A Plan to Reduce Narcotics in Mississippi by 20%

The "Randy Plan"

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With my letter from the U.S. Attorney General bulging my shirt pocket and pen in hand, I will briefly propose a plan to de-escalate Mississippi's mounting opioid crisis. I have stumbled upon this plan out of desperation. In my experience, for most problems there is usually a solution, but the one at hand involving opioid abuse has been especially elusive. At the time of the Attorney General's urgent appeal a year ago, results of the opioid epidemic were devastating. Today they are even worse!

Readers of the following proposal are already well aware of the surmounting opioid problems of our state and nation. Overdose deaths involving prescription opioids quadrupled from 1999 to 2015 and so have sales of these prescription drugs. In this period of time, more than 183,000 people have died in the U.S. from overdoses related to prescription opioids with more than 15,000 dying in 2015 alone. Our emergency departments are rampant with drug seekers. It is reported on the CDC website that every day more than 1,000 people are treated in ERs for not using their prescription opioids as directed. In my experience I would expect the number to be much higher.

Overprescribing continues to fuel the opioid epidemic. Today, nearly half of all U.S. opioid overdose deaths involve a prescription opioid. The most common drugs involved in prescription opioid overdose deaths include methadone, oxycodone, and hydrocodone with the highest rates among people between 25 and 54 years. Men have been more likely to die from overdoses, but the mortality gap between men and women is closing.

Mississippi physicians have traditionally been high prescribers of opioids, as have those in many other Southern states. Tennessee, Alabama, and West Virginia often lead nationwide in per capita prescriptions of opioids as well as benzodiazepines, the combination which has proven so deadly in overdoses. There is a wide variation among states with the prescribing rate in Alabama in 2012 being 2.7 times the rate in Hawaii. U.S. prescribers wrote 82.5 prescriptions for opioids per 100 persons in 2012, enough for every adult in the United States to have their own bottle of pills!

Annual CME for prescribers, drug screening, use of the state PDMPs (prescription drug monitoring programs), pain agreements and pill counting have all been admirable exercises and of some benefit but have not put a noticeable dent in the ravaging epidemic of narcotic overuse and overdosing.

In March, 2016 the CDC sent U.S. doctors their excellent and authoritative *Guideline for Prescribing Opioids for Chronic Pain — United States, 2016.* It was posted online as an MMWR (*Morbidity and Mortality Weekly Report*) early release.The information was extremely well researched, compiled, and written and, if followed, it would abruptly end America's opioid epidemic. I have not heard of any documented reduction in opioid prescribing however, and do not expect to, for despite the millions of dollars expended in the preparation of the report, I expect that very few doctors (other than those involved in its preparation) read the 49 pages.

In contrast, my brief proposal, which follows, is guaranteed to reduce narcotic overprescribing and overuse and with the current state of online communications, I believe it is reasonable and will not be overly expensive.

Despite the accurate data obtained and recorded by the state on individual physicians with the PDMPs, because of the many variables it is impossible to say exactly how many prescriptions the "average" physician in Mississippi prescribes. Everyone believes it to be excessive but "how many is too many?" (We consume twice as many opioids per capita as the second ranking nation, Canada.) There is, of course, a wide variation among reasonable physicians and a much greater range when physicians who prescribe more freely are included. Some doctors and practitioners care for an older population or one consisting of more disabled individuals and a variation in practices will have to be taken into account. But with the information already being obtained by the PDMP, it should not be overly difficult to obtain the total and average narcotic prescription rate in the state and calculate reasonable allotments at the 80 percentile for Mississippi's practitioners. If the average is approximately 2,500 narcotic prescriptions per doctor per year, the total allowed could be reduced to 2,000. Each doctor would receive his or her allotment and would be responsible for and allowed to prescribe only that amount.

Only those physicians with significant narcotic prescription use would be affected by the program. Dermatologists, pediatricians and those belonging to some of the other specialties might not need to participate. According to the CDC, primary care providers account for about half of the opioid pain relievers dispensed and it is probably higher in a rural state like Mississippi. Prescribing rates are generally highest among pain medicine specialists, surgeons, and physical medicine/rehabilitation doctors.

Many other factors and problems will arise such as prescribing across state lines, how to deal with physicians overseeing nurse practitioners or covering for other physicians, which narcotics and dosages will be counted, hospital or nursing home use where out-of-state pharmacies might be used, etc. None of these potential problems are insurmountable and all can all be worked out.

In my opinion, it is safe to say that more than 20% of the total prescribed narcotic tablets are not strictly medically indicated, but no one but the prescribing physician or nurse practitioner is in the position to make the individual decisions that add up to the 80%. It is an easy call to hand out a prescription, but often a difficult one to refuse to do so. But substituting a non-narcotic or offering a lesser number of opioid tablets would definitely be easier for a practitioner if only a finite number of dosages were available to be prescribed.

Reducing the flow of these narcotics by this plan should directly reduce the overdose problem. Most of those who abuse prescription opioids get them from a relative or a friend, but those who are at the highest risk of overdose (those using prescription opioids non-medically 200 or more days a year) get them with their own prescriptions (27 percent), from friends or relatives for free (26 percent), buying from friends or relatives (23 percent), or buying from a drug dealer (15 percent). Those at highest risk of overdose are about four times more likely than the average user to buy the drugs from a dealer or other stranger.

This suggested coordinated effort will be somewhat taxing for narcotic control officials, doctors, patients, and pharmacists; but the guaranteed reduction in prescription narcotic abuse and overdoses will be worth the effort. Expect sufficient complaining from all groups involved. Doctors will, by necessity, become more conservative in their prescribing habits as they ensure that a larger percentage of their narcotic prescriptions go to accommodate those with genuine severe pain. Physicians unwilling to change their liberal prescribing habits might discover that their allotment of prescriptions has been expended before year's end and may have to refer their ailing patient to another doctor who has practiced more conservatively. Each month all practicing physicians could review the PDMP website to review his or her total yearly allotment, the amount used that month, and how much remains (so that prescribing behavior could be altered, if needed).

An annual trial run of this 20% plan for narcotic reduction, I believe, is workable and worthwhile and is within the range of the types of programs that the CDC has been so strongly recommending the past couple of years. Their program, *Prescription Drug Overdose: Prevention for States* was developed to help states combat the ongoing prescription drug overdose epidemic. The purpose of *Prevention for States* is to provide state health departments with resources and support needed to advance interventions for preventing prescription drug overdoses. 16 states were selected through a competitive application process to receive funds in September 2015 and an additional 13 states were funded later, allowing the CDC to reach 29 states with programs and strategies to improve safe prescribing practices and help prevent prescription drug overdose and abuse. Mississippi is not on the map of states that were approved for funding!

Through 2019, the CDC plans to give selected states annual awards between $750,000 and $1 million to advance prevention in four key areas:

1. Maximizing Prescription Drug Monitor Programs

(2) Community or Insurer/Health Systems Interventions

(3) State Policy Evaluations

(4) Rapid Response Projects

The *Prevention for States* program includes evaluation of awarded states' program activities to monitor performance, demonstrate effectiveness, and capture success stories. It seems to me that my proposal may be exactly the type of innovative pilot

program that the CDC wishes to fund! Apparently the $750,000 to 1 million is dangling there just waiting for Mississippi officials to make an application.

The CDC lists four states as having reportable successes under the funded programs. Both New York and Tennessee began requiring prescribers to check the state's PDMP before prescribing opioids (apparently Tennessee specified "painkillers".) Tennessee reported a 36% decline in patients seeing multiple prescribers for the same drugs and New York reported a 75% decrease.

Oregon's anti-drug program consisted of establishment of a PDMP, requiring prior authorization for methadone doses, educating lay persons on using naloxone for suspected overdose and physician and allied health care training. This resulted in a 38% decrease in the rate of poisoning due to prescription opioid overdoses and a reduction of the death rate associated with methadone poisoning of 58% between 2006 and 2013.

Florida seems to have had the most success of all the participating states thus far and may have shown the first documented substantial decline in drug overdose mortality in any state in recent years. They used their money to establish a PDMP and began to regulate pain clinics, stopping health care providers from dispensing prescription opioid pain relievers from their offices. Their 2012 result was a 50% decrease in oxycodone overdose deaths!

Why don't we take the dangling CDC money like Florida and the other states did if we can get it? Regardless, let's not let this opportunity slip by! We can prevail with or without the Federal government if we have to. We can all work together toward making Mississippi the state with the 20% reduction in narcotic prescriptions in 2018!

*Other than personal opinions, all facts were obtained from the CDC's website. This plan has been named the "Randy Plan" in honor of Randy Easterling's work on helping reduce narcotics in the State of Mississippi.