Opioid Epidemic Update & Policy Discussion

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Disclosures

None
Call to Action

In 2016, the Arizona Department of Health Services reports 790 people died as a result of opioid overdoses, a 74% increase in four years.

Governor Doug Ducey Declares State of Emergency June 5, 2017

Applicability – A.R.S. 26-301 & 26-303 allows the Governor to declare state of emergency for conditions of extreme peril to the safety of persons caused by an epidemic. Provides complete authority over all agencies of the state to direct personnel and resources to alleviate the emergency.

Governor Ducey directed Department of Health Services (DHS) to lead the public health emergency response – activated 70 staff, over 7,000 hours spent addressing opioid-related response activities

Opioid Epidemic Webpage

www.azdhs.gov/opioid
Emergency Declaration Key Components

1. Enhanced Surveillance Advisory – Healthcare professionals reporting suspected opioid overdoses, deaths, and neonatal abstinence syndrome through MEDISS

2. Emergency rulemaking to develop rules for opioid prescribing and treatment practices within DHS licensed healthcare institutions

3. Guidelines to educate healthcare providers on responsible prescribing practices

4. Training of law enforcement for administering Naxolone for overdoses

5. Opioid Action Plan submitted 9/5/17; declaration ends upon Governor’s acceptance

Opioid Action Plan Report

Goals & Recommendations

Reduce Opioid Deaths
  • 14 legislative recommendations

Improve Prescribing & Dispensing Practices
  • Regulatory Action Plan (Physician Licensing Boards)
  • Improved use of Controlled Substance Prescription Monitoring Program (PMP)

Reduce Illicit Acquisition and Diversion of Opioids
  • Law Enforcement Plan, Angel Initiative
Goals & Recommendations (cont’d)

Improve Access to Treatment
- Require pain management/substance use in medical school curriculums
- Call-in line, peer recovery supports
- Address federal barriers
- Access to naloxone, Vivitrol, MAT therapy
- Insurance Parity Task Force

Prevent Opioid Use Disorder/Patient Awareness
- Public service announcements for patients, providers and public
- Youth Prevention Task Force

Opioid Action Plan Prescriber Policies

Key Components:

1. Healthcare Institution Rules
2. Opioid Prescribing Guidelines
3. 14 Legislative Recommendations
Origins of the PMP mandate – utilization of PMP went down 17 to 15% in 4th quarter of 2015 prior to legislative session

Usability Performance Measures in SB 1283
• “Integration” with Statewide Health Information Exchange
  o Board of Pharmacy Integration Interest Form
• Integration status reporting – prescribers with integrated EHRs - 4,000 (11/7/17)
• Annual user survey and report to Arizona State Legislature
• Technology waiver – no rules promulgated yet
• PMP System Properties Analysis & Report – never completed

What’s Next?
• APPRISS upgrade – NarxCare Analytics Tool
• Shift from grant funds to dedicated funding source for PMP
• Need to allow delegates to check PMP through EHR or Health Current
• Population health applications
• Enforcement of mandate
Current and Proposed Arizona Policies for Opioid Prescribing

November 11, 2017
Eric Nelson
AOMA 37th Annual Fall Seminar

Disclosures

• None
**Presentation Agenda**

- Respond to the Arizona Statewide Emergency Opioid Epidemic as declared by the Governor
- Review the state-mandated use of the Arizona Controlled Substance Prescription Monitoring Program (CSPMP)
- Discuss the revised Arizona Opioid Prescribing Guidelines
- Identify resources for the integration of electronic health records (EHRs) with the CSPMP

**Mayo Clinic Arizona – by the numbers…**

Core Value: “The needs of the patient come first”

- 600 Physicians and Scientists
- 5600 Allied Health Staff
- 200 Physician Residents and Fellows
- 16,000 Surgeries
- 280 Hospital Beds
- 24 Operating Rooms
How Did Arizona Get Here?

Opioid Timeline

- 1980  WHO devises ladder for pain management
- 1984  Purdue releases MS Contin
- 1996  Purdue releases OxyContin
- 1996  American Pain Society urges pain as a vital sign
- 1998  JCAHO and VA adopt idea of pain as a vital sign
- 2008  Opioid overdose fatalities surpass auto fatalities
- 2016  Opioid overdose fatalities total ~64,000 which is more than Vietnam (58,200) and Iraq (4,500) combined
Arizona Opioid Rules and Legislation

Recent Legislation/Rules (details at the end of this presentation)

• Approved Amendment to A.R.S. 36-2606 (Senate Bill 1283)
• Governor Ducey Executive Order
• A.D.H.S.- authored Emergency Rules (A.R.S. R9-10-120) approved by Office of the Attorney General

1. Amendment to A.R.S 36-2606 (Senate Bill 1283)

• Arizona providers with licenses to prescribe controlled substances must register for and use the Controlled Substance Prescription Monitoring Program (CSPMP) database.
• All prescribers must obtain a CSPMP report for the previous year before prescribing a benzodiazepine or opioid analgesic (Schedule II, III, IV or V).
• Exceptions: hospice, cancer care, inpatient care, dialysis, prescribing controlled substance < 10 days
2. Gov. Ducey’s Executive Order

Notification of Enhanced Surveillance effective June 5, 2017
• Declares State of Emergency due to opioid epidemic
• Authorizes ADHS to initiate Emergency Rule making
• Requires reporting for:
  • Suspected Opioid Overdoses
  • Suspected Opioid Deaths
  • Naloxone doses administered for overdose or death
  • Naloxone Doses Dispensed
  • Neonatal Abstinence Syndrome

3. ADHS Emergency Rules (R9-10-120)

• Approved by Office of Attorney General on July 28, 2017 effective immediately
• Extensive list of required pre-requisites to issue or administer an opioid prescription or treatment
• Exempts ONLY ‘terminally ill’ patients from opioid and benzodiazepine requirements
3. ADHS Emergency Rules Include:

Expectation for provider organizations to:

- Create and monitor compliance with policies/procedures for prescribing, ordering, and administering an opioid
- Includes treatment in outpatient and inpatient settings
- Identify which personnel members may prescribe
- Ensure consistency with national opioid prescribing guidelines

3. ADHS Emergency Rules include:

- Cover conditions that may contraindicate prescribing an opioid or using an opioid
- Cover the criteria for co-prescribing an opioid antagonist
- Include frequency of face-to-face interactions, risk assessments, renewals and monitoring
- Check CSPMP
- Discuss criteria for tapering or discontinuing of the opioid
- Cover criteria for offering a referral for treatment
3. ADHS Emergency Rules include:

Expectation that provider organizations will create and maintain a stringent opioid Quality Management Program

- Review of all opioid related adverse reactions or other negative outcomes or death
- Surveillance and monitoring of adherence to the organization’s opioid-related policies and procedures
- Notification of ADHS within one working day of a death attributed to opioid overdose (with blood sample)

3. ADHS Emergency Rules Include:

Provider requirements - Opioid prescription & administration:

- Conduct a physical examination
- Check the CSPMP 12-month profile
- Conduct a substance abuse risk assessment
- Develop a treatment plan
- Explain the potential risks and benefits of opioid use
- Explain alternatives to an opioid
- Obtain written informed consent
- Document in the EHR the identification of the patient's pain before administration and the effect (patient response) of the opioid administered
ADHS Emergency Rules – October Draft

Exemptions:
• The requirements do not apply to a health care institution’s prescription, ordering, or administration of opioids for:
  • treatment for a patient with an end-of-life condition
  • pain associated with an active malignancy

ADHS Emergency Rules – October Draft

Definitions:
• **Active Malignancy:** A patient is undergoing treatment for:
  • Surgical procedures to remove the cancer
  • Chemotherapy or
  • Radiation treatment
  • There is no treatment or patient is refusing treatment.
• **End-of-Life:**
  • Patient has a documented life expectancy of six months or less
• **Substance Use Risk Assessment:**
  • Evaluation of an individual’s unique likelihood for addiction, misuse, diversion, or another adverse consequence resulting from receiving treatment with opioids.
Is Institutional Compliance Possible?

Workgroup

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Healthcare Institution Compliance

Green Status: ‘Easy Lift’

• **CSPMP Registration and Education**
  • Monthly data pulls on non-compliance

• **Overdose Reporting Requirements**
  • Implement process for reporting known death or suspected opioid overdose to ADHS

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Healthcare Institution Compliance

Green Status: ‘Easy Lift’

• **Referral Process for ‘Addiction’ or ‘Dependency’ patients**
  • Pain specialists for chronic opioid prescribing
  • Create referral plans for chronic opioid patients

• **Align Treatment Guidelines as required by ADHS**
  • Committee in place and documents under review
Healthcare Institution Compliance

Yellow Status: ‘Harder Lift’

- **CSPMP Workflow Plans**
  - Providers need to incorporate CSPMP into their workflow

- **Diffuse Practice Guidelines**
  - Educate providers on Acute/Chronic Opioid Rx guidelines

Healthcare Institution Compliance

Red Status: ‘Heavy Lift’

- **Attorney General Rules on Opioid Administration**
  - Rules that will greatly compromise workflow
  - Engaged with ARMA, AOA, AOMA, AHA to address inhibitory rules

- **Federal Rules Coming?**
  - Preparation for a federal response to the epidemic
  - Guidelines may change current state guidelines
Healthcare Institution Compliance

Departments with **Minimal** Acute Opioid Prescribing Patterns:

*Example: Hospital Internal Medicine, Dermatology*

**Procedure:**
- Providers personally print & review the CSPMP database prior to prescribing the controlled substance.
- Results of the CSPMP are **documented** in the patients record.

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Healthcare Institution Compliance

Departments with **Frequent** Acute Opioid Prescribing Patterns:

*Example: General Surgery, Urology, ENT, Neurology*

**Procedure:**
- MAs/LPNs within the department are delegates for their providers.
- Reason for visit is reviewed prior to patient arrival by MA/LPN.
- Patients with **complaints of pain** (such as post-op) are
  - Flagged by the MA/LPN and
  - CSPMP reports are pulled and reviewed with the provider.
- CSPMP reports are assembled with the remainder of the paper chart for the physician to review at the time of the patient visit.

The clinician reviews the report with the patient and **documents** in the EHR.
Healthcare Institution Compliance

Departments with Chronic Opioid Prescribing Patterns:
*Example: Community Internal Medicine, Family Medicine, Epilepsy Clinic*

Procedure:
- MAs/LPNs within the department are delegates for their providers.
- Chronic opioid therapy patients (>45 days) are brought in for an initial visit.
- MA/LPN performs daily ‘batch’ pulls of CSPMP for patients meeting criteria.
- Chronic opioid therapy packet is prepared for the appointment:
  - CSPMP report
  - Patient Opioid Contract agreement and
  - Patient Educational materials
- Clinician reviews the report with the patient and documents.
- Appointments are automatically scheduled every three months.

Prior to each appointment, the MA/LPN prepares a packet with the CSPMP report.

Opioid Action Plan Solutions
Opioid Action Plan - Proposal

Prescribing:

- **Impose a 5 day limit on all first fills for** opioid naïve patients for all payors
- **Require a limit (and tapering down over years) of doses to less than 90 MME**, exemptions for specific situations would be made in statute
- **Require e-prescribing for Schedule II controlled substance medications**

Opioid Action Plan - Proposal

Promote Safe Prescribing & Dispensing:

- **Require different labeling and packaging for opioids ("red caps")**
- **Eliminate** dispensing of controlled substances by prescribers
- **Require pharmacists** to check the CSPMP prior to dispensing an opioid or benzodiazepine
Opioid Action Plan – Pharmacy Impact

**Prescription Filling:**
- **Corresponding responsibility** to that of the Prescriber (21 CFR 1306.04a) that Rx is for legitimate medical purpose
- Enforce 5 day limit on all first fills
- Limit dispensing to less than 90 MME (unless exception)
- Label and package opioids in containers with red caps
- Check CSPMP prior to dispensing opioid or benzodiazepine……and then?

**Delegates**
- CSPMP access is covered under the Use and Release of Confidential Information (PHI)
- The following delegates are defined:
  - Licensed healthcare professional
  - Unlicensed medical records tech, medical assistant or office manager with HIPPA training
- Approval process involves delegating physician(s)
- Delegate access tracking available to delegating physician(s)
Questions and Discussion