Taneeka Hansen

From: Andrew Elsberg
Sent: Friday, March 04, 2016 12:06 PM
To: Rep. Paul Seaton; Taneeka Hansen
Cc: Jay C Butler; Anne Zink; Carl Heine
Subject: HB 344

Dear Representative Seaton,

I would like to comment on HB 344 on behalf of the Alaska Chapter of the American College of Emergency Physicians. Dr. Anne Zink, Dr. Carl Heine and I have been involved with the Senate version of the bill which has been incorporated into the overall medicaid expansion bill, SB 74.

Thank you for your work to improve the AK PDMP. We are very happy that the importance of this tool has been recognized by so many legislators. The ability to delegate access will help us access the system more often. There are a few changes to the language that we feel would be appropriate to our practice in the ER.

First I would like to let you know how we use narcotic pain medication in the ED. In general we are using IV medication for acute pain control in an injured or ill patient, and we are prescribing short courses (rare to see a prescription for more than 7 days, and most are for 2-5 days) of oral narcotics for pain control during a painful illness or until an injured patient can follow up with orthopedics or the appropriate specialty. All of the ER's in Anchorage have a policy against managing chronic pain from the ER, and those policies include not refilling chronic medication when a patient runs out early or when medications are "lost" or "stolen". I believe this is the case in other parts of the state as well. ER physicians rarely if ever prescribe long acting pain medication. In 2009 approximately 5% of narcotic pain medication was prescribed nationally from emergency departments. While I do not believe there is a magic time at which a patient develops dependence or addiction, a one time short prescription is likely low risk. The times when patients are at risk for developing dependence from ER prescriptions, or that our prescriptions are at risk for diversion tend to be in patients that are visiting the ER multiple times, especially in patients with subjective complaints.

The current system unfortunately takes about 3-4 minutes for me to look up a patient. When our ER (I work at Providence in Anchorage) is busy, which is most of the time, I am looking to be as efficient as possible, to keep patients from waiting too long, to make sure we see the critical patients quickly, and to keep a patient visit from getting longer than it needs to be. Every member of the staff is maxed out when we are busy, and while delegating PDMP access is helpful, there are times I simply can not add a task to others on the staff. I order only the tests I truly feel I need to order, and in the same vein I only want to access the PDMP when I really need to. 3-4 minutes per patient times 10 patients is 30-40 minutes, thats equivalent to getting 2 patients seen and work up started. So a seemingly small amount of time in our environment adds up quickly.

When I see a patient with a broken leg verified by exam and X-ray I don't feel I need to access the database prior to writing them for 3-5 days of a narcotic pain medication. When I see a patient with a subjective complaint, for whom "ibuprofen doesn't work", things like back pain, dental pain, abdominal pain etc, I absolutely feel I should look that patient up. When a patient has been in the ED more than once for an injury, or a chronic complaint I look the patient up. But I (and my colleagues) are opposed to a mandatory look up because in a busy ER that time is not available. Emergency Physicians who work in more rural places have also pointed out that they have had trouble accessing the system due to internet outages or slow internet. There are times that the PDMP is unfortunately not available to these clinicians.

When I see examples of legislation from other states they have addressed this in a number of ways. Some have an exception for drug administration or prescription »in an emergent situation«. Others have a cutoff, Ohio allows prescriptions less than 7 days to be written without mandatory look up. Some states have chosen to have no mandatory look up. In our environment we truly need the flexibility to use the database only when clinically necessary (subjective complaints, repeat visits, frequent visitors, patients with substance abuse issues and pain).

The way the bill is currently written it is unclear to me if the administration of medication in the ER is included.

From Section 5 "(A) access the database to check a patient's prescription records before dispensing a controlled substance to the patient;"

We are often actively managing an unstable patient or agitated patient before accessing the medical record. Review of the database prior to administration of medication in the ED, ICU, or by EMS, flight services or any other emergent administration should not be covered by the bill.

Alaska ACEP is working with ASHNHA to improve communication between ER's using an ED information exchange (EDIE). This allows a physician to see a patients visits to other emergency facilities in the state, in real time. In Washington state this system also automatically pushes PDMP information. We would like to see such a system in Alaska, although we do understand that adding an administrative cost to the state would likely be prohibitive (despite the later savings from such a system). EDIE that pushes PDMP information when a patient registers at an emergency department would streamline this process. Language to implement an EDIE is included currently in SB74. EDIE has been an important part of Washington states' 7 best practices initiative to save money from repeat evaluations, improve coordination of care and decrease abuse and misuse of narcotics.

Thank you very much for your work to improve the PDMP. As an emergency physician who has faced multiple families following a fatal or life altering overdose I am very glad you are addressing this issue. I hope you do not perceive our input on mandatory review as a lack of perspective on the problem. I treat the complications of IV drug abuse almost every shift. I use the database every shift. I have decreased my narcotic prescribing, and put up with patient complaints to the hospital administration for not prescribing for chronic pain. My goal is only to let you know what being required to review every patient looks like in a real world busy ED.

Respectfully,

Andrew Elsberg, MD

AK Chapter of American College of Emergency Physicians Board
EM Physician Providence Alaska Medical Center
206-661-8942 (c)