Prescription Drug Abuse Task Force

August 21, 2012 · 3:00 – 5:00 p.m.

Cross Office Building, Room 208

AGENDA

I. Presentation from Dr. Kevin Flanigan, Medical Director of MaineCare, Maine Department of Health and Human Services

II. Presentation from Ms. Noel Genova, MA, PA-C, Mercy Primary Care

III. Committee Reports
   a. Disposal
   b. Diversion Alert
   c. Education
   d. Prescription Monitoring Program

IV. Legislative Ideas for the first session of the 126th Legislature

V. Next Meeting
   Monday, November 5, 2012, 3:00 – 5:00 p.m.
   Cross Office Building, Room 208

Presentation by Dr. Kevin Flanigan
Medical Director, MaineCare
Maine DHHS

PRESCRIPTION DRUG ABUSE TASK FORCE

August 21, 2012

Why opioids are widely used

- Inexpensive
- Improve patient quality of life
- Speed healing
- Patient satisfaction measures include pain control

Use of Opioids

- Cancer and post-surgery
- Expanded to other types of pain
- Lack of professional consensus

Use of Opioids

- From 1991 to 2009, prescriptions for opioid analgesics nearly triples
- 56% of painkiller prescriptions were given to patients who had filled another prescription for pain from the same or different providers within the past month
- Emergency room visits for non-medical use of pharmaceutical opioids doubled between 2005 and 2009

(Source: National Institute on Drug Abuse)

MaineCare opioid patients

- 85-90% were getting <300 milligrams per day of Morphine Sulfate equivalent
- 10-15% were getting >300 milligrams per day of Morphine Sulfate equivalent

From Drug Management to Pain Management

- Developing strategies based upon type of pain
  - Acute (new onset)
  - Chronic (long term, or poor response to other treatment)
  - Diagnoses known not to typically respond to opioid treatment

Acute Pain

- 15 days per calendar year
- 14 additional days with Prior Authorization
- Face-to-face visit for each Rx
- Up to 3 refills
- Exception for surgeons

Chronic Pain

- Patient must try one or more interventions from treatment plan
- Fail to have adequate response
- Limit on total daily opioids

Chronic Pain

- Discontinuing coverage for selected diagnoses:
  - Headaches
  - Chronic back and neck pain
  - Fibromyalgia

Second Opinion Program

- Patients with illness known to have poor response to opioids
- Physician from a separate practice

Prior Authorization not required for Selected Situations

- End-of-life care
- Cancer pain
- Nursing Home patients
- Inpatient care

Prescription Management Program (PMP)

- Inform physicians about their own treatment patterns in comparison to peers
- Outreach to providers
- Follow-up to encourage providers to bring prescribing into line with peers

Disposal Issues

- Community disposal grants
- New avenues for safe disposal needed

Thank you

- For your time
- For your commitment

Outline for Governor's Task Force on Prescription Drug Abuse

August 21, 2012, Noel J. Genova, MA, PA-C

MMA/BOLIM Chronic Pain Project

The Project

- Resources on MMA website, including articles from the lay press and the medical literature, with in-state political updates. Please peruse prior to the meeting.
- Continuing Medical Education (CME) Home Study, first available in 2008, updated in 2012 (available on MMA's website, www.mainemed.com).
- In-office consultations with or without live CME presentations. To date, visits to >300 prescribers, and their staffs.

Lessons Learned, Changes in Focus

- In 2008, the focus was on initial patient selection, and monitoring with treatment agreements, urine drug screens, and use of the Prescription Monitoring Program. In 2012, these issues remain important, but the focus has shifted to care of patients who are already on chronic opioid therapy, particularly high-dose medication, and to tapering many patients down or off of their medications.
- In 2008, the academic medical literature showed that addiction rates of patients on chronic opioid therapy was <1%. In 2012, we have indications that the rates of addiction in primary care clinical practices may be as high as 25%. We struggle with lack of good evidence.
- In 2008, the medical literature leaned toward efficacy and safety of chronic opioid therapy for treatment of non-terminal chronic pain. There was no "ceiling" on appropriate dosage, and treatment of opioid addicts with high-dose opioids for their painful conditions was recommended. In 2012, the safety of chronic opioid therapy has been disproved, and efficacy seriously questioned, especially at high doses.

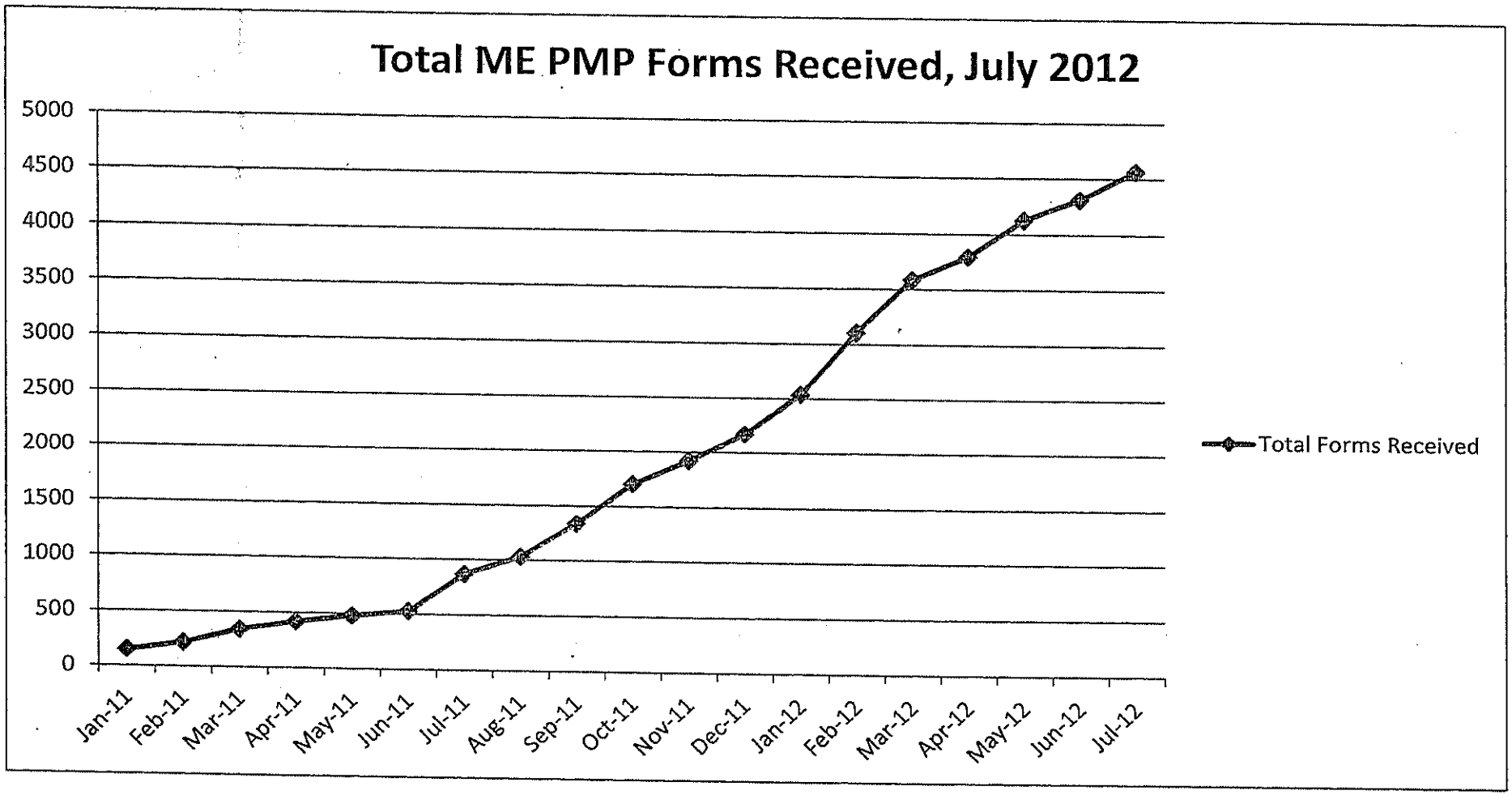
Usefulness and Limitations of Monitoring

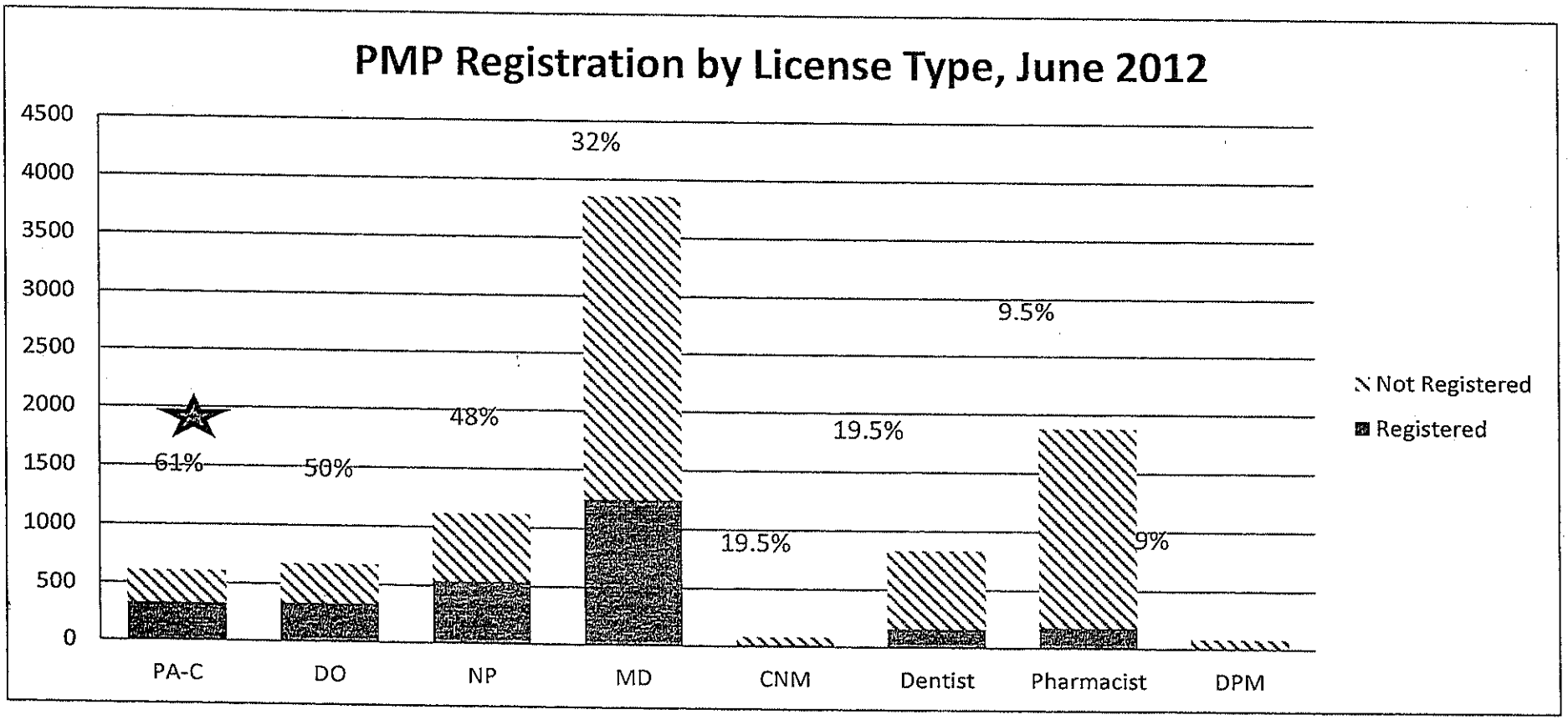
- Use of the PMP impacts "doctor shopping", unless medications are filled at out-of-state pharmacies. Used alone, it cannot reduce risk of drug-related death.
- Use of drug screens helps to identify those with substance abuse disorders. Used alone, it cannot prevent diversion.
- Use of treatment agreements is helpful in that it alerts patients to prescribers' expectations of patients, if they are to continue to receive controlled substances.

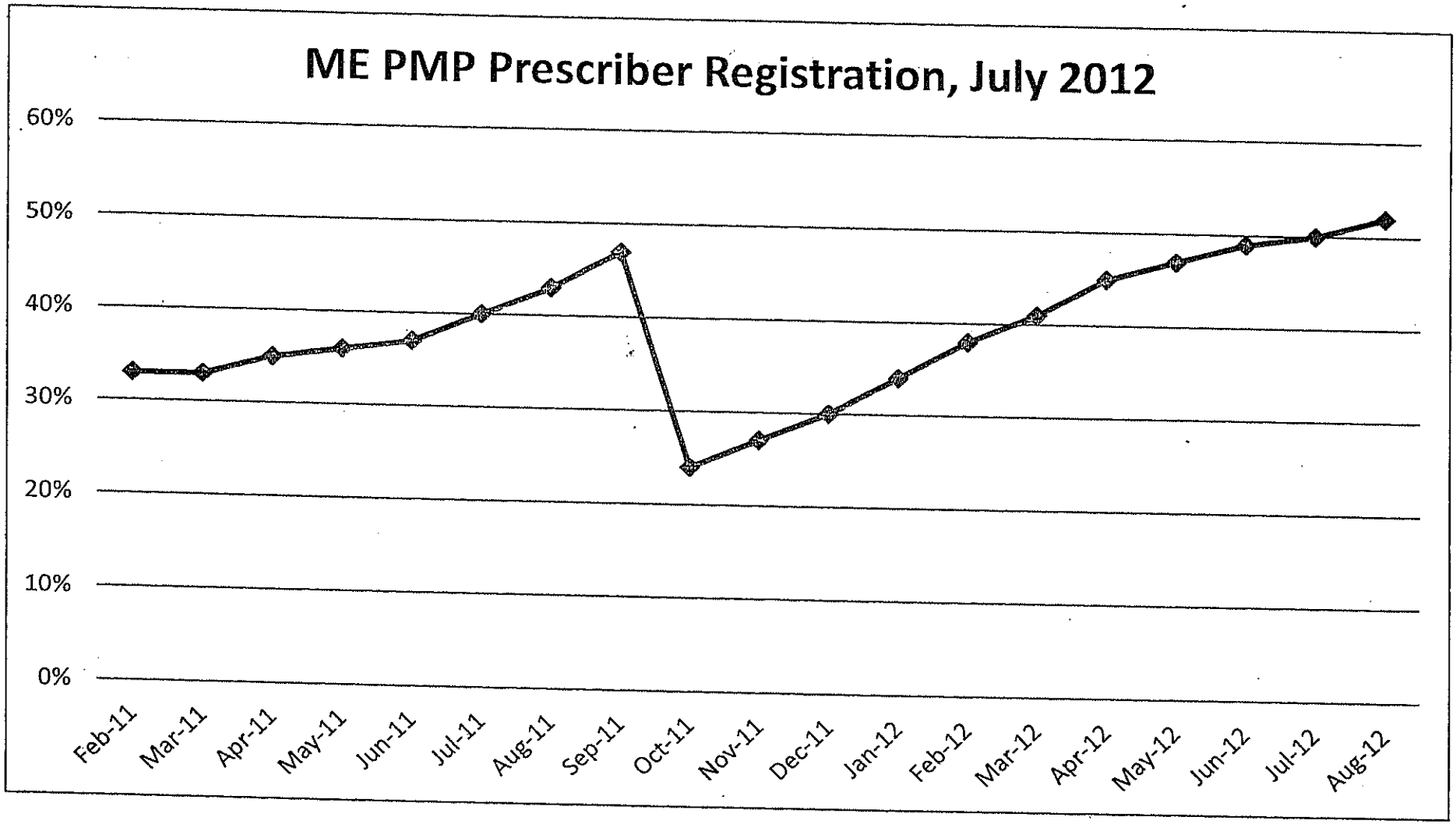
Maine's Prescription Monitoring Program Statistics

Attorney General Task Force Meeting, August 21, 2012

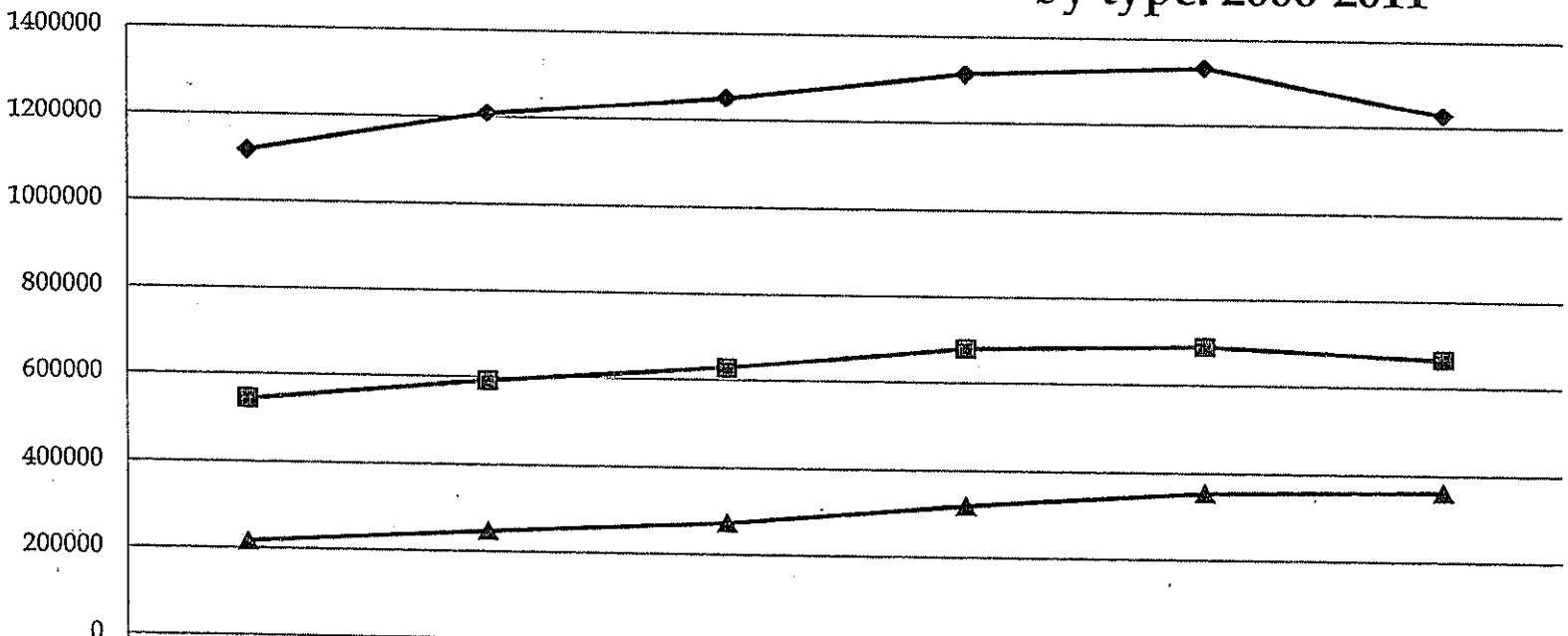
Prepared by, Office of Substance Abuse, DHHS, State of Maine


Total ME PMP Forms Received, July 2012
5000
4500
4000
3500
3000
2500
2000
1500
1000
500
0
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Total Forms Received


PMP Registration by License Type, June 2012
4500
4000
3500
3000
2500
2000
1500
1000
500
0
61%
50%
48%
32%
19.5%
19.5%
9.5%
9%
PA-C
DO
NP
MD
CNM
Dentist
Pharmacist
DPM
Not Registered
Registered


ME PMP Prescriber Registration, July 2012
60%
50%
40%
30%
20%
10%
0%
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12

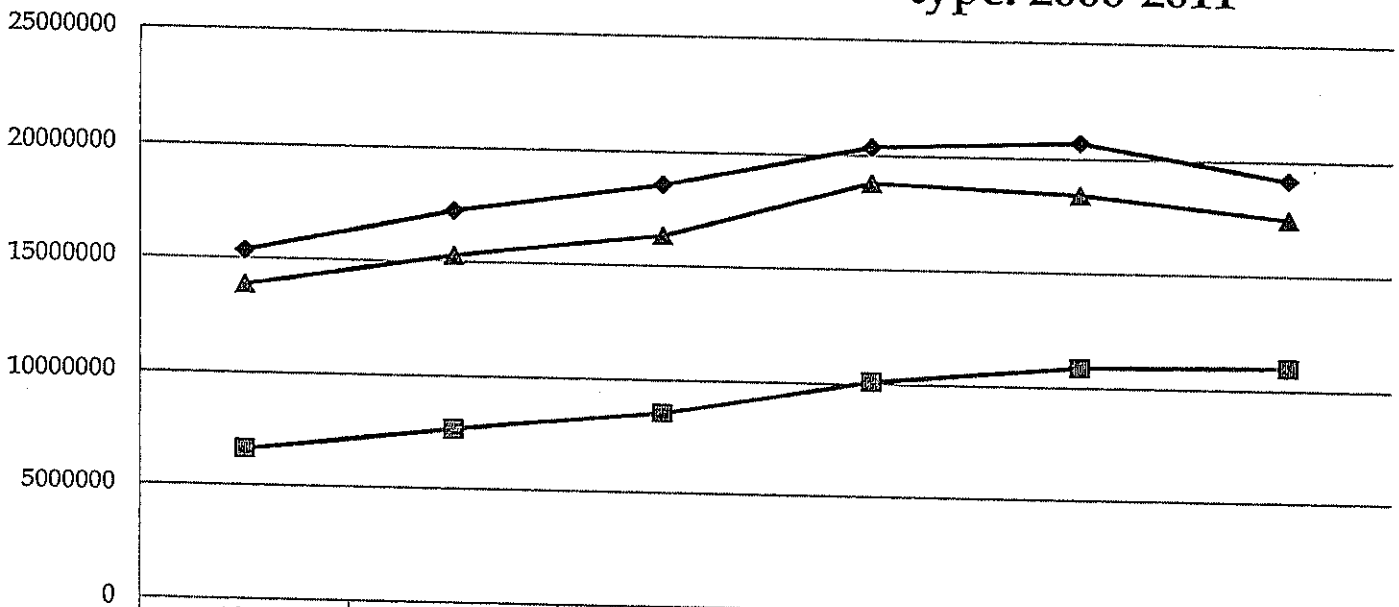
Number of prescriptions filled in Maine, by type: 2006-2011



	2006	2007	2008	2009	2010	2011
Narcotics	1116325	1209010	1252046	1313213	1333213	1229745
Tranquilizers	543357	591160	628719	679695	690119	665004
Stimulants	216280	247453	273599	319647	354361	361276

Source: Maine PMP, 2012

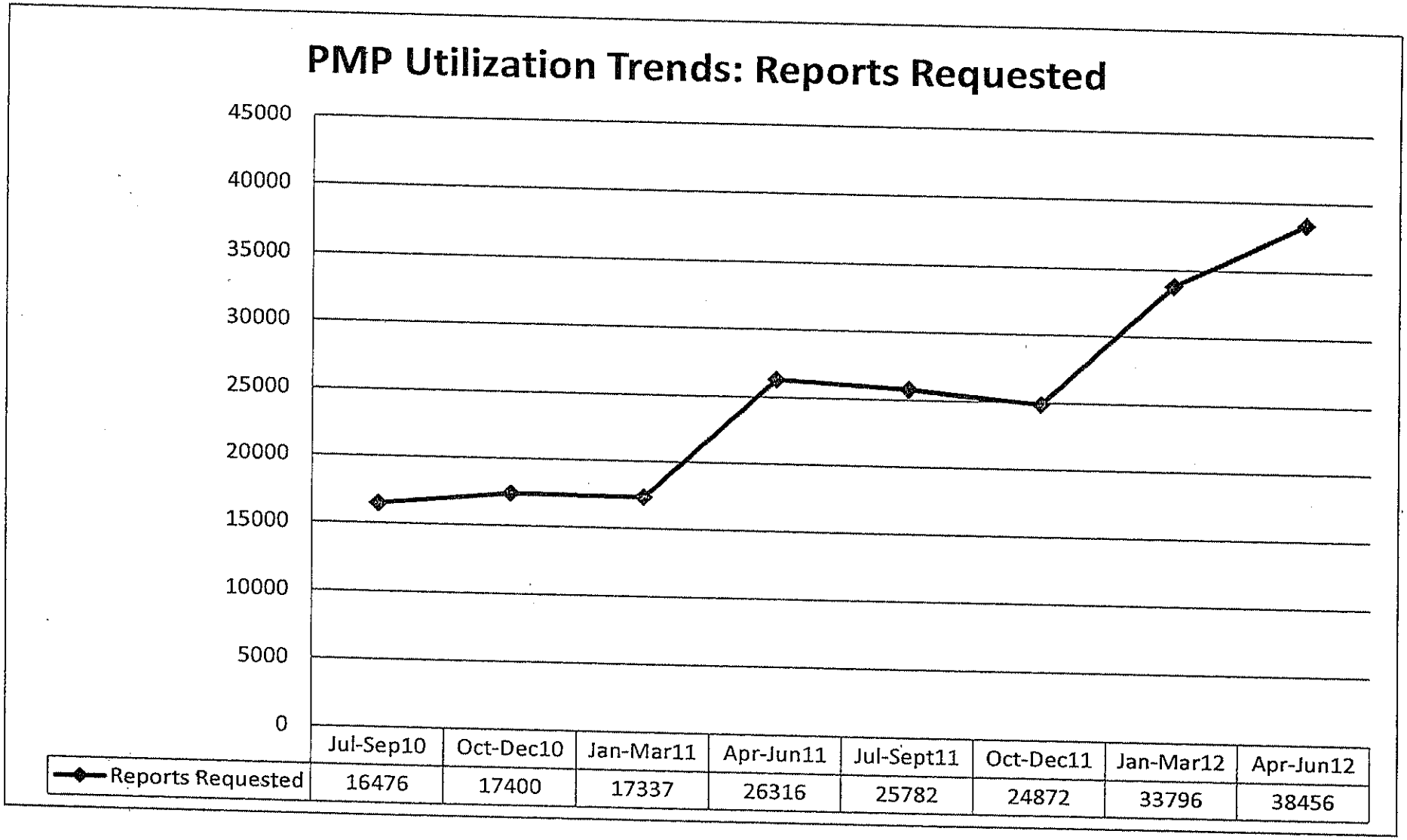
Number of days supply of Prescriptions in Maine, by type: 2006-2011



	2006	2007	2008	2009	2010	2011
Narcotics	15340091	17232181	18548945	20392809	20723488	19168778
Stimulants	6631098	7628640	8517200	10115937	10887207	11011018
Tranquilizers	13858404	15270703	16327383	18791378	18420926	17464666

Source: Maine PMP, 2012

PMP Utilization Trends: Reports Requested



	Jul-Sep10	Oct-Dec10	Jan-Mar11	Apr-Jun11	Jul-Sept11	Oct-Dec11	Jan-Mar12	Apr-Jun12
Reports Requested	16476	17400	17337	26316	25782	24872	33796	38456

Title 22: HEALTH AND WELFARE
Subtitle 2: HEALTH
Part 5: FOODS AND DRUGS
Chapter 604: DISPOSAL OF UNUSED PHARMACEUTICALS HEADING: PL 2003, C. 679, §1 (NEW); §4 (AFF); EFFECTIVE 7/1/05

§2700. Unused Pharmaceutical Disposal Program

1. Establishment; purpose. There is established the Unused Pharmaceutical Disposal Program, referred to in this chapter as "the program." The purpose of the program is to ensure the safe, effective and proper disposal of unused pharmaceuticals. For purposes of compliance with federal law and regulation, the return of pharmaceuticals under this section is deemed to be for law enforcement purposes.

2. Administration. The program is administered by the Maine Drug Enforcement Agency, referred to in this chapter as "the agency," established in Title 25, section 2955.

3. Return of pharmaceuticals. The agency ~~shall~~ may create ~~a~~ systems for the ~~return of~~ safe, effective and proper disposal of unused pharmaceuticals. The systems ~~must~~ may include the use of prepaid mailing envelopes into which the unused pharmaceuticals are placed and returned to a single collection location. The prepaid mailing envelopes must be made available to the public at various locations, including, but not limited to, pharmacies, physicians' offices and post offices. The agency may randomly assess the toxicity of materials received under the program as long as the assessment results do not identify the patient, person who mailed the material, prescriber or pharmacy.

4. Disposal of pharmaceuticals. ~~The agency shall ensure that only agency officers handle the unused pharmaceuticals received pursuant to subsection 3. The~~ All unused pharmaceuticals received under the program must be disposed of ~~by the agency~~ in a manner that is designed to be effective, secure and in compliance with local, state and federal environmental requirements, including the federal Resource Conservation and Recovery Act of 1976, as amended.

5. Unused Pharmaceutical Disposal Program Fund; funding. The Unused Pharmaceutical Disposal Program Fund, referred to in this chapter as "the fund," is established within the agency to be used by the director of the agency to fund or assist in funding the ~~program~~ safe, effective and proper disposal of unused pharmaceuticals. Any balance in the fund does not lapse but is carried forward to be expended for the same purposes in succeeding fiscal years. The fund must be deposited with and maintained and administered by the agency. The agency may accept funds into the fund from any non-General Fund source, including grants or contributions of money or other things of value, that it determines necessary to carry out the ~~purposes of this chapter~~ safe, effective and proper disposal of unused pharmaceuticals. Money accepted into the fund ~~received~~ by the agency ~~to establish and maintain the program~~ must be used for the expenses of ~~administering this chapter~~ safe, effective and proper disposal of unused pharmaceuticals.

6. Rulemaking. The agency shall adopt rules to carry out the purposes of this chapter. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

7. Contingency. The program must operate with funding solely from the fund provided in subsection 5. ~~The program may begin operation for 2 years on July 1st of any year in which notice is given by April 1st by the director of the agency to the State Budget Officer that funding has been procured for the fund that is sufficient to operate the program for 2 years.~~

PMP Subgroup Report to Task Force
August 21, 2012

1. Proposed RULE Change: Real Time Reporting

Current law enables OSA to change pharmacy reporting requirements, but would require a change in Rules governing the PMP to ensure compliance. A federal funding source exists to support testing, implementation and maintenance. This enhancement has a fiscal note.

Current Enabling Statute: 22 MRSA Ch. 1603 §7249.

Reporting of prescription monitoring information

1. Information required. Each dispenser shall submit to the office, by electronic means or other format specified in a waiver granted by the office, specific items of information regarding dispensed controlled substances determined by the office from the following list:

A. The dispenser identification number; [2003, c. 483, §1 (NEW).]
B. The date the prescription was filled; [2003, c. 483, §1 (NEW).]
C. The prescription number; [2003, c. 483, §1 (NEW).]
D. Whether the prescription is new or is a refill; [2003, c. 483, §1 (NEW).]
E. The National Drug Code (NDC) for the drug dispensed; [2003, c. 483, §1 (NEW).]
F. The quantity dispensed; [2003, c. 483, §1 (NEW).]
G. The dosage; [2003, c. 483, §1 (NEW).]
H. The patient identification number; [2003, c. 483, §1 (NEW).]
I. The patient name; [2003, c. 483, §1 (NEW).]
J. The patient address; [2003, c. 483, §1 (NEW).]
K. The patient date of birth; [2003, c. 483, §1 (NEW).]
L. The prescriber identification number; [2003, c. 483, §1 (NEW).]
M. The date the prescription was issued by the prescriber; and [2003, c. 483, §1 (NEW).]
N. The office-issued serial number if the office chooses to establish a serial prescription system. [2003, c. 483, §1 (NEW).]

[2003, c. 483, §1 (NEW) .]

2. Frequency. Each dispenser shall submit the information required under subsection 1 as frequently as specified by the office.

[2003, c. 483, §1 (NEW) .]

Current Rule:
SECTION 5. Requirements for Dispensers

Dispensers must acquire and maintain an identification number issued to dispensing pharmacies by the National Council for Prescription Drug Programs ("NCPDP"), or request that an alternative number be assigned to them by the Monitor or the Office.

Dispensers must provide the information required by 22 MRSA § 7249(1) as follows: electronically; in the form required by the Office; to the monitor; and within seven (7) days of the controlled substance being dispensed.

Suggested Language Change to Rule:
SECTION 5. Requirements for Dispensers

Dispensers must acquire and maintain an identification number issued to dispensing pharmacies by the National Council for Prescription Drug Programs ("NCPDP"), or request that an alternative number be assigned to them by the Monitor or the Office.

Dispensers must provide the information required by 22 MRSA § 7249(1) as follows: electronically; in the form required by the Office; to the monitor; and in real time, or as established by the office, of the controlled substance being dispensed.

2. **Proposed LEGISLATION and RULE Changes: Changing the level at which law enforcement may request PMP data.**

This enhancement would require a change to the statute and Rules Governing the Prescription Monitoring Program as this enhancement is not within the intention of the initial rules and policies governing the PMP. The current statute does not include law enforcement access. Current policy dictates that requests must be made at a level of grand jury subpoena.

Current Enabling Statute: 22 MRSA Ch. 1603 §7250

4. **Access to information.** The following persons may access prescription monitoring information:

A. A prescriber, insofar as the information relates to a patient under the prescriber's care; [2003, c. 483, §1 (NEW).]

B. A dispenser, insofar as the information relates to a customer of the dispenser seeking to have a prescription filled; [2003, c. 483, §1 (NEW).]

C. The executive director, or a board investigator as designated by each board, of the state boards of licensure of podiatric medicine, dentistry, pharmacy, medicine, osteopathy, veterinary medicine, nursing or other boards representing health care disciplines whose licensees are prescribers, as required for an investigation, with reasonable cause; [2003, c. 483, §1 (NEW).]

D. A patient to whom a prescription is written, insofar as the information relates to that patient; [2009, c. 196, §1 (AMD); 2009, c. 298, §1 (AMD).]

E. Office personnel or personnel of any vendor or contractor, as necessary for establishing and maintaining the program's electronic system; [2009, c. 1, §14 (COR).]

F. The Office of Chief Medical Examiner for the purpose of conducting an investigation or inquiry into the cause, manner and circumstances of death in a medical examiner case as described in section 3025. Prescription monitoring information in the possession or under the control of the Office of Chief Medical Examiner is confidential and, notwithstanding section 3022, may not be disseminated. Information that is not prescription monitoring information and is separately acquired following access to prescription monitoring information pursuant to this paragraph remains subject to protection or dissemination in accordance with section 3022; [2011, c. 218, §1 (AMD).]

(Paragraph F as enacted by PL 2009, c. 298, §3 is REALLOCATED TO TITLE 22, SECTION 7250, SUBSECTION 4, PARAGRAPH G)

G. The office that administers the MaineCare program pursuant to chapter 855 for the purposes of managing the care of its members, monitoring the purchase of controlled substances by its members and avoiding duplicate dispensing of controlled substances; and [2011, c. 218, §2 (AMD).]

H. Another state pursuant to subsection 4-A. [2011, c. 218, §3 (NEW).]

Suggested Language Change to Statute:

I. A Maine law enforcement agency or investigator, as designated by the agency and approved by the office may request prescription monitoring program information from the office, insofar as it relates to a current active investigation. Prescription monitoring information in the possession or under the control of a law enforcement agency is confidential and, may not be disseminated. Public release of PMP information would be an unwarranted personal invasion of privacy pursuant to 16 M.R.S. 614(1)(c). Information that is not prescription monitoring information and is separately acquired following access to prescription monitoring information pursuant to this paragraph remains subject to protection or dissemination in accordance with 16 M.R.S. 614(1)(c). The Office may approve or deny any request for information. All law enforcement requests shall be made in a procedure determined by the office.

Current Rule:
SECTION 7. Access to Prescription Monitoring Information
Note current language does not include law enforcement access. Current policy dictates that requests must be made at level of grand jury subpoena.

Suggested Language Change to Rule:

Addition of:

8. Law Enforcement

A. A Maine law enforcement agency, or investigator, approved by the office, requesting prescription monitoring program information shall make the request in the format established by the office. The request shall include information including name, date of birth and case number.

B. The decision of the office to approve or deny the request shall be considered as final.