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# Opioid Prescribing and Monitoring – 2021 Updates

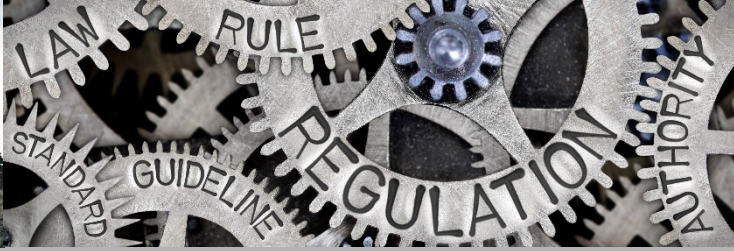
## Washington Medical Commission

Monday, May 3<sup>rd</sup>, 2021

Dr. Greg Terman

Dr. Alden Roberts





# Before We Begin



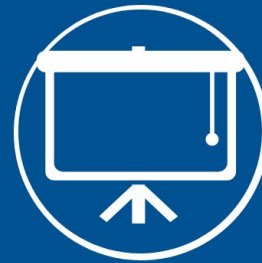
## Questions

Questions will be answered at the end. You can submit a question at any time through the question module.



## Tech Issues

Look for the 'Help' button at the top of the webinar control panel.



## Presentation

The slide deck and presentation recording will be available on our website within the next few days.



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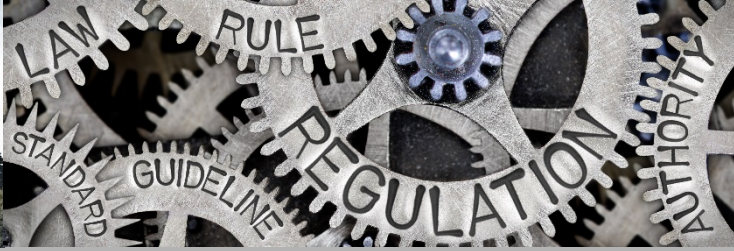


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# Faculty and Staff Disclosures

- This webinar is not funded by any commercial entity.
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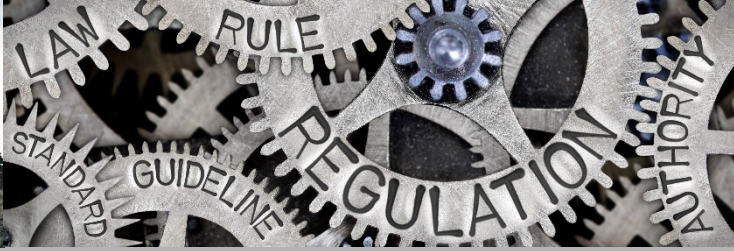
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# Objectives

- Identify the types of pain governed by these rules;
- Identify exclusions;
- Understand additional CME Requirement;
- Understand Prescription Monitoring Program (PMP) requirements;
- Incorporate changes into daily practice;



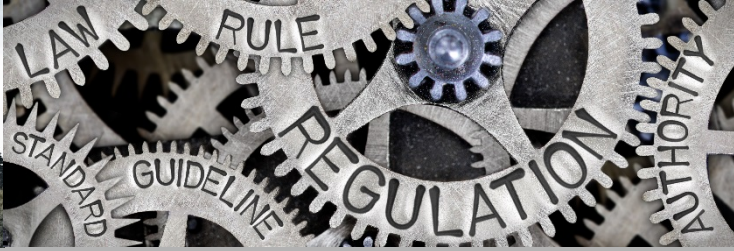
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# Specific Objectives for Today

- In depth discussion on requirements for documentation;
- Extended Q&A regarding coprescribing;
- WMC recommendations on tapering of opioids – updated for 2021;
- Best practices related to new patients who are waiting for consults;
- Does refusal to refill equal abandonment?



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# History

- Instructed by the legislature in ESHB 1427
- Legislative response due to the doubling of opioid related deaths between 2010 and 2015
- WMC adopted rules that would establish prescribing requirements with the goals of:
  - Reducing opioid overdose and addiction rates;
  - Reducing burden to opioid treatment programs;
- Opioid Taskforce was created
  - Meetings were held with expert testimony and public comment;



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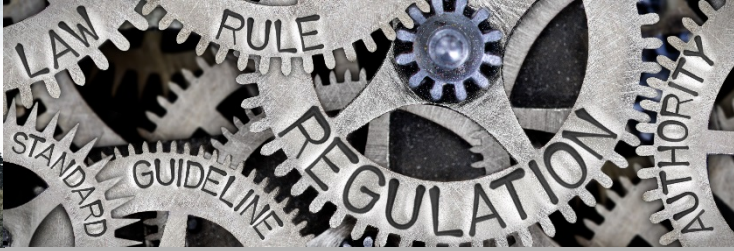


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# Continuing Medical Education (CME) Requirements

- One-time CME regarding best practices in the prescribing of opioids;
- At least one hour in length;
- Completed by the end of your first full CME reporting period after January 1, 2019 or during the first full CME reporting period after initially being licensed - whichever is later.



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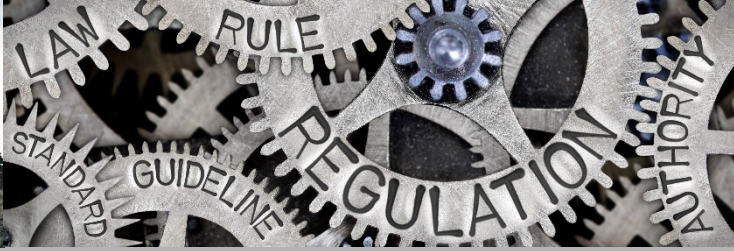
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# Opioid Rules: Do's and Don'ts

## Covered Phases of Pain

- **Acute;**
- **Perioperative;**
- **Subacute;**
- **Chronic;**

## Excluded from the Rules

- The treatment of patients with cancer-related pain;
- The provision of palliative, hospice, or other end-of-life care;
- The treatment of inpatient hospital patients;
- The provision of procedural medications;



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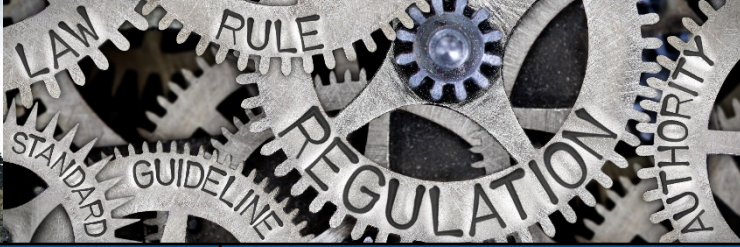


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<b>Acute Pain 0-6 Weeks</b>	<b>Subacute Pain 6-12 Weeks</b>	<b>Chronic Pain 12+ Weeks</b>
<p>Conduct and document a patient evaluation.</p>	<p>Conduct and document a patient evaluation.</p>	<p>Conduct and document a patient evaluation.</p>
<p>If authorizing a re-fill, query the Prescription Monitoring Program (PMP). Document any concerns.</p>	<p>Consider risks and benefits for continued opioid use.</p>	<p>Complete a patient treatment plan with objectives.</p>
<p>Document a patient treatment plan.</p>	<p>Consider tapering, discontinuing, or transitioning patient to chronic pain treatment.</p>	<p>Complete a written agreement for treatment.</p>
<p>Provide patient notification on opioid risks, safe storage and disposal.</p>	<p>Document transition to chronic pain if planning to treat patient with opioids beyond 12 weeks in duration.</p>	<p>Periodically review the treatment plan and query the PMP quarterly for high-risk, semiannually for moderate-risk and annually for low-risk patients.</p>



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# Coprescribing Data

- Even the earliest studies of prescription opioid fatalities in the U.S. (e.g., Hall et al. *JAMA* 2008) reported that more than 2/3 of decedents had ingested multiple contributory substances – largely alcohol and sedatives.
- Nonetheless, from 2000 to 2014 the estimated prevalence of concurrent prescribing of benzodiazepines and opioids increased by nearly 250% (Vozoris *J Sleep* 2019)



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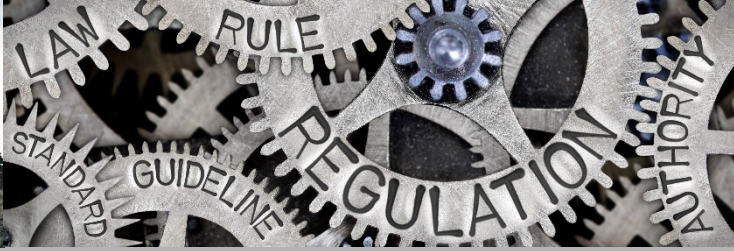
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# Coprescribing Rules

You cannot knowingly prescribe opioids in combination with the following medications without documentation of medical decision making:

- Benzodiazepines;
- Barbiturates;
- Nonbenzodiazepine hypnotics
- Carisoprodol
- Sedatives



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# Coprescribing Rules (for naloxone)

A provider prescribing an opioid needs to also provide a prescription for naloxone (or confirm that one has already been given and is current) to any high-risk\* patient.

\*High-risk" is a patient at high risk of opioid-induced morbidity or mortality, based on factors and combinations of factors such as medical and behavioral comorbidities, polypharmacy, current substance use disorder or abuse, aberrant behavior, dose of opioids, or the use of any concurrent central nervous system depressant.



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# Prescription Monitoring Program (PMP)

- You are required to register or have access.
- PMP query must be completed prior to:
  - First refill or renewal of an opioid prescription;
  - At each pain transition treatment phase;
  - Periodically based on the patient's risk level;
  - Providing episodic care to a patient who you know to be receiving opioids for chronic pain.



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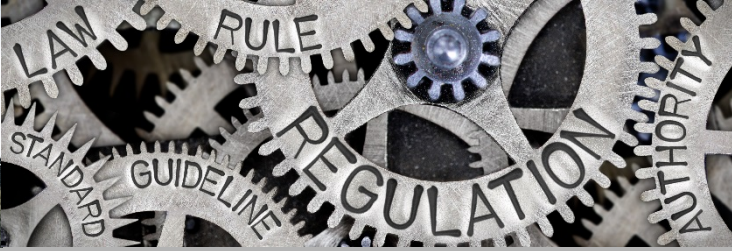
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# PMP (continued)

- You CAN delegate PMP query ability to another DOH licensed professional working with you.
- Pertinent concerns discovered in the PMP must be documented in the patient record.
- If you are using an electronic medical record (EMR) that integrates access to the PMP (currently mandated 9/1/2021), you must perform a PMP query every time you prescribe an opioid or a sedative described in the coprescribing rule.



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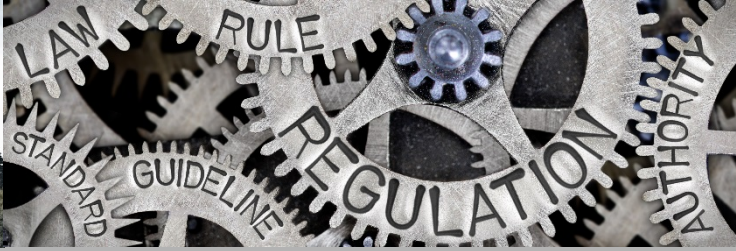


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# Legacy Patients

When presented with a new patient receiving chronic opioid pain medications:

1. It is normally appropriate to maintain the current opioid doses initially.
2. Treatment of a new high dose chronic pain patient is exempt for the mandatory consultation requirement if:
  - The dosage in excess of 120 MED is under an established written agreement
  - The dose is stable and non-escalating
  - The patient has a history of compliance with treatment plans
  - Documented pain control.
  - This exemption applies only to the first three months of care



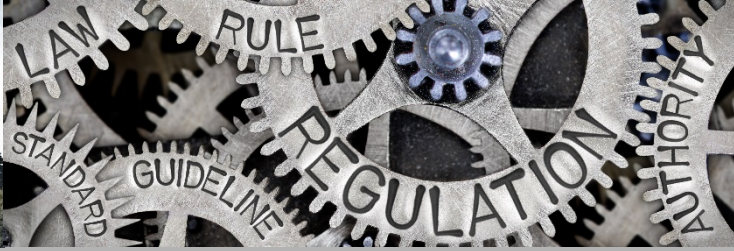
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# Tapering Patients

- Over time, gradual dose adjustments (including tapering) should be considered in the treatment plan.
- Consider tapering (or referral for a substance use disorder consultation) when there is:
  - A request by the patient.
  - A deterioration in patient pain or function
  - Noncompliance with written agreement
  - Unauthorized dose escalation
  - A severe adverse event (including overdose)
  - Evidence of misuse, abuse, substance use disorder or diversion
  - An escalation of opioid dose which produces no improvement in pain or function (other treatment modalities are indicated)



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## Since the Passing of the Rules: FDA

“Health care professionals should not abruptly discontinue opioids in a patient who is physically dependent. When you and your patient have agreed to taper the dose of opioid analgesic, consider a variety of factors, including the dose of the drug, the duration of treatment, the type of pain being treated, and the physical and psychological attributes of the patient. No standard opioid tapering schedule exists that is suitable for all patients. Create a patient-specific plan to gradually taper the dose of the opioid and ensure ongoing monitoring and support, as needed, to avoid serious withdrawal symptoms, worsening of the patient’s pain, or psychological distress.”



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## Since the Passing of the Rules: CDC

“The Guideline is not intended to deny any patients who suffer with chronic pain from opioid therapy as an option for pain management. Rather, the Guideline is intended to ensure that clinicians and patients consider all safe and effective treatment options for patients. [...] The CDC encourages physicians to continue to use their clinical judgment and base treatment on what they know about their patients, including the use of opioids if determined to be the best course of treatment.”



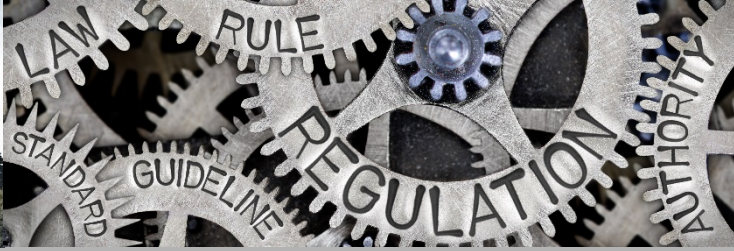
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# Frequently Asked Questions



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# Will these rules impact all types of pain management?

No.

These rules do not apply when treating patients with cancer related pain, palliative, hospice, end-of-life care, inpatient hospital patients, or procedural pre-medications.

There are documentation and assessment requirements for other types of pain including: acute (0-6 weeks), perioperative (surrounding the performance of surgery), subacute (6 to 12-weeks) and chronic (months or years).



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# Do MDs and PAs have to register with the Prescription Monitoring Program (PMP)?

Yes.

If you prescribe opioids in Washington, you must register with the PMP or demonstrate proof of access to the program.



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# When should I check the data in the Prescription Monitoring Program (PMP)?

PMP query must be completed at points in the process:

- At the first refill or renewal of an opioid prescription;
- At each pain treatment transition phase;
- Periodically based on the patients' risk level;
- For episodic care of a patient currently on opioids for chronic pain.



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# When Should I Check the PMP? (Come September...)

- [Senate Bill 5380](#) ([RCW 70.225.090](#))
- Every time you write a prescription of an opioid or sedative (as described in the coprescribing rule)



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# What is the “inappropriate treatment of pain”

The rules for prescribing opioids state, “The inappropriate treatment of pain is a departure from standards of practice.” For the purpose of these rules that includes:

- Nontreatment;
- Undertreatment;
- Overtreatment, and;
- The continued use of ineffective treatments.



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## Additional Resources

- [AMDG Guideline on Prescribing Opioids](#)
- [BREE Collaborative – Opioid Prescribing](#)
- BREE Collaborative - [Opioid Prescribing: Long-Term Opioid Therapy Report and Recommendations](#)
- [HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics](#)



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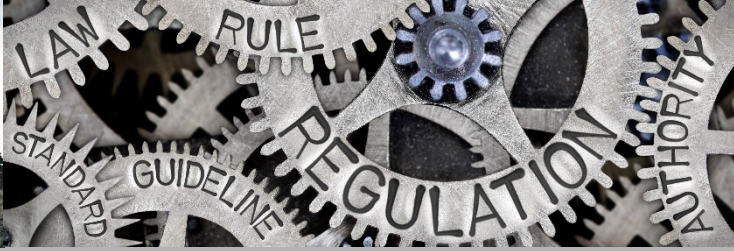


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# Thank You!



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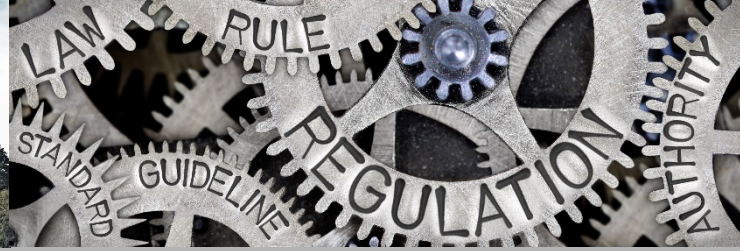


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# Differences From Other Professions

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Acute Pain Prescribing Limits	7 Days (acute non-operative) and 14 Days (acute perioperative ) unless clinically documented			
Subacute Pain Prescribing Limits	14 days unless clinically documented			
Chronic Pain	Mandatory Consultation when prescribing over 120 MED // provide naloxone (high risk patients) Written agreement for treatment // periodical review of treatment plan and PMP			
PMP Requirement	Prior to first refill or renewal	Prior to every opioid or Benzo Prescription	First Prescription or First refill or renewal in clinical exception documented	Second refill or renewal
ICD Code, Diagnosis or Indication for Use Included on Prescription	Not Required		ICD Code or diagnosis must be included on all opioid prescriptions	Not Required



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