Opioid Misuse:

Options for Prevention, Identification, and Treatment

(including certain policies already implemented in Utah)

Revised 4/21/16

This is an evolving document. Suggestions for change are welcome.
The inclusion of options in this document is not any indication of their merit.

1. PHARMACEUTICAL MANUFACTURERS

a. Improve prescriber education
b. Increase production of abuse-deterrent opioids (extended-release and long-acting)

2. PRESCRIBERS

a. Engage in continuing professional education about opioid prescribing
b. Comply with opioid prescribing guidelines
    i. Utah Department of Health 2009 Guidelines
    ii. U.S. Centers for Disease Control and Prevention 2015 Guidelines
        1. Limit to acute pain for 3 – 7 days
        2. Use alternatives for chronic pain
        3. Use of lowest possible dose
        4. Use of immediate-release formulations
        5. Exceptions for active cancer, end-of-life care, and surgery
    iii. Condition-specific pain management protocols
c. Screen patients for substance misuse and refer them to treatment programs
d. Improve patient education
e. Co-prescribe naloxone with opioids
f. Use patient assessment tools and pain management contracts
g. E-prescribe controlled substances (or a subset thereof) to reduce fraud and monitor treatment compliance
h. Use secure prescription pads
i. Engage in peer review of prescribing practices
j. Abide by prescribing limits
    i. Limit the amount of first-time prescription (or other prescriptions) to a specified number of days
    ii. Limit daily supply to a morphine equivalent
    iii. Limit patient's daily morphine equivalent for all prescriptions combined
    iv. Limit emergency department prescribing/dispensing
    v. Prohibit doctor dispensing of opioids

vi. Limit the prescribing of pain medications by prescribers who are not pain specialists to a specified number of morphine equivalents per day (e.g., 50 under CDC's proposed prescribing guidelines and 120 in Washington; see 2010 Washington legislation)

vii. Refer patient to a pain specialist

k. Use the controlled substance database (prescription drug monitoring program) more effectively

i. Increase usage (check for first-time prescriptions; check periodically for each patient; check always; etc.)

ii. Develop workflow-friendly interface with electronic health records and other processes

iii. Evaluate prescribing practices in light of:

1. notices from DOPL about the prescriber's patients who have died from drug related causes;

2. notices from DOPL about the prescriber's patients who have been treated for overdose or poisoning or who have been convicted of drug related DUI

iv. Request controlled substance database notification for patients meeting specified dispensing criteria

l. Involuntarily commit a person who is an immediate danger to self or others to a drug treatment facility for up to 72 hours (proposed in Massachusetts)

m. Use pain medication treatment plans

n. Use pain medication agreements and informed consent

o. Perform a physical examination and substance use disorder assessment prior to prescribing a controlled substance

p. Obtain continuing professional education on alternatives to opioids

q. Use baseline drug testing for new patients and periodic drug testing for other patients to monitor compliance with treatment plan and detect use of other drugs

3. DISPENSERS

a. Increase use of controlled substance database

i. Check all nonresidents

ii. Check all cash transactions

iii. Check all out-of-state prescriptions

b. Integrate use of controlled substance database into pharmacy workflow (Kroger pharmacists check nearly 100% of controlled substance prescriptions)

c. Improve pharmacist response to red flags

d. Install pharmacy drop-boxes for the disposal of unused drugs

e. Require identification of those picking up prescriptions

f. Dispense at-home deactivation kits with drugs (Delaware completed a pilot program)

g. Obtain standing order for dispensing naloxone

h. Allow partial fills so that only the amount requested by a patient is dispensed, up to the amount prescribed

4. INSURERS

a. Structure coverage, prior authorization, and cost sharing parameters to incentivize compliance with CDC guidelines and other prescribing guidelines
b. Educate insureds
c. Cover abuse-deterrent opioids (extended-release and long-acting) (however, see results of 2015 PEHP study)
d. Cover naloxone
e. Cover the broad spectrum of treatment services, including medication-assisted treatment
f. Cover controlled substance database access by prescribers and dispensers
g. Use a patient review and restriction program to limit an at-risk patient to a single prescriber and a single pharmacy or pharmacy chain (e.g., BlueCross BlueShield of Massachusetts)
h. Require prior authorization for an initial prescription (e.g., BlueCross BlueShield of Massachusetts)
i. Limit initial quantities prescribed (e.g., BlueCross BlueShield of Massachusetts)
j. Work on development of more user-friendly controlled substance database interface
k. Use claims analysis to analyze dispensing patterns and notify, educate, and intervene as appropriate

5. PATIENTS

a. Securely store medications
b. Properly dispose of unused medications
c. Obtain and act on education by prescribers, dispensers, public service campaigns, etc.
d. Obtain naloxone for family and friends
e. Reduce drug sharing behaviors
f. Reduce drug seeking behaviors
g. Develop realistic expectations about pain management
h. Complete periodic education and counseling during treatment of chronic pain (proposed by Georgia 2015 H.B. 407)
i. Use a voluntary revocable non-opioid directive, where appropriate, to alert practitioners to not prescribe or administer opioids

6. TREATMENT COMMUNITY

a. Co-locate substance use and mental health treatment providers with physical healthcare providers
b. Build infrastructure for full spectrum of treatment options

7. STATE – PRESCRIPTION DRUG MONITORING PROGRAM, INCLUDING USE OF THE CONTROLLED SUBSTANCE DATABASE

a. DOPL notify prescribers of patient overdose, poisoning, drug related DUI
b. DOPL notify prescribers of patients meeting criteria established by prescriber
c. DOPL notify patient-designated third parties when a controlled substance is dispensed to a patient
d. DOPL notify prescribers with suspect prescribing patterns
e. Map controlled substance database data geographically
f. Promote third-party analysis of de-identified data
g. Batch process to screen an entire day's calendar of patients
h. Develop workflow-friendly interface (e.g., single sign-on) with electronic health record systems and other processes, and dispensers' point of sale system (see 2016 H.B. 239, Access to Opioid Prescription Information via Practitioner Data Management Systems (McKell); see also "Examining Legislative Proposals to Combat our Nation's Drug Abuse Crisis," Statement by Michael P. Botticelli, Director of National Drug Control Policy, before the United States House of Representatives Subcommittee on Health of the Committee on Energy and Commerce, Thursday, October 8, 2015)
i. Expand access to database information, as appropriate (e.g., to drug courts, treatment professionals, prisons and jails, law enforcement, prosecutors, state medical examiner, physician assistants, physician residents, licensing boards, etc.)
j. Maintain data quality
k. Monitor database use to ensure data security
l. Mandate use for patients meeting certain criteria (KY, TN, and NY mandate use of a PDMP; "As of June 2014... 22 states had laws mandating that prescribers and in some cases dispensers use the PDMP in certain circumstances")
m. Mandate use for first prescription and at least once every year thereafter
n. Notify third-party payers (see Kentucky)
o. Provide unsolicited reports to law enforcement and professional regulatory boards
p. Develop automated expert systems to expedite analyses and reports (e.g., NARxCHECK)
q. Share analytics for identifying problem patients and prescribers with prescribers, dispensers, insurers, and third-party researchers
r. Create a Controlled Substance Database Advisory Board to make recommendations to the Legislature and the Division of Occupational and Professional Licensing
s. Provide immunity to prescribers and dispensers for use of database
t. From "Prescription Drug Monitoring Programs: An Assessment of the Evidence for Best Practices," by The Prescription Drug Monitoring Program Center of Excellence, Brandeis University
    i. Collect positive ID on persons picking up prescriptions
    ii. Collect data on method of payment, including cash transactions
    iii. Integrate electronic prescribing with PDMP data collection
    iv. Improve data quality
    v. Link records to permit reliable identification of individuals
    vi. Determine valid criteria for possible questionable activity

vii. Conduct periodic analyses of questionable activity
viii. Develop expert systems to guide analyses and reports
ix. Record data on disciplinary status, patient lock--ins
x. Optimize reporting to fit user needs
xi. Integrate PDMP data with health information exchanges, electronic health records
xii. Publicize use and impact of PDMP
xiii. Proactively identify and conduct outreach to potential high--impact users
xiv. Conduct recruitment campaigns
xv. Streamline certification and enrollment processing
xvi. Mandate enrollment
xvii. Mandate utilization
xviii. Institute financial incentives
xix. Delegate access
xx. Evaluation of PDMPs
xxi. Funding of PDMPs
xxii. Adopt a uniform and latest ASAP reporting standard
xxiii. Collect data on nonscheduled drugs implicated in abuse
xxiv. Reduce data collection interval; move toward real--time data collection
xxv. Enable access to data by appropriate users; encourage innovative applications
xxvi. Enact and implement interstate data sharing among PDMPs
xxvii. Collaborate with other agencies and organizations
xxviii. Collect data on all schedules of controlled substances
xxix. Institute serialized prescription forms
xxx. Conduct epidemiological analyses
xxxi. Provide continuous online access to automated reports
xxxii. Send unsolicited reports and alerts
xxxiii. Conduct promotional campaigns
xxxiv. Improve data timeliness and access
xxxv. Conduct user education

8. STATE – OTHER

a. Update Department of Health 2009 opioid prescribing guidelines
b. Improve availability of behavioral health treatment services for incarcerated population
c. Expedite Medicaid coverage following incarceration
d. Promote the availability of "on-demand" treatment (see Baltimore)
e. Leverage medical examiner's role
f. Use patient review and restriction programs for Medicaid, Workers' Compensation, and state employees health program
g. Regulate pain clinics
h. Leverage Workers' Compensation to identify and treat misuse

i. Use Medicaid and PEHP to incentivize prescriber compliance with prescribing guidelines
j. Increase funding for treatment
k. Promote stakeholder collaboration
l. Implement syringe exchange programs (See 2016 H.B. 308, Disease Prevention and Substance Abuse Reduction (Eliason)
m. Create safe-injection sites (connection to substance use treatment and medical care for overdose victims)
n. Create adequate and sustainable funding stream for deterrence, intervention, and treatment
o. Leverage drug courts
p. Incentivize diversion to treatment by all stakeholders at all points of contact with substance users
q. Develop Medicaid as a model for identification, intervention, and treatment, including the use of claims analysis
r. Use public health model to address misuse epidemic
s. Join with other states to reduce illegal online prescribing of opioids. "According to the National Association of Boards of Pharmacy, 96 percent of entities selling drugs online are illegitimate and operating in violation of U.S. law. These illegal online drug sellers provide easy access to opioid pain relievers."
t. Promote take-back programs conducted by law enforcement in conjunction with the DEA
u. Screen elementary and secondary students for substance use disorders
v. Require Schedule II prescriptions to be filled within a specified number of days (e.g., 3, 7, 30, 60, etc.)
w. Create a pain management resource center to offer technical assistance to prescribers
x. Urge the Centers for Medicare and Medicaid Services to revise Hospital Consumer Assessment of Healthcare Providers and Systems survey measures relating to pain management

9. OTHERS

a. Report number of drug exposed infant births (hospitals)