**Brian Sandoval**
***Governor***

**Richard Whitley**
***Director***

State of Nevada

# Department of Health and Human Services

*Reasoning Behind the Development of the Governor's Controlled Substance Abuse Prevention Act*

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# Learning Objectives

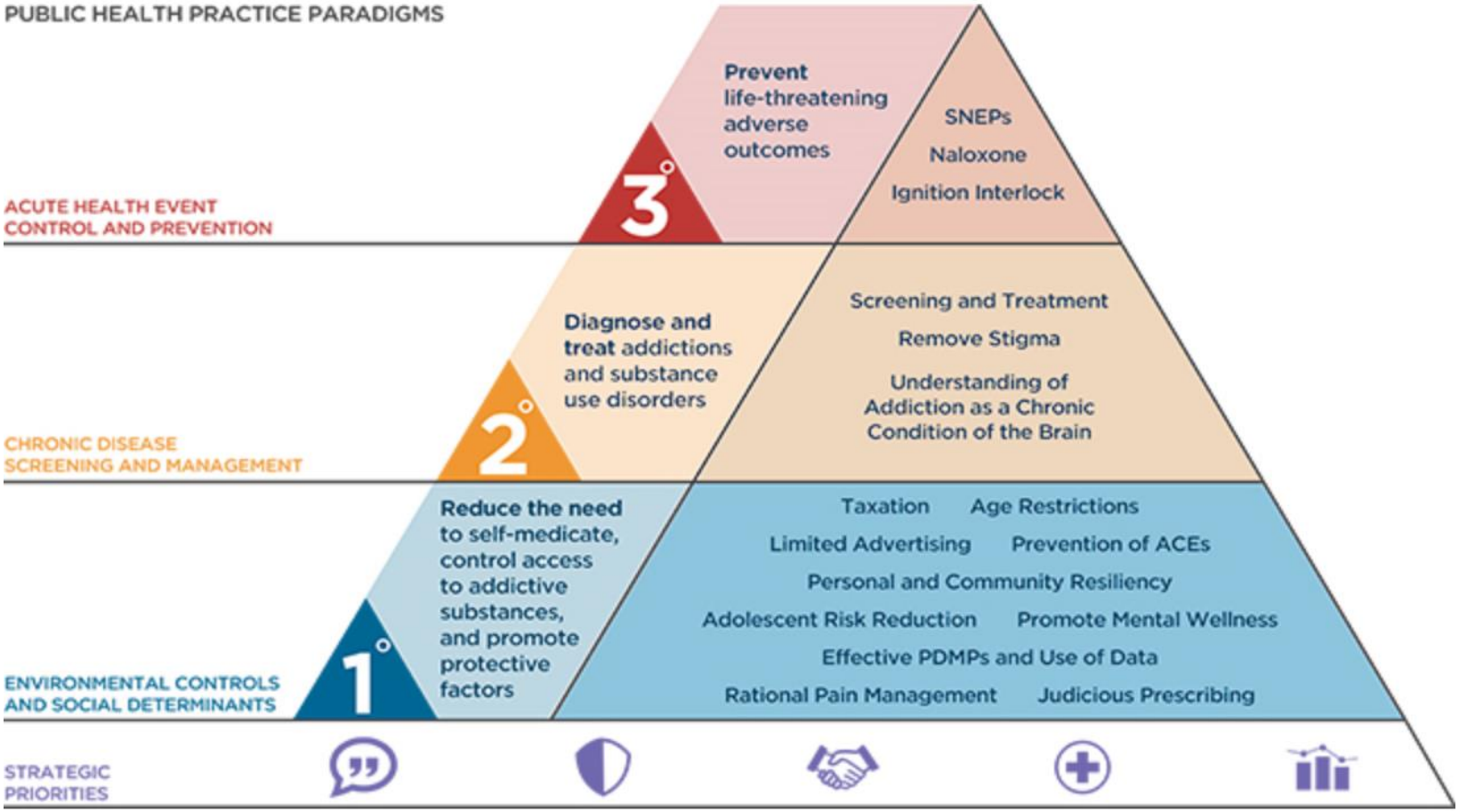
Participants will be able to:

- Identify trends in legislation on prescribing guidelines, limits, and mandates.
- Identify risk factors for opioid use disorder in patient populations.

# Prescription Drug Abuse Prevention Act

- ✓Prioritize patient safety and responsibility
- ✓Preserve clinical decision-making
- ✓Promote the patient-prescriber relationship
- ✓Reduce the amount of inappropriate prescribing
- ✓Prevent addiction to prescription drugs through monitoring and mitigating risk
- ✓Enhance the quality of care for patients with acute and chronic pain
- ✓Avoid the legislation of the practice of medicine by establishing a standard of care

# Prevention Strategies




**"An ounce of prevention is worth a pound of cure."-Benjamin Franklin**

# Unused Medications and Diversion

In the Spring of 2017 the DEA collected **912,305 pounds—456 tons**— of expired, unused, and unwanted prescription drugs for disposal at more than 5,300 collection sites.

Total amount of prescription drugs collected by DEA since the fall of 2010 to **9,015,668 pounds, or 4,508 tons**

# Dual Problems of Stock and Flow

Naïve and new to treatment

Initial Prescriptions

Treatment lasting shorter than 30 days

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Medically Necessary, Clinically Appropriate Treatment

Treatment Adherent

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Physiologically dependent

Addicted

In need of specialty care

# National Legislative Trends

# Supply and Dosage Limits

Non-surgical acute pain

Connecticut, Maine, Massachusetts, New York, Pennsylvania, and Rhode Island

Laws limiting initial prescriptions to 3,5,7 days

Pennsylvania: No opioid prescriptions in observation, urgent care, or ER's

Maine: Dosage limit maximum 100MME

30 days chronic/7 days acute

# Vermont's Prescribing Limits

| Pain | Average Daily MME *(allowing for tapering)* | Prescription TOTAL MME based on expected duration of pain | Common average DAILY pill counts | Commonly associated injuries, conditions and surgeries |
|---|---|---|---|---|
| **Minor** pain | No Opioids | 0 total MME | 0 hydrocodone<br>0 oxycodone<br>0 hydromorphone | molar removal, sprains, non-specific low back pain, headaches, fibromyalgia, un-diagnosed dental pain |
| **Moderate** pain | 24 MME/day | 0-3 days: **72 MME**<br>1-5 days: **120 MME** | 4 hydrocodone 5mg or<br>3 oxycodone 5mg or<br>3 hydromorphone 2mg | non-compound bone fractures, most soft tissue surgeries, most outpatient laparoscopic surgeries, shoulder arthroscopy |
| **Severe** pain | 32 MME/day | 0-3 days: **96 MME**<br>1-5 days: **160 MME** | 6 hydrocodone 5mg or<br>4 oxycodone 5mg or<br>4 hydromorphone 2mg | many non-laparoscopic surgeries, maxillofacial surgery, total joint replacement, compound fracture repair |
| **For patients with severe pain and extreme circumstance, the provider can make a clinical judgement to prescribe up to 7 days so long as the reason is documented in the medical record.** | | | | |
| **Extreme Pain** | 50 MME/day | 7 day MAX: 350 MME | 10 hydrocodone 5mg or<br>6 oxycodone 5mg or<br>6 hydromorphone 2mg | similar to the severe pain category but with complications or other special circumstances |

# National Policy Trends

**Pharmacies**

CVS Health Policy for 2018 limiting initial prescriptions to one week and preferring short-acting over long-acting.

**Payers**

Cigna imposing prior authorizations on some opioid prescriptions with an overall goal of reducing opioid by 25% by 2019

# National Policy Trends

**Medicaid**

Quantity Limits

Prior Authorization

Clinical Criteria

Step Therapy

PDMP Requirements

Required Pain Consultation

Drug Utilization Review

Alternative Therapies

Restriction for Conditions

Provider Education

# CDC Guidelines

## GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

### IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

# Tools for Managing and Mitigating Risk

- ✓PDMP check
- ✓Informed Consent
- ✓Risk Assessment
- ✓Medication Agreement
- ✓Guidance on Considerations for
- ✓Identification of Risk
- ✓Toxicology Screening
- ✓Evidence-based Diagnosis
- ✓Co-prescribing naloxone

# Prescription Drug Monitoring Program

Shared with 22 other states including AZ and Utah. Does not include CA.

Identifies “doctor shopping”

Reduces risk of duplicate prescribing and potentially dangerous drug-drug interactions

Monitoring prescribing trends across prescribers

# Informed Consent

Platform for patient education

Risks/Benefits of Treatment

Increases patient satisfaction

Can be worked into clinic flow

Requires specific information:

safe storage/disposal

availability of naloxone

alternative treatments

# Risk Assessment and Mitigation


Current and past mental health and substance use disorders are risk factors for inappropriate use of controlled substances for pain and increased risk of overdose

Overdose risk is linked to misuse, co-morbid health conditions, behavioral health conditions

Screening and assessment tools can be integrated into practice environments to identify and stratify risk

# Medication Agreement

Contract between patient and prescriber

Details expectations for continued prescribing

Provides guidance for what can be expected during treatment

Documents conditions leading to discontinuation of prescribing controlled substances (i.e. multiple providers)

# Clinical Considerations for Continued Prescribing

Allows for broad consideration of patient history, behaviors, adherence, and response to treatment before prescribing and throughout treatment. Factors to consider include but are not limited to:

- ❑Whether there is reason to believe a patient is not taking or is diverting the opioids prescribed
- ❑Whether there has been no appreciable impact on the chronic pain despite being prescribed for a period of time that would generally have an impact
- ❑Whether there is reason to believe patient is taking or using additional opioids not prescribed by any treating physician
- ❑Attempts by patient to obtain early refills of opioid-containing prescriptions
- ❑Number of instances when patients allege their prescriptions were lost or stolen
- ❑Patient engages in apparent aberrant behavior or shows apparent intoxication
- ❑Patient's opioid usage shows an unauthorized dose escalation

# Toxicology Screening


**NOT** Required by new law

Can be used to monitor patient adherence to medications and facilitate communication

Used to detect presence of other substances that may compromise patient safety (i.e. benzodiazepines)

Used to detect absence of prescribed medications and possibility of diversion

No one data point should be used to determine if prescribing should continue

# Evidence Based Diagnosis

"Low back pain" continues to be the most common diagnosis

Lack of specificity

Patients have a right to know what the diagnosis is they are being treated for

Weak evidence for most diagnoses

# Co-Prescribing Naloxone

Bias and stigma remain high for co-prescribing

Highlights risk of taking opioids

Universal precaution for all patients on opioids

Risk can be stratified by existing factors such as

-concurrent use of benzodiazepines

-recent emergency treatment for opioid related reasons

-co-morbid medical conditions (i.e. COPD, renal dysfunction)

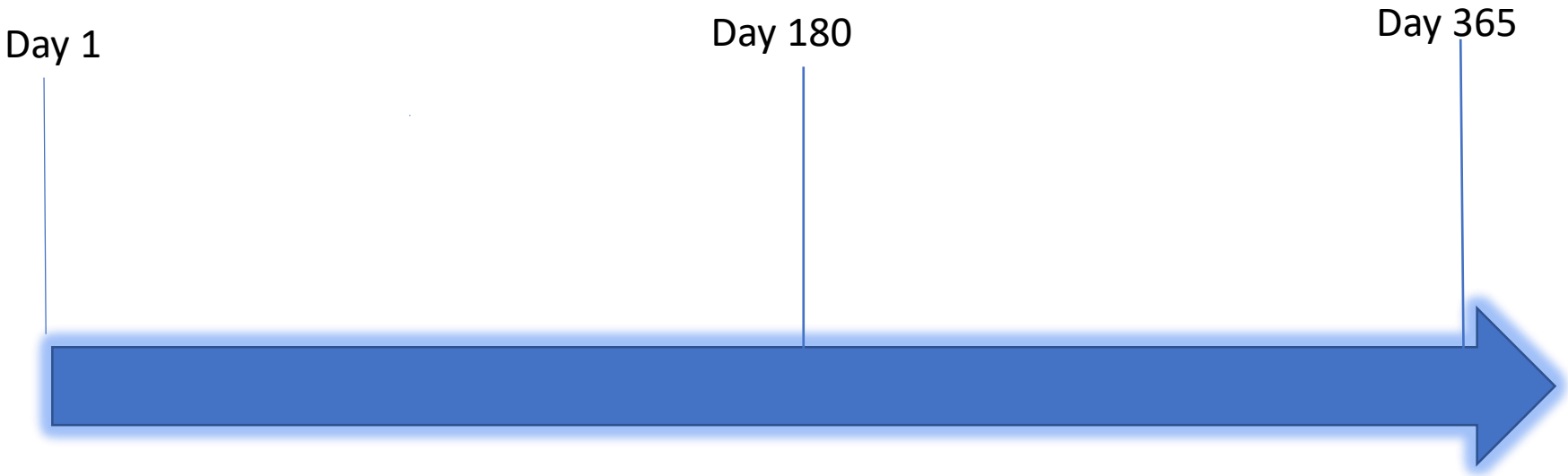
-daily does >100MME

# Prescribe 365

First known measure to define “over-prescribing”

365 days of medication for 365 days

Does not distinguish dosage



# Behavioral Health

Complex relationship between behavioral health, mental health and addiction, with chronic pain

Current and past mental health and substance use disorders, as well as a history of trauma, are risk factors for inappropriate use of controlled substances for pain

Chronic pain, and opioids, are also known to contribute to the development of depression

Many patients co-prescribed opioids and benzodiazepines

# New Onset Depression

Opioid related new-onset depression was associated with longer duration of use, not dosage.

Across three different healthcare systems, approximately 10% of patients had developed new-onset depression after 30 days of opioid treatment.

The study controlled for pain severity and daily MME.

# Patient Management

**Managing Physiological Dependence**

Withdrawal:

opioid withdrawal syndrome following cessation

opioids or similar substances taken to avoid or relieve withdrawal symptoms

Tolerance:

taking more opioids to achieve intoxication or desired effect

marked diminished effect with continued use of same amount

# Identification of Addiction

**Addiction** is characterized by:

**inability to consistently abstain**

**impairment in behavioral control**

**craving**

**diminished recognition of significant problems with one's behaviors and interpersonal relationships, and**

**a dysfunctional emotional response**.

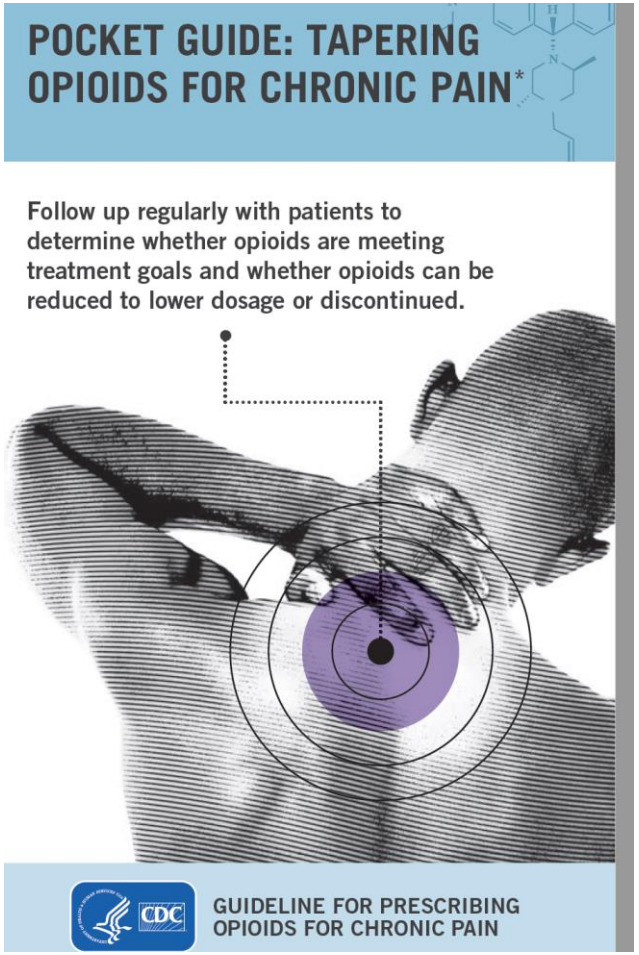
Like other chronic diseases, **addiction often involves cycles of relapse and remission**. Without treatment or engagement in recovery activities, **addiction is progressive and can result in disability or premature death.**

# Patient Management

Tapering/Discontinuation of Treatment

Ability to expand practice to include treatment of OUD

Ethical/legal implications



# Prescriber Support

**University of Nevada, Reno**

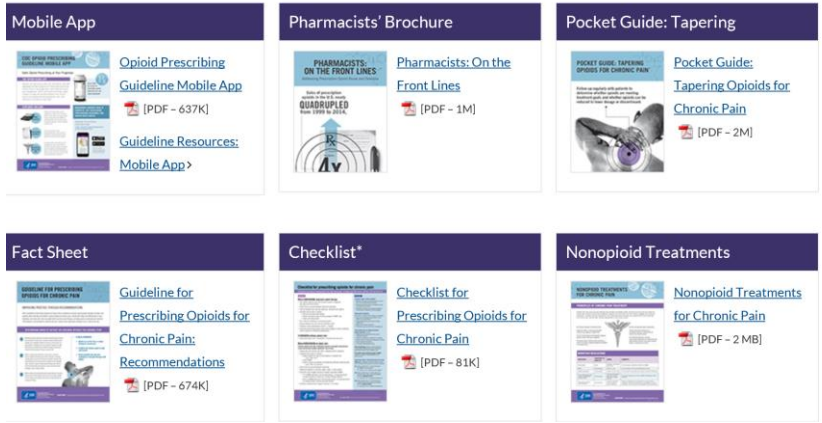

**Nevada Occupational Boards**

KNOW YOUR PAIN MEDS

**SAMHSA**

PCSS O TRAINING

**Centers for Disease Control and Prevention**



# Patient Education

## Opioid Campaign Materials #knowyourpainmeds

### Targeted Patient Education Materials

3 Target Areas

| Older Adults - Chronic Pain Patient | Injury Patients | Middle Aged Everyday Walk-ins |
|---|---|---|
|  |  |  |
| Things are changing? | You have options. | Start the conversation. |

## Clinician Commitment to Patient Prescription Safety Poster


Clinician Commitment to Patient Prescription Safety Poster [PDF – 2 MB]