



EXTRA! EXTRA!

Information about Opioid Prescribing and Monitoring

Medical Commission Chair Response to the New Opioid Rules

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In 2017, the legislature passed Engrossed Substitute House Bill 1427, which basically said that there is a prescribing problem that aggravates the opioid problem in this country. They were correct, and they charged the prescribing entities to fix it.

To the legislature's credit, they let practitioners do so rather than trying to fix it themselves. They did not say that the cause of the "opioid epidemic" was bad doctors or bad prescribing, and that statement would have been patently incorrect. However, they did have expectations which, if we had not addressed, they certainly would have.

One of the big problems in developing rules of this type is that it is really difficult to work on a pain

management process in which best practice isn't the goal. Regulatory bodies cannot make rules designed to achieve "best practice," because not everyone agrees on what best practice looks like, because best practices change with new information, and not every patient follows the pathway that best practice recommendations are based on. Rules are designed to assess what is minimally acceptable practice. You are encouraged to review the best practices from the AMDG, CDC, and Bree Collaborative.

The majority of changes in these rules revolves around three areas:

1. Registration and use of the PMP;
2. Acute non-operative pain and Acute perioperative pain;



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3. The transitions between acute and subacute pain and subacute and chronic pain;

There are minimal changes around the treatment of chronic pain.

Registration and use of Prescription Monitoring Program (PMP):

1. Providers who prescribe schedule II-V medications must be registered with the PMP or otherwise have access to the PMP through their work. A lot of folks may need to learn how to access and use this service. The DOH website has a walkthrough and videos to help you through the process.



Prescription Monitoring Program

The WMC has been made aware that the WA PMP is not the easiest program to sign-up for, or access, when it is not integrated into the EMR. WA PMP was developed and is maintained by the Department of Health. Your Medical Commission has no authority to modify or replace the current system.

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Opioid Prescribing and Monitoring FAQ

We know that you must have more questions than this PDF can provide, so we have created a FAQ with some of our most common questions. If you would like to request the Medical Commission answer your questions in person, send us an email.

Answers on Page 6



Program Manager Words of Wisdom

The new opioid prescribing rules for allopathic physicians and physician assistants will be effective January 1, 2018. We have begun our education efforts regarding the changes to opioid prescribing. I encourage you to contact me with any questions you may have about these new rules.

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2. Providers for whom the PMP is integrated with their EMR need to check the PMP every time opioids or sedatives are prescribed.
3. Providers for whom the PMP is not integrated into their EMR have less stringent requirements because the process is cumbersome, time consuming and can be very frustrating. But while these providers don't have to check the PMP every time, best practice is to do so, if possible.

Acute Non-operative pain and Acute Perioperative Pain

Acute Non-operative pain and Acute Perioperative Pain are new areas for pain rules. The problem that is being addressed in the treatment of acute non-operative and perioperative pain has several origins:

1. There are many problems for which opioids have been prescribed in the past for which opioids are not the best choice of treatment. Alternatives to opioids should be considered when appropriate.
2. Leftover opioids are problematic. Most of us don't know how many pills our patients take after surgery or after an ankle fracture. For example: After a surgery I had, I received 60 oxycodone and used two. There are a few recent studies that look at this, and AMDG has established recommendations based on literature for this problem. While more than 1/2 of substance use disorder patients say that they started on prescription opioids, those opioids were often originally prescribed for someone else.
3. It is really easy for an operative patient or an injured patient to continue to get refills of opioids for a much longer time than intended, and safety checks are usually neglected.
4. The co-prescribing of opioids and sedatives, while fairly common after injury or surgery, is a dangerous combination. The rules say don't do this unless you are able to document why this is appropriate.

The Transition Areas: Acute to Subacute, and Subacute to Chronic

This brings us to the third major change in the rules: the transition from acute pain to subacute pain that occurs at 6 weeks of pain, and from subacute pain to chronic pain at 12 weeks.

While these durations of pain are by definition arbitrary, these are high risk periods, and patients need to be reassessed regarding the effectiveness of the pain medication at around 6 weeks, when they enter the subacute phase of pain, and again at 12 weeks when they enter the chronic phase of pain. Thoughtless renewal of pain medications in these patients is problematic and can lead to substance use disorder.

Treating patients in pain

Pain is like any other symptom or disease, but most of us haven't had very much training in how to optimally take care of patients in pain. As a surgeon, my training consisted of how to write a prescription.

The goal of practitioners who take care of patients in pain should be to learn how to take excellent care of those patients, during the acute phase, the subacute phase, and in some practices, the chronic phase. Practitioners need to manage their own continuing medical education based on the patients they see.

For a lot of reasons, many practices have already ceased to care for patients with chronic pain. Fear of discipline should not be one of those reasons, but it appears to be. As with most disciplinary actions initiated by the Medical Commission, sanctions surrounding treatment of chronic pain involve treatment that most practitioners (and many lay people) would recognize as clearly being well below standard of care. Fear of the rules or of disciplinary action should not be used as an excuse to not manage these patients.

In conclusion, there are four major take-aways that I think are important.

1. Learn how to treat pain well. The purpose of these rules is to avoid inappropriate treatment of pain. This includes non-treatment, under-treatment, over-treatment, and the continued use of ineffective treatments.
2. The Medical Commission has no interest in disciplining good physicians and physician assistants who are trying to do a good job, but as with any other disease process, providers may need to justify and document why they are managing things the way they are.
3. There are a few changes to the management of chronic pain, but not all that many. However, there are new sections that relate to the management of acute non-operative pain, acute perioperative pain, and the transitions to subacute and chronic pain. You need to be familiar with these changes.
4. And finally, practitioners need to register with the Prescription Monitoring Program, and to use the PMP appropriately for their circumstances.