

The other epidemic:
Prescription Drug Abuse in the US
Ten prevention ideas from the states

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Presented at the National Conference of State Legislatures “Injury Prevention Through the Life Cycle” meeting in Atlanta, May 14, 2009.

Rate of unintentional drug overdose death in the U.S., 1970-2006



Unintentional drug overdose rates in the United States have risen since the 1970s. The sharpest increases have occurred since 1999. Most of this most recent increase is traceable to increasing involvement of prescription drugs, principally the narcotic painkillers, whose technical name is “opioid analgesic.” Drugs in this group include oxycodone, hydrocodone, morphine, fentanyl, methadone, and others.

Rates are crude rates per 100,000 persons. Source is National Vital Statistics System (NVSS).

1970-78 is ICD 8 codes E850-859, (unint. pois. by drugs), as reported in Samkoff, AJP 1982;72:1251

1979-98 is ICD 9 codes E850-858, (unint pois. by drugs), source is WONDER

1999-2006 is ICD 10 codes X40-44, (unint. pois by drugs), source is WONDER

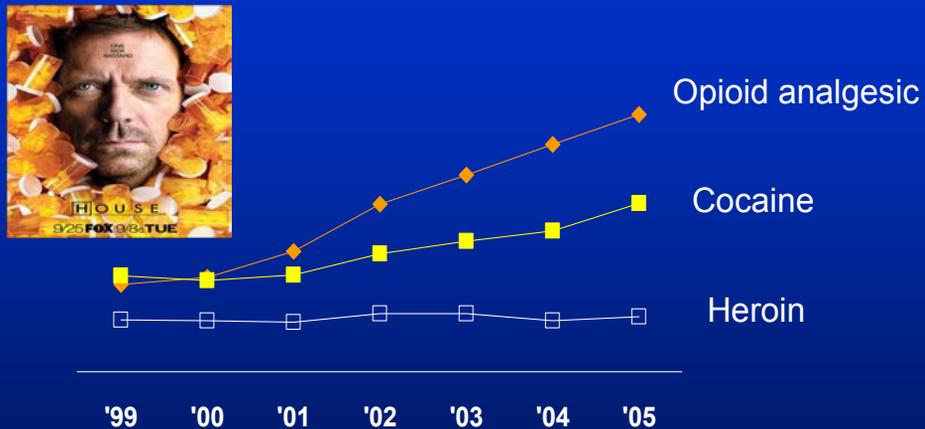
Drug overdose death rates by state, 2006



You can track drug overdose deaths, not including those determined to be suicides, using information from national death certificates. This map shows age-adjusted rates by states for drug overdoses. There are clusters of high rates in Appalachia and in the Southwest.

Source: WONDER underlying cause mortality files, age-adjusted rates. Deaths whose underlying cause was coded to unintentional (X40-44) or undetermined intent (Y10-14) drug poisoning. Latest national data available as of 5/09.

Unintentional drug overdose deaths by major type of drug, U.S., 1999-2005



This demonstrates a little appreciated fact: by 2005, more drug overdose death certificated cited prescription opioid analgesics than cited cocaine or heroin combined.

In addition to the change from street drugs to script drugs, the typical drug user has changed. The typical drug abuser today is more likely to resemble Dr. House, the middle-aged, white male character on a TV show of that name who is addicted to a prescription opioid, Vicodin.

Source: National Vital Statistics System, multiple cause of death dataset.

Totals add to more than total deaths because more than one drug may be listed per death.

Opioid analgesic is ICD10 codes T40.2-T40.4.

State government responses have been described in reports



Prescription Drug Overdose:

State Health Agencies Respond

Trends Alert:

Prescription Drug Diversion



Given that this problem has been growing since the 1990s, states have already made a number of policy responses, which have been summarized previously. CDC ourselves worked with the Association of State and Territorial Health Officials to put out a report in 2008.

We interviewed 9 state health officers or their designees and asked them what they were doing about the problem. The most common answers were “task forces” and “prescription drug monitoring programs.”

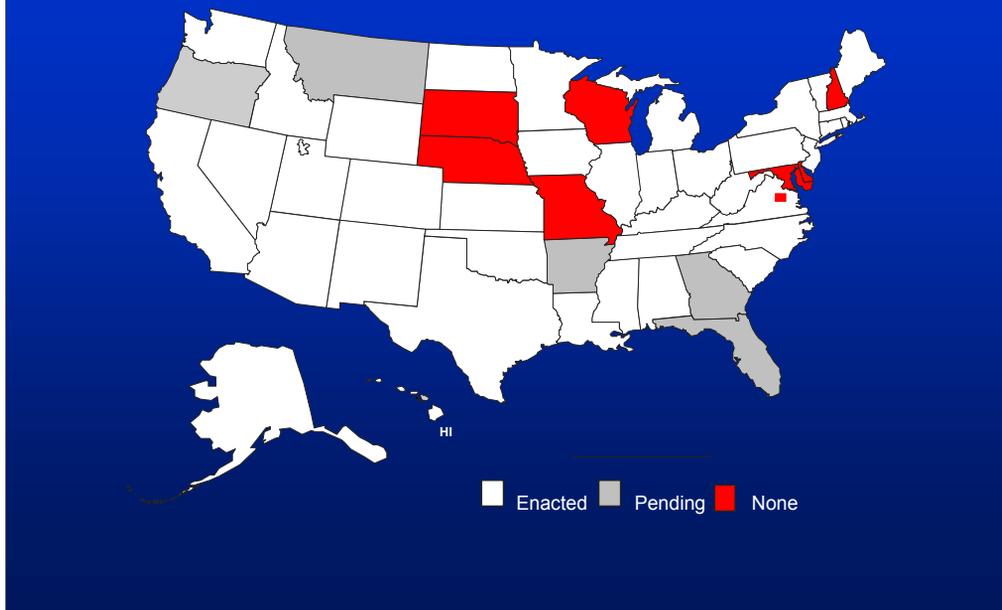
This report is available at: http://www.astho.org/pubs/RXReport_web.pdf.

The Council of State Governments also published a “Trends Alert” in April, 2004 entitled: Prescription Drug Diversion. This report covers prescription monitoring programs, physician education, and theft and fraud controls.

It is available at:

<http://www.csg.org/pubs/Documents/TA0404DrugDiversion.pdf>.

#1 State Prescription Drug Monitoring Programs



Turning to the first idea from the states, mentioned by both reports, prescription drug monitoring programs. Such programs have been around since the 1940s, but have recently multiplied with financial support from the Dept of Justice.

Program: PDMPs collect details on prescriptions for abuseable drugs electronically from all pharmacies in a state.

Prevalence: 38 enacted; 32 operational; 5 with pending legislation; 8 have no legislation pending (as of 2/09) Source:

<http://www.namsdl.org/documents/StatusofStates2-4-09Web.pdf>

Cost: About \$350,000/yr. Some states spend much more. Federal support is available.

Goal: Stop nonmedical use & irresponsible prescribing

Evidence of effectiveness: Anecdotal evidence suggests they make abuse investigations easier. One ecological study found they reduced distributions of Schedule II. No evidence that as a group they reduce overdose morbidity or mortality.

#2 Single-copy, Serialized Paper Prescription Forms

Warning Bands - Top & Bottom with security features.

Consecutive Numbering

Thermo-chromic ink

Void Pantograph with chemical protection

Microprinting

THE FACE OF THIS DOCUMENT HAS A COLORED BACKGROUND ON WHITE PAPER.

PHYSICIANS MEDICAL GROUP
A. Bill Coleman, M.D.

Patient Name _____

Address _____ Phone No. (____) _____ Age _____ Gender _____

R

INITIAL QUANTITY
 1 - 24
 25 - 49
 50 - 74
 75 - 100
 101 - 150
 151 & over

No Refills
or
of Refills: _____

REFILL QUANTITY: _____

DO NOT SUBSTITUTE

Prescription is void if more than one controlled substance prescription is written per blank.

A. Bill Coleman, MD
(xxx) xxx-xxxx
12345 First Street
Anytown, XX xxxxx

DEA No. XX 0000000 CA Lic. No. X-00000 X

DATE _____

THE ORIGINAL DOCUMENT HAS A REFLECTIVE WATERMARK ON THE BACK. HOLD AT AN ANGLE TO VIEW.

Single-copy, serialized paper prescription forms

Program: Special required tamper-resistant forms

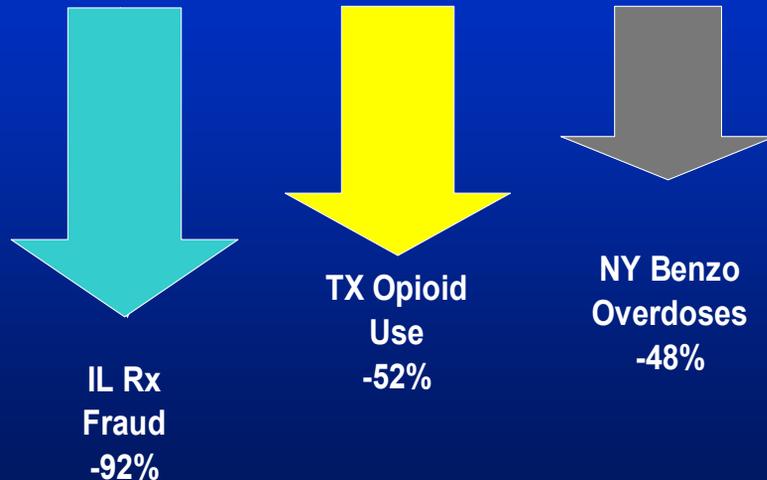
Prevalence: CA, NY, TX; ME requires for Schedule II drugs; Medicaid now requires such forms for all prescriptions;

Cost: Special forms

Goal: Prevent prescription copying, alteration, and counterfeiting

Evidence of effectiveness: Observational studies showed that earlier triplicate forms reduced use of and ED visits involving benzodiazepines and opioids.

Changes with special prescription forms



The literature about the impact of special forms dates back to the 1980s when such forms were introduced.

Illinois's decline was in Schedule II drug prescriptions between 1985 and 1991.

Texas's decline was in all Schedule II drugs in 1982

New York's decline occurred in 1989 when benzodiazepines were added to the triplicate prescription form.

Data from: Department of Health and Human Services Office of Inspector General. Multiple Copy Prescription Programs: State Experiences. Published June, 1992. pages 5-6

Available at: <http://www.oig.hhs.gov/oei/reports/oei-12-91-00490.pdf>

And: The Impact of Prescription Drug Diversion Control Systems on Medical Practice and Patient Care, NIDA Research Monograph 131, 1993. Available at: www.drugabuse.gov/pdf/monographs/131.pdf

#3 Doctor Shopping Laws



Program: Law prohibiting obtaining and failing to disclose the same or similar prescriptions from multiple providers within an inappropriate time frame (30 days in FL) (Examples of a couple of statutes: HAW. REV. STAT. §329-46(a) (2008); FL. STAT. §893.13(7)(a)8 (2008)).

Prevalence: As of December, 2008, there were thirteen states with specific provisions in their law related to doctor shopping: Connecticut, Florida, Georgia, Hawaii, Louisiana, Maine, Nevada, New Hampshire, South Carolina, Tennessee, Utah, West Virginia and Wyoming. A bill is pending in Texas as of 4/09.

Cost: Enforcement staff

Goal: Reduce the practice, which is common among dealers

Evidence of effectiveness: Not studied to date

#4 Pain Clinic Laws



Program: Law requiring that all pain clinics be owned and operated by a physician certified in the specialty of pain management

Prevalence: Louisiana and perhaps others. A bill was pending in Texas as of 4/09.

Cost: Enforcement costs

Goal: Check proliferation of sham clinics

Evidence of effectiveness: Little research to date. It was reported that of 150 existing clinics in Louisiana, only 10 requested licensure after passage of a pain clinic law in that state.

Broward Pain Clinic

At Broward Pain Clinic we respect the right a patient has to seek medical care where ever and with whom ever they want. We feel that we provide patients with the BEST quality pain management healthcare available, and that is why we do not require patients to reside just in the state of florida. **We are currently accepting patients from all states.** We do require that all of our patients have proof of thier pain, whether its an **MRI, CT, or documented medical history of a condition that causes them chronic pain.** If Patients are choosing to change healthcare providers because they feel we can provide them with the healthcare they want or deserve - we will need a **list of current medications from the pharmacy they were recieving medication from,** so that our doctors can continue the management of their pain.



IN HOUSE DISPENSING AVAILABLE IF YOU CHOOSE

Schedule an appointment or have us contact you!

Fill out your paperwork now and save time!!!

An example of pain management clinic in Ft. Lauderdale, FL. Florida has been the destination for people from all over the Southeast seeking opioid analgesics.

Available at: <http://www.browardpainclinic.com/>

#5 Voluntary Return of Unused Pharmaceuticals



Maine Pilot Program

Gressitt, Return of Unused Pharmaceuticals

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Program: Patients mail back unused drugs to state authority for disposal
Prevalence: AS, CA, CO, HI, IA, ME, NY, OR, PA, TN, VA, WI have legislation

Cost: Maine got \$150K from state, \$150K grant from EPA to test the program. Operation costs are not yet clear.

Goal: Reduce use of discarded drugs by abusers; protect environment

Evidence of effectiveness: Not studied to date

#6 Drug Courts



Program: Intensive court-based drug treatment programs as an alternative to incarceration

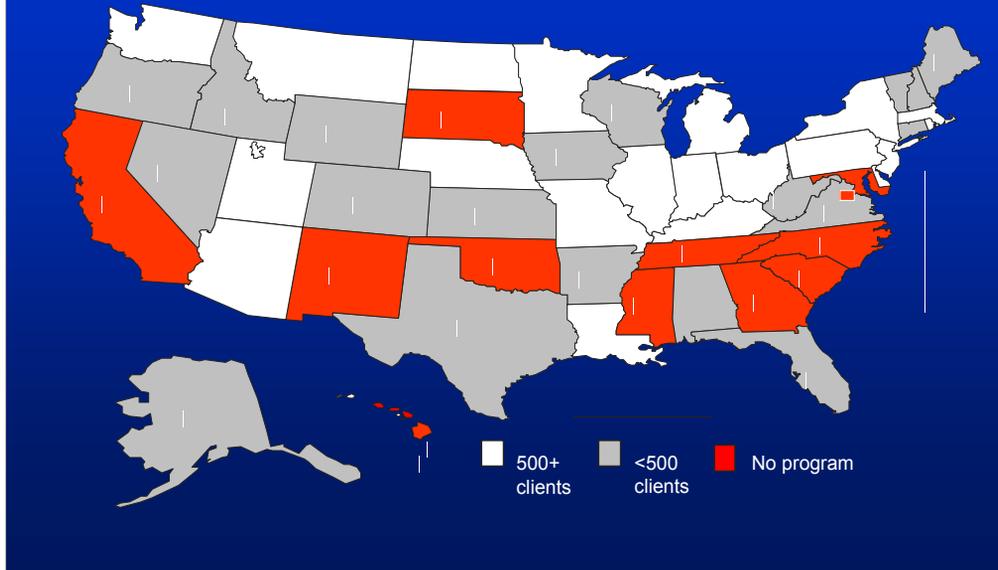
Prevalence: 41 states were funding in 2007

Cost: Savings range from \$4K-\$12K/client

Goal: Stop drug abuse, reduce crime

Evidence of effectiveness: 72% graduate; 75% remain arrest-free for 2 yrs after graduation. Extensively evaluated.

#7 Medicaid Patient Review and Coordination or “Lock-In” Programs



Individuals of low-income or in Medicaid programs are more likely to be prescribed narcotic painkillers and more likely to abuse them. They are at much greater risk of a prescription drug overdose, in part because of the medications that Medicaid is paying for. Most states have “lock-in” programs that restrict heavy users of opioids to one doctor and one pharmacy. This helps reduce doctor shopping.

State PRC or “lock-in” programs with one or more active clients in June of 2007 ranked in decreasing order by number of clients:

NY, WA, IN, LA, MO, IL, NE, OH, MT, UT, ND, VA, TX, AL, CT, WV, WI, KS, IA, AS, FL, WY, ID, VT, COL, AK, NH, ME

Source of data: Phyllis Coolen, RN, MN, of the WA State Department of Health and Social Services, presented in part in Atlanta on January 14, 2009 at the CDC conference: State Strategies for Preventing Prescription Drug Overdoses.

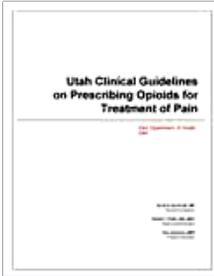
Changes in mean daily dosage of opioid analgesics among 518 PRC clients after enrollment for narcotic abuse, WA, 2006



PRC= Patient Review and Coordination Program. PRC is managed by the Washington State Medicaid Program. These patients were referred to the PRC in 2006.

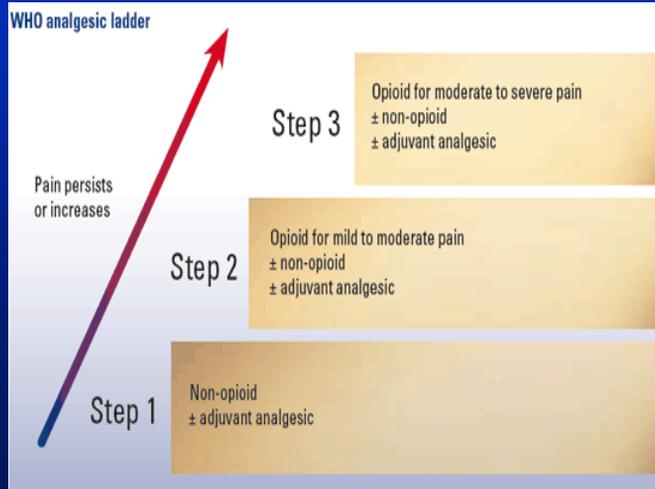
In addition, total narcotic claims went from 2274 to 839. WA reports savings of greater than \$1.5 million/month in Medicaid costs from this program.

Source: Phyllis Coolen, RN, MN, of the WA State Department of Health and Social Services, presented in Atlanta on January 14, 2009 at the CDC conference: State Strategies for Preventing Prescription Drug Overdoses.



#8 Clinical Guidelines for Chronic and/or Acute Pain Management

Washington State weighs limiting narcotic doses



Program: State-sponsored clinical guidelines management of pain

Prevalence: Washington and Utah

Cost: Utah appropriated \$300,000 for development of guidelines and other recommendations

Goal: Improve clinical management of pain. The Washington guideline includes a recommendation to refer to a pain specialist patients receiving more than 120 milligrams of morphine equivalent per day.

Evidence of effectiveness: Not studied to date

Weblinks for these guidelines:

WA (www.agencymeddirectors.wa.gov)

Utah (<http://health.utah.gov/prescription/guidelines.html>)

#9 Emergency Department Programs to Manage Drug-Seeking Patients



Program: Enrollment of heavy ED users in a special program

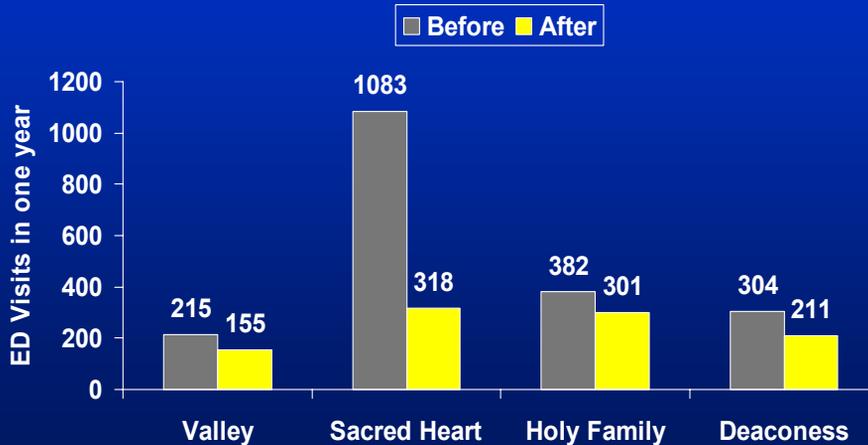
Prevalence: Selected hospitals

Cost: Annual savings of \$2,400 per patient in Spokane Consistent Care Program

Goal: Reduce ED burden

Evidence of effectiveness: Pre-post analysis (seen next slide)

ED visits per year by 40 Consistent Care Program clients before and after program initiation, Spokane hospitals, 2006-2007



There was a dramatic reduction in ED visits during the year following enrollment in the Spokane Consistent Care Program among all participating hospitals. In addition, the state Medicaid program saved 33% on ED claims in the year following enrollment among the Medicaid eligible in Consistent Care.

Presented at a 2009 CDC Conference on State Strategies for Preventing Prescription Drug Overdoses by Dr. Darin Neven, Medical Director, Consistent Care Program, Providence Sacred Heart Medical Center, Spokane, WA

#10 Naloxone and Harm Reduction Programs



Program: Secondary prevention through “harm reduction”

Prevalence: MA, Western NC, NM, NY including NYC, Chicago, Baltimore, and other urban areas

Cost: ?

Goal: Prevent deaths from opiates/opioids in particular

Evidence of effectiveness: One pre-post study noting a decline in opiate deaths in Chicago. MA reports flattening of rates.

Summary

What?

No shortage of intuitively appealing approaches
Shortage of rigorous evidence of effectiveness

So What?

More evaluation work is urgently needed.

What Now?

CDC is evaluating and funding others to evaluate strategies.

Thank you

The findings and conclusions in this report are those of the author and do not necessarily represent the views of the Centers for Disease Control and Prevention.



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