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Health Department announces updated drug overdose numbers

PMP data show amount and volume of prescribed controlled substances is not decreasing

PROVIDENCE – The Rhode Island Department of Health (HEALTH) recently reported the latest numbers on apparent accidental drug overdose deaths, use of Narcan by Rhode Island Emergency Medical Services, and prescribed controlled substances.

Since January 1, 2014, there have been 162 apparent accidental drug overdose deaths, nine of which occurred in the month of October.

Of the total number of apparent accidental drug overdose deaths since January 1, 2014, 141 (90%) of the screened cases involved at least one opioid or medication. At least 59 (38%) of the screened cases involve fentanyl that appears to have come from an illicit source.

These apparent accidental drug overdose deaths have taken place in 30 different cities and towns in Rhode Island affecting men and women of all ages and ethnicities:

115 men and 47 women ranging in age from 20 to 65: 31 people in their twenties, 48 people in their thirties, 37 people in their forties, 40 people in their fifties, and 6 people in their sixties; 148 people were white, 13 were black, and 1 was Asian.

Since January 1, 2014, Rhode Island Emergency Medical Services (EMS) has administered 1267 doses of Narcan. From April 2–October 14, emergency departments in Rhode Island have administered Narcan 87 times.

Data from Rhode Island's Prescription Monitoring Program (PMP), which are available to the public on the Department's website, continue to demonstrate that the amount and volume of prescribed controlled substances is not decreasing. In September, 116,383 individuals filled a prescription for a schedule 2, 3, or 4 drug in Rhode Island. Likewise, in September alone, 1.16 million doses of stimulants, 1.6 million doses of schedule 2 pain medicines, and 5.4 million doses of benzodiazepines were prescribed.

"It is clear that Rhode Island continues to experience a prescription drug and street-drug overdose crisis. Despite all of the media attention and the increased focus in the medical community, overdoses and over-prescribing are still happening. This is still a major crisis and we need to continue to put forth our state's best effort to combat addiction and overdose deaths," said Michael Fine, MD, director of the Rhode Island Department of Health. ❖

Health Department awarded $3.5M to target chronic diseases

New program addresses obesity, diabetes, heart disease, and stroke

PROVIDENCE – The Rhode Island Department of Health was awarded a grant of $3.5 million to support implementation of population-wide and priority population approaches to prevent obesity, diabetes, and heart disease and stroke, and reduce health disparities in these areas among adults on a statewide basis.

The State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease awards are part of a U.S. Department of Health and Human Services (HHS) initiative to support public health efforts to reduce chronic diseases, promote healthier lifestyles, reduce health disparities, and control health care spending. The Centers for Disease Control and Prevention will administer the grants, which will run for 4 years, subject to availability of funds.

Overall, HHS awarded $69.5 million in new grant awards to 21 state and large-city health departments to prevent obesity, diabetes, heart disease, and stroke and reduce health disparities among adults through combined efforts of communities and health systems. The State and Local Public Health Actions awards are financed by the Prevention and Public Health Fund of the Affordable Care Act. This new program complements and expands on a state-level program, State Public Health Actions, that began in 2013.

States will sub-award half of their funds to support activities in four to eight communities each. Community approaches will build support for lifestyle change, particularly for those at high risk, to prevent diabetes, heart disease, and stroke. Health system efforts will focus on linking community programs to clinical services for populations with the largest disparities in high blood pressure and pre-diabetes.

Specifically, the work that communities will do to have a statewide impact will be to employ strategies that promote health, support and reinforce healthful behaviors, and build support for healthy living for the general population and particularly for those with uncontrolled high blood pressure and those at high risk for developing type 2 diabetes. Priority populations include people with racial/ethnic or socioeconomic disparities, including inadequate access to care, poor quality of care, or low income.

"Achieving the best preventive health care is vital to successful health outcomes. Primary care providers supports the work of the health care system through provision of services such as mammography and tobacco cessation counseling for underserved populations, work on issues of health care access, planned care, self-management, patient navigation, and quality prevention services. Through community-based public health efforts that support intensive and sustained interventions that include health care settings, together we can improve population health outcomes," said Michael Fine, MD, Director of Health. "In this country, chronic diseases such as heart disease, cancer, and diabetes are the leading causes of death, disability, and health care costs, accounting for 7 of 10 deaths among Americans each year, and more than 80 percent of the $2.7 trillion our nation spends annually on medical care." ❖

Hydrocodone reclassified as a Schedule II Medication

PROVIDENCE – The R.I. Dept. of Health recently announced that hydrocodone, an opioid-type medication, was reclassified as a Schedule II medication effective October 6, 2014.

Hydrocodone and all its combinations collectively represented the most popular pain medication prescribed in Rhode Island. Vicodin is a common brand name that contains hydrocodone. A review of 2013 data reveals there were more than 22.6 million doses filled. Schedule II medications have stricter regulation, reflective of the increased risk these medications have.

A summary of some of the rules surrounding all schedule II medications:

- The prescription must be written and signed by the prescriber.
- The prescription cannot have refills.
- The prescription is not valid after 90 days from the date it was written.
- A verbal prescription is allowed only in emergency situations and a written prescription must follow within seven days. (The pharmacist will notify the Drug Enforcement Agency if a written prescription is not received.)
- Faxed, original prescriptions are only allowed for:
  Home infusion/IV pain therapy
  Long-term-care facilities
  Hospice/terminally-ill patient
- Prescriptions have the following quantity limitations:
  30-day supply

Practitioners may write up to three separate prescriptions (each for up to a one-month supply) and each prescription must be signed and dated on the date they were originally written. In addition, the practitioner must write the earliest date each of those subsequent prescriptions may be filled, with directions to the pharmacist to fill no earlier than the date specified on the face of the prescription.

These are not all the rules surrounding hydrocodone and its varying combinations; however, prescribers will be responsible for following all of the rules when prescribing hydrocodone.

It is likely this will have a significant impact on office practices as schedule II prescriptions cannot be phoned in to a pharmacy. HEALTH encourages e-Prescribing of Schedule II medications for safety and security. ❖

Kent launches colorectal robotic surgery service

PROVIDENCE – Care New England recently launched a new colorectal robotic surgery service at Kent Hospital.

CHARLES RARDIN, MD, director of minimally-invasive surgery (MIS) at Care New England, said, "Our program is designed to bring the benefits of MIS, which include shorter hospitalization, less pain, quicker recovery and reduction in some complication rates, to a wider group of people. The new technologies such as Firefly imaging, offer promise in the safety and efficiency of gallbladder removal, as well as in several different forms of surgery for cancer care."

Recent advances include a successful launch of a colorectal robotic surgery service at Kent, under the direction of **MELISSA MURPHY, MD,** who completed a colorectal fellowship at Brigham and Women's Hospital in Boston.

Kent is only the second hospital in New England and the first in Rhode Island to utilize a fully robotic stapling device in colorectal surgery. This technological advancement overcomes several limitations of traditional handheld stapling devices and promises fewer complications after surgery. Earlier this year, Care New England also launched a robotic cholecystectomy program for gallbladder removal at Kent.

After installing its da Vinci surgical robot last year, Kent has quickly established a ground-breaking robotics service. Surgeon **JOSEPH BRADY, MD,** became the first in Rhode Island to perform a single site gallbladder removal, allowing the entire procedure to be done through one small incision in the belly button. In addition, Dr. Brady and **BRIAN REED, MD**, became the first in Rhode Island to complete several other surgical procedures robotically, including: Nissen Fundoplication, for gastroesophageal reflux disease (GERD); inguinal hernia repair; and ventral hernia repair. ❖

OHIC awarded $1.1M rate review grant

CRANSTON – The Office of the Health Insurance Commissioner (OHIC) is one of 21 states that have been awarded a $1.1 million "Grant to States to Support Health Insurance Rate Review and Increase Transparency in the Pricing of Medical Services, Cycle IV" from the Center for Consumer Information & Insurance Oversight (CCIIO).

This funding opportunity will allow OHIC to continue to enhance and institutionalize Rhode Island's rate review program, as well as coordinate and streamline efforts to improve price transparency, and increase its ability to analyze vital information about the health care system.

Specific projects OHIC will execute are effective rate monitoring and market conduct review programs; standardization of issuer price transparency requirements; coordination of rate review with form review; increased form transparency and consumer support; and expansion of the All Payer Claims Database (APCD) analytic and reporting activities.

"Rate Review Cycle IV Grant funding will provide needed support as OHIC works to enhance the effectiveness of our rate review process, as well as increase our capacity to collect, analyze, and report relevant data," said Health Insurance Commissioner, Dr. Kathleen Hittner.

With this latest $1.1 million award, Rhode Island has been awarded a total of $8.6 million from the CCIIO Rate Review Grants. ❖

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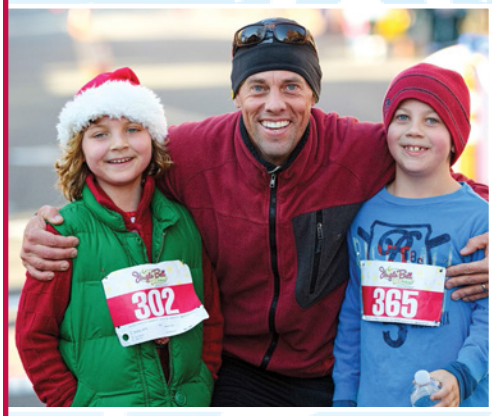

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Urologist Mark Sigman, MD, addresses FDA panel on testosterone replacement therapy

Advisory panel voted nearly unanimously to tighten regulation of multibillion-dollar testosterone industry; recommended studies to demonstrate benefit, safety of testosterone-replacement products

PROVIDENCE – **MARK SIGMAN, MD**, chief of urology at The Miriam and Rhode Island hospitals, co-director of the Men's Health Clinic at The Miriam Hospital, and chief of urology at The Warren Alpert Medical School of Brown University, spoke about hypogonadism last month at a joint meeting of the Bone, Reproductive and Urologic Drugs Advisory Committee and the Drug Safety and Risk Management Advisory Committee.

The combined United States Food and Drug Administration (FDA) advisory panel, whose advice the FDA often follows, gathered to discuss who should receive testosterone replacement therapy, as well as the potential for cardiovascular risk related to the therapy. The FDA has been exploring the risk of stroke, heart attack and death among men taking FDA-approved testosterone products in response to conflicting studies examining the cardiovascular risks in men undergoing testosterone therapy.

"The first testosterone product, which appeared in the 1950s, was prescribed for patients with 'Classic' Low T (testosterone) – hypogonadism due to known underlying medical conditions," Dr. Sigman says. "At that time, drug companies had only to show that testosterone products raised testosterone – not that they improved symptoms. Since then, in spite of the surge in testosterone replacement therapy for Low T, there haven't been any major changes to the indications for the use of testosterone products – so this is a significant industry development."

Among the advisory panel's recommendations in the almost unanimous committee vote were making changes to what has been called vague testosterone-replacement product labels to address the increasingly prevalent use of testosterone for hypogonadism related to aging – or Andropause – Low T due to decreased T production that accompanies aging. The number of testosterone prescriptions has increased approximately eight-fold since 2000. The panel also voted at the meeting to require drug makers to conduct tests or studies to assess the cardiovascular risk related to use of testosterone drugs.

Testosterone deficiency (TD) indicates a low testosterone level in the blood. Hypogonadism indicates a low testosterone level in the presence of symptoms of low testosterone. Testosterone deficiency afflicts approximately 20 to 30 percent of men ages 40-79 years old, with an increase in prevalence strongly associated with aging and common medical conditions including obesity, diabetes and hypertension.

Dr. Sigman's presentation about hypogonadism to the FDA panel focused on what male age-related hypogonadism is and how to diagnose it; the difference between age-related and classical hypogonadism; the reasons behind diagnosing and treating hypogonadism; and the risks of testosterone treatment for hypogonadism. Dr. Sigman spoke about symptoms, indications for treatment, and how all guidelines require symptoms of hypogonadism. He also discussed how Low T alone is insufficient without symptoms – and how the prevalence of Low T (by blood test alone) is greater than the prevalence of hypogonadism (Low T plus symptoms of Low T). While there are a variety of types of testosterone measurements (total testosterone, free testosterone, and bioavailable testosterone), Dr. Sigman says most studies and guidelines are based on Total T.

Dr. Sigman received his medical degree from University of Connecticut School of Medicine. He is a nationally recognized expert on male infertility and sexual dysfunction with over 25 years of experience in the diagnosis and treatment of urologic and reproductive problems. ❖

LIFESPAN

Dr. Sigman's conclusions presented to the panel

- Clinical hypogonadism is common.
- Many symptoms and co-morbidities are associated with low testosterone.
- Criteria for who to treat is controversial, as it's difficult to clearly separate those who benefit from those who don't.
- Reasonable evidence exists that treatment is beneficial for some with either classical or age-associated hypogonadism.
- Long-term safety will not be determined without large clinical trials.

Bradley Hospital study finds sleep difficulties common among toddlers with psychiatric disorders

PROVIDENCE – **JOHN BOEKAMP, PHD,** clinical director of the Pediatric Partial Hospital Program (PPHP) at Bradley Hospital recently led a study that found sleep difficulties - particularly problems with falling asleep - were very common among toddlers and preschool-aged children who were receiving clinical treatment for a wide range of psychiatric disorders. The study, titled "Sleep Onset and Night Waking Insomnias in Preschoolers with Psychiatric Disorders," is now published online in the journal *Child Psychiatry & Human Development*.

"The most common sleep difficulties reported nationally for toddlers and preschoolers are problems of going to bed, falling asleep and frequent night awakenings – collectively, these problems are referred to as behavioral insomnias of childhood," said Boekamp. "Sleep problems in young children frequently co-occur with other behavioral problems, with evidence that inadequate sleep is associated with daytime sleepiness, less optimal preschool adjustment, and problems of irritability, hyperactivity and attention."

Boekamp's team was interested in learning more about sleep and sleep problems in young children with behavior problems, as early sleep problems may be both a cause and consequence of children's difficulties with behavioral and emotional self-regulation. "Essentially, these young children might be caught in a cycle, with sleep disruption affecting their psychiatric symptoms and psychiatric symptoms affecting their sleep-wake organization," said Boekamp.

"This study is a great reminder that it's critical for mental health providers working with young children and their families to ask about children's sleep," he said. "Simple questions about children's sleep patterns, including how long it takes a child to fall asleep at night and how frequently a child awakens after falling asleep, may yield important information that is relevant to clinical care, even when sleep problems are not the primary focus of treatment." ❖

Blue Cross & Blue Shield of RI, CNE launch Maternity Care Initiative

PROVIDENCE – Blue Cross & Blue Shield of Rhode Island, Care New England, and its employed and interested community physicians recently announced the first phase of an initiative providing an integrated care model and innovative payment model for obstetrical patients.

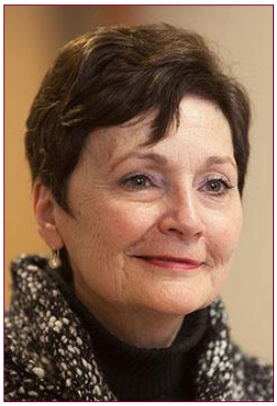
According to **MAUREEN G. PHIPPS, MD**, chief of the department of Obstetrics and Gynecology at Women & Infants, "Providers across our community embrace and adopt best practices and protocols for obstetrics. The initiative with Blue Cross offers a unique opportunity to engage a broader range of partners in the establishment and adoption of community-wide clinical best practices."

"This program is unique in that the architects include physicians, a health care system and a health insurer," said Dennis D. Keefe, president and CEO of Care New England. "The fact that this group produced a new care delivery and payment model is strong testament to the commitment, trust and transparency of all involved."

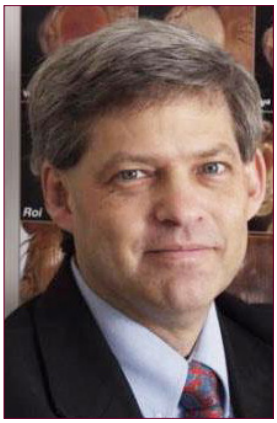
Phase I of the program will focus on the family's experience at Women & Infants Hospital at the time of delivery and the six weeks following delivery; it will include providing an increased level of service in the transition from hospital to home, post-delivery nursing visits, more intensive focus on support of the new family unit, such as family planning and depression screening, as well as education and screening for long-term risks associated with gestational diabetes. Phase II is expected to focus on developing evidence-based care protocols to manage prenatal care.

"This initiative is the best example we have in Rhode Island to date of providers, from the hospital system and from the community, working together to improve on the already strong care model for a population of very important patients. This combined with a new payment methodology that incents an evidence-based, best practice approach to maternity care is just the beginning of larger changes in health care delivery and financing that Blue Cross and all of our provider partners are working toward," said Peter Andruszkiewicz, president and CEO for BCBSRI. "In this new model, the patient is at the center, care teams are coordinated and far more integrated and payment arrangements provide financial incentives for the health of populations."

This program grew out of a long-term strategic partnership between BCBSRI and CNE that launched in 2012. Phase I of this two-part program will launch January 1, 2015 and Phase II will be developed in 2015. ❖



Terrie Fox Wetle, PhD



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Stephen Helfand, MD

American Federation for Aging Research to honor Drs. Wetle, Helfand

PROVIDENCE — **TERRIE FOX WETLE, PhD**, dean of the Brown School of Public Health, and **STEPHEN HELFAND, MD**, professor of biology, will receive awards from the American Federation for Aging Research (AFAR) on Nov. 7 at the annual scientific meeting of the Gerontological Society of America.

Dr. Wetle will receive the federation's Irving S. Wright Award of Distinction, named in honor of AFAR's founder and recognizes exceptional contributions to basic or clinical research in the field of aging. Dean Wetle studies end-of-life care, ethical issues in geriatrics, and promoting health of aging populations. In bestowing the award, AFAR recognized her for "leadership that significantly helped translate biomedical research into public health initiatives."

In a Brown press release, Dr. Wetle said, "I am honored to receive an award named for Irving Wright who was not only an award-winning cardiovascular researcher, but who also had the foresight to launch a foundation to support basic research on aging. His research contributed to our understanding of anticoagulant therapies by translating basic science into clinical applications. In his memory, my Wright Award lecture will focus on translating research to improve health of older populations."

Dr. Helfand, professor of biology in the Department of Molecular Biology, Cellular Biology, and Biochemistry, will receive the Glenn/AFAR Breakthrough in Gerontology (BIG) Award, which AFAR says provides "timely support to a small number of research projects that are building on early discoveries that show translational potential for clinically-relevant strategies, treatments, and therapeutics addressing human aging and health span."

Sponsored by The Glenn Foundation for Medical Research in collaboration with AFAR, two BIG Awards at $100,000 are given annually, selected through a review process led by committee members from leading research institutions nationwide.

Dr. Helfand said he will use the award for research he is conducting with John Sedivy on how DNA changes with age, sometimes liberating harmful "transposable elements" within our genomes. They are looking to reverse those age-related changes in repressive chromatin to suppress the expression and mobilization of transposable elements in order to extend healthy life span. ❖

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