

transmitted, CIO processes the documents, and submits the transmittal to the Supervising DAG based on the geographical location of the subject physician.

**Agenda Item 7      Update on the Opioid Related Death Certificate Information from the California Department of Public Health**

Ms. Kirchmeyer stated that many of the Members may remember that in 2013 Senator Price, who was then the Chair of the Senate Business and Professions Committee, introduced Senate Bill (SB) 62, which would have required coroners to report deaths when the cause of death was the result of prescription drug use. She noted this report would have contained identifying information so the Board could perform an investigation to determine if a physician was inappropriately prescribing. Ms. Kirchmeyer stated that currently the law requires a coroner to report to the Board when he or she received information based upon the findings by a pathologist indicating that a death may be the result of gross negligence or incompetence of a physician. She added that over the last two years the Board has received nine reports from coroner's offices.

Ms. Kirchmeyer stated at that time Senator Price thought that if the coroner did not have to make a determination that a physician was grossly negligent, or incompetent and that the death was related to prescription drugs, it would improve the reporting to the Board and also help identify physicians not following the standard of care. However, due to the fact this bill would have imposed an unfunded mandate, the bill was vetoed.

Ms. Kirchmeyer stated that after the veto of this bill, staff spoke with the Senate Business, Professions, and Economic Development Committee staff about a possible solution. She stated that after these discussions, the Board staff thought that it may be able to find another path to this information. The Board staff contacted the California Department of Public Health (CDPH), who is responsible for collecting all death certificate information. After several months and meetings, the Board signed an Interagency Agreement with the CDPH to obtain information on deaths in 2012 and 2013 related to opioid prescription drugs. Ms. Kirchmeyer noted that this data set used codes that CDPH was using to identify the underlying cause of death and the contributing cause of death in order to identify opioid pharmaceutical related deaths, and in August 2015, the Board received the information for both of those years.

Ms. Kirchmeyer stated that once the data file was received, the Board used the Controlled Substance Utilization Review and Evaluation System (CURES) database to determine who was prescribing to the individuals and also looked at the prescribing practices of the attending physician, or the physician who certified the death. She added that once CURES information was obtained, the reports were sent to experts who reviewed the data to determine if there may be inappropriate prescribing. She noted the Board had one person assigned to this task. Ms. Kirchmeyer stated that all of the reports have now been reviewed, and the Board was working to initiate all of these cases to either begin the process in the CCU by obtaining the medical records or by sending these cases to the field for investigation.

Ms. Kirchmeyer stated that for the two years, 2,692 deaths fell into the categories identified as related to prescription drugs. She noted that of those, 2,256 had a CURES report that needed to be reviewed by a medical expert reviewer. After those reviews, the Board identified 522 cases that needed an investigation opened, concerning a physician who may have inappropriately prescribed. She stated the Board is currently writing letters to request authorization to review medical records.

Ms. Kirchmeyer stated this has been an extensive project and one that still needs a lot of work to complete. However, this process has been invaluable to the Board's role of protecting the consumer and its goal to find proactive ways to investigate. She added that the Board has received very positive feedback from the experts who have been reviewing these cases. One expert stated that although the initial startup process for these cases has been extremely time consuming, it was worth the effort.

Ms. Kirchmeyer added that another expert stated the systematic approach of this project has given the Board a chance to discover who the over-prescribers are, rather than having to wait for specific complaints to be made. The project has been crucial in discovering these providers and protecting vulnerable consumers struggling with addiction.

Ms. Kirchmeyer noted that one expert identified some notable findings in all the cases reviewed, which was quite interesting. She commented that the expert stated that there was a group of patients who died from an overdose unrelated to the prescriptions they were receiving from their physician, revealing the use of diverted or illicit drugs. The expert stated another group of patients had received controlled substances from a large number of prescribers and it was unclear whether any of these providers were aware of the patients' use of multiple prescribers. There was also a group of patients whose death was closely linked to the prescribing habits of their primary provider, which was quite common. The experts had found that in general, providers were writing for high-dose opioids in combination with one or more sedating drugs, such as benzodiazepines, Soma, and sleeping pills. The expert went on to state that this is probably the most important lesson from this work; the specific link of patient deaths related to the known risks associated with high-dose opioids, particularly when linked to the concurrent use of other sedating medications. The experts found that in reviewing the CURES report on these providers, it was common to see many other patients receiving the same combinations and who are at risk for harm.

Ms. Kirchmeyer added that the expert recommended that the Board continue to obtain this information from CDPH every year. Ms. Kirchmeyer stated that the Board would be doing that.

Dr. Lewis stated that death certificates must include if the cause of death is opioid related and that sometimes it is not listed as such. There are some cases where the coroner is not a physician and the information is often times hidden on the death certificate, which makes it difficult to extract that particular data for this study.

Ms. Kirchmeyer noted that is true and stated that the Board will not going to capture every single death that occurs related to a prescription drug. She noted that there were several different categories, all drug related that were used when pulling together this information.

Dr. Lewis wondered what type of education about this program could be provided to coroners to encourage them to report appropriately.

Ms. Kirchmeyer stated that she was actually giving a presentation in September to the Coroner's Association and would be happy to bring this subject up during her presentation.

Judge Feinstein asked if there was an unexplained death and a physician cannot sign the death certificate, such that law, in a county that does not have a medical examiner's office, requires an autopsy or further investigation their Sherriff must use a medical examiner to conduct the autopsy.

Ms. Kirchmeyer stated that there was a bill passed last year that requires the pathologist who performs an autopsy to be a licensed physician.

Judge Feinstein asked how far back in time the Board could go with investigating a death certificate.

Ms. Kirchmeyer stated that has been an issue with this project and due to statute of limitations, the Board could only go back seven years.

Dr. Levine asked if CURES was capable of querying by dose; for example, prescriptions greater than so many milligrams, or perhaps even Morphine milligram equivalents (MMEs).

Ms. Kirchmeyer stated that CURES is capable of querying by MMEs, but she was not sure about running a report by dosages. She noted she would look into it and let Dr. Levine know.

Dr. Levine stated that report could be another pathway to assist in finding overprescribing physicians for this project.

Dr. Bholat agreed with Dr. Levine and stated that using a number of 120 pills per prescription might be a good number to use when running the CURES reports.

Dr. Yip asked Ms. Kirchmeyer how many experts are being used for that large number of cases that need to be reviewed.

Ms. Kirchmeyer stated that they are using any of the experts that are available in the pool that the Board has. She noted that this is a large number of cases to be added to an already stressed unit, so experts in different areas are definitely needed for this project.

Ms. Fellmeth thanked the Board and staff for pursuing this project as this information is so very important. She noted that people are dying all over the country due to this prescription overdose epidemic.

Dr. Yip stated that Ms. Kirchmeyer has the Committee Members support in helping any way possible since this is such a big project.

Ms. Kirchmeyer stated that another good thing that came out of the project is that the Board will be able to use this project to create and justify a Budget Change Proposal for staff for this project.

Dr. Levine stated that the Board should back up one step from death, which would be hospital and emergency department admissions, and monitor those who were admitted with a possible overdose.

Ms. Kirchmeyer noted that CDPH does monitor those admissions. They have a heat map on their website that shows by county how many people have been to an emergency department regarding opioid overdoses. She noted that she will work with CDPH to see if that is something the Board can use as another avenue for this project.

Dr. Levine added that it should be noted that California is one of the states with the lowest number of opioid related deaths per hundred thousand people in the country, which means the state is doing something right, even though there is still plenty to learn.

### **Agenda Item 8      Presentation of Enforcement Statistics**

Ms. Kirchmeyer noted that at the last Enforcement Committee meeting, there was discussion about obtaining statewide enforcement statistics. Around that same time, she stated she had been reviewing some heat maps that CDPH was putting out on prescribing and opioid related deaths in the state. After the meeting, she met with Sean Eichelkraut, the Board's ISB Manager, to discuss what reports would be possible. She noted that on pages ENF 8-1 to ENF 8-9 are pages of some sample reports that were put together.

Ms. Kirchmeyer stated the first report identifies complaints received per 10,000 individuals. The color of the counties themselves is based strictly on population per census information. However, the circle within each county is based upon the number of complaints received per 10,000 individuals. The county is based upon the complainant's address or if no address, upon the physician's address of record.

She added that the information on the following page just puts numbers to the actual chart and also adds the number of licensees per county based upon their address of record.

Ms. Kirchmeyer noted that on page ENF 8-4, was a sample of what a map would look like for information based upon the medical service, which is captured based upon the allegations involved and the type of practice of allegation. She stated this is not based upon the physician specialty or board certification, it is based upon the type of procedure that was being performed, based upon the review of the complaint.

She then noted that lastly, on page ENF 8-7, was a sample of information that can be obtained by the allegation, such as in this case, negligence or incompetence. She stated there are several other allegation codes, and this was just a sample.

Ms. Kirchmeyer added that she wanted to provide this information to the Members to determine if this was something they would like staff to work more on in order to put this information on the Board's website. She noted that an individual could go to the Board's website and obtain the heat map with the information. She added that staff could also build a map to identify disciplinary action per capita per county too. She stated that she knew the Members wanted a place to obtain this sort of information and this is the first try in getting some information.

Dr. Lewis stated that the Board should be careful that the information is not misinterpreted by the public and that the information really need to instruct them on how to read it so that it is interpreted correctly.

Dr. Levine noted that the maps in the documents are three levels of information, which does make it a bit challenging to read/interpret. She suggested if staff is going to post these to the website, to perhaps break up the overlays into single layers for ease of understanding.