Date: March 9, 2018 **Staff:** Alyson Williams	**POLICY ANALYSIS** **PREPARED FOR THE BOARD OF DIRECTORS**	Health District OF NORTHERN LARIMER COUNTY

SB18-022: CLINICAL PRACTICE FOR OPIOID PRESCRIBING

Concerning clinical practice measures for safer opioid prescribing.

Details

Bill Sponsors: Senate – *Tate (R) and Aguilar (D)*, Lambert (R)
House – *Pettersen (D) and Kennedy (D)*, Singer (D)
Committee: House Committee on Health, Insurance, & Environment
Bill History: 2/23/2018-Introduced in House- Assigned to Health, Insurance, & Environment
Next Action: Hearing in House Committee on Health, Insurance, & Environment

Bill Summary

Until September 2021, providers must limit the initial opioid prescription to 7-day supply for a patient with no opioid prescription in past 12 months. It allows the original prescriber to include a single refill of 7 day supply. There are many exceptions to this limitation which are dependent on the type of prescriber (i.e. physician or optometrist) that include: chronic pain, cancer-related pain, undergoing palliative or hospice care, and/or post-surgical pain expected to last more than 14 days. Current law allows for providers or their designees to query the Prescription Drug Monitoring Program (PDMP); this bill requires the person accessing the PDMP to report their health care specialty the first time they utilize the program. Furthermore, the bill requires the PDMP to be searched before prescribing the first refill for an opioid, with exceptions similar to those listed previously. The bill mandates a report be made to the General Assembly regarding the findings of a federal grant.

Issue Summary

The Prescribing of Opioids

Nationally, the opioid prescribing rate has decreased 13.1 percent, to 70.6 prescriptions per 100 people, from 2012 to 2015.[1] However, the average duration of opioid prescriptions increased during the same time.[1] Although the prescribing amount, Morphine Milligram Equivalents (MME)[2], has decreased nationally in the past few years to 640 MME per capita, it is still substantially above the 180 MME per capita that was measured in 1999.[1]

In 2016, the opioid prescribing rate in Colorado was 59.8 per 100 people, which has decreased from 73.5 prescriptions per 100 people in 2012.[3] State-specific research by the Colorado Department of Public Health and Environment (CDHPE) delineated that the number of opioid prescriptions per person increased with age.[4] One quarter of Coloradans have admitted to using pain medications in ways that were not prescribed by their provider.[5] Similarly, 29 percent of Coloradans have use pain medications that were not prescribed

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[1] Guy GP Jr., Zhang K, Bohm MK, et al.(July 2017). Vital Signs: Changes in Opioid Prescribing in the United States, 2006–2015. *MMWR Morb Mortal Wkly Rep 2017*;66:697–704. doi: http://dx.doi.org/10.15585/mmwr.mm6626a4

[2] Morphine Milligram Equivalents is a value that is assigned to opioids to represent their relative potency to provide for the ease of comparison.

[3] Centers for Disease Control and Prevention. (July 31, 2017). *U.S. Prescribing Rate Maps.* Retrieved from https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html

[4] Colorado Department of Public Health and Environment (July 2017). *Colorado Prescription Drug Profile.* Retrieved from https://www.colorado.gov/pacific/sites/default/files/PW_ISVP_Colorado%20Rx%20Drug%20Data%20Profile.pdf

[5] Colorado Chapter of the American College of Emergency Physicians (2017). *2017 Opioid Prescribing and Treatment Guidelines: Confronting the Opioid Epidemic in Colorado's Emergency Departments.* Retrieved from http://coacep.org/docs/COACEP_Opioid_Guidelines-Final.pdf

to them.[5] In Larimer County, the prescribing rate has dropped from 84.2 prescriptions per 100 people in 2012 to 62.2 prescriptions per 100 people in 2016.[3]

Prescribing Guidelines

The Centers for Disease Control and Prevention (CDC) promulgated guidelines regarding the prescription of opioids in 2016.[6] The CDC recommended that when prescribing opioids for acute pain it should be sufficient to prescribe a quantity for three or less days, and rarely for more than seven. That should be adequate to address the expected duration of pain severe enough to require opioids while decreasing the risk of long-term use. Furthermore, the guidelines suggest that the use of a PDMP can ensure that the patient is not taking any other opioids or could have a negative interaction between two prescriptions.

In August 2017, the Colorado Department of Health Care Policy and Financing (HCPF) implemented the first set of new rules for the Colorado Medicaid program that limited an initial opioid prescription to a 7-day supply and limited refills, with prior authorization required after four refills.[7] The second phase of the rule began in October 2017 and applies to chronic pain. The rule limited dosages of opioids to a certain threshold (250 Morphine Milligram Equivalents [MME] per day) for pain management and anything above that MME requires prior authorization.

In 2017, the Colorado Chapter of the American College of Emergency Physicians (COACEP) promulgated practice and policy recommendations regarding opioids.[5] One of the practice recommendations is the frequent consultation of the PDMP by emergency department (ED) physicians. The recommendations also suggest prescribing the lowest effective dose in the shortest appropriate duration and refusing to refill lost or stolen opioid prescriptions. In the policy section, COACEP recommends that the Colorado PDMP develop an automated query system that can be more readily integrated into electronic health records.

Opioids and Pain

Recently, research regarding the effectiveness of different types of pain management for both chronic and acute pain has been proliferating. In regard to the dosage of opioids prescribed, a study found adults with chronic pain that used lower or intermittent doses and those that had regular or high doses had similar pain outcomes.[8] This demonstrates that, depending on the patient, chronic pain management may not necessitate a regular or high dosage opioid prescription. A novel study of two urban EDs in New York City demonstrated that for adult patients presenting with acute extremity pain there was no statistical or clinical difference in pain alleviation after two hours between those receiving opioid drugs and those who took the non-opioid alternative.[9] As the compendium of research on the effectiveness of opioids versus non-opioids has been growing over recent years, there has been a recent movement to adopt a strategy known as Alternatives to Opioids (ALTO) to greater utilize non-opioids for pain management.

Pain has been regarded as a patient's "fifth vital sign," and opioids have been increasingly prescribed to bring the patient back to equilibrium.[5] Some believe that this has generated an overemphasis on a patient's pain and the quickest way to treat it. Although this pain measure is subjective, it is a component of patient

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[6] Dowell D., Haegerich T.M., Chou R. (2016) *CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016*. MMWR Recommendation Report; 65(No. RR-1):1–49.doi: http://dx.doi.org/10.15585/mmwr.rr6501e1

[7] Colorado Department of Health Care Policy and Financing. *Colorado Medicaid to Tighten Opioid Usage Policy.* Retrieved from https://www.colorado.gov/pacific/hcpf/news/colorado-medicaid-tighten-opioid-usage-policy . Accessed on Dec 6, 2017.

[8] Turner, J. A., Shortreed, S. M., Saunders, K. W., LeResche, L., & Von Korff, M. (2016). Association of Levels of Opioid Use with Pain and Activity Interference among Patients Initiating Chronic Opioid Therapy: A Longitudinal Study. *Pain*, *157*(4), 849–857. http://doi.org/10.1097/j.pain.0000000000000452

[9] Chang, A.K., Bijur, P.E., & Esses, D. (Nov 2017). Effect of a single dose of oral opioid and nonopioid analgesics on acute extremity pain in the emergency department. *JAMA;* 318(17):1661-67. doi: 10.1001/jama.2017.16190

satisfaction ratings, thus many physicians feel compelled to address it with opioids to negate any sense of pain or discomfort the patient is experiencing.

Prescription Opioids, Misuse, and Opioid Use Disorder

Many studies in the past decade have focused on the relationship between prescription opioids, opioid misuse, opioid use disorder, and opioid overdose deaths. Among patients receiving opioid prescriptions for pain, higher opioid doses were associated with increased risk of opioid overdose death.[10] Another study that focused on postsurgical opioid prescriptions found that each refill and week of a prescription is associated with in large increase among opioid naïve patients (i.e. an individual who has either never had an opioid or has not received opioids for a 2-3 week period).[11] This correlates with a study that found that once opioids have been continued for 90 days, patients are more likely to remain on the drug for years.[12] Interestingly, opioid prescriptions from the ED to opioid naïve patients are more likely to adhere to CDC guidelines for opioid prescribing than those prescribed from a non-ED setting and are associated with a lower risk of progression to long-term use.[13] However, another study found that there is wide variation in rates of opioid prescribing existed among physicians practicing within the same ED, and rates of long-term opioid use were increased among patients who were opioid naïve and received treatment from prescribers who prescribe at higher rates than their cohorts.[14] Among children, the use of prescribed opioids before the conclusion of high school is independently associated with future opioid misuse among those who have little experience with drugs and who disapprove of illegal drug use.[15]

Prescription Drug Monitoring Program (PDMP)

Since 2014, 49 states had implemented a PDMP, with Missouri's governor signing an executive order in 2017 for one to be implemented. A 2016 study of PDMPs found that if programs monitor all classes of drugs that have medical use and an abuse potential and increase the frequency of updating the program, there is an association with larger declines in opioid-related overdose deaths than with other programs.[16] Another study on PDMPs has found that those that do not require provider participation are not effective in decreasing inappropriate utilization of prescription opioids.[17]

The Colorado PDMP was first authorized by law in 2005 and was enhanced by law in 2014 to the program that is currently running.[18] Practitioners and pharmacists, even in other states, can query information on Colorado patients.[19] Pharmacies must upload prescription data during every business day for medications that are classified as Schedule II-V.[18] However, physicians are not required to query the PDMP.

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[10] Bohnert, A.S., Valenstein, M., Bair, M.J., et al. (Apr. 2011). Association between opioid prescribing patterns and opioid overdose-related deaths. *JAMA;* 305(13):1315-21. doi: 10.1001/jama.2011.370.

[11] Brat, G.A., Agniel, D., Beam, A., et al. (Jan. 2018). Postsurgical prescriptions for opioid naïve patients and association with overdose and misuse: retrospective cohort study. *BMJ* 360:j5790. doi: 10.1136/bmj.j5790

[12] Martin B.C., Fan M.Y., Edlund M.J., Devries A., Braden J.B., Sullivan M.D.. (2011) Long-term chronic opioid therapy discontinuation rates from the TROUP study. *J Gen Intern Med*: 26(12):1450–7. doi: 10.1007/s11606-011-1771-0

[13] Jeffery, M.M., Hooten W.M., Hess, E.P.,, et al.(March 2018). Opioid Prescribing for Opioid-Naïve Patients in Emergency Departments and Other Settings: Characteristics of Prescriptions and Association with Long-Term Use. *Ann Emerg Med*; 71(3):326–336. doi: 10.1016/j.annemergmed.2017.08.042

[14] Barnett, M.L., Olenski, A.R., & Jena, A.B. (Feb. 2017). Opioid-Prescribing Patterns of Emergency Physicians and Risk of Long-Term Use. *New England Journal of Medicine;* 376(7): 663-673. doi: 10.1056/NEJMsa1610524.

[15] Miech,R., Johnston, L., O'Malley,P.M., Keyes, K.M., &Heard, K. (Nov 2015). Prescription Opioids in Adolescence and Future Opioid Misuse. *Pediatrics;* 136(5):e1169-77. doi: 10.1542/peds.2015-1364

[16] Patrick, S.W., Fary, C.E., Jones, T.F., & Buntin, M.B. (2016). Implementation of Prescription Drug Monitoring Programs Associated with Reductions in Opioid-Related Death Rates. *Health Affairs.* 35(7): 1324-32. doi: 10.1377/hlthaff.2015.1496

[17] Buchmueller, T.C., & Carey, C. (Feb. 2017). The effect of prescription drug monitoring programs on opioid utilization in Medicare. *National Bureau of Economic Research;* Working Paper No. 23148. Retrieved from http://www.nber.org/papers/w23148.pdf

[18] Colorado Department of Regulatory Agencies (2014). *Colorado's Prescription Drug Monitoring Program- 2014 and Beyond* [Presentation]. Retrieved from https://www.deadiversion.usdoj.gov/mtgs/pharm_awareness/conf_2014/august_2014/gassen.pdf

[19] Colorado Department of Regulatory Agencies (2018). *About Program.* Retrieved from https://www.colorado.gov/pacific/dora-pdmp/about-program

This Legislation

The bill limits an initial opioid prescription to a 7-day supply, if the patient has had no opioid prescription in the previous 12 months. The original prescriber can include a single refill of the 7-day supply. It is stipulated that these prescriptions can be done electronically. This limit has certain exceptions included in the bill text and also stipulates what professions may utilize these exclusions. Using their judgement the prescriber can exclude patients from the limits that:

- Have chronic pain, or have been transferred from another licensed provider that prescribed the opioid[20] (Podiatrist, Dentist, Physician, Physician Assistant, Advanced Practice Nurse, Optometrist, Veterinarian)
- Has been diagnosed with cancer and has cancer-related pain (Podiatrist, Dentist, Physician, Physician Assistant, Advanced Practice Nurse, Optometrist, Veterinarian)
- Is undergoing palliative care or hospice care that is providing relief from symptoms, pain, & stress from serious illness to improve quality of life (Physician, Physician Assistant, Advanced Practice Nurse)
- Has post-surgical pain expected to last longer than 14 days (Podiatrist, Dentist, Physician, Physician Assistant, Advanced Practice Nurse, Optometrist, Veterinarian)

This bill requires the prescribing provider or their registered designee must report their health care specialty the first time they use the Prescription Drug Monitoring Program (PDMP). Each provider/designee must query the PDMP before prescribing the first refill. There are exceptions to this query requirement if the patient is:

- Receiving the opioid in a hospital, skilled nursing facility, residential facility, or correctional facility
- Experiencing cancer-related pain
- Receiving palliative or hospice care
- Experiencing post-surgical pain expected to last longer than 14 days
- Receiving treatment during a natural disaster or mass causality incident
- Received only single dose for single test/procedure

The PDMP must utilize industry standards in order for prescribers/designees to have direct access to data from an electronic health record to the extent that the query relates to a current patient of the practitioner. If PDMP is not available or down due to technical failure, the prescriber/designee must attempt to access the PDMP to comply with the query requirement. These requirements regarding the utilization of the PDMP ends September 2021. The bill stipulates that the reports provided to prescribers/designees are confidential, cannot be requested under the Colorado Open Records Act, not subject to civil subpoena, and not allowed for any proceeding against a prescribing provider.

The bill requires the Colorado Department of Public Health and Environment (CDPHE) to report to the General Assembly on or before December 1, 2019. The report must include findings from the federal grant "Prescription Drug Overdose Prevention for States Cooperative Agreement." This study concerns analysis on PDMP integration methods and health care provider report cards. CDPHE must forward findings to the Center for Research into Substance Use Disorder Prevention, Treatment, and Recovery Support Strategies at

[20] Chronic pain is defined in the bill as pain that lasts longer than 90 days or past time of normal healing as determined by the prescriber.

the University of Colorado Health Sciences Center to use info to provide voluntary training for providers in targeted areas.

Reasons to Support

Supporters assert that reducing prescribing will also reduce the quantity of drugs available for misuse and abuse. Creating this limit will reduce the chance that the development an opioid use disorder will develop in opioid naïve patients. Additionally, it decreases the possibility that excess opioid pills fall into the hands of someone other than the intended patient. This bill protects the availability of these opioid products for those who have chronic illness or cancer, which is a usual trepidation for consumers.

Supporters

- Colorado Association of Local Public Health Officials
- Colorado Children's Campaign
- Colorado Coalition for the Homeless
- Colorado Consumer Health Initiative
- Colorado Cross-Disability Coalition
- Colorado Fraternal Order of Police
- Colorado Hospital Association
- Colorado Medical Society
- Colorado Nurses Association
- Colorado Occupational Therapist Association
- Colorado Psychiatric Society
- Colorado Society of Anesthesiologists
- Colorado Society of Eye Physicians & Surgeons
- National Alliance on Mental Illness
- Public Health Nurses of Colorado
- UCHealth

Reasons to Oppose

Some believe that policies that aggressively limit prescription opioid prescribing could drive people to turn to illicit drugs and injection opioids, such as heroin. Some assert that this policy could force patients to live with inadequately treated pain. This inadequately treated pain could lead to other physical and behavioral health issues for the patient. Other opponents may assert that this is an intrusion into the provider-patient relationship and the practice of medicine. The Colorado Department of Regulatory Agencies (DORA) established a multi-profession opioid prescribing policy that is currently being updated through a stakeholder-input process. This forum could be a more appropriate way to address opioid prescribing.

Opponents

- No opposition has been made public at this time.

About this Analysis

This analysis was prepared by Health District of Northern Larimer County staff to assist the Health District Board of Directors in determining whether to take an official stand on various health-related issues. The Health District is a special district of the northern two-thirds of Larimer County, Colorado, supported by local property tax dollars and governed by a publicly elected five-member board. The Health District provides medical, mental health, dental, preventive and health planning services to the communities it serves. For more information about this summary or the Health District, please contact Alyson Williams, Policy Coordinator, at (970) 224-5209, or e-mail at awilliams@healthdistrict.org.