


OPIOID PRESCRIBING RULES

VERMONT
DEPARTMENT OF HEALTH

May 17, 2017 – Webinar

Outline

- Introduction and Universal Precautions
  - Dr. Levine, Commissioner, Health Department *15 Minutes*
- Acute Pain
  - Dr. Patti Fisher, UVMMC *20 Minutes*
- Chronic Pain
  - Dr. Patti Fisher, UVMMC *10 minutes*
- VPMS
  - Hannah Hauser, VPMS Program Manager *10 Minutes*
- Questions
  - *15 Minutes*

The Problem

- As many as four out of five heroin users begin by abusing prescription drugs
- Of those who abuse prescription opioids, seven out of 10 received these drugs through methods of diversion
- Opioids are overprescribed. They are prescribed:
  - Too often
  - At too high a dose
  - For too long
- Prescribers play a role in the supply and use of opioids in communities.

Patient-level surveys of opioid use after surgery

- Dartmouth Hitchcock researchers examined opioid prescribing patterns after general surgery outpatient procedures. Results:
  - Wide variation in quantity provided for each operation
  - An average of only 28% of pills were used
  - To satisfy 80% of patient needs, could reduce prescription amounts by 43%

1: Hill M, McMahon M, Stucke R, & Barth R. Wide Variation and Excessive Dosage of Opioid Prescriptions for Common General Surgical Procedures. *Annals of Surgery*. 2016; doi: 10.1097/SLA.0000000000001993

Patient-level surveys of opioid use after surgery

- UVM study (Nov. 2016), after general and orthopedic surgery, same wide variation found even within a practice. Results:
  - 7% did not receive an opioid
  - Of the 93% who received an opioid
    - 12% did not fill the prescription
    - 30% that filled the prescription didn't use any
    - The overall median proportion used = 26%

New Persistent Opioid Use After Minor and Major Surgical Procedures in US Adults

- In a cohort of previously opioid-naive patients, approximately 6% continued to use opioids more than 3 months after their surgery, and as such, prolonged opioid use can be deemed the most common postsurgical complication.
- New persistent opioid use is not different among patients who underwent minor and major surgical procedures, thereby suggesting that prolonged opioid use is not entirely due to surgical pain.

Chad M. Brummett, MD1,2; Jennifer F. Waljee, MD, MPH, MS2,3; Jenna Goesling, PhD1; et al
JAMA Surg. Published online April 12, 2017. doi:10.1001/jamasurg.2017.0504

High-Level Overview of Rules

Note that providers should read the full rules which can be found here:

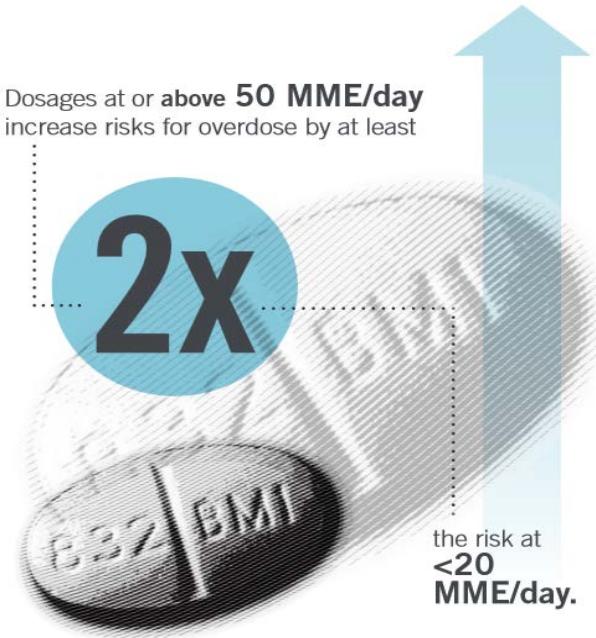
http://www.healthvermont.gov/about-us/laws-regulations/rules-and-regulations

Universal Precautions

- First consider non-opioid and nonpharmacologic treatments
- Upon first prescription prescribers must:
  - discuss risks and safe storage and disposal
  - provide a patient education sheet, and
  - receive an informed consent for all first opioid prescriptions
- Co-prescribe naloxone for prescriptions over 90 MME or if also on benzodiazepines
- Check the prescription monitoring system for everyone's first prescription exceeding 10 pills or a replacement prescription

Opioid Prescribing for Acute Pain

- First prescription to opioid naïve patients:
  - Consider non-opioid treatment
  - Prescribe minimum needed for pain
  - 350 MME (50 MME per day for 7 days) limit
  - Ensure a safe transition of care to patients PCP
  - Avoid long-acting opioids



MME Limits for First Prescription for Opioid Naïve Patients Ages 18+

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 0 oxycodone 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** 1-5 days: **120 MME**	4 hydrocodone 5mg or 3 oxycodone 5mg or 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** 1-5 days: **160 MME**	6 hydrocodone 5mg or 4 oxycodone 5mg or 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 6 oxycodone 5mg or 6 hydromorphone 2mg	similar to the severe pain category but with complications or other special circumstances

Opioid Prescribing for Minors

Teens who used opioids for legitimate reasons in high school had a 33% increased risk for future misuse compared to their peers.[1]

- Consult with pediatrician before prescribing in ED
- Opioids as last resort for minor injuries
- Limits the first prescription to a total of 72 MME (24 MME for 3 days)

[1]Miech R, Johnston L, O'Malley PM, Keyes KM, Heard K. Prescription Opioids in Adolescence and Future Opioid Misuse. Pediatrics. 2015;136(5):e1169-e1177.

MME Limits for First Prescription for Opioid Naïve Patients Ages 0-17

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 0 oxycodone 0 hydromorphone	molar removal, sprains, non-specific low back pain, headaches, fibromyalgia, un-diagnosed dental pain
Moderate to **Severe** pain	24 MME/day	0-3 days: **72 MME**	4 hydrocodone 5mg or 3 oxycodone 5mg or 3 hydromorphone 2mg	non-compound bone fractures, most soft tissue surgeries, most outpatient laparoscopic surgeries, shoulder arthroscopy

Prescribing Opioids for Acute Pain

- Prescribing limits do not apply to
  - palliative care
  - end of life or hospice care
  - patients in nursing facilities
  - pain associated with significant or severe trauma
  - pain associated with complex surgical interventions such as spinal surgery
  - pain associated with prolonged inpatient care due to surgical complications
  - medication assisted treatment for substance use disorders
  - patients who are not opiate naive

Opioid Prescribing for Chronic Pain

- Screening, Evaluation and Risk Assessment
  - Documented medical evaluation including a *physical exam*
  - Document any *diagnoses* which support the use of opioids
  - Document what *non-opioid, including non-pharmacologic treatments* that have been tried or considered
  - Evaluate and document *benefits and the individual patient's relative risks* (including risk for misuse, abuse, addiction or overdose for the individual)
  - Perform an assessment of any comorbid conditions affected by the treatment with opioids
  - Screen for the use of other controlled substances including MAT with methadone or buprenorphine

Opioid Prescribing for Chronic Pain

- Universal precautions apply
  - Informed Consent, Controlled Substance Treatment Agreement to be repeated annually
- Requires pain management plans and ongoing assessments of opioid effectiveness
- Sets a trigger for revaluation at 90 MME
- Stable patients must be evaluated at least every 90 days
- Co-prescribe naloxone for prescriptions over 90 MME or if also on benzodiazepines

Opioid Prescribing for Chronic Pain

- Every 90 day re-evaluation
  - Dose
  - Effectiveness
  - Adherence to treatment regimen (not just opioid rx)
  - Functional assessment
  - Potential for the use of non-opioid or non-pharmacologic alternatives
  - Any co-morbid conditions that may be affected by treatment with opioids
  - Assessment of individual risk factors that may lead the prescriber to modify the pain management regimen

Prism requirements for Chronic Pain Patients

- Chronic Pain in problem list
- Enroll patient in chronic pain topic in Health Maintenance
  - Informed consent and prescription agreement
  - Tracking UDS, pill counts
  - Functional assessment at clinician-dictated interval
- Screening for substance use (COMM)

VPMS Rules: Required Prescriber Queries

- The first time the provider prescribes an opioid
- Starting long-term pain therapy of 90 days or more
- Prior to writing a replacement prescription
- At least annually for patients who are receiving ongoing treatment
- The first time prescriber prescribes a benzodiazepine
- When a patient requests an opioid or a renewal from an Emergency Department or Urgent Care Center

Law Requires Dispensers to query the Vermont Prescription Monitoring System

Dispensers must check the prescription monitoring system when:

- Dispensing an opioid to a **new patient**
- A patient **pays cash** for an opioid, but has insurance
- A patient requests a **refill** of an opioid before it is due
- The dispenser knows the patient is being prescribed an opioid by **more than one prescriber**

Exemption for a hospital-based dispenser dispensing a quantity of an opioid that is sufficient to treat a patient for 48 hours or fewer.

If you remember nothing else…

- First consider non-opioid and nonpharmacologic treatments
- Upon first prescription, prescribers must:
  - discuss risks and safe storage and disposal
  - provide a patient education sheet, and
  - receive an informed consent for all first opioid prescriptions

If you remember nothing else….

- For acute pain in opioid naïve adult patients:
  - 350 MME (50 MME per day for 7 days) limit
  - Use the table, noting bolded items are maximums
- For chronic pain: screening, evaluation, risk assessment, universal precautions:
  - Re-evaluation trigger 90 MME
  - Stable patients must be evaluated at least every 90 days
- Naloxone co-prescription: for prescriptions over 90 MME or concomitant benzodiazepines

If you remember nothing else regarding when to query VPMS

- First time opioid prescription exceeding 10 pills or replacement prescription
- For chronic pain: starting nonpalliative long-term prescription over 90 days and annual for ongoing prescription
- First time benzodiazepine prescription

Resources

- Act 173 *An act relating to combating opioid abuse in Vermont*
  - http://legislature.vermont.gov/assets/Documents/2016/Docs/ACTS/ACT173/ACT173%20As%20Enacted.pdf
- VDH Rule Governing the Prescribing of Opioids for Pain
  - http://www.healthvermont.gov/sites/default/files/documents/2016/12/REG_opioids-prescribing-for-pain.pdf
- VDH Vermont Prescription Monitoring Rule
  - http://www.healthvermont.gov/sites/default/files/documents/2016/12/REG_vpms-20170701.pdf
- Patient Information Sheet
  - http://www.healthvermont.gov/alcohol-drugs/professionals/resources-patients-and-providers
- Informed Consent Template
  - http://www.healthvermont.gov/alcohol-drugs/professionals/resources-patients-and-providers
- Office of Primary Care and Area Health Education Centers (AHEC) Program
  - http://www.med.uvm.edu/ahec/workforceresearchdevelopment/toolkits-and-workbooks/opioid_prescribing

Contacts

- Vermont Prescription Monitoring System
  - Hannah Hauser Hannah.Hauser@Vermont.Gov
  - 802-652-4147
- Opioid Prescribing Rules
  - David Englander David.Englander@Vermont.Gov
  - 802-863-7280
- Quality Improvement Assistance
  - Nicole Rau Nicole.Rau@Vermont.gov
  - 802-951-5803