

RESPONSE TO THE MASSACHUSETTS OPIOID PRESCRIPTION DRUG EPIDEMIC



2014 Report of Best Practices

Joint Policy Working Group

With the goal of reducing diversion, abuse and addiction
and protecting access for patients suffering from acute and chronic pain

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Table of Contents

Executive Summary	3
Report	7
Scope of the Problem	7
Legislative Directive	9
Joint Policy Working Group	10
Best Practice Strategies and Recommendations	12
Focus Area 1: Education	12
Focus Area 2: Prevention	16
Focus Area 3: Screening	18
Focus Area 4: Tracking & Focus Area 5: Monitoring	20
Focus Area 6: Treatment	24
Summary of Strategies and Recommendations	25
Additional Considerations	30
Appendix	31

Table of Figures and Tables

Figure 1: Rates of All Poisoning and Opioid-Related Poisoning	8
Figure 2: Leading Mechanisms of Injury Deaths, MA Residents, 2010	9
Figure 3: Berkshire County: Rates of Questionable Activity	13
Table 1: Focus Area (Education) Key Best Practice(s)	14
Figure 4: Individuals with Opioid and Benzodiazepine Prescriptions	16
Table 2: Focus Area (Prevention) Key Best Practice(s)	17
Table 3: Focus Area (Screening) Key Best Practice(s)	18
Table 4: Potential Doctor and Pharmacy Shopping by Practitioner in MA (CY 2012)	21
Table 5: Potential Doctor and Pharmacy Shopping by Practitioner ¹ in MA (CY 2012)	21
Figure 5: Individuals in MA with High Daily Morphine Milligram Equivalents	22
Table 7: Focus Area (Tracking) & Focus Area (Monitoring) Key Best Practice(s)	23
Table 8: Focus Area (Treatment) Key Best Practice(s)	24
Table 9: Summary of Strategies, Best Practices and Recommendations	25
Table 10: Policy Working Group Meeting Schedule	31
Table 11: Policy Working Group Speaker List / Affiliations	31
Table 12: Best Practices Resource Table	33

Executive Summary

A Collaborative Effort

In 2012, the Massachusetts Legislature provided a statutory directive to address prescription drug abuse. This directive, through Chapter 244 of the Acts of 2012, *An Act Relative to Prescription Drug Diversion, Abuse and Addiction*, is a comprehensive law designed to address the public health emergency related to prescription drug abuse. Section 21 of Chapter 244 established a “joint policy working group to investigate and study best practices, including those in education, prevention, screening, tracking, monitoring and treatment, to promote safe and responsible opioid prescribing and dispensing practices for treatment of acute and chronic pain with the goal of **reducing diversion, abuse and addiction and protecting access for patients suffering from acute and chronic pain.**”

The MA Department of Public Health’s (DPH) Drug Control Program (DCP) coordinates and oversees implementation for the majority of this mandate. The underlying causes – and consequences - of prescription drug abuse are multifactorial and present many challenges to public health and beyond. A Joint Policy Working Group (herein referred to as the Policy Working Group) of key stakeholders and experts have been brought together to investigate and study best practices for safe and responsible opioid prescribing and dispensing practices.

DPH appreciates the efforts of those organizations and individuals who participate in the Policy Working Group. Because of this input and expertise, the Drug Control Program can continue to develop prevention, monitoring and evaluation strategies to curb prescription drug abuse in Massachusetts. Organizations in the Policy Working Group are as follows (individuals are listed in the Appendix):

- The Department of Public Health, as chair
- The Board of Registration in Medicine
- The Board of Registration in Nursing
- The Board of Registration in Dentistry
- The Board of Registration in Podiatry
- The Board of Registration in Pharmacy
- The Massachusetts Dental Society
- The Massachusetts Medical Society
- The Massachusetts Hospital Association
- The Massachusetts Pain Initiative
- The Massachusetts Association of Physician Assistants
- The Massachusetts Coalition of Nurse Practitioners
- The Massachusetts Podiatric Medical Society
- A community pharmacist practicing in a chain pharmacy setting
- A community pharmacist practicing in an independent pharmacy setting
- A physician specializing in pain management appointed by the Commissioner
- An individual specializing in substance abuse counseling and therapy appointed by the Director of the Bureau of Substance Abuse Services

Legislative Directive for Addressing Prescription Drug Abuse

The Policy Working Group is charged with submitting a report of its findings, along with any recommendations, to the Commissioner of the Department of Public Health and to the General Court. This report, while a report of findings and recommendations informed by the Working Group’s discussions and deliberations, does not necessarily represent the views of each individual member. DPH and DCP are responsible for the overall content of this report.

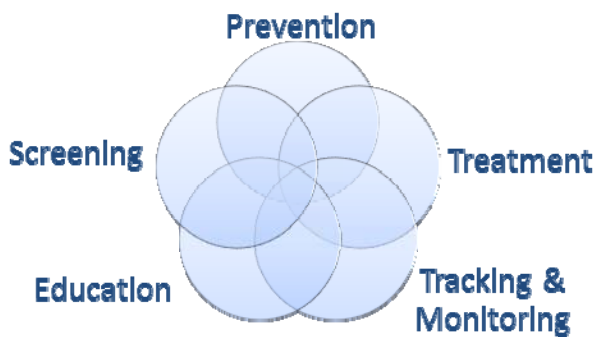
Section 21 of Chapter 244 further states, “The commissioner, after reviewing the Policy Working Group’s findings and recommendations, shall promulgate regulations relative to safe and responsible opioid prescribing and dispensing...” Consequently, this report will help to inform the development of regulations implementing the mandates within Chapter 244, which include (full language in the Appendix):

- A practitioner who prescribes controlled substances shall automatically and without further action be registered as a participant in the prescription monitoring program...
- The department shall promulgate rules and regulations relative to the use of the prescription monitoring program by registered participants, which shall include requiring participants to utilize the prescription monitoring program prior to the issuance, to a patient for the first time, of a prescription for a narcotic drug that is contained in schedule II or III... The regulations shall specify the circumstances under which such narcotics may be prescribed without first utilizing the prescription monitoring program...

Six Areas of Focus for the Investigation and Study of Best Practices

Section 21 of Chapter 244 specified six areas of focus for the Policy Working Group: **education, prevention, screening, tracking, monitoring and treatment**. For each of the six focus areas, this report provides the following information:

- Strategies and data relating to the focus area
- Current national and state-based best practices related to the focus area
- Recommendations for the Commonwealth related to the focus area



There are many areas of overlap and synergy between the six focus areas. For example, prescribers **screening** each patient at the point of service create opportunities for **education** and **prevention**. **Monitoring** will provide an overview of the prescription drug landscape across the Commonwealth, while **tracking** will allow the Drug Control Program to take a targeted approach to sending alerts to providers. Effective and appropriate treatment of a patient’s pain, as well as early identification of an individual’s prescription drug abuse, will support **prevention efforts**. Taking a holistic approach to each of these areas helps inform the development of sound recommendations.

Focus Area 1: Education

Key strategies for education related to opioid prescription drug abuse are to develop provider and dispenser-specific educational materials and to understand the efficacy of community interventions in reducing abuse and misuse of controlled prescription drugs.

There are best practices in the area of education, clinical practice guidelines and pain management. Many other states and organizations have developed examples of such resources, which could be adapted for use in Massachusetts.

Recommendations

1. The DCP will work with the various boards of registration to assist in the development of criteria for training and continuing education materials related to prescription drug abuse (e.g. online continuing education credits, online video training.).
2. Registered Individual Practitioner¹ provider and specialty associations develop guidelines to support best practice clinic guidelines, such as the Washington Agency Medical Directors' Group Opioid Dosing Guideline for Chronic Non-Cancer Pain and specialty-specific opioid dosing guidelines and institute pain management treatment agreements between providers and patients through such guidelines.
3. Pharmacist groups develop dispensing guidelines such as the Northeastern University School of Pharmacy Best Practices for Pharmacists to Reduce Prescription Opioid Abuse.
4. The DCP will work with professional schools and training programs to support curricula development that increases knowledge and understanding of opioid abuse.

Focus Area 2: Prevention

In addition to the use of screening tools (further described below), recommendations for preventing prescription drug abuse include increasing awareness of higher-risk prescribing practices and providing data that can indicate areas of increased risk.

Clear guidelines for both prescribers and dispensers of opioid prescriptions can preserve providers' flexibility in treating patients while helping to reduce the risk of opioid dependence and overdose.

Recommendations

1. Implement best practices in preventing overdose morbidity and mortality (monitor daily morphine milligram equivalents in clinical practice at the point of care and through the PMP).
2. Track the frequency of patients receiving both opioid prescriptions and prescriptions for benzodiazepines, and other medications that are identified, that can increase the risk of overdose when taken in combination with opiates.
3. Provide community-level data to providers and community leaders to help develop effective interventions.

Focus Area 3: Screening

A key recommendation for screening is to detect prescription drug abuse at the patient level and also at the program level through monitoring and tracking.

Best Practices for screening patients include using the MA Prescription Monitoring Program (PMP); the NIDA Quick Screen V1.0 and NIDA – Modified ASSIST V2.0 (a guide designed to assist clinicians in screening for drug use); the BU SBIRT: Brief Negotiated Interview / Active Referral to Treatment (a screening tool); and other best practice guidelines. The Work Group recognizes the statute that requires all participants to utilize the PMP prior to seeing a new patient with limited exceptions under circumstances that will be outlined in the regulations.

Recommendations

1. Optimize utilization of the online PMP through current regulations requiring participation in the PMP by all prescribers at the point of care and pharmacists at the point of dispensing.
2. Allow delegate access to the PMP to enable more in-depth and effective screening.

¹ 105 CMR 700.001 a Registered Individual Practitioner shall mean a physician, dentist, veterinarian, podiatrist, nurse midwife, nurse practitioner, psychiatric nurse, nurse anesthetist or physician assistant who is registered pursuant to 105 CMR 700.004

3. Stand-up the one-way interface of the online PMP with electronic health records (EHR).
4. Implement guidelines for use of Screening, Brief Intervention, and Referral to Treatment (SBIRT), such as with the Drug Abuse Screening Test (DAST-10) at the point of care.
5. Work with commercial payers and the Bureau of Substance Abuse Services (BSAS) to provide information on reimbursement for SBIRT.
6. Promote the use and access of the BSAS Helpline, along with Alcoholics Anonymous and Narcotics Anonymous.

Focus Area 4: Tracking & Focus Area 5: Monitoring

Tracking and monitoring opioid prescribing and dispensing are critical factors to containing and addressing opioid abuse in the Commonwealth. Because there is a significant degree of overlap between these two focus areas, the Policy Working Group identified strategies, best practices and recommendations jointly for tracking and monitoring.

Key recommendations for tracking and monitoring include:

- Issuing alerts to prescribers regarding individual patients who receive prescriptions from multiple prescribers and fill prescriptions at multiple pharmacies
- Monitoring individuals receiving more than 100 mg daily morphine milligram equivalents (MME) of opioid medications
- Enhancing MA PMP for more complete monitoring at the local and/or regional level, not just state level monitoring

Recommendations

1. Increase utilization of prescription monitoring program data at the point of care. Enhance office practice utilization and use of delegates with the MA Online PMP batch look-up.
2. Analyze PMP data to provide community-level analysis.
3. Continue with electronic alerts for prescribers and also send electronic alerts to dispensers; continue to support law enforcement case investigations.
4. Notify regulatory agencies responsible for authorized prescribers and pharmacists after review by the Medical Review Group, which is a group of five physicians and pharmacists that review questionable prescribing of providers and make recommendations to the respective boards for additional investigations as needed.

Focus Area 6: Treatment

The key strategies for treatment fall into two overarching categories: 1) treating addiction and 2) treating pain in a way that reduces the risk of future addiction. The MA BSAS publishes Practice Guidance papers which describe best practices, as well as why and how practice in specific areas can be improved.

Recommendations

1. Identify best practices for treating acute and chronic pain by different types of providers and in different practice settings.
2. Identify practice guidelines to identify (through screening tools identified above) and treat dependency or addiction.
3. Identify resources for treating specific populations, e.g. treating pain in patients taking buprenorphine.

Report

Scope of the Problem

National Impact of the Prescription Drug Abuse Epidemic

Approximately 6.1 million Americans abuse or misuse prescription drugs (SAMHSA, 2012). Abuse, particularly of prescription painkillers, has serious negative health consequences and can result in death. Over the past decade, the rate of prescription drug abuse has increased rapidly. Starting in 2011, the Centers for Disease Control and Prevention (CDC) called the overdoses of prescription opioid pain relievers an epidemic (MMWR, 2011). The number of persons who received treatment for nonmedical use of pain relievers increased 170 percent from 360,000 persons in 2002 to 973,000 in 2012 (SAMHSA, 2013).

“The misuse and abuse of prescription medications have taken a devastating toll on the public health and safety of our Nation. Increases in substance abuse treatment admissions, emergency department visits, and, most disturbingly, overdose deaths attributable to prescription drug abuse place enormous burdens upon communities across the country. So pronounced are these consequences that the Centers for Disease Control and Prevention has characterized prescription drug overdose as an epidemic, a label that underscores the need for urgent policy, program, and community-led responses.”

- R. Gil Kerlikowske, Director of the Office of National Drug Control Policy Executive Office of the President Office of National Drug Control Policy. *Examining the Federal Government's Response to the Prescription Drug Abuse Crisis*. June 14, 2013.

The term “opioid” refers to any substance that stimulates the body’s opioid receptors, whether that substance is naturally derived (e.g., morphine, codeine), semisynthetic (e.g., hydrocodone, oxycodone), or synthetic (e.g., methadone, fentanyl).² Opioids marketed for pain relief are called opioid analgesics (Davis, 2013). Since 1999, there has been a four-fold increase in the number of intoxication deaths involving opioid analgesics in the United States (MMWR, 2011).

A study published in 2011 estimated that in 2006, nonmedical use of prescription painkillers resulted in an estimated economic cost of just over \$53 billion on the U.S. economy, including \$42 billion in lost productivity, \$8.2 billion in increased criminal justice costs, \$2.2 billion for drug abuse treatment, and \$944 million in medical complications (Hansen et al., 2011).

Prescription Drug Abuse in Massachusetts

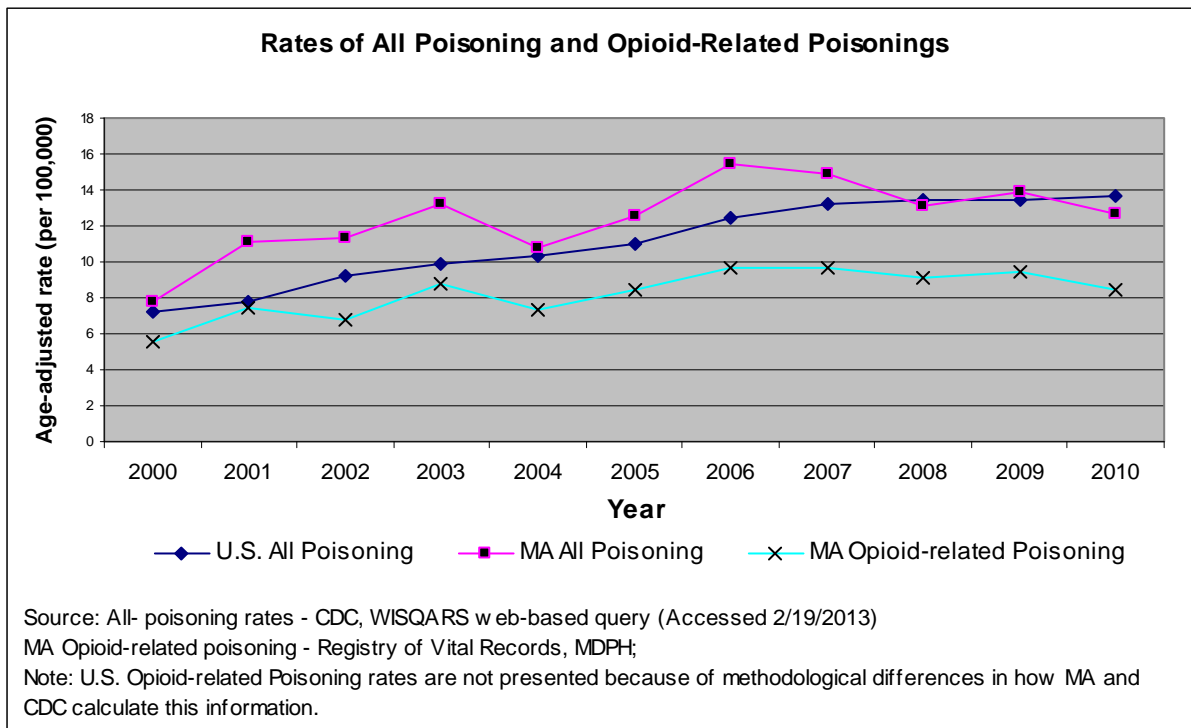
Massachusetts shares in the nationwide prescription drug abuse problem. Between 1990 and 2010, the drug overdose mortality rate in Massachusetts increased 197 percent from 3.7 to 11 deaths per 100,000 persons. In 2010, the drug overdose mortality rate was twice the motor vehicle accident death rate (5.5

² MA General Law Chapter 94C includes opioids under the broader category of narcotics; “Narcotic drug” is defined in Chapter 94C as any of the following: (a) Opium and opiate, and any salt, compound, derivative; (b) Any salt, compound, isomer, derivative, but not including the isoquinoline alkaloids of opium; (c) Opium poppy and poppy straw; (d) Coca leaves and any salt, compound, derivative, or preparation of coca leaves, and any salt, compound, isomer, derivative, but not including decocainized coca leaves or extractions of coca leaves which do not contain cocaine or ecgonine. [Refer to: <https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXV/Chapter94c> for non-abbreviated definition].

deaths per 100,000). To put this into perspective, prior to 2000, motor vehicle death rates usually exceeded the overdose mortality rates (TFAH, 2013).

Figure 1 shows the relative increase in “all poisoning” and “opioid-related poisoning” death rates in Massachusetts residents between 2000 and 2010. Rates of U.S. “all poisoning” are also displayed for purposes of comparison. The most notable increases in MA opioid-related poisoning rates have occurred between 2000 and 2006 with relatively stable or slightly decreased rates between 2006 and 2010.

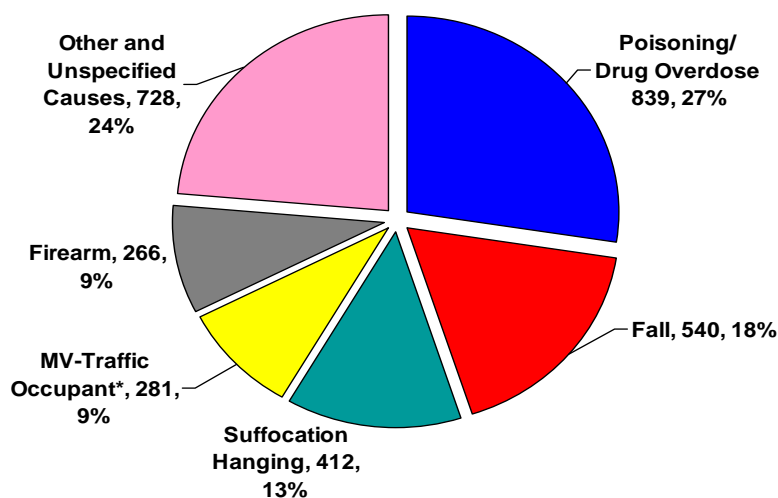
Figure 1: Rates of All Poisoning and Opioid-Related Poisoning



From Fiscal Year (FY) 2001 to FY 2011, analyses of Massachusetts Prescription Monitoring Program (PMP) data indicated that the number of prescriptions for all Schedule II opioids, including oxycodone products, increased 88 percent, from 1.4 million to 2.6 million (DPH-PMP). This increase in the number of opioid prescriptions dispensed in the state coincides with the increase in fatalities related to opioid-related poisonings over this time period in the Commonwealth. In CY 2010, 86.2 percent of all poisoning deaths in Massachusetts (724 of 839) were due to drug poisoning and 66 percent of all poisoning deaths in MA (N= 555 of 839) were associated with an opioid (DPH 2014)³.

³ [MDPH]. 2014. Massachusetts Department of Public Health, Bureau of Community Health and Prevention, Injury Prevention and Control Program. February, 2014.

Figure 2: Leading Mechanisms of Injury Deaths, MA Residents, 2010



*Includes occupants, motorcyclists, and unspecified persons

Legislative Directive

Chapter 244 of the Acts of 2012 *An Act Relative to Prescription Drug Diversion, Abuse and Addiction* (Chapter 244) addresses the epidemic of prescription drug abuse. Section 21 of Chapter 244 (text included in the Appendix) established a “joint policy working group to investigate and study best practices, including those in **education, prevention, screening, tracking, monitoring and treatment**, to promote safe and responsible opioid prescribing and dispensing practices for acute and chronic pain with the goal of reducing diversion, abuse and addiction and protecting access for patients suffering from acute and chronic pain.”

The Joint Policy Working Group (formerly the Best Practices Work Group (BPWG)), is charged with submitting a report of its findings, along with any recommendations to the Commissioner of the Department of Public Health, and to the General Court. In support of the legislative directive, the Policy Working Group is comprised of 17 members and includes one representative from each of the following:

- The Department of Public Health, as chair
- The Board of Registration in Medicine
- The Board of Registration in Nursing
- The Board of Registration in Dentistry
- The Board of Registration in Podiatry
- The Board of Registration in Pharmacy
- The Massachusetts Dental Society
- The Massachusetts Medical Society
- The Massachusetts Hospital Association
- The Massachusetts Pain Initiative
- The Massachusetts Association of Physician Assistants
- The Massachusetts Coalition of Nurse Practitioners
- The Massachusetts Podiatric Medical Society
- A community pharmacist practicing in a chain pharmacy setting
- A community pharmacist practicing in an independent pharmacy setting
- A physician specializing in pain management appointed by the Commissioner
- An individual specializing in substance abuse counseling and therapy

Section 87 of Chapter 38 of the Acts of 2013 amended the language of Chapter 244 pertaining to requirements for utilizing the PMP. Regulations implementing these changes are under development. The revised language is in the appendix.

Joint Policy Working Group

The Joint Policy Working Group met six times in 2013 and is continuing to meet in 2014. Please refer to the Appendix for information about past meetings. The Policy Working Group came together to identify and determine the best practices in the six areas outlined by the legislative mandate: **education, prevention, screening, tracking, monitoring and treatment**. To enhance the Policy Working Group deliberations, all members were invited to share their expertise on safe and effective opioid prescribing.

The Policy Working Group meetings provided rich content discussion on specific topics related to opioid drug use. For the full meeting minutes, please refer to the MA Drug Control Program's Best Practices Policy Working Group website at:

<http://www.mass.gov/eohhs/gov/departments/dph/programs/hcq/drug-control/best-practices-workgroup.html>).

Due to the groundbreaking legislative mandate for prescriber enrollment (Massachusetts was only the third state to have such a mandate at the time), the Joint Policy Working Group used some of its meeting time to engage in robust discussion of the merits of the law. This healthy debate allowed the Drug Control Program to hear the perspectives of the Policy Working Group's members and their affiliated organizations. Following these discussions, the Joint Policy Working Group focused on the six focus areas and the corresponding best practice recommendations for Massachusetts. The overriding desire of the Policy Working Group is to comply with the directive and intent of the law in a way that is effective, efficient and sustainable for everyone.

Meeting Overview

During the April meeting, the Best Practices Policy Working Group provided feedback on the Drug Control Program's draft regulations for implementing Chapter 244 of the Acts of 2012's legislative mandate for PMP utilization. The group focused on identifying clinical situations where it would be optimal to utilize the PMP for prevention and monitoring. In addition, group members provided recommendations for system improvements that would enhance adoption of the PMP into routine clinical workflow.

In the July meeting, members of the Policy Working Group provided additional feedback on draft regulations implementing Chapter 244 of the Acts of 2012. Some Policy Working Group members discussed concerns about the proposed regulations imposing mandatory use of the Online PMP by practitioners.

During the September, October, November, and December meetings, the six focus areas were discussed in greater detail. Meetings included presentations by staff and invited expert guest speakers. At the December meeting initial discussions took place on the draft working group report.

Policy Working Group Approach

The Policy Working Group employed a thoughtful approach to addressing the legislative mandate. Through expansive research, the Policy Working Group found a number of promising strategies that have been developed to address the prescription drug epidemic; particularly focusing on prevention and providing effective substance abuse treatment. Currently, 22 states have laws that require or recommend education for doctors and other healthcare providers who prescribe prescription pain medication. Furthermore, 16 states now require medical providers to use prescription drug monitoring programs (PDMP). Recent evidence suggests that states taking a comprehensive approach to the problem of overprescribing have achieved measurable reductions in the number of prescriptions with questionable activity, such as multiple prescriptions by multiple providers filled at multiple pharmacies (TFAH, 2013).

The CDC has provided a number of recommendations on addressing the prescription drug overdose epidemic. These include, but are not limited to:

- Better access and utilization of state PDMPs,
- Patient review and restriction programs,
- Health care provider accountability,
- Laws to prevent prescription drug abuse and diversion, and
- Better access to substance abuse treatment (CDC, 2011).

Additionally, other organizations have also reviewed and outlined best practices regarding PDMPs and safe prescribing. For example, Brandeis University's PDMP Center of Excellence (COE) has identified sending unsolicited reports (either via electronic alerts or sending hard copy reports) as a best practice to help reduce the occurrence of doctor/pharmacy shopping and other types of prescription drug abuse (COE-PDMP, 2012).

In Massachusetts there is a wealth of data collected by the Drug Control Program's Prescription Monitoring Program that is underutilized in helping frame the nature and extent of the problem and can be used to make well informed data-driven policies and ensure that best practices for opioid prescribing are adopted.

Best Practice Strategies and Recommendations

In Chapter 244, the Legislature provided the framework for six focus areas to address opioid prescription drug abuse: **education, prevention, screening, tracking, monitoring and treatment**. This report provides the following information for each of the six focus area:

- Strategies and data relating to the focus area
- Current national and state-based best practices
- Recommendations for the Commonwealth related to the focus area
- Future considerations to continue addressing efforts

Focus Area 1: Education

Strategy: Develop educational materials

One strategy for reducing abuse, diversion and addiction to opioid medications is to develop educational materials, such as best practices guidelines, on the treatment of acute and chronic pain. Because of the complexity of the prescription drug abuse problem, educational programs for providers should be multifaceted. The MA Drug Control Program staff suggests the following groups as potential recipients of educational materials: health care providers, professional schools, patients and their caregivers, regulators, insurance companies, law enforcement and drug companies.

The DCP can work with schools to assist in developing curricula that help students and future health care professionals understand the scope of the prescription drug abuse problem, and best practices for safer prescribing or dispensing of controlled substances that incorporate prevention, intervention and evaluation methods. Additional emphasis should be on outreach to middle and high school students to make these age groups aware of the dangers of prescription drug abuse.

Existing statutory requirements outlined in the General Laws c. 94C Section 18(e) require, “Practitioners who prescribe controlled substances, except veterinarians, shall be required, as a prerequisite to obtaining or renewing their professional license, to complete appropriate training relative to: (i) effective pain management; (ii) identification of patients at high risk for substance abuse; and (iii) counseling patients about the side effects, addictive nature and proper storage and disposal of prescription medications. The boards of registration for each professional license that requires such training shall develop the standards for appropriate training programs.” The MA Drug Control Program can work with the various boards of registration to assist in the development of training and continuing education materials directed at prescription drug abuse.

Educational materials should be provided to not only educate members of each of the particular groups but to encourage their members to educate others as well. In addition, these materials should take into consideration the perspectives of patients and their caregivers, treatment specialists, emergency service providers and professional schools. Curriculum should include education on proper pain assessment and management.

Develop Guidelines

In addition to educational materials, many guidelines and best practices for safe opioid prescribing have been developed and are available (see the description of the Washington State Agency Medical Directors’ Group guideline below). Guidelines for pharmacists who dispense opioids are not readily

available. Faculty and students at the Northeastern University Bouvé College of Health Sciences School of Pharmacy are drafting best practices for pharmacists.

The Washington State Agency Medical Directors' Group guideline for treating acute and chronic pain in primary care settings was presented to the Policy Working Group. It is an example of a well-known treatment guideline. Originally released in 2007, it was updated in 2010. The hallmark of this guideline is the recommendation to not prescribe more than an average daily Morphine Equivalency Dose (MED) of 120 mg without the patient either demonstrating improvement in function and pain or first obtaining a consultation with a pain management expert. While other states have produced their own guidelines, the Washington state guidelines have been recommended by the CDC and used as a reference in other best practices materials. Adopting guidelines such as these will support many of the legislative mandates while building consistency among providers across the Commonwealth.

Strategy: Educate about Community Interventions

Statement: Community interventions have proven to be effective in addressing the prescription drug epidemic. For example, in 2008, a community-based initiative titled “Project Lazarus” provided a comprehensive, community-based drug abuse prevention program in Wilkes County, North Carolina. The goal of Project Lazarus is to coordinate community-based drug abuse prevention in response to high rates of overdose deaths, many from prescription opioid abuse. Project Lazarus combines a number of prevention approaches, including use of prescription history information collected by North Carolina’s prescription drug monitoring program (PDMP) to motivate, guide and track its prevention efforts.

Data: Efforts to educate the provider community about the prescription drug epidemic and identifying doctor/pharmacy shoppers, as well as aggressively enrolling providers into the MA Online PMP have been undertaken in Berkshire County with notable success. Prior to automatic enrollment of practitioners in January 2013, the proportion of prescribers enrolled from Berkshire Health Systems (the largest healthcare network in Berkshire County), was considerably higher than the proportion for the state overall. The figure below shows rates of questionable activity (i.e., doctor/pharmacy shopping) between 2009 and 2011 in Berkshire County compared to the state. Berkshire County has been a leader in the effort to reduce abuse and misuse of opioid and other controlled prescription drugs.

Figure 3: Berkshire County: Rates of Questionable Activity

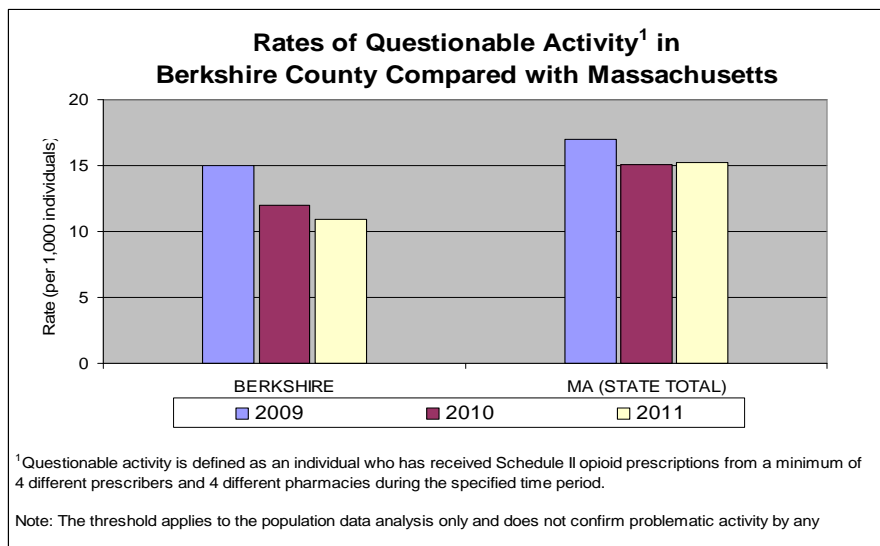


Table 1: Focus Area (Education) Key Best Practice(s)

Best Practice Model	Description
SCOPE	SCOPE of Pain is a series of continuing medical education and continuing nursing education activities designed to help safely and effectively manage patients with chronic pain, when appropriate, with opioid analgesics.
Mass Med Society 1	This course series addresses opioid prescribing practices, monitoring opioid therapy and managing risk when prescribing opioids. Also, the opioid abuse epidemic is examined in detail. This was jointly sponsored with The Answer Page, Inc.
Mass Med Society 2	As the use of opioids for the management of pain has continued to increase, physicians need to be aware of the legal concerns of pain management and actionable steps they can take in their practice that may reduce risk.
PDMP COE	Brandeis University's PDMP Center of Excellence's white paper describes what is known about PDMP best practices. It also describes and assesses the evidence supporting the selection of these best practices and documents the extent to which PDMPs have implemented these best practices.
VA/ DoD	The Department of Veterans Affairs / Department of Defense: Evidence Based Clinical Practice Guideline on Management of Opioid Therapy for Chronic Pain makes recommendations based on determination of appropriate criteria such as effectiveness, efficacy, population benefit or patient satisfaction and a literature review to determine strength of the evidence in relation to these criteria.
UTAH	Utah has developed guidelines to assist clinicians who choose to use opioids to treat patients with pain (acute and chronic non-cancer) and to manage that treatment as safely as possible.
WA AMDG	The Washington State Agency Medical Directors' Group Opioid Dosing Guideline for Chronic Non-Cancer Pain was originally published in March 2007 and updated in 2010. The guideline was developed in collaboration with actively practicing providers with extensive experience in the evaluation and treatment of patients with chronic pain. It is intended as a resource for all opioid prescribers treating adult patients for chronic non-cancer pain.
New York City	The New York City Department of Health and Mental Hygiene created guidelines to help reduce the misuse of prescription opioid analgesics by establishing standards for prescribing from the Emergency Department.
OHIO	Ohio Emergency and Acute Care Facility Opioids and Other Controlled Substances (OOCs) Prescribing Guidelines provide a general approach in the prescribing of OOCs.

Recommendations

1. The DCP will work with the various boards of registration to assist in the development of criteria for training and continuing education materials related to prescription drug abuse (e.g. online continuing education credits, online video training.).

2. Registered Individual Practitioner⁴ provider and specialty associations develop guidelines to support best practice clinic guidelines, such as the Washington Agency Medical Directors' Group Opioid Dosing Guideline for Chronic Non-Cancer Pain and specialty-specific opioid dosing guidelines and institute pain management treatment agreements between providers and patients through such guidelines.
3. Pharmacist groups develop dispensing guidelines such as the Northeastern University School of Pharmacy Best Practices for Pharmacists to Reduce Prescription Opioid Abuse.
4. The DCP will work with professional schools and training programs to support curricula development that increases knowledge and understanding of opioid abuse.

⁴ 105 CMR 700.001 a Registered Individual Practitioner shall mean a physician, dentist, veterinarian, podiatrist, nurse midwife, nurse practitioner, psychiatric nurse, nurse anesthetist or physician assistant who is registered pursuant to 105 CMR 700.004

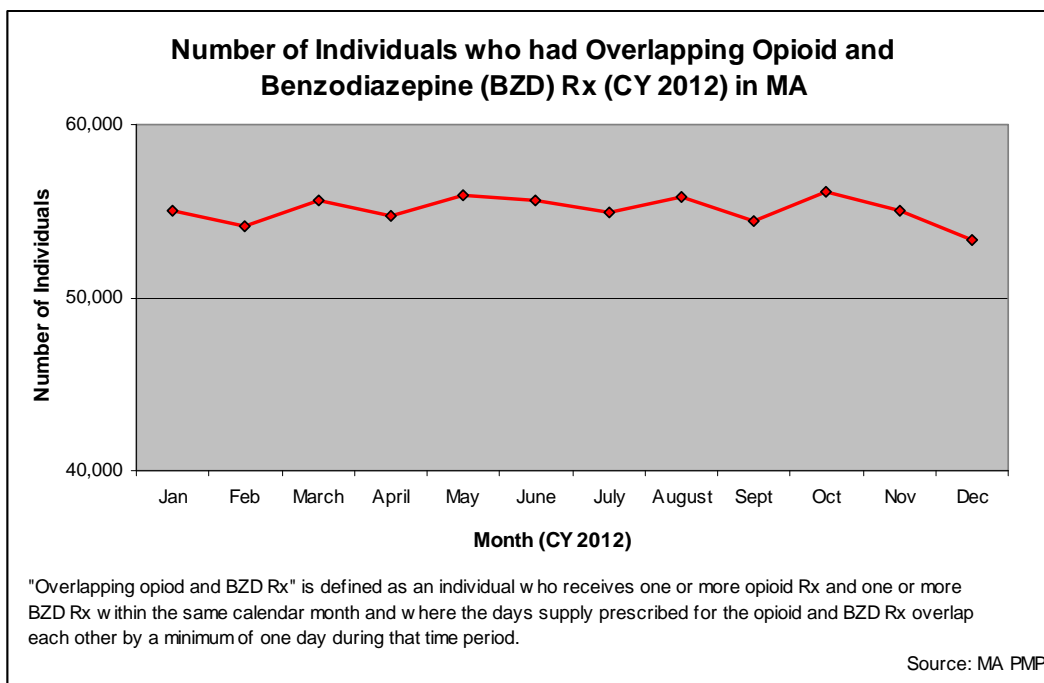
Focus Area 2: Prevention

Strategy: Identify frequency of combined opioid and benzodiazepine use and increased risk of overdose

Statement: Poly-substance abuse has been found to be a significant predictor of drug overdose. Preventing poly-substance abuse may help curb drug overdose. Studies indicate that a majority of patients being treated for overdose had consumed more than one class of drugs. This percentage increases markedly when only fatal overdoses are assessed (Jones et al., 2012). Prescription opioids are commonly abused in combination with benzodiazepines (BZDs). In Massachusetts, opioid drugs were also implicated in over 85 percent of cases in which the medical examiner identified the primary cause of poisoning death as BZDs.⁵

State Data: A month-to-month analysis of overlapping opioid and BZD prescriptions during CY 2012 illustrates the prevalence of combined opioid and BZD use (Figure 2). Access to both opioids and BZDs increases the risk for overdose and overdose death. In any given month, over 50,000 individuals in MA had access to both opioid and BZD prescriptions. Reducing the unnecessary or inadvertent use of this combination of medications across the Commonwealth could potentially reduce the risk of overdose.

Figure 4: Individuals with Opioid and Benzodiazepine Prescriptions



Community-based PMP data analyses can help communities understand prescription drug trends in their areas. PMP data should be analyzed by community and provided to communities across the Commonwealth. This data may give an early warning of changes in patterns such as prevalence of

⁵ BZDs are listed as the primary cause of death in only a small proportion of total poisoning/overdose deaths. Within this small subset, however, there is frequently a co-occurrence of an opioid drug.

doctor shopping, prevalence of persons receiving more than 100 mg daily morphine equivalents of prescriptions, changes in prescribed opioid drugs and drug combinations, prescribers exhibiting aberrant prescribing patterns, and other indicators. Community-level data will enable providers and community leaders to understand best ways to focus interventions, measure progress and evaluate their programs effectively.

Table 2: Focus Area (Prevention) Key Best Practice(s)

Best Practice Model	Description
VA/ DoD	The Department of Veterans Affairs / Department of Defense: Evidence Based Clinical Practice Guideline Management of Opioid Therapy for Chronic Pain makes recommendations based on determination of appropriate criteria such as effectiveness, efficacy, population benefit or patient satisfaction and a literature review to determine strength of evidence in relation to these criteria.
WA AMDG	The Washington State Agency Medical Directors’ Group Opioid Dosing Guideline for Chronic Non-Cancer Pain was originally published in March 2007 and updated in 2010. The guideline was developed in collaboration with actively practicing providers with extensive experience in the evaluation and treatment of patients with chronic pain. It is intended as a resource for all opioid prescribers treating adult patients for chronic non-cancer pain.
UTAH	Utah has developed guidelines to assist clinicians who choose to use opioids to treat patients with pain (acute and chronic non-cancer) and to manage that treatment as safely as possible.
New York City	The New York City Department of Health and Mental Hygiene created guidelines to help reduce the misuse of prescription opioid analgesics by establishing standards for prescribing from the Emergency Department.
OHIO	Ohio Emergency and Acute Care Facility Opioids and Other Controlled Substances (OOCs) Prescribing Guidelines provide a general approach in the prescribing of OOCs.

Recommendation(s)

1. Implement best practices in preventing overdose morbidity and mortality (monitor daily morphine milligram equivalents in clinical practice at the point of care and through the PMP).
2. Track the frequency of patients receiving both opioid prescriptions and prescriptions for benzodiazepines, and other medications that are identified, that can increase the risk of overdose when taken in combination with opiates.
3. Provide community-level data to providers and community leaders to help develop effective interventions.

Focus Area 3: Screening

Strategy: Use of existing screening tools

The Joint Policy Working Group discussed the use of screening tools such as SBIRT (Screening, Brief Intervention, and Referral to Treatment) for identifying abuse or misuse of opioids. Time constraints in high volume practice settings, as well as the lack of standardized reimbursement, were mentioned as barriers to utilizing SBIRT tools. It was discussed that some screening tools can take 5 minutes or less to complete. Policy Working Group participants support the availability of and payment for use of effective screening tools at the clinical discretion of prescribers. A presentation by Dr. Peter Kreiner of Brandeis University showed how MA PMP data can be used to evaluate community prevention initiatives designed to reduce abuse and misuse of prescription drugs through screening.

Table 3: Focus Area (Screening) Key Best Practice(s)

Best Practice Model	Description
MA PMP	According to the National Alliance for Model State Drug Laws (NAMSDL), a PDMP is a statewide electronic database which collects designated data on substances dispensed in the state. The PDMP is housed by a specified statewide regulatory, administrative or law enforcement agency. The housing agency distributes data from the database to individuals who are authorized under state law to receive the information for purposes of their profession ⁶ .
NIDA Quick Screen V1.0 and NIDA – Modified ASSIST V2.0	This guide is designed to assist clinicians serving adult populations in screening for drug use.
BU SBIRT: Brief Negotiated Interview / Active Referral to Treatment	This tool links to screening tools that are often used in clinical settings. While most of these instruments are intended for adults, two have been designed for asking adolescents about substance use and other high-risk behaviors.
UTAH	Utah has developed guidelines to assist clinicians who choose to use opioids to treat patients with pain (acute and chronic non-cancer) and to manage that treatment as safely as possible.

Recommendation(s)

1. Optimize utilization of the online PMP through current regulations requiring participation in the PMP by all prescribers at the point of care and pharmacists at the point of dispensing.
2. Allow delegate access to the PMP to enable more in-depth and effective screening.
3. Stand-up the one-way interface of the online PMP with electronic health records (EHR).
4. Implement guidelines for use of Screening, Brief Intervention, and Referral to Treatment (SBIRT), such as with the Drug Abuse Screening Test (DAST-10) at the point of care.

⁶ http://www.deadiversion.usdoj.gov/faq/rx_monitor.htm

5. Work with commercial payers and the Bureau of Substance Abuse Services (BSAS) to provide information on reimbursement for SBIRT.
6. Promote the use and access of the BSAS Helpline, along with Alcoholics Anonymous and Narcotics Anonymous.

Focus Area 4: Tracking & Focus Area 5: Monitoring

Tracking and monitoring opioid prescribing and dispensing are critical factors to containing and addressing opioid abuse in the Commonwealth. Because there is a significant degree of overlap between these two focus areas, the Policy Working Group identified strategies, best practices and recommendations jointly for tracking and monitoring.

Monitoring patients and tracking prescription drug use in the Prescription Monitoring Program (PMP) database were the topics of two presentations. Mr. Leonard Young, epidemiologist for the MA PMP, presented data on practitioners with greater than or equal to 10, 25, 50 or 100 patients who met criteria for seeking controlled substance prescriptions from multiple prescribers and pharmacies. The PMP began issuing electronic alerts of questionable activity, sent by email to prescribers enrolled in the MA Online PMP, in December 2013.

Mr. John Eadie of the PDMP Center of Excellence presented best practice standards for PMPs. This included discussion of data collection and dissemination to authorized users, data analysis to identify patterns of patient behavior and comparison of the MA PMP with other states. Members recognized that both the monitoring of patients through use of MA Online PMP and receiving PMP alerts are essential for health care providers.

Strategy: Alert practitioners who prescribe to patients over standard thresholds

Statement: A review of PMP data shows that a large proportion of practitioners prescribe Schedule II or III opioids to patients who exhibit patterns of potential doctor/pharmacy shopping. Results of a survey of prescribers who received an unsolicited prescription report from the Drug Control Program on a patient with suspected doctor/pharmacy shopping activity showed that only 14 percent of respondents believed there was a legitimate medical reason for all or nearly all of the prescriptions for the patient for whom they received the report. Of the prescribers reporting sufficient knowledge of the patient, only 12 percent said that they were aware of most of the other prescribers on the report.

State Data: During 2012, over 40 percent (n = 9,753) of all MA practitioners prescribed Schedule II or III opioids to 10 or more patients who received a Schedule II or III opioid prescription from at least one other prescriber and filled such prescriptions at two or more pharmacies. One of every 10 practitioners (n = 2,276) prescribed a Schedule II or III opioid to 10 or more patients who received a Schedule II or III opioid from four or more different prescribers and filled prescriptions at four or more different pharmacies during 2012. Contrary to many anecdotal statements from prescribers and dispensers, this type of behavior is not simply restricted to a small subset of the provider community across the state; it is very pervasive and not always easily detected without using tools like the Online PMP.

Table 4: Potential Doctor and Pharmacy Shopping by Practitioner⁷ in MA (CY 2012)

Schedule II & III Opioids: At least 2 Prescriptions & 2 Pharmacies – 12 Months	Practitioners (N)	Percent*
Practitioner with >= 100 patients meeting criteria	840	3.7
Practitioner with >= 50 patients	2,551	11.1
Practitioner with >= 25 patients	5,469	23.8
Practitioner with >= 10 patients	9,753	42.5

Table 5: Potential Doctor and Pharmacy Shopping by Practitioner in MA (CY 2012)

Schedule II & III Opioids: At least 4 Prescriptions & 4 Pharmacies – 12 Months	Practitioners (N)	Percent*
Practitioner with >= 100 patients meeting criteria	17	0.07
Practitioner with >= 50 patients	139	0.6
Practitioner with >= 25 patients	627	2.7
Practitioner with >= 10 patients	2,276	9.9

Source: MA PMP

In reviewing these data, it is important to note that these data do not illuminate the clinical characteristics of the patients, and cannot differentiate between patients who might have multiple prescribers and pharmacies due to complex, extended care for serious medical illness, for example, versus patients who might be doctor or pharmacy shopping in conjunction with misuse or abuse of opiates

⁷ Practitioners comprise the following provider categories: MDs, DDSs, DMDs, DOs, and DPMs

*Percent of practitioners who prescribed at least one Schedule II or III opioid prescription during 2012 (n = 22,941)

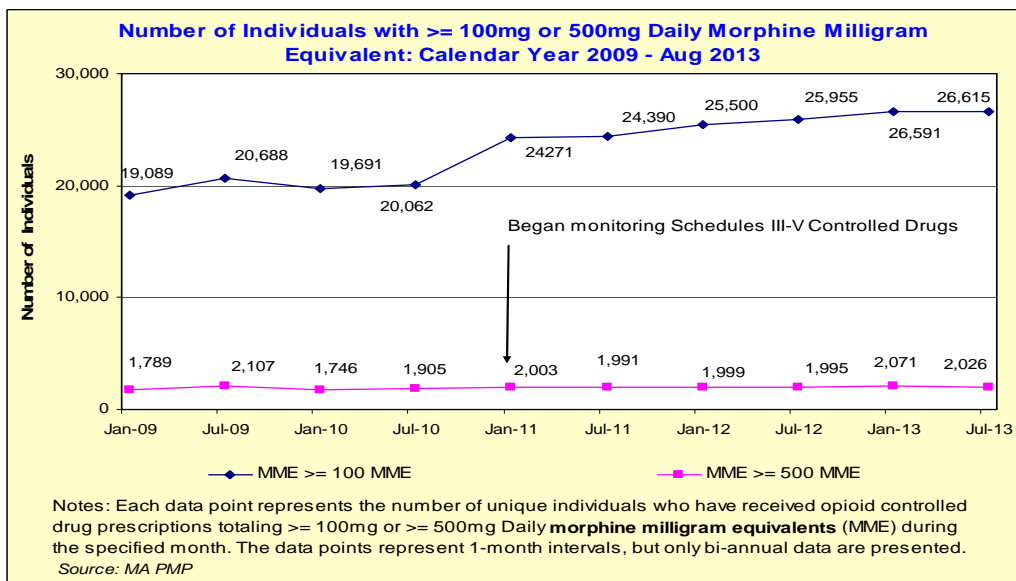
Note: Excludes prescription records where the reported DEA number is a hospital DEA (i.e., only includes records where an individual prescriber can be identified.)

Strategy: Identify frequency of individuals receiving ≥ 100 mg daily morphine milligram equivalents (MME) and associated risk of fatal and non-fatal overdose

Statement: The amount of daily morphine milligram equivalents (MMEs) prescribed has become increasingly used by researchers and government agencies to better gauge the abuse and overdose potential of opioids. Evidence suggests that individuals receiving more than 100 mg daily MMEs are nine times more likely to overdose (Dun et al., 2010). The CDC recommends that if a patient's dosage has increased to 120 mg MME per day or more without substantial improvement in function and or pain, a consultation from a pain specialist should be sought.

Data: Figure 4 presents a time series analysis of the number of individuals in MA, who received either 100 mg or more, or 500 mg or more, of daily MME during specified months between January 2009 and July 2013. Since January 2011 (when MA PMP began monitoring Schedule III-V medications in addition to Schedule II medications), the number of individuals who received 100 mg or more of daily MME each month has slowly but steadily increased, with over 26,000 individuals meeting the 100 mg daily MME threshold in January and July 2013. These individuals are at higher risk for fatal and non-fatal opioid overdose. Between 1,746 and 2,071 individuals received 500 mg or more of daily MME during the specified time periods.

Figure 5: Individuals in MA with High Daily Morphine Milligram Equivalents



Strategy: Use of Delegates and Batch Look-up

The PMP enhancements that were discussed included the delegate user functionality and batch lookup. The delegate user enhancement feature would allow authorized primary account holders (licensed prescribers and pharmacists) to have delegated support staff perform patient queries in the PMP on their behalf. Batch lookup would enable a file of patient names to be uploaded and queries to be done for multiple patients at one time. The MA Department of Public Health's Drug Control Program staff conveyed that the batch lookup feature is in the testing phase of development and will become available within the year. Those who requested the delegate user functionality also suggested that prescribers be allowed to create more than two delegate user subaccounts. However, delegate user functionality that expands to more than two delegate users per prescriber will require additional resources. The Drug Control Program will continue to investigate this option.

Additionally, the PMP is an integral component of the Commonwealth’s Substance Abuse Strategic Plan and efforts are continuing to expand the capabilities of this important clinical tool, including electronic health record (EHR) integration. The Executive Office of Health and Human Services (EOHHS) has built a health information exchange (HIE), known as the Mass HIWay. HIE infrastructure will enable connections between the PMP and many EHRs through a single interface. By linking EHR systems directly with the online PMP database prescribers and dispensers will not only save valuable time, they will also have the option to view the most relevant information for their medical practice.

Table 7: Focus Area (Tracking) & Focus Area (Monitoring) Key Best Practice(s)

Best Practice Model	Description
MA PMP	The MA Online PMP is a tool that supports safe prescribing and dispensing by tracking controlled substance prescriptions in the Commonwealth.

Recommendation(s)

1. Increase utilization of prescription monitoring program data at the point of care. Enhance office practice utilization and use of delegates with the MA Online PMP batch look-up.
2. Analyze PMP data to provide community-level analysis.
3. Continue with electronic alerts for prescribers and also send electronic alerts to dispensers; continue to support law enforcement case investigations.
4. Notify regulatory agencies responsible for authorized prescribers and pharmacists after review by the Medical Review Group, which is a group of five physicians and pharmacists that review questionable prescribing of providers and make recommendations to the respective boards for additional investigations as needed.

Focus Area 6: Treatment

The key strategies for treatment fall into two overarching categories: 1) treating addiction and 2) treating pain in a way that reduces the risk of future addiction. The DPH BSAS publishes Practice Guidance papers which describe best practices, as well as why and how practice in specific areas can be improved.

Table 8: Focus Area (Treatment) Key Best Practice(s)

Best Practice Model	Description
MA BSAS Guidance(s)	The DPH BSAS publishes Practice Guidance papers which describe best practices as well as why and how practice in specific areas can be improved. These are intended to be used by BSAS providers in assessing and improving programs and services, and by consumers in understanding what best practice should look like. Each guide contains summaries, with embedded links, of research and resources, as well as a link to provide feedback to BSAS.
SCOPE	SCOPE of Pain is a series of continuing medical education and continuing nursing education activities designed to help safely and effectively manage patients with chronic pain, when appropriate, with opioid analgesics.
WA AMDG	Washington State Agency Medical Directors' Group The Opioid Dosing Guideline for Chronic Non-Cancer Pain was originally published in March 2007 and updated in 2010. Sponsored by the AMDG, the guideline was developed in collaboration with actively practicing providers with extensive experience in the evaluation and treatment of patients with chronic pain. It is intended as a resource for all opioid prescribers treating adult patients for chronic non-cancer pain.
New York City	The New York City Department of Health and Mental Hygiene created guidelines to help reduce the misuse of prescription opioid analgesics by establishing standards for prescribing from the Emergency Department.
OHIO	Ohio Emergency and Acute Care Facility Opioids and Other Controlled Substances (OOCs) Prescribing Guidelines provide a general approach in the prescribing of OOCs.

Recommendations

1. Identify best practices for treating acute and chronic pain by different types of providers and in different practice settings.
2. Identify practice guidelines to identify (through screening tools identified above) and treat dependency or addiction.
3. Identify resources for treating specific populations, e.g. treating pain in patients taking buprenorphine.

Summary of Strategies and Recommendations

Table 9: Summary of Strategies, Best Practices and Recommendations

Category	Strategy	National / State-based Best Practices	Recommendation(s)
Education	<ul style="list-style-type: none"> • Strategy: Develop educational materials • Strategy: Understand efficacy of community interventions in reducing abuse and misuse of controlled prescription drugs 	<ul style="list-style-type: none"> • SCOPE • Mass Medical Society 1 & 2 • PDMP Center of Excellence • Veterans Administration / Department of Defense: Evidence Based Practice Clinical Practice Guideline Management of Opioid Therapy for Chronic Pain • Utah guidelines for opioid prescribing 	<ol style="list-style-type: none"> 1. The DCP will work with the various boards of registration to assist in the development of criteria for training and continuing education materials related to prescription drug abuse (e.g. online continuing education credits, online video training.). 2. Registered Individual Practitioner⁸ provider and specialty associations develop guidelines to support best practice clinic guidelines, such as the Washington Agency Medical Directors' Group Opioid Dosing Guideline for Chronic Non-Cancer Pain and specialty-specific opioid dosing guidelines and institute pain management treatment agreements between providers and patients through such guidelines. 3. Pharmacist groups develop dispensing guidelines such as the Northeastern University School of Pharmacy Best Practices for Pharmacists to Reduce

⁸ 105 CMR 700.001 a Registered Individual Practitioner shall mean a physician, dentist, veterinarian, podiatrist, nurse midwife, nurse practitioner, psychiatric nurse, nurse anesthetist or physician assistant who is registered pursuant to 105 CMR 700.004

Category	Strategy	National / State-based Best Practices	Recommendation(s)
			<p>Prescription Opioid Abuse.</p> <p>4. The DCP will work with professional schools and training programs to support curricula development that increases knowledge and understanding of opioid abuse.</p>
Prevention	<ul style="list-style-type: none"> • Strategy: Use of existing screening tools • Strategy: Identify frequency of combined opioid and benzodiazepine use and increased risk of overdose 	<ul style="list-style-type: none"> • Veterans Administration / Department of Defense: Evidence Based Practice Clinical Practice Guideline on Management of Opioid Therapy for Chronic Pain • Washington State Agency Medical Directors' Group <i>The Opioid Dosing Guideline for Chronic non-cancer Pain</i> • Utah guidelines for opioid prescribing • New York City guidelines for opioid prescribing • Ohio Emergency and Acute Care Facility Opioids and Other Controlled Substances (OOCs) Prescribing • Guidelines 	<ol style="list-style-type: none"> 1. Implement best practices in preventing overdose morbidity and mortality (monitor daily morphine milligram equivalents in clinical practice at the point of care and through the PMP). 2. Track the frequency of patients receiving both opioid prescriptions and prescriptions for benzodiazepines, and other medications that are identified, that can increase the risk of overdose when taken in combination with opiates. 3. Provide community-level data to providers and community leaders to help develop effective interventions.
Screening	Strategy: Utilize screening tools and make screening tools available to prescribers	<ul style="list-style-type: none"> • The MA Prescription Monitoring Program (PMP) and the MA Online PMP • NIDA Quick Screen V1.0 and NIDA – Modified ASSIST V2.0 	<ol style="list-style-type: none"> 1. Optimize utilization of the online PMP through current regulations requiring participation in the PMP by all prescribers at the point of care and pharmacists at the point of dispensing.

Category	Strategy	National / State-based Best Practices	Recommendation(s)
		<ul style="list-style-type: none"> • BU SBIRT: Brief Negotiated Interview / Active Referral to Treatment • Utah guidelines for opioid prescribing 	<ol style="list-style-type: none"> 2. Allow delegate access to the PMP to enable more in-depth and effective screening. 3. Stand-up the one-way interface of the online PMP with electronic health records (EHR). 4. Implement guidelines for use of Screening, Brief Intervention, and Referral to Treatment (SBIRT), such as with the Drug Abuse Screening Test (DAST-10) at the point of care. 5. Work with commercial payers and the Bureau of Substance Abuse Services (BSAS) to provide information on reimbursement for SBIRT. 6. Promote the use and access of the BSAS Helpline, along with Alcoholics Anonymous and Narcotics Anonymous.
Monitoring & Tracking	<p>Strategy: Notify practitioners who prescribe to patients who are potentially engaging in doctor/pharmacy shopping activity</p> <p>Strategy: Monitoring patients who are prescribed most frequently dispensed drug</p>	<ul style="list-style-type: none"> • The MA Prescription Monitoring Program (PMP) and the MA Online PMP • Mass Medical Society 2 	<ol style="list-style-type: none"> 1. Increase utilization of prescription monitoring program data at the point of care. Enhance office practice utilization and use of delegates with the MA Online PMP batch look-up. 2. Analyze PMP data to provide community-level analysis.

Category	Strategy	National / State-based Best Practices	Recommendation(s)
	<p>products</p> <p>Strategy: Identify frequency of individuals receiving ≥ 100 mg daily morphine milligram equivalents (MME) and associated risk of fatal and non-fatal overdose</p> <p>Strategy: Enhance MA PMP for More Complete Monitoring</p>		<ol style="list-style-type: none"> 3. Continue with electronic alerts for prescribers and also send electronic alerts to dispensers; continue to support law enforcement case investigations. 4. Notify regulatory agencies responsible for authorized prescribers and pharmacists after review by the Medical Review Group, which is a group of five physicians and pharmacists that review questionable prescribing of providers and make recommendations to the respective boards for additional investigations as needed.
Treatment		<ul style="list-style-type: none"> • Drug Abuse: MA Bureau of Substance Abuse Services (BSAS) Guidance(s) • Pain: Washington State Agency Medical Directors' Group <i>The Opioid Dosing Guideline for Chronic Non-Cancer Pain</i> • Pain: New York City guidelines for opioid prescribing • Pain: Ohio Emergency and Acute Care Facility Opioids and Other Controlled Substances (OOCs) Prescribing Guidelines • Pain: SCOPE 	<ol style="list-style-type: none"> 1. Identify best practices for treating acute and chronic pain by different types of providers and in different practice settings. 2. Identify practice guidelines to treat dependency or addiction. 3. Identify resources for treating specific populations, e.g. treating pain in patients taking buprenorphine.

Category	Strategy	National / State-based Best Practices	Recommendation(s)
		<ul style="list-style-type: none"> <li data-bbox="814 331 1171 358">Pain: Mass Medical Society 1 	

Additional Considerations

The Joint Policy Working Group identified additional areas for consideration in planning policies to address prescription drug abuse. In weighing different policy options, policymakers should take a planned and thoughtful approach to ensure that actions are effective, feasible and sustainable.

1. Delegates – Any new regulations will need to clearly define the active use of delegates in the online PMP. Delegates will play a crucial and critical role for prescribers as automatic enrollment is implemented and prescribers comply with requirements to use the PMP.

The use of delegates will require accountability to ensure patient information is kept confidential and to protect the primary account holder from other users having unwarranted access to information under their accounts. Even within the confines of the Health Insurance Portability and Accountability Act of 1996, medical and public health information systems must contain an audit trail of each person that accesses a patient's information. The lack of a mechanism to track who is accessing an individual patient's information could put providers at risk for privacy violations.

There are 30 states throughout the US that use delegates in their PMP systems. The expected high workload anticipated as a result of mandatory checks makes the use of delegates essential. The challenge facing the MA DPH and the DCP is to identify how delegates can be used in a responsible manner while still allowing prescribers to have the support they need.

2. Assess the feasibility of having pharmacies report prescriptions within 24 hours to improve the timeliness of data within the online PMP. Pharmacies in New York and seven other states report opioid dispensing to their PMPs within 24 hours. In Massachusetts, it can take two to three weeks for a record of a dispensed prescription to appear in the PMP. This lag limits the utility of the PMP to detect doctor or pharmacy shopping in real time.

Appendix

Joint Policy Working Group Meeting Content

At the April 2013 meeting, the Joint Policy Working Group provided feedback on the Department’s draft regulations for implementing Chapter 244 of the Acts of 2012 regarding mandatory PMP utilization. The group focused on identifying clinical situations where it would be optimal to utilize the PMP for prevention and monitoring. In addition, group members provided recommendations for system improvements that would enhance adoption of the PMP into routine clinical workflow.

During the July 2013 meeting, members of the Joint Policy Working Group provided additional feedback on draft regulations implementing Chapter 244 of the Acts of 2012, particularly the mandate for PMP utilization by practitioners. Some Joint Policy Working Group members were concerned about the proposed regulations imposing mandatory use of the Online PMP by practitioners.

Attendees stated that DPH should consider other states’ regulations that limit PMP utilization to specific instances such as: a defined list of certain situations; only when prescribing more than a seven day supply of opioids; or prior to prescribing an opioid. In addition, PMP is only one of many clinical tools for addressing prescription drug abuse. Other tools, such as lab tests and pill counts, are also useful when engaging patients in discussions concerning prescription drug abuse. Patient intervention strategies should include but not be limited to use of the PMP.

During the September, October and November 2013 meetings the six focus areas were discussed. Meetings included presentations by staff and invited speakers. At the December meeting the two presentations were on the patient’s perspective of pain and treatment for prescription drug abuse.

Table 10: Policy Working Group Meeting Schedule

Meeting Date	April 25, 2013	July 26, 2013	September 9, 2013	October 9, 2013	November 8, 2013	December 18, 2013
TOPIC/ AREA OF FOCUS	Chapter 244 of the Acts of 2012 and proposed regulations	Chapter 38 of the Acts of 2013, Section 8 Proposed regulations to promote safe and responsible opioid prescribing	Prescription drug abuse data review. Best Practice Areas of Focus <ul style="list-style-type: none"> • Education • Treatment 	Discussion of SBIRT tool (Screening, Brief Intervention, and Referral to Treatment) Best Practice Areas of Focus <ul style="list-style-type: none"> • Screening • Prevention 	Discussion of group efforts towards statutory deliverable, report Best Practice Areas of Focus <ul style="list-style-type: none"> • Tracking • Monitoring 	Discussion of draft report Best Practice Areas of Focus <ul style="list-style-type: none"> • Treatment
PRESENTOR	Group discussion	Group discussion	Len Young Diane Neelon	Peter Kreiner	John Eadie Len Young	Hilary Jacobs Cindy Steinberg

Table 11: Policy Working Group Speaker List / Affiliations

Speaker List and Affiliations	
Hilary Jacobs, LICSW, LADC MA DPH, Bureau of Substance Abuse Services. Opioid Treatment	John Eadie Director, PDMP Center of Excellence Utilizing PMP for Tracking and Monitoring
Leonard Young, M.S. M.A. Epidemiologist MA DPH, Drug Control Program PMP Data and Patient Prescription Histories	Cindy Steinberg, National Director of Policy & Advocacy, U.S. Pain Foundation Chair, Policy Council, Massachusetts Pain Initiative
Peter Kreiner, Ph.D., Principal Investigator PMP Center of Excellence MA PMP Community Level Data Analysis	Diane M. Neelon, R.N., B.S., J.D Director of the Office of Health Policy, Department of Industrial Accidents DIA Treatment Guideline 27 – Chronic Pain

Best Practices URLs

Education

VA/ DoD

URL: http://www.healthquality.va.gov/COT_312_Full-er.pdf

UTAH

URL: <http://www.health.utah.gov/prescription/guidelines.html>

WA AMDG

URL: <http://www.agencymeddirectors.wa.gov/opioiddosing.asp>

New York City

URL: <http://www.nyc.gov/html/doh/downloads/pdf/basas/opioid-prescribing-guidelines.pdf>

OHIO

URL: <http://www.health.ohio.gov/ed/guidelines.aspx>

Prevention

VA/ DoD

URL: http://www.healthquality.va.gov/COT_312_Full-er.pdf

WA AMDG

URL: <http://www.agencymeddirectors.wa.gov/opioiddosing.asp>

UTAH

URL: <http://www.health.utah.gov/prescription/guidelines.html>

New York City

URL: <http://www.nyc.gov/html/doh/downloads/pdf/basas/opioid-prescribing-guidelines.pdf>

OHIO

URL: <http://www.health.ohio.gov/ed/guidelines.aspx>

Screening

MA PMP

URL: <http://www.mass.gov/eohhs/gov/departments/dph/programs/hcq/drug-control/ma-online-prescription-monitoring-program/>

NIDA Quick Screen V1.0 and NIDA – Modified ASSIST V2.0

URL: <http://www.drugabuse.gov/sites/default/files/pdf/nmassist.pdf>

BU SBIRT: Brief Negotiated Interview / Active Referral to Treatment

URL: <http://www.bu.edu/bniart/sbirt-in-health-care/sbirt-Educational-materials/sbirt-screening-tools/>

UTAH

URL: <http://www.health.utah.gov/prescription/guidelines.html>

Monitoring and Tracking

MA PMP

URL: <http://www.mass.gov/eohhs/gov/departments/dph/programs/hcq/drug-control/ma-online-prescription-monitoring-program/>

MA BSAS Guidance(s)

URL: <http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/providers/program-licensing/principles-of-care-and-practice-guidance.html>

Treatment

SCOPE

URL: <http://www.scopeofpain.com>

WA AMDG

URL: <http://www.agencymeddirectors.wa.gov/opioiddosing.asp>

New York City

URL: <http://www.nyc.gov/html/doh/downloads/pdf/basas/opioid-prescribing-guidelines.pdf>

OHIO

URL: <http://www.health.ohio.gov/ed/guidelines.aspx>

Table 12: Best Practices Resource Table

Cross Reference of Best Practice with the Six Focus Areas	Education	Prevention	Treatment PAIN	Treatment	Screening	Monitoring	Tracking	Notes
MA PMP					•	•		
MA PMP (Alerts)							•	
MA BSAS Guidance				•				
NIDA					•			
UTAH	•		•		•			
VA /DoD	•		•					
OHIO	•	•	•					
NYC	•	•	•					
WA AMDG	•	•	•					
SCOPE	•		•					
PDMP COE						•	•	

Mass Med Society 1	•		•					
Mass Med Society 2	•					•		
BU SBIRT					•			
Pharmacist Guidelines								In process

Joint Policy Working Group Members (*please note this list contains appointees of those organizations invited to participate as outlined in the statute*).

Name	Agency/Organization
Scott Aronson	MA Podiatric Medical Society
Harry Schneider	MA Podiatric Medical Society
Cindy Steinberg	MA Pain Initiative
Bill Ryder	MA Medical Society
Anuj Goel	MA Hospital Association
Hilary Jacobs	MA Dept of Public Health - BSAS
Madeleine Biondolillo	MA Dept of Public Health – Bureau of Health Care Safety and Quality
David White	MA Dental Society
Stephanie Ahmed	MA Coalition of Nurse Practitioners
David Probert	MA Association of Physician Assistants
Andrew Stein	Independent Pharmacist
Michele Matthews	Chain Pharmacist
Joanne Trifone	Chain Pharmacist
Daniel Alford	Boston Medical Center
Leroy Kelly	Board of Registration in Podiatry
Sheila York	Board of Registration in Podiatry
Kenneth Freedman	Board of Registration in Pharmacy
Anita Young	Board of Registration in Pharmacy

Laurie Talarico	Board of Registration in Nursing
Jean O'Brien	Board of Registration in Medicine
Mina Paul	Board of Registration in Dentistry
Deborah Allwes	MA Department of Public Health – BHCSQ, Drug Control Program

Chapter 244 of the Act of 2012: For full reference, please refer to:
<https://malegislature.gov/Laws/SessionLaws/Acts/2012/Chapter244>

Chapter 38 of the Acts of 2013, Section 87

Chapter 38 of the Acts of 2013 SECTION 87. "Subsection (c) of section 24A of said chapter 94C is hereby further amended by striking out the second paragraph, added by section 8 of chapter 244 of the acts of 2012, and inserting in place thereof the following paragraph:-

The department shall promulgate rules and regulations relative to the use of the prescription monitoring program by registered participants, which shall include requiring participants to utilize the prescription monitoring program prior to the issuance, to a patient for the first time, of a prescription for a narcotic drug that is contained in schedule II or III. The department may require participants to utilize the prescription monitoring program prior to the issuance, to a patient for the first time, of benzodiazepines or any other schedule IV or V prescription drug, which is commonly abused and may lead to physical or psychological dependence or which causes patients with a history of substance dependence to experience significant addictive symptoms. The regulations shall specify the circumstances under which such narcotics may be prescribed without first utilizing the prescription monitoring program. The regulations may also specify the circumstances under which support staff may use the prescription monitoring program on behalf of a registered participant. When promulgating the rules and regulations, the department shall also require that pharmacists be trained in the use of the prescription monitoring program as part of the continuing education requirements mandated for licensure by the board of registration in pharmacy, under section 24A of chapter 112. The department shall also study the feasibility and value of expanding the prescription monitoring program to include schedule VI prescription drugs."

References

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[CDC] Centers for Disease Control and Prevention. 2011. Policy Impact: Prescription Painkiller Overdoses. URL: <http://www.cdc.gov/homeandrecreationalsafety/rxbrief/>

[COE-PDMP] Center for Excellence-Prescription Drug Monitoring Program. 2012. Prescription Drug Monitoring Programs: An Assessment of the Evidence for Best Practices. Prescription Drug Monitoring Program Center of Excellence. Prepared for the Pew Charitable Trusts. URL: http://www.pewhealth.org/uploadedFiles/PHG/Content_Level_Pages/Reports/PDMP_Full%20and%20Final.pdf

Center for Excellence Prescription Drug Monitoring Program (COE-PDMP). 2012. Notes from the Field: Project Lazarus: Using PDMP Data to Mobilize and Measure Community Drug Abuse Prevention.

URL: http://pdmpeexcellence.org/sites/all/pdfs/project_lazarus_nff_a.pdf

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