Maine’s New Opioid Prescribing Law and the Opioid Crisis: Implications for Providers

Tuesday, May 3, 2016
12PM – 1PM

Audio is available through your computer speakers.

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Tuesday, May 10, 12:00PM – 1:00PM
Building Clinical and Community Connections Series
From Crisis to Thriving: Building Strategic Industry-Community Partnerships to Improve Health

Tuesday, May 17, 12:00PM – 1:00PM
Preparing for MIPS: Performance Counts

Tuesday, June 7, 12:00PM – 1:00PM
Geriatric Care Series
Screening Elderly Patients for Fall Risk: The CDC’s STEADI Toolkit
Today’s Presenters

**Lisa Letourneau, MD, MPH**
Lisa is the Executive Director of Maine Quality Counts. A graduate of Brown University. The Brown/Dartmouth Program in Medicine and the Harvard School of Public Health, Lisa has served as an emergency physician, a health plan medical director and as Senior Director of Clinical Integration for MaineHealth.

**Noah Nesin, MD, FAAFP, MAFP**
Noah is the Vice President of Medical Affairs at Penobscot Community Health Care. He previously served as Medical Director of Health Access Network and has worked as a family physician in the Lincoln area for almost 30 years.

**Gordon H. Smith, Esq.**
Gordon has been the Executive Vice President of the Maine Medical Association since 1993. A frequent lecturer to medical groups on legal topics, Gordon is a graduate of the University of Maine and the Boston College Law School.
Maine's New Opioid Prescribing Law & the Opioid Crisis: Implications for Providers

Lisa Letourneau MD, MPH
Maine’s Opioid Crisis: A Rising Death Toll!

In 2014, there were 208 drug related overdose deaths compared to 131 motor vehicle related deaths.

2014: Maine’s overdose death rate exceeds natl avg!
2015: Maine deaths increased by 31%!

Source: Office of the Chief Medical Examiner, Maine Bureau of Highway Safety/Maine Department of Transportation

*ME State Epidemiological Outcomes Workgroup (SEOW) Oct 2015
272 Lives Lost

- 272 Mainers lost to opioid/heroin deaths in 2015
- ME overdose death rate increased 31% from 2014 to 2015
- Maine leads nation in rate of long-acting opioid prescriptions
Maine’s Opioid Crisis: Affecting our Babies

In 2014, there were a total of 961 reports of drug affected baby notifications.

From 2005 to 2014, the number of drug affected baby notifications increased by 480%.

*This measure reflects the number of infants born in Maine where a healthcare provider reported to OCFS that there was reasonable cause to suspect the baby may be affected by illegal substance abuse or demonstrating withdrawal symptoms resulting from prenatal drug exposure (illicit or prescribed appropriately under a physician’s care for the mother’s substance abuse treatment) or who have fetal alcohol spectrum disorders.


*Maine State Epidemiological Outcomes Workgroup (SEOW) – Oct 2015
1013 Maine Babies Impacted at Birth

• 1 in 11 babies in Maine born drug-affected in 2015

• Maine’s infant mortality rate (7.1/1000) above national average, and climbing
What If... Imagine the Headlines?

- 272 Mainers Die of Flu...
- Over 1000 Maine Babies Sickened by Environmental Toxin...
- 272 Mainers Killed by Drunk Drivers...
Opioid Crisis = Largest Iatrogenic Public Health Disaster in US History

And we are contributing!

• 80% of people arrested for heroin report opioid use started with prescription meds – legally or illegally obtained!
• Huge levels of diversion of prescribed meds
• Youth particularly at risk for using diverted opioids – medicine cabinets, “pill parties”
Opioids for Chronic Pain: Our 21st Century Equivalent?
Addressing the Crisis: Building a Comprehensive Approach

- Education/Prevention/Harm Reduction
- Treatment
- Law Enforcement

Maine Opioid Collaborative
The Role of Clinicians & Practice Teams?

- Education/Prevention/Harm Reduction
- Treatment
- Law Enforcement

Maine Opioid Collaborative
LD 1646/Chptr 488: Opportunity & Risks

• Offers opportunities for ME clinicians:
  – Re-examine, limit opioid prescribing patterns
  – Identify patients on high-dose opioids

• Presents risks if not well implemented
  – Need for compassionate tapering of pts on high-dose opioids
  – Need to appropriately recognize addiction & refer for appropriate treatment
The Potential of Collective Impact

In surprising turn, Maine toddlers had nation’s highest vaccination rate in 2014

The coverage for seven vaccines protecting against 11 diseases reached 84.7 percent, a 16.7-point increase over 2013.

This Simple Strategy Helped Maine Achieve The Nation's Highest Vaccination Rate For Toddlers

The state is stepping in to combat anti-vaxxers.

Christina Wilkie
National Reporter, The Huffington Post

THE HUFFINGTON POST
Caring for ME

• Proactive, positive leadership response to Maine’s opioid crisis and (likely) legislation mandating prescribing limits
• Partnership of MMA & QC
• Promote shared communication, education & support
• Help providers maintain compassionate approach to chronic pain management, addiction
• Partners welcome!
• www.mainequalitycounts.org/caringforme
• More to come…
How Did We Get Here?

"And with 10 being the highest, you're sure you're only at a 6?"
Fertile Ground

- Targeting of rural, poor states
- Targeting of unsophisticated (naive?) providers
- Knowledge vacuum
- Lack of physician and provider self efficacy
- Willing specialists leading the way
- Some corrupt physicians
Leading to the Birth of...
The American Pain Foundation:

• Heavily funded by Purdue, Cephalon and others
• No ceiling dose for opioids for chronic pain
• Shut down in May, 2012 after US Senate launched an investigation
“Pseudoaddiction”

• Coined by Dr. David Haddox and Dr. David Weissman
• Based on a single case of a 17 year old leukemia patient with pneumonia and chest wall pain being treated as an inpatient
• Embraced by APF and Federation of State Medical Boards (also receives funding from PhRMA)
“Pseudoaddiction”

“It led us down a path that caused harm. It is already something we are debunking as a concept.”

Dr. Lynn Webster, Past President AAPM
And...

The American Academy of Pain Medicine & The American Pain Society

• In 1996 issued joint statement stating that chronic pain should be treated with opioids and the risk of addiction is low (<1%)

• Chair of group issuing the statement was Dr. David Haddox

• Statement was removed from AAPM website in fall of 2011
And...

• In 2006 Purdue Pharma paid a $635 million fine for its deceptive marketing of Oxycontin.
• Purdue Pharma’s CEO paid $11 million personal fine.
• Purdue Pharma made over $3 billion from Oxycontin in 2010 alone.
• Dr. David Haddox is now VP of Health Policy at Purdue Pharma.
And...

- **AHRQ September 30, 2014:**
  “Evidence of long-term opioid therapy for chronic pain is very limited, but suggests an increased risk of serious harms that appears to be dose-dependent.”
There are no studies of...

- Long term opioid therapy vs. no or non-opioid therapy
- Variations in effectiveness based on type of pain and patient characteristics
- Outcomes related to pain, function or quality of life compared to non-opioid therapy.
The Harm
The Harm

- Lifetime prevalence of OUD is 35%
- 169 Mainers died of drug overdose in 2010, 272 in 2016
- Our prescribing has increased for every payer group except MaineCare
- 66% of pills used by highest risk abusers of prescription pain meds are obtained from family and friends
The Harm

• 779 babies born with NAS in Maine in 2012, over 1000 in 2015

• Maine leads the nation in the rate of prescriptions for long acting opioids (21.8 Rx/100 people vs. national average of 10.3)

• 265% increase in deaths from prescription opioid overdose in men since 1999, 400% in women
What is “High Dose?”

≥100 Morphine Equivalents

*Overdose defined as death, hospitalization, unconsciousness, or respiratory failure.
Primum Non Nocere

We in primary care are uniquely positioned to make an immediate, positive and enduring impact on the quality of life and outcomes for our patients, for our providers and for our community. We have to solve this.
Definition of Pain

An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage. It is a subjective phenomenon.

*International Association for the Study of Pain (IASP)*
Where Do We Start?

• Open our minds and eyes.
• Recognize our personal and professional deficiencies and barriers.
• Improve our knowledge.
• Improve our self-efficacy.
• Develop an evidence based and reality informed approach to the management of chronic pain.
• Sustained, compassionate engagement
Where Do I Start?

- Compassionate language
- Intentional management of acute prescriptions
- Strengthen knowledge of risks/benefits of all treatment options
- Don’t be fatalistic
- Know the meds you do prescribe.
- Don’t use opioids in circumstances when they shouldn’t be used.
- Gain your proper role in the management of this important problem.
- Educate patients and caregivers (and staff and colleagues and public)
- If chronic opioids are part of the treatment plan use drugs and doses that limit risks and use tools to properly assess risk, monitor use and evaluate for important adverse effects/toxicities.
- Don’t work in isolation.
Communicate Risks of Opioids

“There are very significant risks associated with opioids.”

- Accident
- Injury
- Accidental overdose
- Premature death
- Heart Disease
- Driving
- Becoming the victim of a crime
- Dependence
- Addiction
- Side Effects
“I’ve been thinking a lot about your care. As new information becomes available it is more and more apparent that these medications are not the right ones for your problem, and I think we need to move to a safer and more effective treatment plan. I know this will be difficult for you and I know it is frightening to consider. I will work with you and be available for you and we will get there together.”
**Tapering Plan for Client with Chronic, Non-Cancer Pain**

Please Fax to: Narcotic Review Program (360) 725-2122

**Client's Name:**

Short and long acting narcotics should be tapered separately; first taper the short acting agent, then taper the long acting.

**Tapering short acting narcotics:** As a general rule, if the % of total MED is < 10% of the initial total MED of all narcotics, taper by 10% of the initial total dose (milligrams) every 3 days. If the % of the total MED is > 10% of the initial total MED, taper by 10% of the initial total dose (milligrams) every week.

**Tapering long acting narcotics:** As a general rule, taper by 10% of the initial total dose (milligrams) until down to 30% of the initial total dose (milligrams). Then, taper by 10% of the remaining 30% of the initial taper (milligrams).


According to the Agency Medical Directors Opioid Guidelines, symptoms of an abstinence syndrome, such as nausea, diarrhea, muscle pain and myoclonus can be managed with clonidine 0.1-0.2mg orally q6hours or Catapress-TTS 1 patch/weekly. Sleep problems can be treated with zolpidem and/or low dose tricyclic agents, such as doxepin 10-50mg qhs. **DO NOT TREAT WITHDRAWAL SYMPTOMS WITH ADDITIONAL OPIOIDS OR BENZODIAZEPINES.**

<table>
<thead>
<tr>
<th>Initial Total Dose</th>
<th></th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Opioid Type</th>
<th>Baseline Opioid</th>
<th>Current mg/Day</th>
<th>Current MED/Day</th>
<th>% of Total MED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short Acting</td>
<td></td>
<td></td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>
Dose Equivalency Calculator

Opioid Dose Calculator

Instructions: Fill in the mg per day for whichever opioids your patient is taking. The web page will automatically calculate the total morphine equivalents per day. how to add this calculator to your smart phone or tablet home screen here: Android or iPhone/iPad.

<table>
<thead>
<tr>
<th>Opioid (oral or transdermal)</th>
<th>mg per day</th>
<th>Morphine equivalents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Fentanyl transdermal (in mcg/hr)</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Methadone</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Morphine</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Oxycodone</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Tapentadol</td>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>

Patient’s Name:  
Today’s Date: October 16, 2013
Pain Disability Index

Pain Disability Index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category indicating the overall impact of pain in your life, not just when pain is at its worst.

For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Family/Home Responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school).
No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Recreation: This disability includes hobbies, sports, and other similar leisure time activities.
No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Social Activity: This category refers to activities, which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.
No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Occupation: This category refers to activities that are part of or directly related to one's job. This includes non-paying jobs as well, such as that of a housewife or volunteer.
No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Sexual Behavior: This category refers to the frequency and quality of one's sex life.
No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Self Care: This category includes activities, which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dressed, etc.)
No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Life Support Activities: This category refers to basic life supporting behaviors such as eating, sleeping, and breathing.
No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst Disability

Signature __________________ Please Print __________________

Date ___________
Opioid Risk Tool

Date __________________________

Patient Name ______________________

<table>
<thead>
<tr>
<th>OPIOID RISK TOOL</th>
<th>Mark each box that applies</th>
<th>Low Score</th>
<th>High Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Family History of Substance Abuse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>[ ]</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Illegal Drugs</td>
<td>[ ]</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>[ ]</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>2. Personal History of Substance Abuse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>[ ]</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Illegal Drugs</td>
<td>[ ]</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>[ ]</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>3. Age (Mark box if 16 – 45)</td>
<td>[ ]</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>4. History of Preadolescent Sexual Abuse</td>
<td>[ ]</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>5. Psychological Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attention Deficit Disorder, Obsessive Compulsive Disorder, Bipolar, Schizophrenia</td>
<td>[ ]</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Depression</td>
<td>[ ]</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

TOTAL ______________________

Total Score Risk Category
Low Risk 0 – 3
Moderate Risk 4 – 7
High Risk ≥8

Adverse Childhood Experiences
Resources

• DAST
• AUDIT
• CDC Guidelines
• Johns Hopkins guideline
• Washington Agency Medical Directors Guide
• Bangor Area Controlled Substance Work Group Documents
• Diversion Alert

• **MQC Pain Playbook:**
  
  [www.mainequalitycounts.org/page/2-1401/controlled-medication-playbook](http://www.mainequalitycounts.org/page/2-1401/controlled-medication-playbook)
nnesin@pchc.com
Maine’s New Opioid Prescribing Law & the Opioid Crisis: Implications for Providers

Gordon H. Smith, Esq., Executive Vice President
Maine Medical Association
May 3, 2016
Facing the Opioid Crisis Today

• Opioid abuse epidemic gains attention of state and federal policymakers throughout 2015
• About a half dozen relevant bills submitted for consideration by the 127th Maine Legislature during the 2016 session
• Opioid abuse issue has substantial political energy behind it; legislative action seemed certain from the session’s start
• MMA and other advocates sought health care practitioner licensing board regulatory action rather than legislative intrusion into the physician-patient relationship
• Finally, preventing legislative action not a realistic strategy; MMA and other advocates successfully moderated LePage Administration proposal through lengthy negotiations
Key Bills in 2016 Session

- LD 1537, *An Act To Combat Drug Addiction through Enforcement, Prevention, Treatment and Recovery* (PL 2015, Chapter 378) - submitted by Speaker of the House and President of the Senate
- LD 1646, *An Act To Prevent Opiate Abuse by Strengthening the Controlled Substances Prescription Monitoring Program* (PL 2015, Chapter 488) - introduced by the Governor to provide limits on the prescription of opioids
- LD 1648, *An Act To Amend the Laws Governing the Controlled Substances Prescription Monitoring Program and To Review Limits on the Prescription of Controlled Substances* - introduced by Sen. Roger Katz (R-Kennebec) as an alternative to LD 1646; did not pass, but some concepts included in final version of LD 1646
Overview of Chapter 488

- Effective 90 days after adjournment, though some provisions have other timeframes specified (~July 29th)

- Components include:
  - Required PMP check for prescribers and dispensers
  - Prescribing limits on MMEs per day
  - Prescribing limits on length of scripts
  - Exception for emergency rooms, inpatient hospitals, long-term care facilities, or residential care facilities
  - Exception for medication-assisted treatment for substance use disorder
  - Exception for active and aftercare cancer treatment, palliative care, and end-of-life and hospice care
  - Other exceptions may be determined by rule
  - Mandatory CME
  - Mandatory electronic prescribing
• **Acute pain**
  - Normal, predicted physiological response to a noxious chemical or thermal or mechanical stimulus.
  - Typically associated with invasive procedures, trauma and disease and is usually time-limited.

• **Chronic pain**
  - Persists beyond the usual course of an acute disease or healing of an injury.
  - May or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years.
Key Definitions

• **Prescriber**
  - Licensed health care professional with authority to prescribe controlled substances
  - Includes veterinarians

• **Administer**
  - Action to apply prescription drug directly to a person
  - Does not include delivery, dispensing, or distribution of a prescription drug for later use
Key Definitions

- **Palliative care**
  - Patient-centered, family-focused medical care that optimizes quality of life by anticipating, preventing, and treating suffering caused by medical illness or physical injury or condition that substantially affects quality of life
  - Addresses physical, emotional, social, and spiritual needs
  - Facilitates patient autonomy and choice of care
  - Provides access to information
  - Discusses patient’s goals for treatment and treatment options, including hospice care
  - Manages pain and symptoms comprehensively
• **Serious illness**
  - Medical illness or physical injury or condition that substantially affects quality of life for more than a short period of time
  - Includes, but is not limited to, Alzheimer’s disease and related dementias, lung disease, cancer and heart, renal or liver failure
Prescriber Responsibilities

• Required PMP check
  - Upon initial prescription of benzodiazepine or opioid medication
  - Every 90 days following

• Exception
  - No PMP check is required for benzodiazepine or opioid medication directly administered in an emergency room setting, an inpatient hospital setting, a long-term care facility, or a residential care facility
Prescriber Responsibilities

• Electronic Prescribing
  - Beginning July 1, 2017, prescribers with the capability to electronically prescribe must prescribe all opioid medication electronically
  - A waiver may be available in some circumstances

• Continuing Education
  - A prescriber must complete 3 hours of CME on the prescription of opioid medication every 2 years as a condition of prescribing opioid medication
• Morphine Milligram Equivalents (MMEs)
  - New opioid patients after effective date of law (~July 29th)
    • May not prescribe any combination of opioid medication in an aggregate amount of more than 100 MMEs per day
  - Existing opioid patients with active prescription in excess of 100 MMEs per day as of effective date of law (“Legacy patients”)
    • From effective date of law (~July 29th) until July 1, 2017, may not prescribe any combination of opioid medication in an aggregate amount of more than 300 MMEs per day
  - Exception for medical necessity documented in the medical record until January 1, 2017 or the effective date of DHHS rulemaking on exceptions, whichever is later
Prescription Limits

- **Acute Pain**
  - Script may not be written for more than 7-day supply within a 7-day period

- **Chronic Pain**
  - Script may not be written for more than 30-day supply within a 30-day period

- Scripts may be renewed without limit based on medical necessity

- Limits apply only to opioid medications
Prescription Limit Exceptions

• When prescribing for:
  - Active or aftercare cancer treatment
  - Palliative care
  - End-of-life and hospice care
  - Medication-assisted treatment for substance use disorder
  - Other circumstances determined by rulemaking

• When directly ordered or administrated in:
  - An emergency room
  - An inpatient hospital
  - A long-term care or residential care facility
Deadlines

• **Effective date is 90 days after adjournment (~July 29th)**

• **January 1, 2017**
  - Mandatory checks of the PMP
  - Limits on scripts for acute and chronic pain

• **July 1, 2017**
  - Mandatory electronic prescribing
  - Patients with active prescriptions in excess of 100 MMEs must be tapered to an aggregate amount of 100 MMEs or less per day

• **December 31, 2017**
  - CME requirement
Penalties

- Civil violation
- Subject to fine of $250 per incident up to a maximum of $5000 per calendar year
- But, no penalties may be imposed for violating prescribing limits until PMP enhancements are implemented
Other Provisions

- Prescription Monitoring Program (PMP)
  - PMP data access by certain hospital and pharmacy staff and a province of Canada
  - Automatic registration of pharmacists and veterinarians
  - “Enhancements” to PMP
    - “Dosage converter” to/from MME
    - Automatic distribution of de-identified peer data to prescribers annually
    - Improved delegation to non-prescriber staff
    - Improved speed and communication
- DHHS and Bureau of Insurance reporting requirements
Questions?

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- Andrew MacLean, Deputy EVP & GC: amaclean@mainemed.com; 207-215-7462 (Cell)
- Peter Michaud, Associate GC: pmichaud@mainemed.com; 207-475-3312 (Cell)