



**Prescription Opioid Abuse: Fighting Back on  
Many Fronts  
PCMA  
Alliance for Health Reform  
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ED HOWARD: My name is Ed Howard and I am with the Alliance for Health Reform and on behalf of Senator Rockefeller, Senator Blunt and our Board of Directors, I want to welcome you to this program today on the large and growing problem of pain killer abuse, specifically opioid abuse in America today. Not only are there thousands of deaths each year from these abuses, but the illicit demand for the opioids has created problems for healthcare providers, for drug suppliers, law enforcement, anybody paying for prescription drugs. At the same time, you have countless individuals who are in severe pain, sometimes at levels that these powerful drugs can relieve and efforts to control their abuse have to be balanced by the real needs of these patients. So today we are going to take a look at the extent of the problem and at some of the many efforts to cope with it by individuals and the institutions that are affected by it.

We are very pleased to have as our partner in today's program, the Pharmaceutical Care Management Association, PCMA, whose members aim to enhance the value of pharmacy dollars that are spent by employers, health plans, other players, in benefit arrangements covering something like two thirds of America's population. Joining me and moderating today's discussion is the head of PCMA, the CEO, Mark Merritt. Mark?

MARK MERRITT: Great, thanks Ed, I appreciate that and thanks all of you for coming this early. I'm trying to think if I would be here if I wasn't actually speaking. But thanks so much, it's a great forum, it's one of the few remaining forums in town where I think real business gets done on healthcare, where there is real discussion, real debate and I appreciate you Ed, hosting this. Also, thanks to Senator Rockefeller and Blunt and others who are involved in the Alliance and I think this issue is unique, because in Washington we have been conditioned to view healthcare as just another divisive issue. Almost like a social issue. Where in the end you know nothing is going to get done or whatever does get done is going to be so filled with politics that it doesn't accomplish all the things you hoped it would.

This is a real issue though. This isn't a political healthcare issue, this is a real issue, not just because it's an epidemic that has cost 20,000 a year their lives, but it really touches every part of healthcare from cost, waste fraud and abuse, health – again, increasing illicit demand for these products. The role of providers and so forth. If there is a silver lining to this policy, it is one of the policies that you really can solve with a good policy solution and without all the political landmines that destroy so many other good ideas. I mean, it's bipartisan; they have bipartisan solutions to this. It's a solution where it is provider centric; providers in this case pharmacists and particularly from our view have a role here. It saves money, it doesn't cost money. So you don't need more money. You don't need to revamp the healthcare system, you just need to modernize and tweak things just a bit. As the Office of the Inspector General at HHS recently said, the solution is to have patients choose a pharmacy where they get pain killers and other drugs that are subject to abuse, diversion and so forth and monitor the supply because these are prescription drugs we are talking about. This is not Breaking Bad and meth labs in RV's, these are prescription drugs where their supply chain is very solid and if you could just keep that from crossing the pharmacy counter into the wrong hands, you win. So that is really what

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we need to do. We are focused on that, we are thankful to folks like Congressman Kevin Brady and Frank Pallone and Gus Boracus, Ben Ray Louhan and others who have led the way on this, particularly on the Safe Pharmacy idea. The idea of the patients having one pharmacy maybe two if they are snowbirds, where they get these products so that you can make sure that they are not drug store shopping. Not getting one script real or falsified and sending it to 20 pharmacies in a given day where community drug stores don't talk to each other. You need to fix that and get this out of the dark ages using the health IT and the other tools that we have available.

So I'm going to stop there. I'm really interested in what these folks have to say, I'm looking forward to hearing from them.

ED HOWARD: Terrific, thank you very much, Mark. I should add to your list, somebody who is very interested in this is Senator Rockefeller and you will be hearing more about West Virginia later on in the program, but it's obviously a problem in his jurisdiction.

Couple of quick notes, you see the Twitter #opioidabuse, if you want to use that and instructions on how to get WiFi if you need to have WiFi to tweet, are on each of your tables. There is a lot of background information in your packets including biographical information on our speakers and there will be a video recording of this event probably on Monday on our website, Allhealth.org. A couple of days later we will have a transcript on the same website along with electronic copies of all of the materials that you see in your packets. You can ask our panel a question at the appropriate time. There are microphones you can use to ask a question orally, there are green question cards in your packets that you can write a question on and it will be brought forward. And then a blue evaluation form, which I hope you will use as we go along to keep score and to tell us anything that you would like to tell us about the quality of programs, what topics and speakers you would like to hear in the future and try to improve these briefings for your use.

I think that is all of the overhead announcements, let's get to the panel. As Mark alluded to, we have quite a stellar lineup for you today and we are gonna start with Grant Baldwin. Grant is from the Centers for Disease Control and Prevention – CDC, where he directs the Center of Unintentional Injury Prevention, which is part of the National Center for Injury Prevention and Control. One of his principle areas of responsibility is the Center's prescription drug overdose prevention efforts and we have asked Dr. Baldwin to give us a sense of the breadth of the issues involved in overdose prevention and particularly from a public health perspective. Grant, thanks very much for joining us.

GRANT BALDWIN: Thanks a lot, Ed and thank you Mark for inviting me as well. Good morning and it's certainly a pleasure to be here today. My role is talk about the burden and who is at risk for prescription drug overdose and also discuss CDC's public health approach to prevention. CDC really has played an important role in sounding the alarm, raising the visibility, the health impact of prescription drug overdoses and working to better understand the causes of the epidemic. This includes the increase in the

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prescribing of opioids and the treatment of chronic non-cancer pain where the utility for long term pain relief is uneven and the risks may in fact outweigh the benefits. This gathering today is another marker of the ground swell of large-scale, bi-partisan and multi-sector support and commitment to address this epidemic.

So if a picture is worth a thousand words, then these pictures are worth 125,000, that is the number of prescription drug related deaths in the last decade. This time series map shows state based drug overdose mortality rates shifting between 1999 and 2010. Prescription drug overdoses are among the few causes of death that are on the rise and the trends, as you see on the slides, are pretty stark. Similar to how state based obesity maps in the last 30 years poignantly highlighted the bulging waistlines of Americans, these drug overdose maps show the epidemic taking hold across the country. Every state has seen dramatic increases in mortality rates with some states in Appalachia and the South being among the hardest hit. As most of you know, opioid pain relievers such as Oxycotin and Vicadin are responsible for driving the dramatic increase in overdose deaths in the last decade. The purple line is the one to follow on this slide. The trajectory and rate of increase for opioid analgesics is much different than that from other drugs. Between 1999 and 2010 and you can readily see the four fold increase in deaths. The number of deaths from opioids far outnumber those from heroin and cocaine and in 2011, nearly 17,000 died from a prescription opioid overdose or about one death in every 30 minutes. I also flagged a recent sharp growth in heroin overdose deaths, a phenomenon not unrelated to the opioid overdose epidemic and I will discuss that more later in my presentation.

One driver of the increase in opioid overdose deaths is an abundance of supply of these very powerful drugs. This graph shows the relationship between the sales of opioids, the green line, and the number of deaths from them, the blue line. As you can see, as the amount of opioids sold increased, so too did the number of deaths. The supply of opioid pain relievers is larger than ever. The quantities sold in 2011 was four times that sold in 1999. The red line shows that substance abuse treatment admissions for opioids increased dramatically as well during that same time period. By the way, opioid related overdose costs and estimated 20 billion dollars in medical and work loss costs annually.

At the core, the prescription drug overdose epidemic is a prescribing problem. Healthcare providers wrote more 259 million prescriptions for opioid painkillers in 2012 with wide variation across states. Healthcare providers in the highest prescribing state, Alabama, wrote almost three times as many prescriptions per person as those in the lowest prescribing state, Hawaii. Most of the highest prescribing states were in the South. Earlier studies suggest that regional variation and the use of prescriptions cannot be explained by the underlying health status of the population. As CDC Director Tom Frieden said recently, sometimes the treatment becomes the problem. To reverse this epidemic, we need to improve the way we treat pain. Rates of opioid use and overdose death are highest among men, people in their working years of life and non-Hispanic whites. Poor and rural populations in general are more likely to experience the prescription overdose as well. Finally, those at greatest risk are likely to have multiple prescriptions, are seeing

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multiple prescribers and are on a high daily dose. These risk factors have important implications for prevention.

As I mentioned earlier, heroin use and overdoses are increasing too. However, they remain far lower than opioid misuse and abuse. Though CDC's national mortality data only go through 2011, cities, counties and states from across the country have reported recent increases in heroin overdoses. Later this week, CDC will release a study on heroin prescription opioid mortality in 28 states that will further examine these trends. Several things appear to be driving the increase in heroin overdoses, including widespread prescription opioid exposure and increases in rates of opioid addiction. An increase in the heroin supply and the cost of heroin relative to prescription drugs are also factors. More than three out of four people seeking treatment for heroin dependence were exposed to opioids before heroin and more than 7 out of 10 people who reported past year heroin use in 2008-2010 reported using opioids non-medically in the past year. The relationship between prescription opioid abuse and heroin frankly is not that surprising. Heroin is an opioid and both drugs act on the same receptors in the brain and produce similar effects.

The connection between opioids and heroin misuse suggest that public health interventions addressing the opioid epidemic may help curve the heroin abuse and overdose problem. Much of CDC's work addresses state level interventions and Alan will be talking about a couple of these in great detail. States of access to the major levers that can reverse the epidemic, specifically states maintained prescription drug monitoring programs or PDMP's, regulate healthcare professions monitor the problem in their state health departments and run large public insurance programs such as Medicaid. Prescription drug monitoring programs are state run databases that track the dispensing and prescribing of controlled substances. Though virtually all states have an operational PDMP, these programs vary considerably between states in both their scope and their impact.

Another lynchpin intervention are patient review and restriction programs or lock in programs. These programs enable state Medicaid programs to reign in Medicaid patient overuse and possible abuse of physician services and prescription drugs, without having to terminate Medicaid benefits all together. They do this by restricting patients suspected of over utilization to a single designated provider, pharmacy or both.

Success is possible and recent accomplishments in Florida are a testament to the opportunities before us. Prior to 2010, Florida had a major problem with prescription drugs and between 2003 and 2009, Florida saw an 84% increase in prescription drug overdoses with eight people dying every day. Pill mills were rampant. Beginning in 2010, Florida legislatures took action, tightening controls on pain clinics and how they were regulated. The DEA and the Florida law enforcement officials worked together on Operation Pill Nation and other actions followed. Florida saw huge decreases in opioid prescribing and overdoses, especially with Oxycodon. Opioid overdoses dropped by 27% and Oxycodon overdoses dropped by a staggering 52%. So while it is an earlier marker, it spotlights the promise and possibility.

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CDC is focused on improving data quality and the use of data to monitor trends and the causes of the epidemic. Strengthening the state public health capacity and improving patient safety by supporting healthcare providers and systems. One of our signature initiatives is a six million dollar program known as prevention boost. It began in 2014 and it equips states with the resources they need to prevent prescription drug overdoses. Our goal is to advance prevention in three key areas. Maximizing prescription drug monitoring programs, improving public insurance mechanisms to protect patients and evaluating policies to identify prevention strategies that work. That five prevention boost states, Kentucky, Oklahoma, Tennessee, Utah and West Virginia are among the states with the highest drug overdose burden in the U.S. and have demonstrated the readiness and collaborative approach needed to make immediate progress on the epidemic.

There is a proposed 15.6 million dollar increase for CDC's state level prevention work and fiscal year 15 and CDC hopes to leverage these resources to expand and maximize our state level efforts. So with that, I'm out of time, let me turn it over to Allan from Pew.

ED HOWARD: Allan, let me just let people know how important it is that they listen carefully to what you are going to say. Allan is, as Grant said, from Pew Charitable Trusts. He's the Senior Director for Drugs and Medical Devices and oversees a whole range of initiatives including one on prescription drug abuse. He is a pharmacist by profession and Alan is going to tell us about some of the policy initiatives already in place to deal with overdoses including those state based drug monitoring programs that you have heard from Grant about. Allan, thank you very much for being with us.

ALLAN COUKELL: Well thank you and I would like to thank the Alliance for Health Reform and PCMA for the opportunity to be here today. Pew is a non-profit, non-partisan research and policy organization and as Ed has said, this is one of the areas that we are focused on and it's an important area.

So I'm going to quickly talk a little bit more about prescription drug monitoring programs, which Grant touched on. The Federal Policy landscape, really I'm going to focus on patient review and restriction programs and then if there is time I want to talk about one other drug that I think is particularly important.

Grant has done a great job of giving us sort of the epidemiology of the drug abuse crisis. It is absolutely a fraud and abuse problem, but it's also a public health problem and it's also a problem with chronic disease management. I put up the cover of the IOM report on pain control to remind us of that. We have 100 million Americans who have chronic pain, a lot of them as Grant has said, are getting opioids and not all of them appropriately. As we think about this population, we have got to make sure that we are not just cutting off the supply. A big part of dealing with this has got to be getting people into some kind of coordinated effective pain control. I think that is an important thing to keep in mind as we go through. One big part of this that I won't talk about today though is medical practice making sure that physicians are equipped to deliver effective pain control.

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So prescription drug monitoring programs – this is a report that we commissioned in 2011. Prescription drug monitoring programs are state databases that collect all controlled substances scripts; they vary, as Grant has said, a lot from state to state. The field is changing so fast that a lot of what is in our 2011 report is no longer relevant and we are going to update it and I borrowed some slides with more recent data. Here is a quick schematic. So the pharmacy has prescriptions, he fills prescriptions, they update that into a database, the clinical user, the physician, logs onto the database to see if their patient is getting scripts filled elsewhere. This is the big weakness. We can build the database, but if the doc doesn't log on and check it, they won't work. It's an extra step and an extra log on, which is just not going to happen. So utilization is a big problem. One thing we can do is send proactive reports out to the docs so that we are not waiting for someone to go and check a database. Something that is relatively new, but promising, is using the existing architecture of health information exchanges to get PDMP data into electronic health records (EHR) and at least one state has actually made that – declared it a public health database, which means that hospitals can receive meaningful use credit for integrating the PDMP.

The other thing – so public health and law enforcement are also accessing and then data exchange between other states. So a number of organizations have deep knowledge of PDMP's. I borrowed some slides here from the Training and Technical Assistant Center, which is funded by the Department of Justice and sits at Brandeis University. So here we are, the landscape in 2014, every state except Missouri now has an acting legislation for PDMP's, most of them are operational. This is how often the pharmacy data goes in, so about half of the states are doing it weekly, 17 states are doing it daily, one state, Oklahoma, is updating in real time. The relevance of that of course is if the data is a month behind and you are going to the PDMP to see if the patient is also going to get scripts filled somewhere else, you are not going to know.

This is 2012 data, this is unsolicited reports, so the proactive reporting to the doc that I mentioned, so you see momentum there towards more of that, but still a lot of states not doing that, it's an important thing to drive up that utilization and get it in front. This is an interesting trend, mandatory utilization, so this is requiring the doc to use it. What this means varies a lot by state, but it is catching on and New York for example, when the mandated utilization of the PDMP, queries to the database went from 11,000 a month to 1.5 million a month. Really remarkable. Here is delegate axis, so it doesn't have to be the doc. Some mid level healthcare practitioner in the office can check it. So another way to get that information in front of the prescriber. So there is delegate access in 2014.

Interstate operability, coming along nicely and funding. So a fair number of states now have some dedicated funding. It doesn't mean they have adequate funding and it certainly doesn't mean that Congress can relax about funding the Hal Rogers Program, which has been crucial to building these databases and the Nasper Program which has not been funded for a couple of years but is another really important potential source of funding for PDMP's. So moving along. So a lot of agencies – and this certainly isn't all of them,

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are playing important roles here. I am going to focus mostly on CMS and on patient review and restriction (PRR) programs. So a PRR, patient review and restriction, also called Lock-in, although I avoid that because I think it sounds prerogative and punitive. I think we have to brand it but also think about it as a way to get people into coordinated care. People with chronic pain, if they are seeing 10 doctors, they are not getting good care.

So most state Medicaid programs have a PRR, they vary widely in what they are doing, many of them are on the books and not terribly active. Here is Washington State as an example and this comes from a recent paper in a Journal of Managed Care Pharmacy, which is I think the best published analysis of what exists in Medicaid Lock-in program. So here is Washington, somewhat typical. So if a patient within a three month period meets any of the following criteria, four or more prescribers, four or more pharmacies, ten or more prescriptions with two or more prescribers in a month, the plan says, you need to commit to one pharmacy and/or one physician in order to get keep getting reimbursement. One of the weaknesses of course is if somebody is really bent on avoiding detection, they can go outside and pay cash, they don't show up in the funders records. If only there was a way to find cash prescriptions. Well, there is, the prescription drug monitoring program, but it is important that gets integrated into the Lock-in.

This is a busy slide. Key message – so Washington about seven years ago did a randomized trial – not of their highest users but of kind of mid level people who are eligible for the Lock-in. A good number of patients enrolled. Bottom line is costs fell in the PRR program, rose in the control arm, emergency department costs down, overall savings about \$4,000 per person, per year. No significant effect on health outcomes, but maybe that is not surprising, given the duration of the study and the difficulty of connecting these things. Also, self-reported health status similar so people also didn't seem to be harmed by the program.

So here is the characteristics of the Lock-in run by a PRR by Humana. Similar sort of eligibility criteria. A couple of good things about this plan. One is that it includes an offer of treatment, so it's not just restricting to pharmacy, but offering the patient access to treatment. There is review by a fairly healthy staff, so it's not just generated by an algorithm, there is some judgment involved and it is important to say that this same plan could not operate this program in Medicare part D because right now that is not allowed, so that is one of the things that we could fix to allow these some organizations to run these programs in Medicare part D.

Just quickly on one drug. There has been a lot of focus recently on Zohydro and the need for abuse deterrent formulations and so on. One of the things that I think is really important that is flying under the radar is methadone. So the gray bar is methadone deaths, the bars on the left are other opioids. So methadone – this is not methadone for heroin addiction, this is methadone used as a treatment for chronic pain. It's a long acting opioid and it accounts for two percent of opioid prescriptions and 30% of deaths. CDC and FDA and professional associations recommend against its use as a first line therapy

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and yet it remains on the preferred drug list in Medicaid in most states. So that is certainly something we could look at. So thank you.

ED HOWARD: That is terrific. If we can get you to pass the clicker down. We are going to turn next to Jo-Ellen Abou Nader from Express Scripts, where she is their Senior Director of fraud waste and abuse services. That means she is preventing those things. Now with billions of dollars at stake and the powerful pull of addiction at work, there is no getting around the incentives toward fraud and abuse. For more than a dozen years, Jo-Ellen has been rooting out that fraud and abuse for Express Scripts and she is here to share some of her experiences in that activity with us. Jo-Ellen, thank you.

JO-ELLEN ABOU NADER: Thank you very much. Can everybody hear me?

Alright so Express Scripts is a pharmacy benefit manager and we have a unique position in that we service today one in three Americans across the country. One point four billion scripts a year, it's quite a bit. With that, we have a lot of data analytics and mining capabilities, predictive analytics capabilities, but to give you a picture of how we fit in as a PBM, a patient will take a prescription into a retailer and that prescription will then be adjudicated through the system to a pharmacy benefit manager. It will bump up against edits, refill too soon edits, clinical edits, the patient will then get their prescription, Express Scripts will pay the pharmacy for their services and then the payers will then pay Express Scripts. So that is how the process works.

With that, we have to service 3500 clients across the country and they are very concerned about this issue. They are very concerned from many different aspects. The concern from the stance of ER visits are going up. We are seeing a large number of short day supplies of prescriptions coming out of ER's. But it is not just the prescriptions that are coming out of ER's, it is all the medical services associated. The x-rays, the CAT scans, the loss of productivity at work for the employers, the risk to their organization, you know if they have somebody that is traveling down the highway as their job and they may be on these prescriptions, there is risk for the organizations. They want safety for their members long term and their family members. In addition, there is a fine line between crossing that fine line with fraud. So we want to make sure that we are trying to get it early to prevent future behavior.

As I said, the medical claims associated with them getting the prescriptions is a one to \$41 multiplier. For every dollar on the prescription side, it is \$41 one the medical side for them to doctor shop. Again, it is the x-rays and CAT scans and all the fees that are associated with them to get that sometimes generic Percocet script, which is very costly.

So we take a comprehensive look. We are looking at all of the claims for a patient regardless if they are within a specific state. They could cross multiple states. We have the ability to look outside of just the PDMP's view. So yes, as Allan said, Missouri is the only state and that is where Express Scripts resides. We are seeing an increase of scripts coming into the State of Missouri from neighboring states such as Illinois and we have

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done studies on that. So we are very aware. But as the PBM representing over 3500 clients, we have the ability to look across all 50 states for their members. So we can look at the physicians and the pharmacies they are going to and look for trends across the United States. Again, we are looking at predictive models. How do we identify it earlier? How do we identify risk scores for not only the pharmacies but the physicians and the members based on their utilization and how they are practicing medicine. My team has clinical knowledge, I have pharmacists, I have pharmacy techs that have worked face to face with patients at retail, mail order, infusion, specialty, various areas. I also have people from investigative backgrounds. So it takes a diverse team to work these types of cases.

To give you a couple case studies, this was an actual case where it started out as a drug seeker. One individual drug seeker that was doctor shopping to multiple physicians. As I said, we have a comprehensive approach. We don't just look at one patient and their utilization, we are looking at the physicians they are going to and is there an issue there? Or is it the pharmacy that they are going to and are they linked to multiple other pharmacies or are there owners that are involved? And so in this case, an individual drug seeker ended up being five cases involving seven clients, 17 members, half of them had their ID's stolen in this case. Nineteen prescribers, 80 pharmacies, 28 counties and over 200 claims. Again, these are low dollar drugs sometimes because they are generic and that is what they want at times is the generic hydrocodone. However, the multiplier on the medical claims is astronomical for these.

The second is a case study and we call this patient, Ann. So Ann was a doctor shopper. She went to 17 prescribers within a 14 month timeframe, 43 prescriptions and five pharmacies. She had over 2800 unit doses of prescriptions in a year and you might say, Jo-Ellen, how did she get such a thing through your judication edits? Well, the doctor shoppers are pretty slick. When they want their drugs, they try to circumvent our edits and that is why we have the analytics we do, to try to identify those early. What happened is that Ann was going to multiple ER's. You can see the list on the pie chart, to get the controlled substances. Short day supplies, long and short acting controlled substances and many different types to circumvent the edits for refill too soon, max daily does, etcetera. So what we did is we actually locked in Ann, into a restriction program that the payer had signed up for. They wanted to get their members treatment, they wanted to get their employee treatment and what happened is we sent the letter out to the patient restricting her to one physician and one pharmacy to get only her controlled substances. So the restriction program allows her to get her antibiotics, any other types of drugs, but the controlled substances she needed to go to one physician to get her pain therapy. So with that, Ann actually signed up for an employee assistance program and she is actually doing very well. She is restricted to the one physician and one pharmacy, but her treatment is going very well and we received feedback from the clients. So these are the success factors with us being able to intervene earlier than later so that there isn't a death associated long term in these cases.

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Again, there is a fraud side to these pictures and sometimes it does cross over into fraud. Like I said, it's the collaboration with the clients that are very important with the payers. We want to make that we are intervening as early as possible to improve health outcomes for the patients and we also want to make sure that if there is potential fraud or ID theft, that we are getting those early too and protecting those victims in ID theft. We are also looking at physicians and pharmacies – are the physicians the ones that are actually attributing to the disease for these patients? If so, we need to take action on them. From a pharmacy perspective, since we manage those contracts with the pharmacies, we have over 65,000 in our network across the country. We work these cases very closely. We want to make sure that they are serving the patients as we expect them to, from their contracts. If they are not, we are going to take action on them as well.

We work with government officials across the country such as the medic with the Centers for Medicare and Medicaid Services (CMS) to make sure that we are targeting these pharmacies that are not behaving appropriately. From a member perspective, we want to make sure that we are early helping them early on to get case management or a restriction program or some type of case management through the health plans that they can assist them with their behavior. The last thing we want is for their benefits to be terminated because we want to make sure that they are getting help.

So the three key takeaways that I want you to make sure that you have – the PBM's - the pharmacy benefit managers are uniquely positioned to not only identify but to investigate these cases for fraud waste abuse and to collaborate with our payers. We want to make sure that there is a restriction program. We would love to see one in the Medicare world because our payers are really struggling. They are struggling because they do not have a way to control the behavior and the tools to be able to do that. So with that, I will turn it over to you, Ed.

ED HOWARD: Great, thanks very much, Jo-Ellen.

Finally, we are going to hear from Dr. Sarah Chouinard. She is the Medical Director at Community Care of West Virginia, a federally qualified health center serving a large part of that state. She is also involved in a whole bunch of state and national leadership roles in areas like rural health and information technology and public health, all of which are relevant to this conversation. Pain killer abuse isn't an abstract concept with Dr. Chouinard, it is a problem she has to cope with every day and today she is going to let us get a look at some of the problems she and her colleagues at Community Care encounter and how they deal with them. Doctor?

DR. SARAH CHOUINARD: Well, thanks for having me. I think I'm the boots on the ground perspective here. Everything that has been said so far is something that I think about on a daily basis as a rural health practitioner. I had some slides prepared. A lot of this has already been covered and I'm going to go through these quickly, but I did want to show you two things. This is where we are located. So this is Central West Virginia. We are nowhere near a large city. We have 50 healthcare providers working in these

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locations, 20 of those are doctors, and the other 30 are mid level practitioners, nurse practitioners, physician assistants. This clinic is a very typical site for us. This is one of our locations, so just picture yourselves going to your doctor's office and this is your doctor's office. The people working in these offices are people like me and the people showing up in these offices are showing up on things like this.

This isn't a joke. This is two weeks ago. A patient came in to see one of my colleagues just drenched in sweat and apologized, he said his father in law needed the car that day and rode that bicycle seven miles to get to the clinic. So I'm not over dramatizing, I'm not trying to make it sound like something it isn't, this is just exactly how things are where we are practicing.

We have 30,000 patients that we are taking care of in our clinics and so in those clinics, one of the things that happened – I have been there for ten years – is this prescription drug abuse problem sort of crept up on us. So originally all of our family doctors – and these are people who went into family medicine because they really do want to treat the variety of illnesses that afflict all of the people who are in your families and see them in their own communities. None of these people went into medicine because they had an interest in treating chronic pain. I think importantly, none of these people are equipped, myself included, to treat chronic pain. Chronic pain is a specialty. I went through a rotation in surgery and they told me that I could take out an appendix. I would never do that in my office. I don't see chronic pain as much different from doing an appendectomy. It is a specialty, it requires special training and the training that we get as family doctors now after residency is a mandatory three hours every two years. So if any of you would feel confident in my ability to treat your chronic pain, that would be silly. Yet the demand is there. So one of the things that I think people outside of our communities think is realistic is, well send them to a pain doctor. Or send them to a pain clinic. If you will go back to that slide that was the picture of our office, I would ask where those are? Where are those pain clinics? Where are those places that we are supposed to send these individuals? Transportation is an issue. Money in general is an issue for these patients and what we strive to do is allow people to keep care in their own communities.

One of the things that Allan said is, he said we need to get people into coordinated effective care. He also said that one of the weaknesses is the doctor's ability or interest in using these PDMP's. Well, one thing that really happened simultaneously is Medicaid expansion and Medicaid expansion has really increased the need for more primary care physicians in places like the place that I work. One of the things that has always been an issue for us is recruiting and retention. Again, if any of you would like to work in those communities, sign right up, but it is difficult to find people to come work in rural West Virginia. In our own state, we have had this tremendous ability to both recruit and retain primary care physicians and the dirty little secret is not because we are so great at what we do, it's because we have a way to allow family physicians to wipe their hands clean of having to treat chronic pain. We developed a program that is really innovative and that I think is something that if we could figure out how to spread nationally, could really help

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do two things – lessen the burden on family docs who typically don't want to do this anyway and also improve the care that people can get. If I were in your shoes, I would be asking myself, why do the doctors write all these drugs? Why are there so many pills? That is something that people in my family ask me. Ultimately don't all these drugs come from you? I mean, not all of them, but lots of them do. I think the answer is two fold. It's a lot easier to write a script and end the conversation than it is to actually go down the whole pathway of coming up with alternatives. In a place like rural West Virginia, the alternatives are few and far between. I think that is number one. Number two is the opposite effect, which is, I will take a hard stance, I'm writing no prescription drugs under any circumstances that are pain controllers and then there are those patients who really have true, legitimate chronic pain who don't get treatment.

When this epidemic started very early on, I had a patient who was a coal miner, a deep miner and he came in one day and I knew him well. He said, "Look, so here is the deal..." He has a legitimate diagnosis, documented with one of those expensive MRIs. Had been to a neurosurgeon, inoperable, nothing else had worked. He had been to a pain clinic in one of the nearby cities because he had the ability to get there and ultimately this guy was recommended that he take Lortab, a prescription pain medication. He said, "Either you write you the Lortab and I will keep working as a coal miner, making one of the rare people in rural West Virginia, six figures doing that. Or you can cut me off and I will go on disability. You pick." So those are the kinds of conversations that happen in the exam room on a pretty regular basis.

So to this program. Here is what we did as a solution. Let me go back to the page that shows our locations. So, that might look like it's not too far away, but these are real rural, real country roads that people are driving through. So in the center of that green geographic area we have hired an anesthetist who is a pain specialist. He has no real interest in doing family medicine, but does have a special interest in addictions medicine and in outpatient pain medicine. So hiring a doctor that has such an expensive salary and also such a high demand in a place like a hospital was a tough thing to do, but we were able to recruit him and now every one of our patients who has chronic pain, has to send their patient to this physician first for sort of a once over. He does the workup; he looks to see if the patient is amenable to any kind of alternatives and then sends those patients back to us as primary care doctors. When you mention the importance of how do we get doctors to comply with PDMP's, well I guess if you are the medical director, you can make them. So one of the things we have said is every patient has to have a pain contract. That contract is – as long as the contracts that you see in other places, one of the issues was making them readable for a lot of our patients, but it essentially says, we will do urine drug screens when we see appropriate. You will have one every time you come into the office to check to see if you are compliant with your medications. You will bring in your pill bottles, we will count your pills, we will look at the PDMP on a routine basis and if any point we need your attention and we need you to be in the office, you will be there. The patients who need chronic pain treatment and need the pills show up and say, this is in no way shape or form a burden. We need this medication and we will toe the line because we understand the importance of doing so because we understand that this is

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an epidemic that is affecting our communities. So what we have now is of all of our patients who have been sent through the program, 30% of those people have stayed on prescription drugs. They have stayed on their narcotics that they had been on and they have been sent back to their primary care doctor. They are living their life through their contract, through their urine drug screens, through pill counts, etcetera. 30% of those patients have been recommended or enrolled in a rehab program for addiction. Those patients have either been successful or not, but 30% have been sent. 20% were taken off of their medications because they were able to have treatment that was something that was not a prescription drug. They were able to be on something that was ibuprofen, exercise, physical therapy, injections, etcetera and 20% failed to maintain their contract and either had what we call a dirty urine or otherwise didn't show up for their appointments.

So we think it's been a big success. It's something that has made it that right now family doctors who are finishing their training call me and say, "Hi, I'm interested in working for you." I say, "Let's cut to the chase, is it because you don't have to write pain pills?" And they say, "Yep. I really want to treat diabetes. I want to treat hypertension. I want to see kids. I want to do well baby checkups. I don't want to deal with chronic pain. So I would rather drive 40 minutes from a place where a lot of people in West Virginia would choose to live and I will get in my car and drive so that I can avoid this problem." So thank you. I just wanted to give you the perspective of how real all of this work is.

ED HOWARD: Thanks very much, Sarah, that is a striking series of portraits and I think it sets up the discussion about how we go about helping you and your colleagues and the patients you serve as well as trying to deal with this major problem that afflicts West Virginia and so many other states. Mark and I have some questions and I would invite you to throw them at anyone you would like. If any of the panelists have comments they would like to make based on what they have heard from their fellow panelists, I would welcome those as well. You can take part in this by asking a question at a microphone, by filing out a green question card and Mark, do you want to start?

MARK MERRITT: Sure, can I borrow your mic? I have a question for Allan and the doctor and anybody else. It seems that doctors are either overwhelmed by this problem or they think they can kind of eyeball their way out of it without using IT, without checking with a prescription drug monitoring program or so forth. It kind of reminds of when President Bush said that thing, "I looked into Vladimir Putin's soul – but you can't really see that much." So what is the solution there? How do you get providers more engaged in using real time IT?

ALLAN COUKELL: Well, I give a couple of infrastructure things. Get it into the electronic health record I think is the Holy Grail. If it just automatically pops up in front of you every time you see a patient, which is important. Proactive alerts are a shorter term, easier way to do that. Making it accessible through the health information exchange. Making it a delegate access so that somebody who does the pre-treatment screen can pull that information – just print it out and put it on the chart so that it doesn't

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take 30 seconds or a minute out of a very short consult. The other thing that I will just say that is relevant here is that there have been a couple good studies saying that when the PDMP data was presented to the doctor, did they know? Most cases they didn't. In these studies they were surprised to know how many other physicians their patient was seeing. That information changed their prescribing and it changed it in two ways. Sometimes they didn't write the script, but sometimes they found out that their patient wasn't being seen – who they thought was drug seeking wasn't been seen somewhere and they felt more comfortable prescribing. So I think that is good to know.

GRANT BALDWIN: I will just add a couple things to that. One is, Allan didn't mention the importance of universal utilization and the increase in doctors using – in a state like New York, once it became universally utilized, that is critical. Some of the other innovations that he spoke about, obviously providers have a timed limited amount of times to see individual patients, integrating all of these fixes will not necessarily extend the amount of time, but actually make it easier for the healthcare team to do their job in an efficient manner in that same 10 to 15 minute block.

DR. SARAH CHOUINARD: I will add one other comment which is, I think the idea of sending those lists proactively is a great idea. Hydrocodone this month moves from being a schedule three to a schedule two drug. We went and printed the list last week of every one of our provider's list of hydrocodone prescriptions, presented those providers with those lists and said, this will now turn into one of those prescriptions that will need to be referred to our anesthetist. Eight out of ten people were very surprised by the amount of hydrocodone they had written in the last three months, so I do think that just that sort of innocent awareness piece is key.

ED HOWARD: Following up on that, I wonder if some of our panelists could address some of the problems that we have been experiencing with electronic health records, with physicians being frustrated at the time they have to spend tending those with the difficulty of accessing the records themselves and one final aspect of this that I came across in reviewing some of the materials that were put together is that the National Governor's Association study that is reprinted in your packets, concludes that the PDMPs are useful but underused. I wonder if folks could comment on those related aspects.

DR. SARAH CHOUINARD: I think one of the key elements is practice redesign. There is whole push towards the patient centered medical home model. The National Committee for Quality Assurance (NCQA) does certification to create medical homes and communities and it's a totally involved discussion, but in short there is a big emphasis on care teams so that if a patient comes in, it's not just that they get worked up by a nurse with a blood pressure and a chief complaint. Instead there is a whole team of people seeing that patient. As far as using this, I think you are right that it's hard for the physicians to navigate not only electronic health records, but these additional databases. We have our nursing staff pull all of that information for the providers ahead of time. So why ask the docs to try to go through and navigate that, instead just have the nurse present them with, okay, you are about to see this next patient, here is the deal. Here is

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what their PDMP says. Here are the last five scripts, I have highlighted anything that looks abnormal or a red flag or hey, we looked at all of that and nothing came up as a red flag, go ahead and proceed as planned. I think that is the key is not asking them to spend the time to do it. I would go back again to Medicaid expansion and it really has changed the demand for healthcare services in our communities. It's great, we are thrilled to death that we have an increased demand for people who are not seeking care before because of being uninsured, but it just makes that time piece even more important.

ALLAN COUKELL: I completely agree with Sarah. I emphasized EHR's and I talked about health information exchanges. If a PDMP sends data to the Health Information Exchange (HIE), it still requires the hospital and the care system to build their end and they have a lot of things on their to-do list right now. So I do think, as Sarah said, optimizing these low tech things that we can do immediately is really important.

GRANT BALDWIN: Yeah, CDC is involved in a couple of projects. Allan had mentioned the Office of the National Coordinator; as well to evaluate PDMP EHR integration because we see the long term, which is really a Holy Grail for us in getting better utilization. As several of us have talked about, PDMP's really vary widely in their legislative scope as well as in their funding, so some states are only funded at several hundred thousand dollars, where other states, literally tens of millions of dollars go into PDMP – the running of the state prescription drug monitoring program. That has really big implications for the utility of that data and the availability of that data at the point of care.

So the last point I wanted to make is the power of the single sign-on and the delegated access because Sarah had mentioned in West Virginia that is possible, but in many states that is not possible, so that really does limit the clinician in that short window of time that they have to see each patient.

ED HOWARD: How about the issue Allan raised of states being able to communicate with other state's PDMP's? Is that a wide spread phenomenon? Can West Virginia tap into Pennsylvania?

DR. SARAH CHOUINARD: We have an issue in any of our border communities. One of the things that I do a day a week is serve as the medical director for our state's health plan. So another angle that I see from this is them coming up with those lock-in programs and asking about those patients. A lot of time what we find is that the patients who are on those border communities we will flag after a patient has been doctor shopping across the border. So my answer is, we don't do it well in West Virginia, we don't have a solution for it or are aware of the fact that the HIE's that are statewide are great, but it's going to be that real national database that is going to make the difference.

ALLAN COUKELL: I would just add, there is a lot of momentum towards interstate data sharing. The sort of contribution to burden of disease probably varies. If you are a big state like California or Texas, you may be less concerned about what lies across the

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border. If you are a small state with five contiguous bordering states, it may be a bigger part of the problem. One of the things that is important to recognize is that the barrier to data sharing is not just technical and not even primarily technical, it's on legal templates and one state the nurse can access the data and the joining state, the nurse can't access the data, then you have to have a complex legal arrangement to get them to exchange data. So that is a big barrier.

GRANT BALDWIN: I would say that technological possibilities are there. Pimix and PDMP interconnect are two hubs that allow data sharing in a fairly robust way, but as Allan mentioned, it really is the legislative challenges. The Health Insurance Portability and Accountability Act (HIPAA) variation across states that are really sort of driving the barrier for interstate operability of PDMP's.

ED HOWARD: Grant, is there a piece of the program you were describing, the CDC grant program that would encourage states to move toward cooperation?

GRANT BALDWIN: Part of the prevention boost program is in fact a maximized PDMP utilization, so things like better leveraging of state inoperability is critically important, but sending, as Sarah had mentioned, sort of proactive reports is another great example. Many states restrict who can access the PDMP and some states, even state Health Departments can't use it to sort of public health end and obviously we at CDC are very interested in using those data to inform practice at the population health level.

ED HOWARD: We have some folks at the microphone. Would you identify yourself and your affiliation?

AUDIENCE MEMBER: My name is Becky Vaughn, I'm Vice President for Addiction Services at the National Council for Behavior Health. We work with and represent publicly funded prevention and treatment providers all over the country and obviously they are being overrun with this issue. But I'm particularly fascinated with this West Virginia model. I don't know what the population is in your Center, but is one addiction doctor specialist enough for your size population? Is there anything particularly special about West Virginia that would keep this from becoming sort of a replicable model for other rural areas that are struggling with all the things that you talked about?

DR. SARAH CHOUINARD: So to answer your question, we started out with one anesthetist, we now have four midlevel providers working with him. Three nurse practitioners and a physician's assistant. We have a waiting list of 397 patients. I checked the day before we came to Washington, which was on Friday afternoon. They are working as quickly as they can. We are using one of those in the capacity of only doing behavioral health services with those patients and the real issue is, it's absolutely something that can be replicated, it's finding the anesthetist who would want to do that work. A lot of those people who go into anesthesia want to serve that role in its traditional capacity or want to work in a day center or somewhere that they can do more procedure based medicine with fluoroscopy and other interventions. So this is very

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grassroots and I think the issue is that it takes a special person who wants to be in a rural community in this capacity. But that really is the only barrier. I mean, if we could get that workforce built up, I think it's highly replicable.

AUDIENCE MEMBER: Are you utilizing community based providers or are there even any community based providers you can utilize in that area?

DR. SARAH CHOUINARD: For mental health or for additional pain services?

AUDIENCE MEMBER: Mostly for mental health and addiction.

DR. SARAH CHOUINARD: So we are in the midst of that now. We are working with our behavioral health specialist at the state level through the Substance Abuse and Mental Health Services Administration (SAMHSA) and we are working on getting touch screens in the offices and speaking about the electronic health record, an online piece through our patient portal that will allow patients at home to answer a sort of a generic behavioral health survey that if the questions are flagged in and around addictions, medicine or pain medication abuse, it sort of prompts them to another set of questions that then is just sent to us as their primary care providers. We then can integrate the behavioral health services through Telehealth and sort of on it goes. So the answer is, yes, but boy is there fertile ground for more to do.

AUDIENCE MEMBER: Hi, Whitney Englander with the Harm Reduction Coalition. Thank you so much to the panelists for a great briefing so far and the problem of opioids is so complex we could be in here for days discussing it and the various comprehensive strategies. Noticeably missing from the conversation has been the role of Naloxone in preventing fatalities associated with overdose. What will it take to get some leadership around greater access and utilization of this medication which has shown incredible efficacy in states like Massachusetts and other states that are able to saturate communities with Naloxone and create a protective factor? Massachusetts saw a 50% reduction in overdose rates in counties with Naloxone. So what will it take for some leadership to expand access through community based programs and co-prescribing?

ED HOWARD: I would ask whoever would like to take that on, to spend a few seconds to explain exactly what we are talking about.

GRANT BALDWIN: Sure, I will start answering the question, thank you for it. Naloxone is an overdose reversal drug; it is an opioid antagonist that basically stops an overdose in progress almost instantaneously. It is very, very powerful. We at CDC are very committed working along with colleagues at SAMHSA of increasing Naloxone utilization, given its promise and potential, especially among police and fire and more basic EMS providers. So there is a real promise there. For us at CDC, we are also worried, really from a primary prevention perspective. How do we stop people from becoming addicted to opioids in the first place? So that is some of where the sensitivity

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exists, but we – personally me and I think CDC more broadly, were very committed to increasing Naloxone utilization and access.

AUDIENCE MEMBER: Good morning, my name is Jeff Larato and I'm from the National Institute on Drug Abuse at NIH. The first thing I want to do is endorse what Whitney just said, for those of you who don't know about Naloxone, please read up on it, all of the federal agencies are really working hard to get that out more. I really just have a lot of thoughts, but I won't hog the mic. Two things. Coming from a research agency at the NIH, we haven't really talked about research here today, so I just wanted to give a plug for the work that we and our colleagues are doing, [drugabuse.gov](http://drugabuse.gov) if you want to learn more about that. The second is, one of the things that you have highlighted today both intentionally and not, is the dramatic need for drug abuse and addiction treatment in this country and the relative lack of access that – not many, but most people who need it don't have right now. Dr. Chouinard, I was getting increasingly frustrated, not because what any the rest of you were saying was wrong or bad, but until you started talking about the real need for treatment, as a primary necessary focus of what all of you and all of us are trying to do, it's really dramatic and I didn't want that to get lost from the discussion. Thanks.

ED HOWARD: Comments? Are you going to let it stand? Okay. Yes, go right ahead.

AUDIENCE MEMBER: Hi, Mike Miller, I'm a health policy physician, consultant and blogger. I've been working on this issue on and off for a number of years and one of the challenges I think is that it's often characterized, I know even in the IOM Report, as an issue related to chronic pain. But its kind of like chasing down the horses after they have left the barn, because no patient starts with a diagnosis of chronic pain or a disease of chronic pain. They start with acute pain that becomes chronic and one of the challenges I think as Dr. Chouinard said, it's a lot easier to write a prescription than to deal with something more complicated. And I wondered if she could talk about and I know it's not primarily a primary care issue, it's more about procedural and ER situations, but how we could go about addressing the issue of how acute pain is dealt with, with prescriptions and other modalities as a way to reduce the number of people who end up having chronic pain.

DR. SARAH CHOUINARD: I think one of the problems is, I don't see the demand for pain medication for acute pain too much – I guess it's very similar to over prescribing antibiotics. It's expectations. So I practiced medicine in California for a while, a mother would bring in her child and say, please do not give my precious baby an antibiotic because I don't want poison in his or her little bloodstream. In West Virginia, they are like, give this kid an antibiotic and let's get done with this. So it is cultural, I think is the point. And if you look at antibiotic prescribing rates, they are very, very high in West Virginia compared to in California. The same is true of prescriptions being written for pain medications and drug overdose deaths. We are number two or three – I think Grant said Alabama was number one, but we are on the top five list. So I think with acute pain, people come in and they say things like this. I mean, a woman just this Thursday had

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broken coccyx. She fell and slipped on a step – I mean, boy does that hurt. She said, can I have some of those Hydros? Quote. And – sure, what are those? So there is no consideration of maybe, maybe Tylenol would work. Maybe sitting on a donut, you know, those spongy things you can sit on to relieve the pressure, maybe that would work. It is an automatic expectation that a narcotic pain medication is the solution for any pain. Then what happens is it's this quick, addictive potential of these medications that people are treated acutely and then they truly have a psychiatric component to the addiction. It's less about pain and more about addiction. So I think the answer is allowing the pendulum swung. I mean, remember about ten years ago, there were doctors wandering around with buttons that said, No Pain with a red circle and a line through it because we were accused of under treating pain. Now the pendulum has swung way in the opposite direction. I mean, they used to say, hey, you will get sued if you don't write pain medicine for these people. "They" will sue you. Now it's, gosh, don't write anything or you will be a pill mill. So I think the real answer is, just getting back to the midline and allowing the word to be out that you don't have to use a narcotic for every bump.

AUDIENCE MEMBER: I think the coccyx fracture is a great example. I just know of a few clinicians where after minor procedures they have written for 60, 90, 100 opioid where the patient should be on maybe a opioid for two or three or four days. Where are the rest of those pills going to go?

DR. SARAH CHOUINARD: Right, I think that's the key.

JO-ELLEN ABOU NADER: I think we would be remiss if we didn't say that having that number of controlled substances in your house, that we really need to secure them for the youth, because that is where a lot of these cases – I was at the Fed Up Rally yesterday, where you see so many of the children across the country being impacted by this disease. So I think we really need to make sure that we are locking those up as well. You have probably seen that in West Virginia.

DR. SARAH CHOUINARD: Yeah, one thing that I didn't mention that is part of our requirements, this is just in our clinic, this has nothing to do with legislation and state law, nothing. Patients have to come back every month for their pain medications. You legally can write more drug. I legally only have to check the PDMP once a year. I mean, where the law is and what we require and we simply say that, if it's that important, you will be there. So making patients show up and only giving 30 days worth of the prescription, we think is a huge piece of this because people throwing rocks through picture windows in houses to break into medicine cabinets is not exciting news anymore. It is common, it happens. Little old ladies houses are broken into on a regular basis because people are assuming, hey, she looks like she has arthritis; I bet there is something good in her medicine cabinet. So if there is less there and if the word on the street is that there is only a 30 day supply in any household, maybe its less enticing.

GRANT BALDWIN: I was going to make a point about your comment about dose and duration really resonated with me. Sort of amplifying Sarah's point. As dose goes up, the

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risk goes up quite dramatically, but I think there is also attention here with cost, so alternate forms of therapy, cognitive behavioral therapy, physical therapy are costly. Allan mentioned in his remarks the issue around methadone. Two percent are prescriptions, 30% of deaths. It's also one eighteenth the cost of the next cheapest opioid, so the reason its listed as the preferred drug of choice on many drug formularies is because from that tension between sort of cost containment, it's pretty cheap. So there are some realities there that we as a country need to wrestle with as well.

AUDIENCE MEMBER: Abigail Joseph, Senator Markey's office. Dr. Chouinard, I was very interested in the contract process that you guys have in West Virginia and was interested in hearing a little bit more about the 30% that you said were referred to treatment and what their success rates have been and if you can talk about some of the limitations for treatment in those rural areas, aside from just the recruitment and retention piece.

DR. SARAH CHOUINARD: Well in short, we don't do enough and its not successful enough and there aren't enough beds and there aren't enough bodies to treat them. That is really the skinny on that answer. Part of what has been a success too is the personality of this anesthetist that we have. He is very bristly and people either love him or hate him because he says things like, you might have pain, but we are going to talk about that after we talk about your addiction. That can be kind of uncomfortable for people. So he refers them to outpatient and inpatient programs, but understand that like many other states, we are no exception. All of the beds are full. To get there is impossible. It's a call and if we happen to have a bed available when you show up, we will give it to you, but it might be taken on your way here. I think a comment was made earlier about where the focus should be and the focus should be expanding outpatient services and expanding inpatient services so that the people who actually do want help, have it. We have lost a lot of people who were ready for treatment, who we didn't have a treatment plan available, who then went back to using. So I think that – I would love to tell you that we had some success story, but we certainly don't.

ED HOWARD: Sarah, there is a card with a question that is quite closely related, but it's interested in one of the 20% categories. That is those who don't comply or don't pass their drug test. You have sort of addressed it I think in your response just now. What kind of alternatives are there for those people? Any kind of follow up that you can try to steer them toward so that they don't fall through the cracks? Telemedicine? Almost anything?

DR. SARAH CHOUINARD: No is the short answer. We don't have enough available to us. When you talk about the 20% that fail, those are people who either came in who also had street drug in their drug screens. Who had no drugs in their drug screens, because they are diverting the medication instead. I mean, any scenario you can think of, we have seen it. That 20% is a pretty hard stop. Where we have made it clear from the beginning, the contract could not be clearer about what it takes and if you follow the contract, you will be allowed to have any appropriate medication that you would need. So with that 20%, most of the time what happens is they come back to us as primary care providers

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and we write them a taper of their medication, simply so they don't withdrawal from those medications, but then as far as actually getting treatment for their pain, it's probably high and dry. We are happy to see them and offer them non-narcotic alternatives, but it's not like in the clinic that I showed you. I'm doing injections of Para spinal muscles. So it's not great.

AUDIENCE MEMBER: Melanie Nathanson, I am a partner in a healthcare and income security firm in town. Thank you all, this has been incredibly illuminating and really interesting to hear such consensus and on one of Ed's panels, normally there is not.

ED HOWARD: We are going to get downgraded on our rating for that very consensus.

AUDIENCE MEMBER: It's good, it's very telling. I'm curious, both Jo-Ellen and Allan noted the importance of PRR programs, particularly on the Medicaid side and in the private pay side. Dr. Chouinard, I'm curious, I don't know if West Virginia has a PRR program in Medicaid and how you interact with that lock-in program, but I also noted that almost all of you talked about the potential to have similar programs in Medicare and would love to hear how that might work and what those programs would look like and the potential benefits to expand into that program as well. Thanks.

DR. SARAH CHOUINARD: So I hope this is just brutally honest. If we have a program in Medicaid, I don't know about it. So we might, but I certainly don't know about it as a practicing clinician. I will say this, our state payer, our state health insurer who covers school teachers and bus drivers and state road workers, etcetera, where I'm the medical director. It is a program that we do internally. There is nothing required about it. So we run those audits and then we contact physicians and sort of say, hey did you know – really as a courtesy and in hopes that we have to – we can cut down on the number of those drugs that we have to cover as the plan. So Medicaid does that audits as well, only because a good friend and colleague serves as their medical director and we talk about those programs, but if it's a state requirement, I don't know about it. I guess the point is, if it is a state requirement, it's not effectively getting to the rural health community.

ALLAN COUKELL: So I just checked, West Virginia does have a PRR, but I think that makes the point that I would make, which is this is an optimization problem. The programs are on the books in most states, but the number of eligible people who are actually enrolled is probably pretty small and we don't know how to say to a state, these are best practices or these are the things that are really going to have an impact. So we have some work to do that. It's also not the only legitimate way that a Medicaid department might want to tackle this. They could do some other kind of case management thing, but it is a tool that we could optimize. Right now, we can't optimize it in Medicare part D, to the question, because the authorizing legislation as its interpreted doesn't allow walk-ins in part D. So we need to allow them and then we need to think about what are the elements of an effective program? Do we just enable them or should there be some safeguards? Should there be a mandatory appeals process? Should the person who is being referred have some input as to which doctor and which pharmacy

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they go to? How long should they last? Those are all things that may or may not need to be in the legislation, but we certainly have to give that tool to the plans.

JO-ELLEN ABOU NADER: So the PRR that we manage today is very successful, we do it not only for the commercial side, the health plans, but we also do it for TRICARE. TRICARE at any one time has over 1,000 locked in to a 111 program, which is what they call their restriction program. So we have seen success on the commercial side, we are seeing on average one hundred dollars per member per month savings. Again, a lot of it is generic drugs, but we are seeing considerable savings and not only cost, but trying to get assistance for these members.

MARK MERRITT: I just have a follow-up question on that. One thing we haven't talked a lot about is the role of the plans and the PBM's and that is our industry. The best data, we have it and the PDMP's not only do not talk to each other and are delayed in how they are updated, but there is not easy access from plans and that is not coordinated and so we talk about all these policy regulatory solutions which are important, but we have all this real time data that is kind of left on the side. I don't know if you have any comments on that.

JO-ELLEN ABOU NADER: So again, it's really up to the payers to decide what they want to do with the restriction program. Some of them are more aggressive than others. Some of them are kind of skittish or they don't have the resources to be able to manage the case management on their end. Again, it comes back to resources. I think they are all very concerned and they want those tools to be able to manage this and I think Medicare is going to be key. I have stood at the medic meetings quarterly for the last six years in the Medicare space and the plans are struggling with not knowing what to do with members that are drug seeking and not having the tools to handle that. So we really need something in the Medicare space.

GRANT BALDWIN: I was just going to make the point that one step above patient review and restriction programs, some private insurers and managed care organizations like group health in Washington State have been at the forefront of both containing costs and improving patient safety by running what they call a coordinated care program which involves many of the things that Sarah has highlighted – whether it be drug screens, step therapies, drug reviews – it's a much more comprehensive holistic approach to managing an individual's care. It has huge cost gains or cost savings to the managed care organizations, but improves patient safety on the whole as well. There is some real potency there.

ED HOWARD: I would assume that group health has a bunch of Medicare beneficiaries. Do they apply these initiatives to that population?

GRANT BALDWIN: I don't have the answer to that, but I can research that.

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ED HOWARD: One final aspect of this, before we let it go and that is, someone has asked what programs, what states, what providers do around the country with the nine or ten million dual eligible? Where Medicaid may have a restriction whether you know about it or not. But you also have Medicare eligibility. Can you put your Medicaid beneficiaries who are also Medicare beneficiaries in that program?

ALLAN COUKELL: I defer to anyone else if they want to correct me, but if the dual are getting their drugs through part D, then I would assume that they can't be in a lock in program. There is an added challenge with that population which is unlike most people in part D, they can change plans quite frequently. So if one plan said, we are going to restrict you to a provider or a pharmacy and the person was really set on avoiding that, they could switch plans. So that is something they will have to think about.

ED HOWARD: There is a policy opportunity there, for those of you who are out.

AUDIENCE MEMBER: Good morning, Andrew Kessler on behalf of the ICNRC, the International Substance Abuse Counselors. Jo-Ellen, you mentioned in an answer to a question before about prevention aimed at youth in terms of limiting the number of pills prescribed, so on and so forth, which prompts me to ask a question about another special population, which is on the other end of the spectrum, those over the age of 50 or even over the age of 65 who represent only 13% of the population, but are written about a third of all prescriptions. If you look at the numbers, the one demographic that is outpacing all others in terms of opioid abuse are those over the age of 50 and yet here we are in Washington where most programs that look at prevention, especially community based prevention are aimed at youth. None of us object to this, yet it tends to ignore those who are at risk for many complications when it comes to opioid abuse, such as broken hips, broken bones and other problems that come along with opioid abuse and lead to other health problems. Can any of you on the panel address any programs or ideas that you have seen for substance abuse prevention for those who are perhaps over the age of 50 or over 65, because that is where we see the numbers bearing out a very serious problem in terms of increase of abuse?

DR. SARAH CHOUINARD: I don't know of any programs that are aimed at specifically the elderly or geriatric population. All I can say is that the program that we have in place is all comers. I think that part of the issue there is some assumption that Grandma is not going to really be a drug addict. So whether it's intentional or not, the problem there too is that a lot of co-morbidities in the elderly – cancer diagnosis, severe osteoarthritis, there are guidelines that state that opioids are appropriate treatment. So I think what happens is that it's a slippery slope issue. In West Virginia, of the programs that I know about, there are none that are targeted to that population, but also not targeted specifically at youth. I mean, most of these are just looking at the topic, age aside.

GRANT BALDWIN: I think that is some of the real power of the interventions we have talked about this morning, whether its PDMP's, PRR's, we haven't really talked much about clinical guidelines and how they can be better utilized. The real potency of those

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interventions is they are sort of one stop shops, if you will. They are equal opportunity in helping people.

JO-ELLEN ABOU NADER: And as Mark talked about, the amount of data that the PDM's have, this is where we can reach out to the physicians, because I will tell you in many of these cases that we work, the physicians are not aware, number one, that their patient that they have a paid management contract with is going to multiple physicians and then they can address the situation with their member. But it doesn't matter what age they are, you know? The situation happens and so this is the front line for us, to be able to address with the physicians and reach out to them so that they can take care of their patients. There is no need for them to go – like in the examples of 17 different physicians, to get controlled substances. We have seen valid reasons and we go back and look at the diagnosis with the medical claims, there are valid reasons for patients to go to a few, because they have a long term illness and so they need multiples, but it has to be a comprehensive approach in the data. You can't just run data and then label them as a drug seeker, because that isn't valid. We really have to look at the comprehensive approach, look at the medical claims, speaking with a physician, speaking with a pharmacist, to be able to get those patients help.

ALLAN COUKELL: I want to add just one word about the Medicare population. We think about this as a problem in terms of overdose – falls. The risk of falls in this population goes way up if they are on these drugs.

DR. SARAH CHOUINARD: And I will say that this idea of opening up lock in programs to Part D Medicare recipients – I think it's a great idea, the awareness that we would have so that physicians understand there is doctor shopping, but its just like in medical school, they say, before you order a lab test or an x-ray, think long and hard if you want to know those test results. Right? There is that sort of chasing things down and then ordering tests and never really knowing what you were looking for in the first place. With this, what I would caution is – and then what? Speaking to the need for more substance abuse, chronic pain treatment, etcetera, so now we have this lock in and I say, ah ha! So Mrs. Smith, you have been doctor shopping. And now what? Now what? What am I going to do? Mrs. Smith, who is addicted, who is on chronic narcotics, who doesn't have – I mean, I am in a better situation than most people because I have this one employee – I mean, we say, does he have any idea how powerful he is from a contract standpoint? I mean, if he goes away, our entire program implodes, right? We don't have people lined up for his job. With that being said, I think that what we really have to think about from a legislative standpoint is if we are going to be pushing these lock in programs, they should really happen simultaneously with an improved ability to get patients help who fail once they have been locked in.

AUDIENCE MEMBER: Thank you, John Graham from the National Center for Policy Analysis and as I have been standing here, I realized my question is one that might invite too much risk for anyone to answer, so I hope someone will answer it. Dr. Baldwin mentioned a positive correlation between heroin abuse and opioid abuse and you

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mentioned breaking into old lady's houses. I'm wondering if all of the solutions we have discussed are in the healthcare system. Does anyone have anything to say about sentencing guidelines or parole guidelines or anything police and judges can do that will help you all do your jobs better and move everything in the same direction?

JO-ELLEN ABOU NADER: Well, I will speak on behalf of my investigation unit. We work a lot of physician cases, we work a lot of pharmacy cases and we are not seeing strict enough penalties for those pharmacies and physicians that are committing fraud. So I would say yes, we definitely need stricter sentencing guidelines because a lot of these guys are just getting a slap on the hand and then they are moving on and opening up another one or a family member is opening up another one and they start again. So I would definitely encourage that.

MARK MERRITT: If I could just jump in, I think what Dr. Chouinard said is really important. So you find out the person is an addict or whatever and what do you do about it? That to me highlights the role that the pharmacist can play because if they are plugged into this and if there are pharmacy homes, or lock in or whatever you want to call it, they can simply deny the script. They can simply not give it out. Without any further explanation. I often think that the prescribers are the ones who know the most, but the reality is that the supply – the chokehold is right there at the drug store counter. The role that drug stores and pharmacists have, I think is very large in actually preventing the transfer from the drug to the patient and they ought to really play a big role in this and I think it is very hard. If you are the doctor and you don't have another solution, the person is hurting – or say they are – you don't have another solution, you are not sure if you could give this. Then what do you do? So I would just – we haven't talked much about the role of the drug store, but I think they have an important role too.

ALLAN COUKELL: One thing to add is there is some evidence that some people that get addicted to prescription opioid with transition to heroin. The evidence is that the risk period, the latency is very long, which means if we do the things we are talking about, we can intervene before that transition happens.

ED HOWARD: We have just a few minutes left. I guess we will try to accommodate the three of you who are standing to ask your questions, but I would ask that you be as brief as you can, and I would ask the panelists to be as brief as they can in their responses. Go ahead.

AUDIENCE MEMBER: My name is Rachel Gandal and I'm from the American Congress of Obstetricians and Gynecologists. There are a lot of things that we are interested in with this issue in particular. I'm hoping you can speak to how you find a balance or rectify the programs that you have talked about this morning with the growing popularity of patient satisfaction surveys and things like that and a lot of insurers and plans relying on those and either ding doctors financially if their surveys are low or other kind of issues and physicians are penalized in other ways for those lower scores.

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ED HOWARD: So if you don't give me the opioid I will downgrade your rating on the NCQA form.

DR. SARAH CHOUINARD: Actually it was – I don't know if it was true, but there was a rumor in one of our communities in our most southern clinic that health grades was a way that patients communicated about opioid prescribers. So that if someone got a 5, they gave out opioids. If someone got a 1, they did not give out opioids and this is a way to sort of talk to each other about that. So as a physician, you are hoping to get a one so that you don't have people knocking on the door. So I don't know what you do about that from the health plan perspective other than hope that people realize that that sort of funny business goes on.

GRANT BALDWIN: I would just mention a couple of things – being from Ob/Gyn, there is a cascade of other negative health outcomes including an increase in neonatal abstinence syndrome of babies being born addicted to opioids, its really tragic. Some drug driving, which was hinted out earlier, so it's not just being addicted to a prescription opioid, but there is a cascade of other issues that are problematic as well.

AUDIENCE MEMBER: Abigail Joseph with Senator Markey's office. We spent a lot of time talking about prevention at this forum and the PDMP's, a lot of what was talked about was the need for interoperability for sort of standard regulations in terms of what providers have access to the PDMP's in the state. Because of those variables, a lot have argued that perhaps there is a need for a federal PDMP and that was one of the things that you guys haven't discussed and I was wondering if we could get some perspectives on whether you think this is an entity that should be housed and operated by the state or something that should be taken over by the feds?

ED HOWARD: Good question. Go ahead.

MARK MERRITT: That is a really good question. I think a smart way to go about it, it wouldn't solve all the problems, it wouldn't be to have the federal government run one big one, but to simply have uniform standards and to create some way that payers can have better coordination with the PDMP's. Right now each of them is just kind of on an island by themselves with semi-outdated data. I mean, from a drug store shopper or a doctor shopper's perspective, having even a seven day delay is great for them. So if there are uniform standards, more regular updates, more access to payers and again, payers health plans and PBM's and so forth, literally 200 million people plus, active, undated regular files on utilization, that can be used in a very productive way. But uniform standards would be I think a good way to get to what you are talking about.

GRANT BALDWIN: Mark, to your point. Allan had mentioned the Brandeis Center of Excellence on PDMP's they have 35 best practices identified that if a PDMP should have to be maximally utilized, I think that is a great resource. Because the practice of medicine is governed at the state level, I think that is really where we need to be focused because I think that is – there will be a lot more challenge to infuse federal down across the states.

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So I think because of the way medicine is regulated, I think the states are the sweet spot here.

ED HOWARD: Last question coming up.

AUDIENCE MEMBER: Nick Uehlecke with the Ways and Means Committee. In listening to what everyone said up there, it pretty much sounds like the more tools that we give to the plans, to all the providers, the more tools is better. That is the logical way of going. So from my perspective and Ed, thank you very much for mentioning that there is a legislative idea pool here, but my perspective is kind of – a couple of things in the crowd where there might be some inkling of concerns in the back of people's minds and obviously we received tons of comments on what people's concerns are with potential lock in programs for PR's and so if you could just address a couple of these, they are pretty quick. A lot of people are concerned, if Grandma is locked in because she was over prescribed for certain pain medications, can she still go anywhere to get her allergy medications? Can she get her diabetes medications? Is she going to have a problem with access to those? A lot of the concerns that we have gotten and some from some physician groups is, don't tell the doctors what to do. The plan shouldn't be telling them. So if you could address the fact that plans do indeed have medical directors and people that are medically trained as well as this kind of troubling concern that we received as well that we don't have to do anything. CMS and what they are doing is working. So if you could address those, I would appreciate it.

JO-ELLEN ABOU NADER: From the restriction programs, they are only restricted in controlled substances, so they can go to any other physician for non-controls. They can go to any pharmacy for non-controls. It's just related to their controlled substance utilization and that is it. so we want to make sure that they are getting the proper pain treatment from one physician, not 17.

ALLAN COUKELL: And there have actually been a couple analyses of PRR's that specifically looked at that question of did access to non-controlled substances change and found that it did not.

MARK MERRITT: And just to finish that up, one of the reasons and I think that Allan said this earlier that the word lock in is so bad is that Grandma or whoever, they choose their own pharmacy. Nobody is trying to limit the pharmacy; we just need to know which ones they are going to. Everybody needs to know that in the system. So they will be able to get other drugs anywhere they want, but for those controlled substances, it would probably be the pharmacy that she is already going to. Again, your point about trying to make doctors do more and so forth, I think that is significant. I think it gets back to probably the most automatic way to deal with it, although not complete is at the pharmacy level. Pharmacies are already wired, they are electronically adjudicated for 25 years, they already have the technology and if they can prevent the supply moving over, then have some way where providers are alerted and so forth, that is a good way to start

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the program, it doesn't add any other burden to any of the other already overburdened doctors and so forth.

ED HOWARD: I apologize to all of you who wrote questions on cards, there are some terrific questions here that we are not going to be able to address today because we are simply out of time. It is a topic that obviously has a number of different threads that we haven't been able to weave into a single solution yet, but we will come back to it as our ability to schedule something permits. I want to thank our colleagues at PCMA for enticing us into doing this program in the first place and helping us to organize it. Ask you to fill out the blue evaluation forms as we finish up here. Before you do that, or maybe you can do it at the same time, if you would join me in thanking the panel for a terrific and insightful conversation.

[applause]

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