")

HealthInsight Presentation by Kim Bateman on Plan for Provider Behavior Change

Challenges:

Difficulty of time

Overcome skepticism

Change current practice

Limited budget: can't sit down with each physician

Balance the most effective way of changing behavior.

Intervention Methods:

Plan to meet with 10 rural and 20 Wasatch Front groups (small groups)

Give 6-10 large group CME meetings

Partner with Intermountain, U of U clinics, UMIA

Articles in UMA bulletin

Presentation is about 1.5 hours.

Objectives:

Describe epidemic in Utah

Describe Utah's strategy at addressing epidemic

Explain unique dangers of methadone

Implement "6 practices for safe opioid prescribing"

Identify tools to help integrate the 6 practices into their work

Follow up after 1 week and several months after to measure behavior change

Up to 20 possible CME credit hours for physicians who participate fully in the pre-assignment, attend the presentation, and post-assignments.

Slides are included that are specific to each region.

6 points:

1. Start low, go slow: don't consult a conversion table. Start everyone at a low level and work up.
2. Sleep studies are recommended for all patients.
3. Methadone can prolong the QT wave, therefore EKGs are recommended for methadone dose increases to or above 50mg/day
4. Avoid sleep aids and benzodiazepines with opioids
5. Avoid long acting opioids in acute pain
6. Educate patients/family about risk

Tools that will be given at presentations:

- Guidelines
- Risk screening tool
- Sample pain contract
- Controlled Substance Database Demo
- Handouts for patients

Comments:

Are there problems getting a sleep study covered by insurance?

How intense does the sleep study have to be? Some counties don't have the equipment to perform the study.

Suggestion: change the word "contract" to a "medication management agreement"

Art: It has been difficult trying to get this issue into the medical curriculum

Brent Kelsey: We may have an in—we can help get this into the curriculum

Jaye: Many kids get their first taste of narcotics when they get their wisdom teeth pulled. Are you working with dentists at all?

Bob: No. They are not giving long-term prescriptions. We could look at the DOPL database to see if there is a special approach we should use for dentists.

Lots of anecdotal evidence saying that dentists are providing longer prescriptions (30 days) for dental work.

Bob: HealthInsight is specifically teaching for those prescribing for chronic pain, but you've raised a valid point and something we should look at as a potential intervention.

Ben: Is their validity to the sleep studies? If someone has a sleep study that is normal does it mean they won't be sensitive to long-acting opioids?

Kim: When you reach moderate to high doses of narcotics, do a sleep study on all of them. You can't tell with an early diagnosis, you have to wait until they have reached the higher dose to do the sleep study.

Kim: want to reach a good balance of encouraging safe prescribing (not discouraging them from prescribing).

Bob: DOPL law was changed 2 years ago to allow UDOH appropriate use for research.

Media Campaign by Vanguard Media (Cindy Kindred and Jason Carlton)

Background research: surveyed 413 adults (18 and above) across the state (95% confidence level). Of those surveyed, 93% thought the meds were misused, 58% thought sharing prescription meds were very dangerous, 62% said they had been prescribed Lortab during their life. Doctors offices and pharmacies were where respondents said they would look for information on prescription pain medication.

Put together logo ideas and then held 3 focus groups: came up with Use Only As Directed for campaign logo.

Created a TV and radio spot (see useonlyasdirected.org and go to press room)

We are trying to have a united message—working with other groups who have the desire to educate people on prescription pain meds.

Guidelines:

We created two panels of experts: one to develop the recommendations, the other to review the recommendations to ensure that they can be implemented and are usable as well as to identify tools to accompany the recommendations.

Draft will be completed this month. The guidelines will be reviewed by legal. Anticipated date for publication: End of September.

Future of the Program:

Ability to start the program came from legislation. It began as a 2 year program 2007-2009. We don't have ongoing funding. Funding was given by a variety of places: substance abuse, CCJJ, Labor Commission, Workers Compensation Fund. The division will request funding and will determine whether the department will put it in the governor's budget. If it makes it into the governor's budget, we may receive funding for it. State employees can't advocate for it unless it is in the governor's budget. At that point, we would be interested in having your help. We are concerned that this is not a 2-year problem and we hope that this can continue on.

Kim: you have a good group here that can do some lobbying for you when the time comes.

Division of Substance Abuse is committed to this issue through Oct. 2011. We would like to see this program continue.

In preparing the county specific data, I've noticed that there is a drop in the total number of opioid deaths.

Last year, overdose deaths that were determined to be accidental or undetermined intent and only involved non-illicit drugs and included at least 1 opioid totaled: 261. This was a decrease from the 276 in 2006.

Bob: it may be more of a leveling off.

Updates:

Art Lipman: Series of articles in June issue in Journal of Pain (American Pain Society). This is a national issue and, in fact, a world wide issue.

Art Lipman: Program at the university that I want to make you aware of: Symposium on Intersection of Addiction, the Health Sciences, and the Law. It will be held next March/April at the University of Utah. This conference has continuing education available. 2 half day sessions. Free of charge. Looking at having Michael Leavitt and the Drug Czar present.

Abbie Vianes: August is National Medicine Abuse Awareness Month—the mayor will launch a Clean Out the Cabinet campaign.

Idea: Could talk to U of U college of pharmacy to get some volunteers (contact Karen Gunning)

Jaye: efforts to educate people about theft of narcotics? A large portion of people report getting their meds from other people's cabinets/ supplies.

Kevin: often it is addicts who take all their pills and then file a theft report so that their doctor will write them another rx (often dr's won't re-write it unless there is a report filed).

Let's keep the idea of balance in mind. 9% of population genetically predisposed to having a drug-seeking behavior. We need to keep this in mind.

Bob: In the original legislative mandate we are supposed to work with the office of attorney general, but it is vague what that means. If there are issues that cut across—if we should be doing something in terms of public education (if there is evidence about it) we are open to that. At this point, as we look through the controlled substance database and identify patterns, we would recommend ideas to law enforcement.

Chris: a lot of misconceptions about the law enforcement (eg if you write a certain # of prescriptions, you will be flagged). If these misconceptions were clarified, it might help keep from pushing things to one end of the pendulum.

Lynette: notice of proposed rulemaking for electronic prescribing (open for comment through end of September). Please submit your comments on the rule. If the rule passes, there are no state laws that would need to be modified. It would give doctors the opportunity to prescribe electronically rather than given the patient a handwritten prescription (the e-prescription would go directly to the pharmacy).

Federal register June 27 2008 vol 73 #125 or DEA website: www.deadiversion.usdoj.gov

Bob: Controlled Substances Database can be inaccurate because of entry errors. Also, patients have the opportunity to alter the prescription if they are given a prescription into their hands. Electronic prescribing would be a good thing.

DEA launching new website with parent information.