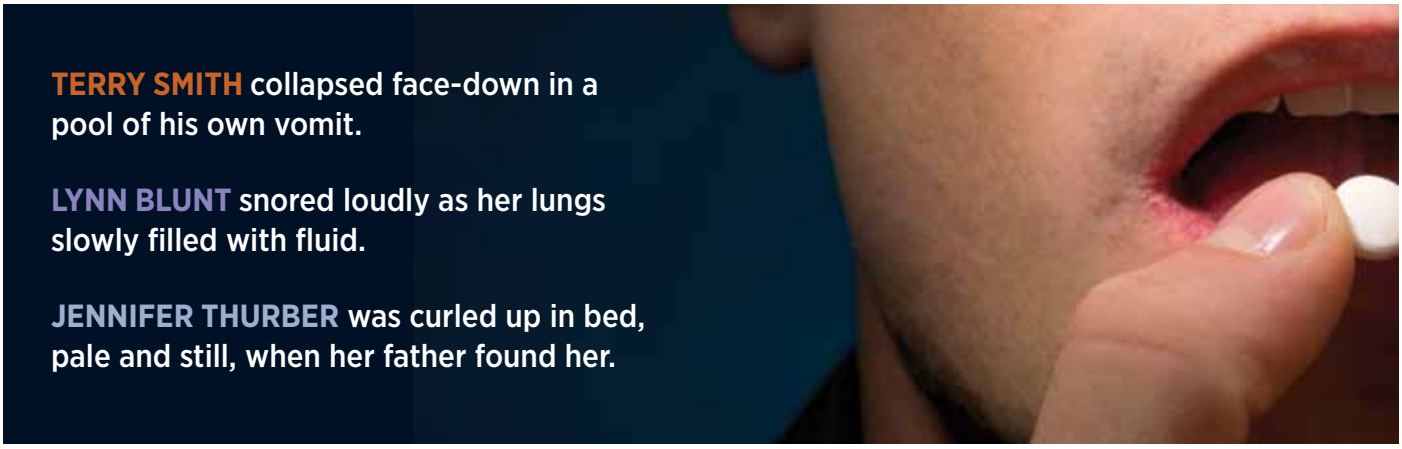
First Databank

FDB ISSUE BRIEF:
Prescription Drug Abuse in America

PART 1
AN EPIDEMIC IN NEED OF A CURE: THE TIME IS NOW



All of these people died from a drug overdose—as chronicled in "Legal Drugs, Deadly Outcomes," a *Los Angeles Times* article published in November 2012.[1] These individuals, however, didn't get some smack, flake or yellow jackets on a less-than-savory street corner from a decidedly-dangerous drug dealer.

Instead, their lives ended prematurely through the use of legitimate prescriptions from their doctor. Yes, they died by taking FDA-approved medications produced by highly-regulated pharmaceutical companies, prescribed by a board-certified M.D., and distributed through a licensed pharmacy.

The fact that these people are far from anomalies is what makes this evolving story so scary.

Consider the following: Every 19 minutes a person dies from a prescription painkiller overdose. According to the CDC, 100 people a day are dying from overdoses, a rate that has more than tripled since 1990.

The CDC also states that today, millions of people in the United States are addicted to opiates or prescription pain pills, and that "more than 12 million people reported using prescription painkillers non-medically in 2010—that is, using them without a prescription or for the feeling they cause."[2]

EVERY 19 MINUTES a person dies from a prescription painkiller overdose.

EVERY DAY 100 people die from overdoses—a rate that has more than tripled since 1990

In fact, drug overdoses killed an estimated 37,485 people in 2009, the latest year for which data are available, surpassing the number of traffic accident deaths by 1,201.[1]

The problem is so dire that it prompted the federal government to release a plan to combat what it calls a "crisis of epidemic proportions."

> **"The toll our nation's prescription drug abuse epidemic has taken in communities nationwide is devastating."**
>
> **GIL KERLIKOWSKE** White House director of national drug control policy

"We share a responsibility to protect our communities from the damage done by prescription drug abuse."[3]

To this end, the Obama plan, "Epidemic: Responding to America's Prescription Drug Abuse Crisis" relies heavily on the expansion of state-based prescription drug monitoring programs, requiring additional education for physicians who prescribe opioid medications, and reducing the prevalence of "pill mills" and "doctor shopping" through law enforcement efforts.[4]

It's definitely not the same hardline law enforcement approach that is typically touted as the answer to illegal drug use and addiction.

The prescription drug overdose problem is much different than many of the common addiction tales that have been infamously told in the cinema and the press and, therefore, requires unique solutions. For example, many people who misuse prescription drugs mistakenly believe these substances are safer than illicit drugs because they are prescribed by a health care professional. Indeed, the dangers associated with prescription medications are not as firmly ingrained in the public consciousness as the dangers associated with street drugs.

Cutting off the distribution of potentially harmful prescription drugs presents a unique challenge as well. While it's routine for law enforcement officials to relentlessly go after all the people who sell street drugs, prescription drugs are legitimately needed by many patients. And, the doctors who prescribe them and the pharmacies that distribute them are typically doing so with the best of intentions. They don't need to be shut down but instead need to have comprehensive medication history information that enables them to more judiciously do their jobs. In other words, all of the data "holes" need to be filled to prevent fraudulent prescriptions from ending up in the hands of drug-seeking abusers.

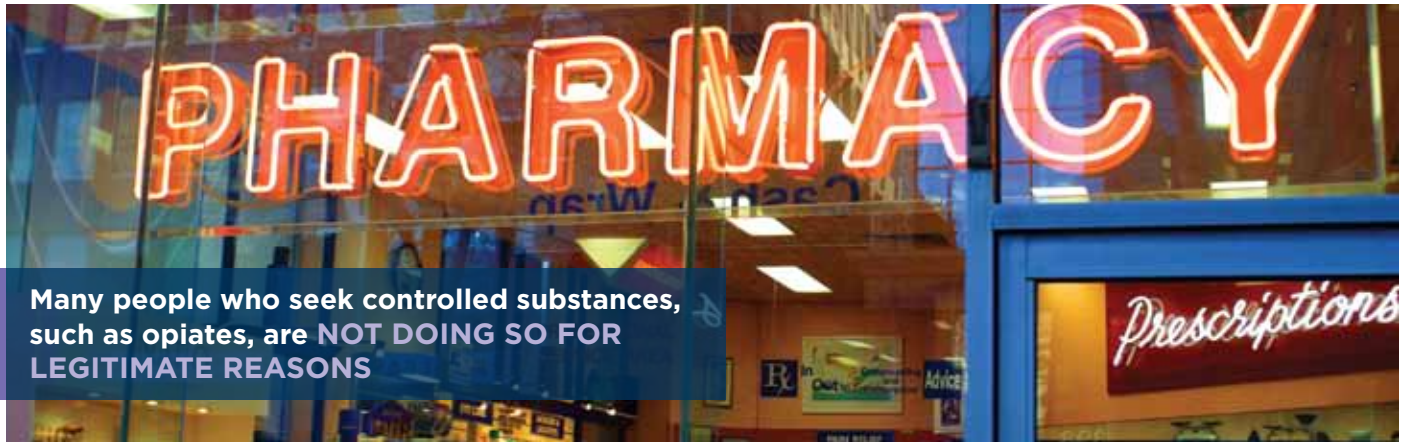
And, it's just a start. To really make a difference, the industry has to dig deep to develop sophisticated solutions and take quick action that will *truly make a difference*.

In this Issue Brief we will explore:

- **how healthcare providers need access** to detailed, up-to-the-minute prescription data to stop drug seekers/abusers;
- **how providers can simultaneously stop** drug seekers while still helping patients who truly rely on controlled substances;
- **the important role** that Prescription Drug Monitoring Programs (PDMPs) can take in the fight to stop prescription overdoses; and
- **why controlled substances** need to be included in the move toward electronic prescribing.

At FDB, we don't have all the answers to this complex problem. But it's time to dive in and explore—and we invite you to join the conversation so we can work together to address this public health epidemic. As an industry we are working hard to get this problem under control. But are we doing enough? If you could name one thing that we, as an industry, could do differently, what would that be? We invite you to share your ideas online in the comments.

PART 2
EMPOWERING CLINICIANS TO MAKE THE RIGHT CLINICAL DECISIONS



Many people who seek controlled substances, such as opiates, are NOT DOING SO FOR LEGITIMATE REASONS

Mary Matson's story is heartbreaking. She suffers from a rare, congenital condition called Medullary Sponge Kidney Disease, a condition that causes kidney and bladder infections, calcification of the kidneys and episodes of painful kidney stones. Debilitated and bedridden, it took Mary a long time to find a pain management doctor that was able to treat her disease successfully with pain medications. Now, Mary faces a new challenge: sometimes she has to drive around for hours trying to find a pharmacy that will fill her prescriptions.[5]

She is not alone.

EVERY YEAR more than 37,000 people die from prescription drug abuse

"Pain affects more people than heart disease, cancer and diabetes combined," said Lynn R. Webster, M.D., the president of the American Academy of Pain Medication.[6] And, as many of these people struggle to access care and treatment, they needlessly suffer. Like Matson, many find it difficult to get prescriptions filled. And, other patients with legitimate life-altering pain can't even get their hands on a prescription because many doctors simply don't want to treat them.

For example, Ed Pullen, M.D., a family physician who blogs at DrPullen.com, pointed out that he no longer accepts pain management patients into his practice.

"Actually, the abuse of opiates has become such a rampant problem that I don't know of a physician in the county who is accepting new pain management patients," he wrote in a blog posted in 2010. "This is sad for patients new to the community with legitimate need for pain medication, but just an impossible position for physicians.

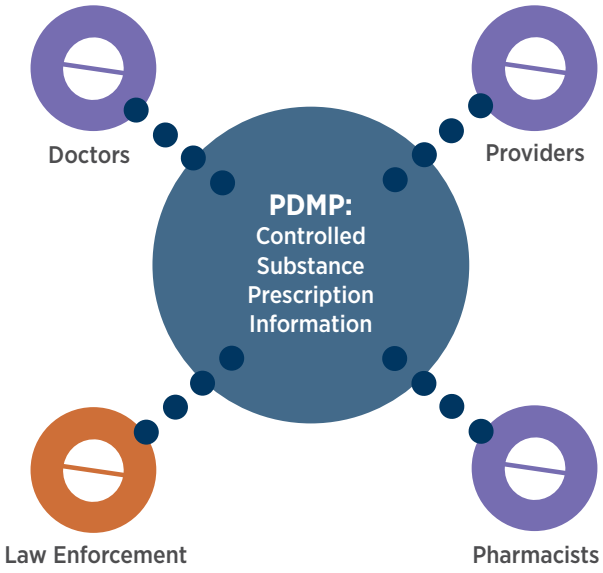
Any physician who becomes known as accepting chronic non-malignant pain patients would be quickly overwhelmed by the droves of new patients needing pain medication who would show up to receive care."

The problem, according to Pullen and many others, is that many people who seek controlled substances, such as opiates, are not doing so for legitimate reasons. Even more troubling, many of these patients have developed Oscar-worthy acting skills, making it especially difficult for providers to determine if they are legitimately in pain of if they are unfortunately addicted to powerful medications.

> "We either **BECOME SUPPLIERS** of the prescription drug culture, or we turn away some appropriate patients."
> DrPullen.com

It's a rock-and-a-hard-place situation, to be sure. Indeed, health care providers don't want to contribute to the prescription drug abuse problem—an "epidemic" that takes the lives of more than 37,000 people per year. Nor do they want to deny the 100 million Americans who are suffering with legitimate pain, according to the Institute of Medicine's 2011 report: *Relieving Pain in America, A Blueprint for Transforming Prevention, Care, Education and Research*.[8]

The solution? Clinicians need to have information at the point of care that can help them escape from this terribly uncomfortable quandary. And, therein lies the potential value of Prescription Drug Monitoring Programs (PDMPs). These programs—which are running in 49 states—have been developed to help medical and law enforcement professionals stop drug seeking behaviors. A PDMP is a statewide electronic database that gathers information from pharmacies on dispensed prescriptions for controlled substances (most states that permit practitioners to dispense also require them to submit prescription information to the PDMP). Many PDMPs provide secure online access to this information for authorized recipients. Originally conceived as a way for law enforcement officials to identify and prosecute drug abusers, the information also carries tremendous value for providers seeking to make informed clinical decisions. With PDMPs, providers and pharmacists can access the much needed information at the point of prescribing where clinical judgment is needed most.



"It all boils down to having information available to the practitioner working in the physician's office or in the emergency department," says Shelly Spiro, executive director of the Pharmacy e-Health Informatics Collaborative, Washington, D.C. "For example, the emergency department doctor could access the data in the PDMP and see if the patient has had other controlled substance prescriptions filled. Armed with this information, the doctor can make a clinically sound decision on whether or not to prescribe the pain medication. Without that information, the physician has an obligation to prescribe the medication if the patient says they are in pain. And, that puts the physician in a precarious position as many of the patients could be unlawfully seeking drugs."

Major PDMP Information BENEFITS

Easier for providers and caregivers to identify drug-seekers and deny access to illegitimate prescriptions

Help prevent inadvertent patient overdose when multiple caregivers are providing treatment

Help clinicians provide prescriptions to patients who are legitimately in pain

First of all, the PDMP information makes it easier for providers and caregivers to identify drug-seekers and to stop them in their tracks by denying access to illegitimate prescriptions. In some cases, having this information may also provide the impetus needed to refer abusers to appropriate treatment programs. Second, access to this data can help prevent patients from an inadvertent overdose in cases where they are being treated by multiple caregivers—and these providers are not aware of the numerous prescriptions that a patient is currently taking. And third, access to information can simply help clinicians provide the prescriptions that patients who are legitimately in pain truly need for their care and treatment.

This is just a broad-brush overview of how valuable the information contained within PDMPs could become as the industry tries to find a way to deal with the prescription drug epidemic while balancing the need to provide quality care to patients who might be needlessly suffering with debilitating pain.

In the coming pages, we will delve into the issue even more by looking at why approaching the prescription drug abuse problem from a medical-clinical perspective might be even more valuable than taking a law enforcement approach; the success of PDMPs so far and what they might be able to accomplish in the future; and the importance of truly integrating prescription information into clinical workflows via e-prescribing systems.

Feel free to add your comments online—and join this important conversation.

PART 3
FIGHTING SOPHISTICATION WITH SOPHISTICATION

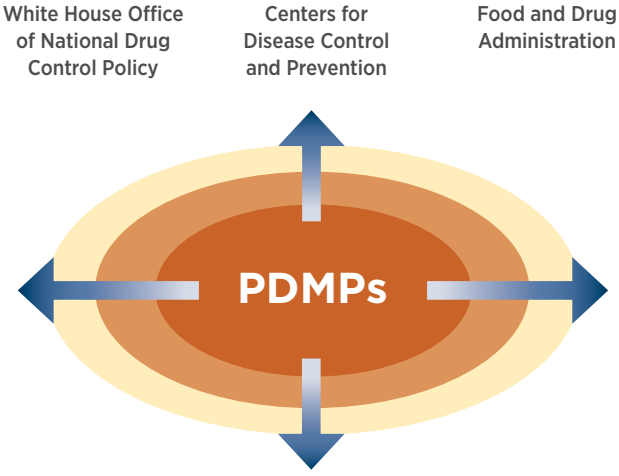
According to an account in *ER Stories: Real Life Tales from the Emergency Room*, a man in his fifties comes into the emergency room and tells the doctors that he has "the worst ripping pain in his chest and back" and it feels the same as when he had an aortic dissection several years ago. He also tells the ER workers that he is from another state traveling on business as a consultant. Because it's the weekend, it's pretty difficult to get hold of a cardiologist, so the ER clinicians give the patient painkillers, as they had an obligation to treat the pain from this potentially life-threatening condition.[9]

That's just one example of the lengths that drug seekers will go in their never-ending quest to get prescription medications. Indeed, they know how to work the system. According to James F. Davis, a board certified interventionist, former addict and founder of a drug rehab center, "professional" drug seekers employ some high-level strategies to dupe doctors into prescribing pain medications. These drug seekers, who typically present themselves well and speak intelligently, might alter their bodies by inflicting injuries such as broken toes, burns and punctures; take drugs that cause real symptoms associated with real conditions; taint their urine or stool with blood or other substances; fake medical evidence by altering x-rays; or provide false identification.[10]

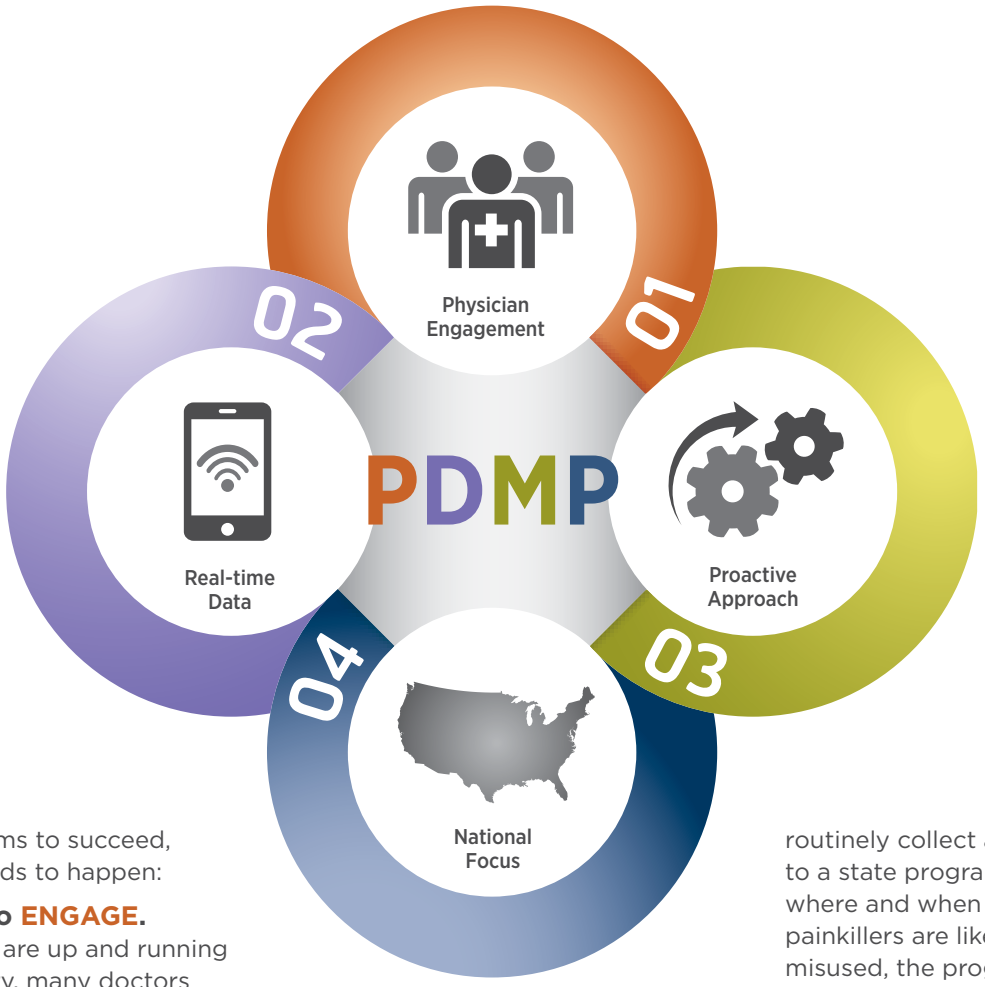
It's SOPHISTICATED SCAMMING at its worst.

Enter Prescription Drug Monitoring Programs (PDMPs). These programs—which are running in 49 states—have been developed to help medical and law enforcement professionals stop drug seeking behaviors. Through these programs, prescription data (usually for the past year, and including information on date dispensed, patient, prescriber, pharmacy, medicine, and dose) are made available on request from end users, typically prescribers and pharmacists, and sometimes distributed via unsolicited reports.

PDMP EXPANSION garners national support



PDMPs are designed to address an important public health issue: help stop drug seekers while making it possible for clinicians to continue to treat legitimate patients with needed medications. As such, the White House Office of National Drug Control Policy, the Centers for Disease Control and Prevention, and the Food and Drug Administration are all rallying to support the expansion of PDMPs. Yet many clinicians are unaware of these programs, and their use varies among states and specialties. Therein lies the rub.



For these programs to succeed, the following needs to happen:

Doctors need to ENGAGE. Although PDMPs are up and running across the country, many doctors simply never, or infrequently, consult the data. Using PDMPs needs to become a standard, non-negotiable part of care delivery.

The PDMPs need to offer REAL-TIME DATA. Logging the prescription information into the system at the time that it is written or filled could make the programs more effective. Real-time access to prescription drug monitoring program databases resulted in a sizable drop in the number of inappropriate prescriptions written for opioids and benzodiazepines in British Columbia, where healthcare providers have access to their own drug monitoring programs, according to a study published online in the *Canadian Medical Assn. Journal*.[11]

The programs need to shift from a reactive approach to a PROACTIVE one. "Being proactive is the key to success in the fight against prescription painkiller abuse," according to John L. Eadie, director of the PDMP Center of Excellence and one of the Brandeis University researchers who recently wrote a report on the drug monitoring programs. "While doctors may routinely collect and report data to a state program that signals where and when prescription painkillers are likely being misused, the program might not share that information with others who can best use it." The report recommends proactively sending alerts about possible abuse to doctors and pharmacists; this practice has been associated with decreased sales of prescriptions, and low rates of doctor shopping.[12]

The focus needs to go NATIONAL. It's easy for drug seekers to cross state lines, so PDMP data has to figuratively cross state lines as well. Interstate collaboration regarding PDMP access is essential. A network that was recently implemented by 20 states, funded by the pharmaceutical industry and organized by state pharmacy boards, allows interstate sharing of PDMPs.[13]

That's a start but it is probably not enough. What we need is a standardized, national PDMP that will enable providers and pharmacists to gain access to information about all patient prescriptions across the country. Do you agree? Do you think anything else is needed to stop the drug overdose problem?

Feel free to add your comments online—and join this important conversation.

PART 4
TAKING THE HASSLE OUT OF THE PDMP PROCESS FOR PHYSICIANS

Doctors understand the prescription drug abuse epidemic in this country better than anyone else. After all, they are the front line medical workers dealing with it day in and day out. And, they are apt to acutely feel the ironic sting associated with the fact that some 37,000 people are dying each year from prescription drugs—the very medications intended to save lives and relieve pain and suffering.

Relatively few clinicians, however, are doing anything about it. Consider the following: nearly every state has a Prescription Drug Monitoring Program. These databases track prescription narcotic sales by gathering data from pharmacists as the drugs are dispensed. Physicians and other clinicians can tap into the databases to identify suspected drug seekers.

However, according to Jeffrey Hammer, principal information systems engineer and project lead for The Mitre Group, an organization that the federal government has appointed to study the prescription drug abuse problem, only 10% to 15% of providers are registered to use the databases—and many of those who are signed up are not tapping in.[14]

While these doctors are apt to understand why they should use the system, they simply don't because it makes their already **TIME-CHALLENGED DAYS** more difficult.

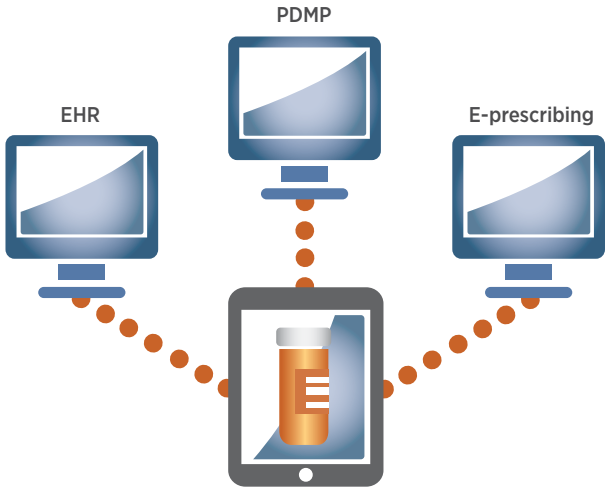
Fortunately, the federal government has taken a step in the right direction by lifting the ban on the electronic prescribing of controlled substances. Previously, controlled substances—which account for about 11 percent of all prescriptions—had to be ordered manually. As such, doctors had to deal with two completely separate workflows, one for run-of-the-mill prescriptions and one for opiates and the like. Now, controlled substances can be included as part of the e-prescribing process.

Checking the PDMPs, however, still adds another cumbersome step. So, while clinicians probably know they should do it, taking action is difficult when they are rushing to deal with a waiting room overflowing with patients, an evening educational conference or their son's first swing in his first Little League game of the season.

It was this type of hassle that stopped clinicians at Wishard Health Services from accessing the state's PDMP (called INSPECT), according to Mitre. Indeed, emergency staff seldom used the PDMP because it added work.

THE SOLUTION: The non-profit organization that developed Wishard's electronic health record (EHR) software wrote **new code that linked the EHR directly to the PDMP**. As a result, Wishard's emergency staff now can search the state's PDMP database without adding steps to the patient admission process.[14]

Certainly, adding the PDMP check into the mix makes the use of e-prescribing and the use of EHRs much more "meaningful." In addition to gleaning all of the clinical and operational benefits typically associated with EHRs, providers can rest easy knowing that they are helping to combat the nation's prescription drug abuse epidemic.



WHEN PDMP checks are linked in, EHR and e-prescribing use is more "meaningful"

Providing financial incentives to providers to meaningfully use the information contained within PDMPs may encourage more providers to integrate PDMP checking into the e-prescribing process. By doing so, the federal government could accelerate the eradication of the prescription drug abuse problem.

But if we are going to do it, we have to do it right. Late 2012, a focus group facilitated by the National Council for Prescription Drug Programs (NCPDP) was held in Baltimore. While members of the group agreed that PDMPs hold great potential, they identified a few caveats. Here are just a few of their recommendations:

- **Make it a national effort.** To truly make monitoring programs successful, the country needs to develop and adopt *national access to PDMP data*. As such, drug seekers could not simply cross state lines to deceive providers into granting prescriptions. And, physicians and pharmacists could confidently prescribe and dispense medications, knowing that they have access to a patient's complete medication history.
- **Speak the same language.** It's important to adopt a minimum data set and standard transaction format across all states for submission and dispensing data. As such, everyone will be singing from the same song book, making communication among PDMPs seamless.
- **Keep it real.** It does little good to make decisions based on data that is a week, a day or even a few minutes old. If a drug seeker obtains a prescription down the street and a physician writes yet another controlled substance script five minutes later without knowledge of the first one, then the PDMP is failing. To prevent such time lags, it's important to leverage the NCPDP SCRIPT Standard, including the Medication History transaction, to query PDMP data in real-time within the prescriber's workflow so that appropriate clinical decisions can be made before the medication is prescribed. In short, to make the PDMPs truly valuable, it's important to provide clinicians with easy access to real-time, comprehensive medication history information from within the prescribing workflow.[16]

We know there needs to be an impetus for national sharing of PDMP information which we may see as part of Meaningful Use Stage 3. In order for this sharing to be successful, the information will need to be provided in a meaningful way as part of the prescribers and dispensers natural workflow. The current situation, which consists of varying state and federal regulations for exchange and access to PDMP data, presents a barrier to the efficient exchange of this critical information.

If, as expected, e-prescribing becomes the primary means of transmitting prescriptions, it can be leveraged to provide standardized data transfer of PDMP information.

Do you think providers should be doing more to leverage PDMP data? There have been suggestions of financial incentives to providers to include PDMP access as part of EHR Meaningful Use Stage 3 requirements. Do you think such an action could help solve the drug abuse epidemic? Share your ideas online in the comments.

PART 5
PRESCRIPTION DRUG ABUSE CALLS FOR A MEDICAL CURE

Instead of turning to controlled substances, clinicians might more effectively treat pain with ALTERNATIVE THERAPIES

Gary Davis told of his experiences with prescription drugs in an essay that ran on the *Yahoo! Contributor Network*. It went like this: Several years ago, Davis fell from a porch and injured his lower back. Since then, he had struggled with chronic pain and had been prescribed oxycodone to relieve some of the misery.

A husband and father of three sons, Davis actually wanted to get off of oxycodone because the medication made him tired all of the time. So, working with his primary care doctor, he started to cut down on the dosage weaning himself to half of his original prescription.

That's when his pain started to flare and Davis realized his greatest fear as a long-term sufferer of pain… he was out of pain medication. Davis, desperate to address the pain, took a dangerous combination of Valium (an anxiety medication) and over-the-counter pain medications.

Better, LESS ADDICTIVE pain medications and treatment could be developed and adopted by the healthcare industry.

The pain subsided some but Davis lost his perception of time and unwittingly wound up taking 15 valium tablets during a 15 hour period. If his wife had not come home and intervened, Davis would have died.[17]

Davis was not suicidal. Nor was he a habitual drug seeker who wanted to get his hands on medications to get high. No, he was actually someone who was suffering from chronic pain who wanted to wean himself from dependence on medications.

Yet his life was still AT RISK.

Stop and think about his situation. There was nothing a law enforcement official could—or should—do about it. Indeed, his story is just one example that illustrates why the United States needs to adopt a medical-clinical approach to truly battle the prescription drug abuse problem.

By doing so, stories such as Davis' could take several different turns:

- Better, less addictive pain medications and treatment could be developed and adopted by the healthcare industry. Instead of turning to currently-available controlled substances, clinicians might more effectively treat pain with alternative therapies. Thus, **patients might not get drawn into the DEPENDENCE that seems so prevalent** with currently available pain medications.
- Providers would be required to check a national Prescription Drug Monitoring Database to check a patient's complete prescription drug history before prescribing medications. Thus, a **patient would not be able to receive a potentially DANGEROUS COMBINATION of medications** from clinicians who are acting independently.

The United States needs to adopt a MEDICAL-CLINICAL APPROACH to truly battle the prescription drug abuse problem

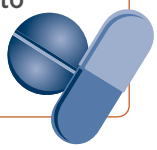
Stephen J. Coddington/*Tampa Bay Times*

- Through education and programs like REMS (Risk Evaluation and Mitigation Strategies), patients and providers would be more aware of the dangers of prescription medications. **Prescription medications are NOT SAFE simply because they are obtained through legitimate means.** Consumers and providers need to know that prescription medications may not necessarily be safe, especially when they are not taken correctly.

These are just a few of the ways that a medical-clinical approach can help curb the prescription drug epidemic in the United States. In many cases, these preventative measures will go a long way in helping stop the prescription drug abuse problem before it starts.

Of course, these prevention measures alone won't completely eliminate the problem. And, law enforcement agencies and officials should continue to crack down on all of the drug seekers who are intentionally duping the system into giving them drugs.

If we put a medical-clinical intervention approach at the center of our efforts, we will be able to more QUICKLY AND EFFECTIVELY address the prescription drug abuse epidemic.



Any other ideas? How else do you think we can stop the problem before it starts? Sound off with your ideas online in the comments!

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Organizations

The White House: Office of National Drug Control Policy (ONDCP)

Substance Abuse and Mental Health Services Administration (SAMHSA)

Office of the National Coordinator for Health Information Technology (ONC)

Alliance of States with Prescription Drug Monitoring Programs (ASPMP)

National Alliance for Model State Drug Laws (NAMSDL)

PDMP Center of Excellence

National Institute on Drug Abuse (NIDA)

National Council for Prescription Drug Programs (NCPDP)

Further Reading

Tampa Bay Times: RxOD: The prescription drug abuse crisis in Florida.

The American Journal of Managed Care: Prescription Drug Harm and Death: An Epidemic. What Is Being Done?

A World of Hurt: Fixing Pain Medicine's Biggest Mistake by Barry Meier.

C-Span Video: Senate Judiciary Committee Hearing, Prescription Drug Abuse, Panel 2, May 24, 2011.

WTHR Investigation: Secret at the Drugstore, Bob Segall, Senior Investigative Reporter.

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