CVS Interrogation 10-10-29

Hello, this is Dr. Ellenberger.

Hi, Dr. Ellenberger.

My name's Jessica Stein.

CVS Health Professional Practice team.

How are you today?

I'm well, thank you.

How are you?

I'm doing well.

We had this time set up for a phone meeting on the Philadelphia time for you.

Yes, ma'am, I've set aside 30 minutes or longer?

Perfect, perfect.

Yeah, apologies for the delay.

We were on hold for a little bit, so...

No problem.

I'm glad we were able to connect.

And then, just to let you know, we're also joined by my partner, Elaine Mulhall.

She and I are both partners with CBS Hulsa on the corporate side.

So you both are trained pharmacists?

Yes.

Good.

Thank you.

Of course.

Um, and I know you met with our team, um, previously, I think I'm around, like, January 2025, um, but just say, um, you know, refresher, whatever King does.

So we do monitoring a controlled substance dispensing.

When something stands out as a trend or an outlier, we just take it as an opportunity to reach out and get a better understanding of that data.

And, um, since you last spoke to our team.

We had, uh, noticed that some trends with the opioids, some considerable growth over the, um, the last, uh, kind of year and a half , um, as well as kind of continued, um, you know, higher doses, um, for, um, like the oxycodone in particular, um, and more patients, uh, like only filling controls at our stores, um, and paying out of pockets.

So we just wanted to have a call with you today to learn a little bit more about the practice and see what might be, you know, driving, you know, some of these changes in the data.

Sure.

All right.

And, um, I have the practice, is it still, um, accurate clinic at 2401 Veterans Memorial Boulevard in Kenner?

Yes.

All right, and I believe from the last conversation, you've been with the practice since 2009.

Is that correct?

Yes.

Maybe it might have been part time in 2008, but yeah.

Okay.

Got it, got it.

And, um, is is accurate clinic, is it, um, like, correct to, like, categorize it as, like, a pain management clinic?

Well, yes, ma'am.

I have a licensed, I'm licensed as a pain management clinic, but I don't emphasize that per se.

I do other things besides pain management.

I do addiction.

I do general practice.

I do urgent care.

And, uh, I do a lot of alternative medicine, and I'm going to get into that later.

But just to say, I, that's, that's the bigger picture.

Okay, got it, got it.

And so, after practice, if you had to, like, destiny, like, what proportion of your patient panel, would you estimate our, um, like, you know, product payment, pain management patient?

About 90%.

Okay.

Okay.

Okay, and then are they, with the, you know, additional services that you offer, like the, um, like, primary care, um, did many of the pain management, uh, patients also, like, utilize you as their primary care provider, or do they have a separate primary care provider?

Well, it's both, but many use me.

Even the ones have their own primary care.

I'll tell you that the patients come to me to confirm if what their primary care are doing is something I would recommend, so I'm kind of a secondary, even when they have a primary, primary care patient or doctor.

Okay.

Understood.

No, I appreciate that information.

Okay.

And then, are you the owner of the practice?

Yes.

Okay.

Got it.

And, um, you know, at this time, are you there?

The only, um, prescriber as a practice, are there other physicians or mid-level providers that you supervise?

I have another physician, uh, who's Chinese.

He does traditional Chinese medicine, he does not prescribe.

I am the only prescriber.

I don't have any mid levels.

Okay, no, I appreciate that information.

But he is an MD.

Sorry, he is an MD, though.

Got it.

Okay.

Understood.

And so, um, you know, when you last spoke to our team, um, you know, uh, back at the beginning of 2025, um, you know, we were only seeing about 18 prescriptions per month of the oxycodone and 11 prescriptions per month at the Hydro photo.

But since that time, it's grown to about 80 prescriptions per month of the oxycodone and about 55 prescriptions per month of the hydrocodone.

So was just kind of, you know, hoping to hear a little bit more about, you know, like, you know, what, uh, you know, really like, you know, drove that growth because that's a pretty big change from what we were seeing about a couple years ago.

Yes, ma'am.

So when you say we, are you referring only to CVS pharmacies?

That is correct.

Okay.

Okay, so to answer, are you ready for me to answer?

I am.

Okay.

So, um, the one of the biggest reasons is, oh, guys, it's, uh, going back to the fact that, uh, in my observations, what's happening is that the DEA is pressuring pharmacies to not fill prescriptions from patients who, uh, live more than 50 miles from the pharmacy or if the prescriber is more than 50 miles from the pharmacy.

Are you aware of that trend?

Um, I mean, I don't think it's like a hard and fast rule, but we do, I think that distance does, um, you know, patients, uh, you know, traveling a distance to either the prescriber, the pharmacy, um, you know, does the, you know, carry some, like, you know, some concerns or red flag to it.

So I could see where, um, you know, some pharmacies, um, you know, may uh, be disinclined to fill those.

Well, let me fill you in on that.

CVS has been pretty good.

I have had CVS pharmacies turn a patient away because I was more than 50 miles from them.

This was a pharmacy in either Harma or Thibodeau.

For the most part, I haven't had problems with CVS using the 50 mile radius as an argument to turn my patients away, but many, many do.

CVS has been good.

I like CVS on many levels, because of their open policy to that.

But it's been a big problem.

And, uh, for example, the pharmacy downstairs, uh, the Rodriguez pharmacy, they see a lot of my patients because they go right downstairs and they live locally.

The DEA came in and said, we don't want you filling anybody more than 50 miles away.

We don't want you to fill any more than 150, really 120, but we don't want you filling 180 pills to anybody anymore.

And that became policy on Rodriguez part.

And I had a lot of patients going there.

Um, I don't remember our conversation last year, so I don't really know how informed you are as to the nature of my practice.

And I'm going to ask for time when you are done getting your needs met that I would like to reopen that conversation.

I think my practice has changed significantly in that time in some ways.

So I want to go over that.

But the problem is, he, I lost a lot of patience.

Well, he he kicked out a lot of patients.

I've had a lot of pharmacies turning patients away as well.

And this is a large reason why CVS is getting more because CVS actually makes an effort to help patients.

These other people are so worried about the DEA.

And I get why they're worried, but, are you familiar with a recent uh, decision made by the 2nd uh, district federal court of appeals?

Are you familiar with what's going down there?

Um, I I'm not sure, but I feel I'm happy to hear about it.

Well, I want to tell you because it influences things.

In February of this year, Noonan Pharmacy, I don't know where they're located, but I'm guessing they're a small pharmacy, but they are in Louisiana, and they filed a lawsuit against the DEA regarding the DEA's pressuring them about filling practices.

Now, there was a variety of things involved in that decision, but what came out of it of importance to us is that the federal court told the DEA, that they had to back off using red flag, things like 50 mile policies as an argument, not to fill a person's not to dispense their medications.

The red flag policies are meant intended only to raise questions, but not to be used as absolutes.

And I can tell you, I can, I, we could rattle off probably 10 or more pharmacies that have used that as an excuse, and there was no discussion.

I even sent letters, but bottom line is, the court said, pharmacists are by law required to dispense whatever the doctor writes unless they have 2, uh, concerns, A, that it's an illegal prescription used for inappropriate purposes, or they know that it's counterfeit.

Other than that, according to this judge in February, they are required.

Otherwise, they themselves are breaking the law.

Now, that was the decision in February.

So I've tried to share that with pharmacists, say, look, you know, it's a policy, it's not a, it's not a, it should be a yellow flag, not a red flag.

It should cause you to stop to evaluate a concern, but the 50 mile policy is an antique based on days before we had the prescription monitoring program in which any pharmacist can look to see whether other people being filled.

The 50 mile policy serves no purpose now.

As you know, pain management is extremely underserved in the nation, especially in Louisiana because of the rural nature of Louisiana.

There are not a lot of pain management practitioners to meet the needs.

So I'm getting more and more referrals for that reason.

Aspen Pharmacy.

Uh, I don't know if you know Aspen, but they were a big opioid dispensing pharmacy because they do a lot of hospice patients.

Any rate, they had difficulties with their distributor, and then so they got basically shut down of dispensing opioids, and they've been absent now for a couple of months as they're working their way up with another distributor.

So I had probably, I could easily say I had maybe 40 or 50 patients maybe going to Aspen, so many of them got shuffled to CVS as well.

But my sending people to CVS and your numbers are reflecting that.

My practice has grown some since 2000, uh, whenever it was early 2025.

Uh, not a huge amount.

Um, uh, but it has grown to some extent.

Regarding oxycodone versus hydrocodone, just so you know, I hate oxycodone.

It's the last opioid I want to prescribe.

The reason you're seeing more is because it's harder and harder for me to get alternatives.

I have when I have paper on hydrocodone, for example, I like hydrocodone as an opioid.

It's not my 1st choice, bupranorphine is always my 1st choice, but hydrocodone I like because I do not see much tolerance building up to it.

I have patients on hydrocodone for 20 years and they're still at 6 a day.

But an oxycodone, I think, well, I assume you would agree that it does build up tolerance more quickly.

So any rate, I don't like oxycodone, but I can no longer get Hysingla very often.

So if I get to a point where someone needs higher than 60 milligrams of hydrocodone, I can't get it.

I had one person who'd been getting 8 hydrocodone for many years, and she, I just did it in 2 scripts, uh, or actually I did it initially in one script, and I just said every 3 hours.

And the pharmacy decided that was too many. They don't want do it anymore. She'd been on the stable dose for a long time. So, I, we had no choice.

I tried to get Hysingla. I can't get it. There's very few pharmacies that carry it. It's expensive, but it is an abuse deterrent, so I like it.

There was another long acting hydrocodone, I forget the name of it now, but it was a really interesting hydrocodone product. It was a combination of immediate and extended release, 20% immediate 80% extended.

So I used that when I had to go higher than 60 milligrams of hydrocodone a day. But it came that they took that off the market.

So I'm stuck when I when I get somebody who needs to move on from hydrocodone, I'm stuck.

I've got to either give them, rotate them to short acting oxycodone, or maybe add a long acting, Morphine is not one of my favorite drugs. It's just not well tolerated. Patients don't really like it.

So I try that, but usually I end up having to go to oxycodone.

I use Levorphanol when I can, but again, it's expensive, a bit more difficult. So, it really, I'm limited.

Now, recently, you probably are aware of a new product called RoxyBond. Are you familiar with that?

I've heard of it.

So RoxyBond is an immediate release oxycodone product, but it has an abuse deterrent character in which there's a hard coating on it which prevents the individual from crushing the tablet so they can't shoot it up, and they can't snort it.

So I am in the process now of introducing that to every oxycodone patient in my clinic, percocet or otherwise.

Now, I'm not forcing it down their throats.
Tthe argument for abuse deterrence doesn't work well with them because they don't abuse. And they think, well, I don't abuse.

I need to change the argument I give them, is that as a branded drug, the quality should be higher and that there will be less supply problems and less substitution of generic oxycodones and percocets that are not as good as what they're used to.

And that's a common problem, not everybody has it, but it is common.

So that's what I'm doing with regards to your oxycodone.

So I try to use Xtampza whenever possible because it's abuse deterrent when I have to use oxycodone. I don't think I have more than one or 2 people on an extended oxycodone that is not Xtampza.

Now, interestingly enough, I had a patient who recently, I've only seen her a few times, she was referred to me. She has breast cancer or had it.

They thought they were through with it, and she came to me with residual breast pain. She had been on 6 percocet a day, and she'd been off of it, I think, for a month or 2, I restarted her at 4 a day to see if she could tolerate that.

She came back and said, no, that really doesn't work for me.
And I said, okay, well, we'll go back to the six. She found masses in her breast and they were hurting. We haven't absolutely confirmed its recurrence, but I'm fairly certain that it is.

So, I sent her to CVS, one of them in either Houma or Thibodeaux. The pharmacist at that end, and I don't know his full name, and I don't want to point at him specifically, but I will tell you that he told my patient, no, I'm not going to give you 180 tablets, I'm only going to give you 120.

He had no argument other than that “you don't need that many pills” is what he told her. So she took the 120.

And she came back and told me the story.I had my staff call down there and both the staff member and the patient were sitting in the room, they heard the conversation, and the pharmacist was extremely rude and dismissive. My staff member was so angry.

So, we kind of let that go. She came back and said, okay, well, he doesn't like 180 pills. Then I'm going to switch you to Oxycodone 15mg 4/day, and let's talk about RoxyBond.

So I wrote Roxy Bond name on the back of her Oxycodone 15 prescription so that I could get a prior authorization started. And I sent her back to the same pharmacy with 120 Oxycodone-15s.

When she got there, the same pharmacist was present. He informed her that, “nope, we don't have 120 in stock. We only have 90, and that's all we're going to give you. And she said, “well, can I come back later when you have more stock?

He said, no, that's the most we're going to give you this month. You're not getting any more. He was quite rude again.

And then she said, “well, what about Roxy Bond?” My doctor wanted to see if you guys would carry RoxyBond.

And he said, oh, it's $5000. How are you going to pay for that?
That was that was his response.

So I have a lot of problems and no, I'm not trying to point out CVS, but it was just interesting because this is a conversation just this week.

So I'm trying to get RoxyBond, if you can put in a word, I can get the RoxyBond rep to talk to you, but I'm trying to use abuse deterrents whenever possible.

I'm not using that argument as strongly with my patients, unless they're high risk and then I forced them on it, but otherwise, I'm going to just give them the alternatives and arguments as to why it might be a better choice.

But, so, that's my policy on Oxycodon.

I hate it.

I don't like prescribing it.

But alternatives are becoming fewer and fewer, but, uh, I just live orphanal is harder to get now.

So anyhow, that's that's that.

I don't prescribe a lot of methadone or fentanyl patches, but sometimes I'll do those if I had to go to high dose, oxycodone.

I'm sorry. You're gonna get it. I'm gonna talk a lot. And I'm sorry.

And I think you have quite a few questions I would like to trade and get through is we have just a limited, you know, amount of time.

That's fine.

Go ahead.

You know, with that, I know you mentioned, you know, oxycodone isn't your, you know, like preference to necessarily use, but, you know, especially with that growth.

Um, you know, we, so we are, you know, about 80 prescriptions per month of oxycodone and even when compared to others in pain management, that's about one. 2 standard deviations away from the average that we see for peace management specialist.

So, you know, I guess, you know, help me understand why we're seeing more of the oxycodone, you know, for your patients compared to others.

Let me speak to that because yes, that is likely to be the case.

In fact, I'm doing research right now on the barriers that patients experience getting their pain managed.

One of the problems that I've identified is that I, you have to understand something about my practice.

I am the only practitioner in the state of Louisiana with an extensive integrative pain program.

I only prescribe.

I don't do interventional procedures.

There's very few of us who only do medical management.

The interventional pain doctors, by and large, do not like prescribing opioids.

They limit them to very small amounts.

I can tell you that I've had multiple patients tell me that their interventional doctors said, when they told them that the injections aren't working, they don't want, they don't want any more injections, and the interventionalist says, well, then you'll have to leave my practice. “I'm not going to give you opioids unless you do procedures.”

That is not uncommon.

So the interventional pain doctors are more interested in doing interventional, that is their training.

There are no interventional practices that I'm aware of, and I'm pretty aware of what's out there, There are no interventional practices that provide full pain management, and by that, I mean, any degree of holistic approach.

They might write gabapentin or Lyrica, but it stops there and they keep their opioids very low as a policy, and it's often inadequate.

So I do write more, and you're seeing more, like I told you, you're seeing more, not because I'm writing necessarily more oxycodone my practice, which, to some degree, I am because of supply problems, but more so because the pharmacies, and I get a lot of referrals from pain, interventional pain, doctors, who say “take over their opioid management, we’ll do continued interventional procedures, but right now the patient doesn't want any” or something like that.

So I get referrals.

I am well respected by the interventional pain community.

But that's it.

So, I'm not overprescribing oxycodone, and I promise you, I'm doing it, because in the end, I'm being forced to, and CVS is seeing it, because you're one of the few pharmacy groups that aren't playing 50 mile policy games.

So I guess, you know, help me understand, like, why are the patients traveling, you know, 50 or more miles to either, you know, you as the provider or to the pharmacy that they're filling at?

I'm glad you asked because when this started, I had a survey done of my patients.

I ask my patients, look, I want to feedback to the pharmacist, who are turning you away for 50 miles, I want you to tell them, why do you travel 50 miles to come to me?

And, I have many, maybe over 200 of these forms filled out with all the reasons, I'd be more than happy to send you the scans of all the reasons why they come here.

But to summarize, many of them come because they don't have a pain specialist in their area.

This is rural Louisiana.

I did a search knowing we might have this conversation last night.

I did a search on open evidence.

Are you familiar with open evidence?

It's an AI only available to practicing physicians.

And I did a search on the AI, asking them about the statistics relative to pain management in Louisiana and access to pain doctors.

We are way under average for the country as to availability of paying specialists in the state of Louisiana.

People come to me because they can't get someone closer.

They come to me because I offer more services.

I do a full integrative program.

I have everything from a physical therapist here, traditional Chinese medicine.

I'm doing research on the use of neutraceuticals based on the anti-inflammatory diet.

Again, a big part of my practice is introducing them to nutrition and diet.

Everyone is screened and instructed in that.

I have probably 200 handouts that I give my patients directed at a holistic approach to their pain management.

But the bottom line is that people come here because I'm it if you want a doctor who treats pain from a fully holistic approach, I mean, there's nobody else in the state of Louisiana that has a practice like mine.

I would encourage you to please go to my website.

And click on the accurate clinic.com at the top of every page, you will see a link that says education.

That's patient education, not mine.

If you click on that, It's simple thing.

Click on the what's new.

And then when you get to what's new, you will see a list of handout after handout, topic after topic, all addressing educational things relative to managing pain.

It is the largest of its kind on the internet.

You have places like Mayo Clinic and stuff like that.

And they do have extensive things on a lot of subjects.

But if you want to focus just on integrative pain management, I'm the biggest one on the internet.

Everybody in this industry could learn from what I've been on. Working on this website for 15 years.

And it's very thorough.

That's why they come.

When my patients come in, almost every visit, they get an educational handout, they get QR codes to my website, that's why they come.

And you'll also see, and like I said, if you want me to send you the scans, I'd love to send them to you.

They come because they feel like I care for them and that sounds kind of silly. I get it, and I'm not trying to brag, but that is the big reason people drive. They feel like I'm actually doing something to help them.

I don't walk in, look at the MRI, say, okay, we're gonna do an epidural. We'll see you next week. No explanations, no education.

I educate my patients more than any other pain practice In the state, and I can back that up.

Lammico, are you familiar with Lamico?

I am not...

Lammico is the leading malpractice provider in the state of Louisiana.

They have told me that I set this standard in the pain management community for the type of practice I offer pain patients.

They tell me I set that standard.

I am the safest prescriber.

If you look at what I do to provide safety for my patients, the amount of education, the amount of screening that I do way exceeds any other pain clinic.

If you look at drug screens, for example, my Millennium is the largest company doing drug screens in Louisiana.

They do the majority of drug screens in Louisiana.

I have the lowest percentage of failed drug screens of any clinic in the state.

So I am safe.

I just need to emphasize that because this all boils down to “Am I a safe prescriber?”

You're asking me questions to confirm that I have arguments for being safe, and I'm telling you, I am the safest opioid prescriber.

I've been here 18 years.

I appreciate that information.

I've never, I am just trying to like keep an eye on time and I do have other questions.

Go ahead.

Um, you know, I appreciate that information about the, um, you know, the, the monitoring and we'll dive, we'll come back to that a little bit, but I want to make sure that I get to the, to the data points, um, you know, for, uh, and then we can come back.

Sorry, go ahead.

Um, I appreciate the information around, um, you know, like where you might be being patients, uh, you know, traveling a greater distance and I think we've discussed the growth of it.

Um, but for dosing, um, you know, we are seeing, you know, an average daily dose of the oxycodone at, like 86 milliequivalents, which is like 2.5 standard deviations away from the average that we see for, uh, you know, pain medicine and 46% of those oxycodone prescriptions are greater than 90 MME.

So, you know, and that's 2.7 standard aviations away from the average.

So again, you know, like help us understand why your patients are needing higher doses of oxycodone when compared to other pain management providers.

Ma'am, if you look and I can provide the statistics at a later date, I don't have them available immediately.

I have patients who've been coming to me for 18 years, and they've been in this clinic even longer than that, some of them.

Many of my patients I've been seeing for more than 10 years, and I'm almost a majority is probably more than 5 years.

I have patients on long-term opioids well beyond If you look at an average pain practice.

You ask them how long they've been seeing patients.

You will learn that a few years.

Now, over the years, people build up tolerance.

And this is going to be reflecting tolerance.

I don't like to go increased doses.

I'm telling you, I do everything I can to avoid going up

I do an ME graph where I monitor the patient's morphine equivalency to the day they started 5 years before my clinic.

So I have a larger population in this clinic who've been on opioids for a longer period of time.

And that would be why.

I honestly, I don't know, full statistics of what other pain doctors do, but, I'm where pain doctors and everybody else send people with difficult to control pain.

They come to me for that.

And I do everything I can outside of opioids more than any other practice.

And sometimes, reluctantly, I may have to go up on their oxycodone.

Like I told you, I don't do this lightly, never lightly.

I even have a special form that I fill out - an increased opioid dosing form.

And in that form, I review all of the arguments surrounding increasing opioid safety arguments, “What else have we tried?”

Did we do Cymbalta?

Did we do gabapentinoids?

Have we tried physical therapy?

I mean, all of those things.

Have we tried alternatives to oxycodone?

I can't explain your numbers exactly because I don't know where they come from but I can tell you that most interventional pain doctors are not long term.

They're not seeing a lot of people who've been on opioids for 15 years and 20 years.

I have patients been on opioids since the 1990s.

Even earlier in some cases.

So that's it.

Now I have, I'm doing research right now on a compound that may help reverse opioid tolerance.

I talk to my patients.

What can we do to reverse your tolerance?

I try rotating microdosing to buprenorphine.

We have that conversation.

So, it's tolerance that is the main driver behind higher doses in my clinic.

There is no, no other argument.

Okay.

And so, you know, like with that, I guess, you know, how do you approach, like, you know, when patients are on these medications long term, like, you know, how do you, you know, approach trying to like reduce their opioid burden?

Like what other, um, you know, tell us a little bit more about, uh, you know, some of the non-opioid, um, therapies you're incorporating to help, uh, you know, either, you know, lower the, uh, the opioid doses or to, uh, you know, prevent needing to go, go higher in doses.

Well, if anytime someone is, let's say, on a short acting opioid and they're needing to go up, my 1st choice is to give them uh, supplemental bupenorphine in the form of a butrans patch or belbuca.

That is my 1st choice out of the gate every time if they can afford it.

Every patient is screened for previous experience with uh, Cymbalta and gabipentinoids.

Almost, there's very few people in my practice, if any at all, that have never been on those medications because those are always tried first in an effort to reduce their tolerance.

I encourage them to do acupuncture. We have full acupuncture here now.

My acupuncture doctor has trimmed down his cost to $40 for a 30 minute treatment to make it as affordable for people.

So I do tend to avoid NSAIDs because I think NSAIDs have a lot of problems with them.

We can get into that conversation other time, but I do use NSAIDs.It just not so much long term, but more for intermittent exacerbations.

I have very extensive, You'll see on my website, if you care to look at it, a huge number of nutraceuticals, all based in the anti-inflammatory diet, all proven safe, all good evidence for benefit, and all of that is available on my website.

So I use alternatives, including curcumin, PEA, Agmatine is a new one, lipoic acid particularly with peripheral neuropathy, but I encourage all of my patients. I'm working on a study right now, a protocol based on these nutraceuticals, everyone in the clinic is enrolled in it.

They aren't required to purchase supplements if they can't afford them, but they are all encouraged to do so, and a large number of patients have engaged the program.

I use Omega 3s, for example, and I've had great success with Omega 3s reducing pain, anywhere from 10 to 40% in some patients.

So, these are all done first.

I do everything I can to introduce alternative ways of treating their pain before I turn to going up on their opioids.

I prescribe medical marijuana. I track that very carefully. I keep them under 20% THC flower whenever possible.

I track their THC use, and I've introduced that as an alternative to going up on opioids.

I'm not in great favor of medical marijuana, I will tell you, but people do respond to it, and it does seem to help reduce the number of patients requiring higher doses.

But there's not an alternative treatment for pain option that has evidence for benefit and evidence for safety, that I do not offer and give a handout on.

That's what I do.

That's why I am this clinic and that's why people come to me because I do offer these alternatives.

Mhm.

And then, um, you kind of touched on it a little bit, you know, earlier, um, you know, some of the, like, you know, higher quantities, and that is something that that we are seeing, you know, I, you know, pretty commonly we're seeing, you know, uh, prescriptions with the quantities, you know, upwards of, you know, 150, uh, 180 tablets, and uh, just when, you know, dispensing, you know, such a high, you know, number of pills to to patience on a regular basis, it just opens up a lot of risk for, um, you know, misuse or diversion.

So, you know, again, help us understand why, you know, we're seeing such high, um, you know, pill quantities for your patient like prescription.

Well, again, it has a lot to do with their buildup of tolerance.

The pharmacokinetics of short acting pills is that 4 pills a day will often not cover a 24 hour period.

You know that as a pharmacist.

You may need to give them every 4 hours.

Now, I could add long acting when I can, and I do always add Beluca or something if I can, but if I have to go adding another full agonist, long acting time release it adds a 2nd pill that just leads to more potential for mistakes, taking the wrong pills.

I monitor for sleep apnea. So with the sleep apnea patients, I tend to avoid the long acting, even if they're on treatment.

But, they do well on it.

I have not in 18 years had one patient die of opioid overdose, not one in 18 years.

Diversion could happen.

I do drug screens all the time.

I even do blood levels on some patients on oxycodone to make sure that their blood levels seem consistent with what they're taking.

But, like I told you, my drug screen profile with Millennium is the best in the state.

I monitor for diversion of selling meds.

I do everything I can to avoid that.

And how often are patients typically drug screens?

Well, unlike every other pain management, I see my patients, every single month, every month, no other pain program does that. well, not no other, but I'm one of the few.

I see them every month.

When I first see a patient, I give them a full safety and compliance review in which I give them screening questionnaires to evaluate every possible potential safety concern relative to the use of opioids, everything from the risk of falling, to sleep apnea, catastrophizing, everything.

And based on that safety review, I stratify people as to if I consider them at low increased or high increased potential for substance abuse.

The number of drug screens that they get is determined by that.

The law requires four a year minimum.

So if a patient is never having failed drug screens, never had any running out early histories, anything like that, they get 4 per year, the minimum, but they are actually random. I would point out that most of the pain management doctors who see people every 3 months, and they give prescriptions in advance.

They see people 4 times a year.
Those are not random.

The law says they have to be random, but if you see people 4 times a year and do drug screen every time, it's predictable, it's not random.

I actually do random.

And if a patient exhibits any aberrant behavior that raises my questions, I put them on a probation in which we then call them randomly.

They agree to certain terms, and we do drug screens on that.

So I have some patients I do drug screens every month because they've had a history in the past of problems or I do six, 8 a year.

So it's not the same for everybody, but that's how I determine it.

Mm-hmm.

Okay.

Um, and then, uh, how about the prescription monitoring program, uh, or PDMP, how often is that checked for each patient?

Ma'am, that's checked every single month.

I've been checking that for longer than a decade.

We check it every month.

You're good.

Okay.

And then, um, I'm just looking at, at the time, and since we, you know, got kind of a late start, I am worried that we, we do need a little bit, um, more time, um, and we, uh, we do have another meeting right after this one.

So I'm wondering if we should go ahead and, um, look for a good time and perhaps that we could get a more direct like line to reach you at because, um, we did wait on hold for almost 10 minutes, which, you know, I wasn't aware.

I'm sorry.

I wasn't aware that you were on hold.

In fact, I was sitting here since 10 o'clock waiting for the call, so I'm not sure how that happened.

Yeah, yeah.

It's okay.

They just kind of have to hold and then I didn't even get a chance to, this day, we had a scheduled call with you.

Oh, they didn't know.

All right.

Well, I'm sorry.

Um, probably just need like, you know, maybe like 20, like 15, 20-ish minutes, like more to get through the last of the questions we want to ask, but, um, does the noon, uh, tomorrow work for you?

Oh, I can make it work.

Um, uh, it's a, yeah, I'd like to get this over with.

So I don't make it where...

Okay, but Okay.

I'm concerned about your judgment of me based on these numbers.

Oh, I apologize. Um, noon, uh, I know noon eastern, here in central time, uh, my my apologies.

So 11 o'clock central. Does that work for you?

I will make it work tomorrow at 11, huh?

Okay.

And then, um, you know, right now, the only number that we have is the office number, is there a more direct line that we could reach you at?

It will not be shared with the field.

It is just internal for our purposes of, you know, continuing the call with you.

Well, you can use my my cell number, I guess, but well, go ahead and call me and then I'll make sure the line is clear so you can call back because I'd like you to be on the clinic phone.

Absolutely.

And, um, what say, um, is the, uh, the alternative is you're welcome.

I can give you my direct line and you can give me a call and then I can add Elaine in.

Oh yeah, that's fine.

What's your number?

Ill call you tomorrow at 11.

Yeah, my direct line is [redacted]

And please forgive me.

What is your name again?

Yeah, Jessica [redacted] with an S on the end or no S?

[redacted]

Can I have any, uh...

Well, I don't know.

Do I need to get any more information about my practice that you might want to hear tomorrow that I can prepare for your questions?

Um, I don't think so.

You know, we got a lot of information, you know, about the practice.

Um, you know, when you stopped our team last year, so it'll just be kind of like verifying, you know, um, you know, there's, uh, you know, any additional

changes and kind of revisiting some of the, the other questions and then just a couple other data points to, to share, but there really isn't anything to uh, prepare for.

That's fine.

I would encourage you to please explore my website and you can see what I do to maintain safety in my practice with opioids.

Um, and I, all right?

All right.

And now, is there a, uh, if I wish to send documents to you, uh, is...

You can send this to my email. Happy to give you that.

What's your email?

[redacted]

[redacted]

I'm sorry, did you see there's there's a dot between your 1st and last name?

That is correct.

Okay, [redacted]

Uh-huh.

At CBS Health, all one word.

Yep. Dot com. Dot com.

All right.

Yep.

Um...

Any rate, uh, okay, that's fine.

As you might assume, your call has concerned me, because I feel like I'm being judged for excessive opioid prescribing, and I really object to that conclusion, because I do everything I can to avoid that, and my patients are well taken care of, and they are safe. I really need for you to understand that.

I think there's misconceptions about opioid prescribing held by many people, pharmacists, and physicians,. Anyway, if you were for some reason, decide, you don't want to fill my prescriptions, use CVS, there's going to be a huge problem for my patients.

I send many of my patients to you guys.

And it's already hard enough for patients to get their pain managed from physicians and pharmacies.

It's a huge problem.

I'm meeting with a senator tonight.

In fact, I have a dinner date with the senator to discuss what can be done to help patients with chronic pain, have better access.

Louisiana is really bad in being able to provide proper pain management to patients.

And sometimes it requires opioids.

And I have a whole non-opioid pain management program for people who don't want to get on opioids.

So I'm not pushing opioids, but they are necessary sometimes and sometimes high doses are necessary.

So, I just really want to emphasize that.

So, there you go.

All right, appreciate your time.

I know I talk a lot, but I believe very strongly what I do is good for patients here, and I am, I'm disturbed to be questioned about that.

So, there you go.

Thank you very much.

I'll call you tomorrow.

All right.

Thank you.

Yes, ma'am.

Bye bye.