prescribers of Controlled Substances. Tennessee's guidelines for prescribing opioids suggest that a prescriber not prescribe over 120 morphine equivalent daily dose. However, looking at the CSMD which is our prescription drug monitoring program, we call it the Controlled Substance Monitoring Program, showed that the top prescribers were prescribing as many as 500 MEDDs, and up to 700. So let's see, what does that represent in terms of pills, something that you might be able to identify with if you've ever had a prescription for a narcotic? At the recommended maximum dose for a primary care provider to prescribe would be hydrocodone, the 10 milligram tablet could have 12 pills in a day with percocet oxy, 8 pills per day. The CSMD revealed that these top prescribers were prescribing as many as or more than 50 hydrocodone tablets for a day for a patient, or 33 percocet. And this wasn't just an isolated handful of people that were prescribing at this level. And for many of us, that dosage would represent lethal dosages, and lead us to believe that the patients were probably not ingesting those medications. Now we looked at our top 50 prescribers who were prescribing the highest MMEs and looked at them and compared them with the DEA registrants. So we found that even though only 22% of the DEA registrants were APRNs, they were prescribing 64%, or almost three times the number of...they were very overrepresented in prescribing the controlled substances. Another red flag was the in-patient hospitalizations for Neonatal Abstinence Syndrome in Tennessee in this. There was a five-fold increase in this 10-year period with almost a thousand cases in 2014, the last year that we have the figures. Drug overdose deaths were also alarming, and we had 1,263 deaths of Tennesseans and that represents more than three deaths per day. It's more than car accidents and gun in Tennessee. We like our guns. Well, these stats and of course many others is just a sampling. I got the attention of our state legislature as well as the boards. And the legislature acted to pass the Prescription Safety Act of 2012 that required registration rather than being voluntary. It mandates a query before an initial prescription of an opioid or a benzo. The dispenser, the pharmacist must identify the method of payment, because as we heard vesterday about cash payments can be suspect. And the pharmacy had to report the prescriptions within seven days, that's now a daily reporting. But at 2012, it was every seven days, and it authorized data sharing. The next act, the Addison Sharp Act of 2013 mandated that chronic treatment guidelines be developed and updated annually, and this has been done with a interdisciplinary panel of experts. The Chronic Pain Guidelines were to be adopted as policy by the prescribing boards, and that this would be the chosen policy rather than rule. I don't know about your state, but rulemaking, we have way less flexibility in... I don't know. We'd probably be still waiting for these to be adopted. And the guidelines needed to be disseminated to the licensees through various sources such as newsletters. And in fact, we've used symposia, face to face contact with patients. And it required two CEs in controlled substance prescribing that had to include

form and the instructions. Our instructions, I don't know if you all ever felt the same way, but people just don't know how to fill out. They don't read the instructions, so we thought if you say it more than once in a little bit different way that some person will get the idea. Well, we

Guidelines. We stepped up email push notifications to our APRNs regarding these new	

You covered a tremendous amount of information in a very short time. I have one big question. though. Who funds this? Does your legislature provide some means for the budget, or anything like that, in order to do this? Our Prescription Monitoring Program in Virginia is entirely funded, right now, because of a Purdue Pharma lawsuit. And the money that's left over from that is what's funding that. So I'm interested to hear if Tennessee is having a broader perspective on it? - Our CSMD is funded by the Prescribing Boards. And it's done in proportion to the...of the number of prescribers. And then, the other efforts, we've just taken on as just part of our workload. - Thank you so much. - You're welcome. Thank you. - [Woman] A very insightful presentation. Thank you. When you do your audits of APRNs, what are you using as your definition of overprescribing? - Well, we're not auditing for overprescribing. We're auditing to see that the person has dotted the I's and crossed the T's. We're auditing for, is there a notice, a current notice in formulate? We don't know where a person's practicing. So the only way that we would know that the notice...that the formulary is current is, if we ask for that in the audit. And we're asking for the...who is your supervising physician? And then, we make sure that we update that online, and for the record, and the formulary of course. We're auditing for the continuing education. If they have not done that, we offer them, "Well, where are the next symposia? Where are you? Here's our schedule. Be there, and submit that documentation, and we'll close out your audit." And then we ask for a copy of their current National Certification. So we're not auditing for the overprescribing. The overprescribing is a function of the CSMD. And as far as...we don't know. I can't tell you exactly what overprescribing would be. But we're looking at those top 50 out of 54,000 prescribers. -