

**Department of Health and Human Services
Division of Medical Assistance**

**NORTH CAROLINA MEDICAID NARCOTIC TASK FORCE
Approved Minutes
May 11, 2009**

The North Carolina Medicaid Narcotic Task Force met on Monday, May 11, 2009, at 10:30 a.m. in room 297 of the Kirby Building.

Participants present: Craigan Gray, M.D., Tara Larson, Patti Forest, M.D., Howard Peckman, Pharm.D., Glenda Adams, Pharm.D., Sara McEwen, M.D., Beverly Lingerfeldt, R.Ph., Leah Terrell, Pharm.D., Kelly Bossenbrock, M.D., Stephanie Christofferson, Pharm.D., Kay Sanford, M.S.P.H., Fred Wells Brason II

Participants via telephone: Bob Gwyther, M.D., Hans Hansen, M.D., Richard Hudspeth, M.D.

The meeting was called to order by Glenda Adams. Participants were welcomed and thanked for taking the time out of their schedules to be a part of this task force. Participants introduced themselves.

Dr. Patti Forest mentioned why this task force was initiated. She emphasized that the purpose of this task force is to make sure our patients get the drugs they need, but to ensure that those who do not need narcotics, do not have the opportunity to obtain them and misuse, abuse or divert them. Dr. Forest stated that our intention is not to deny access when appropriate use of narcotics is needed.

Glenda Adams reviewed two graphs. The first graph looked at North Carolina. Medicaid's utilization of narcotics for calendar years 2004 through 2008. The second graph looked at narcotic utilization by Medicaid recipients in the calendar year of 2008. Both graphs included unique Medication Identification (MID) counts, unique prescription counts, claim counts and dollars paid. Dr. Adams also mentioned that the U.S. Government Accountability Office (GAO) recently visited the Division of Medical Assistance (DMA) because North Carolina was one of the top states for dollars spent on Medicaid prescription drugs (not limited to narcotic utilization). According to the GAO data, North Carolina ranked 6th in fiscal year 2007 for total Medicaid spending on prescription drugs (federal plus state portions). States that ranked higher were New York, California, Texas, Florida, and Illinois.

Kay Sanford provided the group with two handouts: "10 Steps of Universal Precautions in Pain Management" and "Areas for discussion by the Task Force to Prevent Drug Abuse, Misuse and Diversion". These were not discussed at the meeting.

Fred Brason, a task force member and the program manager of the Northwest Community Care Network's Chronic Pain Initiative and Project Lazarus in Wilkes County and chair of the Wilkes Healthy Carolinians Council's Substance Abuse Task Force, presented information about Project Lazarus in Wilkes County, N.C. He mentioned that the overdose death rate in Wilkes County is five times the national and three times North Carolina's rate of overdose deaths. Project Lazarus involves both the community and a coalition of departments primarily the County's Health Department, Substance Abuse Task Force and the Chronic Pain Initiative. Designing Project Lazarus involves the following: community knowledge and coalition, surveillance, prevention, rescue, and evaluation. Each step was explained by Mr. Brason. In Wilkes County, there were 15 deaths with opioids in the first 16 weeks of 2009. Four were Medicaid recipients. At death number ten, a health alert was issued to prescribers. The

ages of those who died from opioid overdoses ranged from 22 to 72 years. Seven out of 11 decedents had physician visits with a prescription for an opioid within two weeks of their death. Examiners reported that approximately 80% of North Carolina's fatal poisonings in 2007 were due to narcotics. Because prevention is not always sufficient, the rescue step focuses on prescribing naloxone nasal spray as an antidote for opioid-induced respiratory depression. The target population consists of those who were discharged from an emergency department (ED) for drug overdose (accidental poisoning) or substance abuse, those with a high dose opioid prescription, new methadone prescription, those recently released from jail or a detox program, and those in methadone or buprenorphine treatment program. Those who spent time in jail are ten times more likely to overdose than the general population. Patient education is included in both the prevention and the rescue steps. The final step is evaluation, which comprised of process evaluation (acceptance), outcome evaluation (reduction in ED visits for substance abuse and accidental overdoses and reduction in deaths from unintentional overdoses) through continued surveillance.

Ms. Sanford presented for Bill Bronson slides on The North Carolina Controlled Substance Reporting System—The CSRS. The CSRS requires all dispensers to report all narcotics dispensed to a centralized database. Reporting once a month began July 1, 2007. August 1, 2008, reporting was increased to bimonthly, on the 15th and 30th. Prescribers can access patient controlled substance prescription profiles from the CSRS website. Although there have been over 300,000 requests for data, less than 13% of the state's medical care practitioners with DEA licenses have applied to use the system. Approximately 10-11% of those aged 12 years and older in the U.S. used antipsychotics and pain relievers for nonmedical use in 2002 through 2004. In N.C., majority of those who died from drug overdoses were white males with an average age of 39 years. Based on a 2002 study of medical examiner records of unintentional poisonings, an opioid had been prescribed to about 60-70% of those who died from an opioid overdose. Ms. Sanford also discussed who can gain access to the CSRS as well as the Division of Mental Health's Substance Abuse Services recommendations for the Do's and Don'ts regarding the reporting system.

Dr. Stephanie Christofferson asked if a list of the Network prescribers who do not have access to the CSRS could be provided. Ms. Sanford responded that the CSRS can provide a list of the prescribers who are registered. The Medical Board can provide a list of prescribers who have DEA numbers. Both lists can be compared to see who is not registered with the CSRS. Only 13% of the prescribers in the state are registered with the CSRS.

Dr. Hans Hansen mentioned that there may be more pharmacies who are not reporting to the CSRS than what is thought. Ms. Sanford asked participants to contact Bill Bronson (919.733.1765) at the CSRS if pharmacies are identified that are not reporting narcotics dispensed.

Tara Larson suggested comparing N.C. Medicaid enrolled pharmacy providers against the CSRS database to identify pharmacies not reporting. Ms. Sanford mentioned that North Carolina law mandates that pharmacies report narcotics dispensed to the CSRS database although some pharmacies may not be aware of the law.

Dr. Forest mentioned that a lot of good work has been done in the state regarding this issue; therefore it is not necessary to duplicate what has already been done. Policy can be made on recommendations from the Narcotic Task Force. Ms. Larson suggested linking provider enrollment with policy.

Chris Collins and James Bowman (special agent in charge with the SBI) were two names recommended to contact regarding this task force.

Educating prescribers about the CSRS as well as funding for the education was discussed.

Ms. Sanford offered to write an article to be published in the N.C. Medicaid Bulletin about the Controlled Substance Reporting System.

Ms. Larson asked if the CSRS was receiving any federal match.

The overall goal of the N.C. Narcotic Task Force is to decrease diversion, misuse and abuse of narcotics. The goals need to be further defined as well as possible solutions.

Mr. Brason mentioned that currently with Project Lazarus, the patient is initially referred to a pain clinic. Once the patient is stabilized, referral is then transferred back to the primary care physician.

The additional correspondence and future meeting dates will be via email.

The meeting was adjourned approximately 12:15 p.m.