

Prescription Pain Medication Program
Steering Committee
March 17, 2009
Rm 401 of Cannon Building, 8:00-10:00am

Present:

Alan Colledge
Teresa Garrett
Iona Thraen
Robert Finnegan
Terri Rose
Noel Taxin
Kim Bateman
Craig Povey
Erin Johnson

Action Items:

- * Iona send most recent version of questions for CS license out to Steering Committee and get feedback on which ones to use. Does it represent the guidelines?
- * Iona send copy of conversion chart for Steering Committee to review
- * Robert Finnegan will write up the generic options that exist and send to group
- * Alan will send the lower-back pain guide as an example for distributing guidelines

Update from DOPL (Noel Taxin)

HB 106

Gives access to mental health therapists
Doctor can designate up to 3 employees to access the database (based on approval from DOPL—background check)
Can include CSDB print out in records (kept to HIPAA standards)
Can patient be given a copy?
Can DOPL tell if I look up a certain patient? Not currently.

Response:

HealthInsight will include this info in their education presentation
Scenario of checking CSDB and seeing that a patient broke his contract—what to do? What obligations does the doctor have?

May 12, Alan's group has a conference—are looking at how to implement guidelines, will review some of these scenarios.

Dr. Hanson: how to identify people who need help and how to make the referral

Changes to CSDB

DOPL is updating the database so that it is more user-friendly. Tom Harper is hired to help make the IT changes and to educate people on the CSDB.

Adding quiz when renewing CS license

In order to add questions to the CS license renewals, Noel needs to write a proposal. A pop-up will occur if the answer is right or wrong (either way the information about the right answer will pop up). Will only be for people who have the controlled substances license. The DOPL person over nurses does not want to refuse a license if they fail the test. Will not hand grade the tests.

Take test and receive feedback on the score. If they got wrong answers, they will be given a chance to re-do the questions they missed at the end of the test. Need to get 100% to move on.

Results: do we want results in 6 months or in 1 year?

After the three months, we can look at the results and see if some questions need changing.

*send questions out to Steering Committee and get feedback on which ones to use

Does it represent the guidelines?

*Iona send most recent version of questions

Preferred Drug List

Methadone be available as preferred agent, but not the ONLY preferred agents. Fentanyl is generic (there are two generics, but they are still expensive). MS Contin (MS extended release or MS immediate release) is generic.

Dosage conversion chart for consideration.

Concern about the conversion chart

*Iona send copy for Steering Committee to review

*Robert Finnegan will write up the generic options that exist and send to group

Grant: Letter of Intent

Basic idea proposal is to translate the opioid guidelines into practice. We intend to do this by adding decision support technology to electronic medical records.

Response:

Add a paragraph on the success of this problem through HB 137

Add 6 safe prescribing practices

Dr. Glen Hanson: Adolescents and Abuse of Opioid Narcotics

(ppt available online under Steering Committee: Other Resources: March)

Important to look at survey questions to see what they are really asking

Drugs are not inherently good or bad, it depends on how they are used and who is managing the use

Utah is low in most other drugs (that have stigma attached to it), but prescription drugs don't have that stigma and they have high reported use because of it.

Vulnerability factors: Traumatic Brain Injury, adolescence, mental and neurological disorders (~50%), genetics, stress, drugs (interfere with decision making)

Cycle: misuse, abuse, dependence, addiction

Comparing brain density: shows immature prefrontal cortex in adolescents. Mature amygdala (which is impulsive).

Very frequently in addicted patients, they have some thing in their family history that makes them at risk for addiction.

Adolescents when feeling withdrawal may be more likely to find a way to continue than an adult would (adolescent thinks about present comfort and not the impact it might have a month down the road).

Dentists generally prescribe a very small amount of opioids (9 Lortab will not result in addiction).

Easy to fix problem when it begins in adolescence rather than feeding the problem and trying to deal with the consequences 20 yrs later (example of high school principal who hurt his back 20 yrs before and received chronic narcotics all those years until a doctor saw that the principal had become addicted and the doctor backs off the prescriptions—principal forges prescriptions).

Working with adolescents is hard because we don't know if testing on them is changing their brain or if they had a brain like that that would have been that way in adulthood.

Very unusual for a dentist to prescribe Oxycontin. They generally come out of school with a fear of narcotics. They prescribe in small numbers.

Current thoughts on permanency and predisposition in plasticity of the adolescent brain?

Can you extinguish a behavior=can you extinguish a pathway that is established in the brain? No—once a behavioral pathway is there it will NEVER go away, but you can suppress it. Treatment tries to suppress the bad pathways and teach the person to reinforce the good pathways.

Of individuals who start using nicotine in adolescence only 5% of them can be treated as adults. If they start using after 20 or 25 yrs old, 95% of them can be treated later.

Is there any reason to believe that if an adolescent is exposed (even if using as directed) they will have established that neuro-pathway that will lead to addiction?

As long as the adolescent is following the rules (using as prescribed) they are ok. If they lose control, it shows that they are beginning down the cycle toward addiction.

Adolescents may be more likely to become addicted if:

Additional risk factors

Use opioids on a long-term basis

Suggestion: send out a post-card to CS licensees about the guidelines (include dentists)

State that upon renewal there will be an exam.

Create Reader's Digest Tool Kit: Make an executive summary and include the tools

UMA 60% of physicians

*Alan will send the lower-back pain guide

Need to have executive summary be more instructive and clear

Ideas of Tools to include in reduced version:

Expectation for function

Risk Screen

Treatment contracts

List of generic drugs (written by Robert Finnegan)

*Send Glen the resources tool for feedback