

Breakout Group 1:

Standards for Supply Chain (Manufacturer to Pharmacy) Control of Prescription Opioid Diversion

- Chain of custody from manufacturer to patient is huge
 - Where should we focus?
 - What weak links in the chain can be most easily addressed

- Structure program with two arms
 - Supply side
 - Locked boxes
 - Disposal of unused drugs
 - (Smart Rx program underway)
 - Education of physicians
 - Third party reimbursement
 - What practical interventions will address demand side?

1. Locked Boxes

- We have precedents
 - Methadone is kept locked for takehomes
 - Locking liquor
- Purpose of the box directs the type of box
 - Protecting an innocent like a child –prevents accidental dosing
 - Less effective for adolescent or visiting drug seekers

Locked Boxes

- Why? Data clear that:
 - Detering access in homes will reduce casual use
 - Will not deter addicted compulsive
- Caveats
 - If only opioids are in the box does it make it easier to identify where opioids
 - Many drugs can be toxic or alter mood when misused: need to put all drug in box
 - Should it be mandatory or voluntary: agreed voluntary
 - Need to be accessible to people who need drugs, eg easy to open with arthritis – perhaps give 3 choices

Locked Boxes

- Need to build awareness of the need to lock: a public education campaign is needed
 - More specific messages from “keep safe and secure: to “keep locked”.
 - Summary brochure of risks of med misuse when pick up med misuse
 - Posters at pharmacy, office, police stations, schools (?unintended consequences, some kids like risk)
 - Possibly could model a campaign on that of sharps boxes (need to review components of the campaign)

Locked Boxes

- Who is responsible?
 - Pharma should have part of responsibility
 - Pharmacies as site of med dispensing
 - Education
 - Availability of boxes at point of opioid dispensing
 - Maybe clinicians
 - Agreements? Informed consent?

Locked Boxes

- Need to think about outcome measures for this intervention
 - Poison control data
 - Medical exam data
 - National Survey Drug Use Health
 - Measure number of locked boxes sold
- Should be piloted in a small area to demonstrate efficacy

Other Med Limit Alternatives

- Handheld computerized dispensing devices that limit access to drugs and provides clinicians with information on use of meds (GW pharma)
- Tab Safe - Home pixus machines

2. Smart Rx Program

- Pilot 6400 pharmacies in the US
- When script filled for CS drug given one of three messages re:
 - Advising of risk
 - Securing drug
 - Disposal

3. Improve Physician Prescribing

- Educate physicians
 - That they are part of the diversion chain
 - How to limit misuse/addiction/diversion risks
 - Legal aspects of prescribing
 - Actual opioid needs in acute/chronic pain
- Encourage third party payors to pay for
 - Physician time to do more comprehensive pain management
 - Toxicology screens
 - Complementary intervention
- Get physicians to use SOAPP
 - Many studies support efficacy in identifying risk

Mandate Clinician Education?

- Mandate physician CME (+/-controversial)
 - By medical licensing boards
- Tie to Controlled Substance registration/licensing?
 - DEA registration?
 - ? State controlled substances license
 - Yes! Should pilot in several states

4. Change insurance medication reimbursement mechanisms

- Change payments/co-pays to support small frequent scripts and renewals
 - (Adds work at pharmacy level)
 - Would reduce residual meds in acute pain settings
 - Allow greater control in chronic pain
- Pay for
 - Physician time to do more comprehensive management of pain
 - Toxicology screens
 - Non-medication management of pain

