Prevention Status Report for Hawaii

Prescription Drug Overdose

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About the Prevention Status Reports

The Prevention Status Reports (PSRs) highlight—for all 50 states and the District of Columbia—the status of public health policies and practices designed to address the following important public health problems and concerns:

- Alcohol-Related Harms
- Food Safety
- Healthcare-Associated Infections
- Heart Disease and Stroke
- HIV
- Motor Vehicle Injuries
- Nutrition, Physical Activity, and Obesity
- Prescription Drug Overdose
- Teen Pregnancy
- Tobacco Use

PSR Framework

Each report follows a simple framework:

- Describe the public health problem using public health data
- Identify potential solutions to the problem drawn from research and expert recommendations
- Report the status of those solutions for each state and the District of Columbia

Criteria for Selection of Policies and Practices

The policies and practices reported in the PSRs were selected because they—

- Can be monitored using state-level data that are readily available for most states and the District of Columbia
- Meet one or more of the following criteria:
  - Supported by systematic review(s) of scientific evidence of effectiveness (e.g., The Guide to Community Preventive Services)
  - Explicitly cited in a national strategy or national action plan (e.g., Healthy People 2020)
  - Recommended by a recognized expert body, panel, organization, study, or report with an evidence-based focus (e.g., Institute of Medicine)

Ratings

The PSRs use a simple, three-level rating scale—green, yellow, or red—to show the extent to which the state has implemented the policy or practice in accordance with supporting evidence and/or expert recommendations. The ratings reflect the status of policies and practices and do not reflect the status of efforts of state health departments, other state agencies, or any other organization to establish or strengthen those policies or practices.

Suggested Citations

For a state report:

Centers for Disease Control and Prevention. Prevention Status Reports: [State name]. Atlanta, GA: US Department of Health and Human Services; 2016. Accessed [month date, year].

For the National Summary:

Centers for Disease Control and Prevention. Prevention Status Reports: National Summary. Atlanta, GA: US Department of Health and Human Services; 2016. Accessed [month date, year].

Public Health Problem

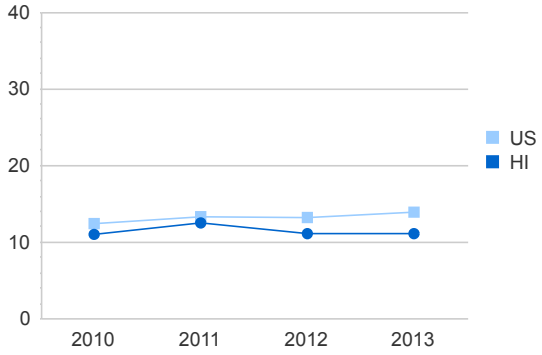
Opioid pain relievers, such as oxycodone, hydrocodone, fentanyl, and hydromorphone, are responsible for three-fourths of all prescription drug overdose deaths and caused more than 16,200 deaths in the United States in 2013 (1). Nationally, deaths involving opioids have quadrupled since 1999 (1).

The sharp rise in prescription opioid overdose deaths closely parallels an equally sharp increase in the prescribing of these drugs. Opioid pain reliever sales in the United States quadrupled from 1999 to 2010 (2).

The severity of the epidemic varies widely across US states and regions. For example, the state with the highest drug overdose death rate has a rate more than 10 times that of the state with the lowest rate. Hawaii's drug overdose death rate for 2013 (11per 100,000 population) is below the national rate (13.8 per 100,000 population) (1).

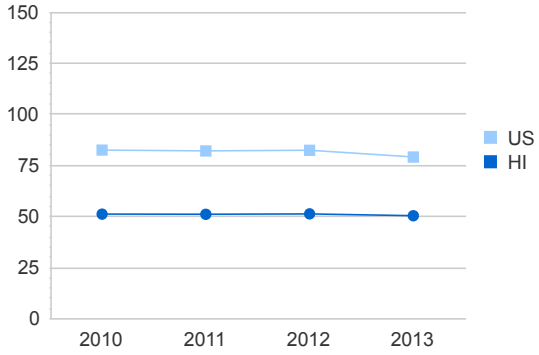
The epidemic of prescription drug overdose imposes a major financial toll nationally and at the state level. The societal costs of prescription opioid abuse were estimated to exceed $55 billion in 2007, including workplace, healthcare, and criminal justice expenses (3). Prescription drug overdose also burdens state Medicaid programs, with prescription opioid abuse costing state Medicaid programs an estimated $8 billion (3).

Drug overdose death rate (age-adjusted per 100,000 population)



Source: National Vital Statistics System (1)

Projected rate of opioid pain reliever prescriptions distributed by retail pharmacies (per 100 population)



Source: IMS Health (4)

Solutions and Ratings

CDC and other agencies continue to identify and evaluate interventions to reduce prescription opioid overdose deaths. This report focuses on two key policies concerning state prescription drug monitoring programs (PDMPs), electronic systems that track the dispensing of controlled substances to patients. The following policies are supported by emerging evidence, expert consensus, and extensive review of the primary drivers of the epidemic (5–7):

- Requiring timely data submission to the PDMP
- Requiring universal PDMP use by prescribers

These policies are especially promising but are not the only interventions needed to address this epidemic. Rather, they should be seen as key pieces in a much larger, multisector approach to preventing prescription drug abuse and overdose. Other important PDMP practices for states to consider include ensuring that their PDMP 1) is easy to use and access (e.g., by allowing delegates of the provider to access the system); 2) can be linked to electronic health records for point-of-care decision making by providers; 3) is accessible to public health agencies for tracking trends; and 4) has the capacity to proactively notify users of high-risk behaviors (5). Also, the Department of Health and Human Services outlines three priority areas to advance a comprehensive approach to reversing the epidemic: improving opioid prescribing practices, expanding use and distribution of naloxone, and expanding medication-assisted treatment to reduce opioid use disorders and overdose (6).

Status of Policy and Practice Solutions

Requirement for timely data submission to prescription drug monitoring program

State-required interval between dispensing a controlled substance and submitting the dispensing data to the state PDMP.

As of July 31, 2015, Hawaii required that dispensing data be submitted to the PDMP within 7 days (8).

Rating	State dispensing data submission requirement
Green	Within 24 hours
Yellow	**More than 24 hours but within one week**
Red	More than one week OR no reporting requirement

Requiring timely submission of drug dispensing data to PDMPs is an important policy to enable informed prescribing and help identify questionable activity (5). When pharmacists dispense controlled substances to patients, they have to enter the prescription into the state PDMP system. However, states vary in how quickly they require pharmacies to submit these data to the PDMPs. Required intervals can range from one month to one day or even "real-time" (i.e., less than five minutes). When there is a significant time lag between dispensing a prescription and submitting data to the state PDMP, providers and other PDMP users lack information about patients' most recent prescriptions. Delayed data submission reduces the usefulness of the prescription history data and has implications for patient safety and public health.

How This Rating Was Determined

The rating reflects data provided by the National Alliance of Model State Drug Laws about state legal requirements for the timeliness of data submission to the state PDMP. CDC translated this information into a rating for each state. The rating does not reflect how fully the state has carried out the law. The "as of" date referenced—July 31, 2015—is the date CDC assessed the law. The date does not reflect when the law was enacted or became effective.

Requirement for universal use of state prescription drug monitoring program

State requirement that prescribers must consult the patient's PDMP history before initially prescribing opioid pain relievers and benzodiazepines, and at least every three months thereafter.

As of October 31, 2015, Hawaii did not require prescribers to consult the PDMP before initially prescribing opioids (9).

Rating	State PDMP use requirement
Green	Prescribers are required to consult the PDMP before initial opioid and benzodiazepine prescriptions and at least every three months thereafter
Yellow	Prescribers are required to consult the PDMP before initial opioid prescriptions and again within one year
Red	**Prescribers are not required to consult the PDMP before initial opioid prescriptions, OR such a requirement does exist but there is no required subsequent check and/or the policy includes subjective standards or broad exceptions**

PDMPs are promising tools, allowing healthcare providers to see patients' prescription histories to inform their prescribing decisions. However, a PDMP is useful to healthcare providers only if they check the system before prescribing, and checking the PDMP prior to prescribing opioid pain relievers and benzodiazepines is particularly important. States have sought to increase PDMP use by requiring providers to consult the PDMP before initially prescribing opioids and benzodiazepines. These policies have significant potential for maximizing the usefulness and promise of PDMPs as a clinical decision support tool (7,10).

How This Rating Was Determined

The rating reflects data provided by the National Alliance of Model State Drug Laws and the PDMP Center of Excellence at Brandeis University about state laws requiring prescriber use of state PDMPs. CDC translated this information into a rating for each state. The rating does not reflect how fully the state has carried out the law. The "as of" date referenced—July 31, 2015—is the date CDC assessed the law. The date does not reflect when the law was enacted or became effective.

For the purposes of this report, a law was deemed to "require" a PDMP check when it applied to most or all prescribers. To be rated green, a state's policy must have required a check for both opioid and benzodiazepine prescriptions; to be rated yellow, the requirement must have applied to at least opioid prescriptions.

Laws were considered to be requiring a PDMP check even if they had limited exceptions to the requirement (e.g., exempting prescriptions written in emergency departments) or if they exempted short prescriptions (i.e., lasting less than seven days). Laws that applied only to limited classes of providers (e.g., only opioid treatment programs or pain clinics) or that had overly broad exceptions (e.g., exempting prescriptions lasting 90 days or less), were not deemed as requiring PDMP checks in this report and were rated as red. In addition, laws in which the requirement depended on a subjective standard (e.g., the provider was required to check the PDMP only when having a reasonable belief of inappropriate use by the patient or only when treating chronic pain) were rated red.

References

1. CDC. CDC WONDER Multiple Cause of Death data, 1999–2013.
2. CDC. Vital signs: overdoses of prescription opioid pain relievers—United States, 1999–2008 (http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6043a4.htm). MMWR 2011;60:1487–92.
3. Birnbaum HG, White AG, Schiller M, et al. Societal costs of prescription opioid abuse, dependence, and misuse in the United States (http://www.ncbi.nlm.nih.gov/pubmed/21392250) (//www.cdc.gov/Other/disclaimer.html). Pain Medicine 2011;12(4):657–67.
4. IMS Health. National Prescription Audit. Unpublished data; 2015.
5. Clark T, Eadie J, Knue, P, et al. Prescription Drug Monitoring Programs: An Assessment of the Evidence for Best Practices (http://www.pdmpexcellence.org/sites/all/pdfs/Brandeis_PDMP_Report.pdf) (//www.cdc.gov/Other/disclaimer.html). Waltham, MA: Prescription Drug Monitoring Center of Excellence, Brandeis University; 2012.
6. US Department of Health and Human Services. ASPE Issue Brief: Opioid Abuse in the U.S. and HHS Actions to Address Opioid-Drug Related Overdoses and Deaths (http://aspe.hhs.gov/basic-report/opioid-abuse-us-and-hhs-actions-address-opioid-drug-related-overdoses-and-deaths) (//www.cdc.gov/Other/disclaimer.html). Washington, DC: US Department of Health and Human Services; 2015.
7. Prescription Drug Monitoring Center of Excellence, Brandeis University. Mandating PDMP Participation by Medical Providers: Current Status and Experience in Selected States (http://www.pdmpexcellence.org/sites/all/pdfs/COE_briefing_mandates_2nd_rev.pdf) (//www.cdc.gov/Other/disclaimer.html). Waltham, MA: Prescription Drug Monitoring Center of Excellence, Brandeis University; 2014.
8. National Alliance of Model State Drug Laws. Unpublished data; 2015.
9. National Alliance of Model State Drug Laws and the PDMP Center of Excellence at Brandeis University. Unpublished data; 2015.
10. Freeman PR, Goodin A, Troske S, et al. Kentucky House Bill 1 Impact Evaluation Prepared for the Kentucky Cabinet for Health and Family Services (http://www.chfs.ky.gov/NR/rdonlyres/8D6EBE65-D16A-448E-80FF-30BED11EBDEA/0/KentuckyHB1ImpactStudyReport03262015.pdf.) (//www.cdc.gov/Other/disclaimer.html). Lexington, KY: University of Kentucky; 2015.