More Gain, Less Pain: Managing Pain without Opioids and Managing Opioid Addiction

Virginia

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Governor’s Framework for Virginia

- Strengthening the foundations of our economy
- Giving every person, particularly every child, the same shot at a healthy, safe, and successful life
- Maximizing taxpayer dollars
Prescription Overdose Deaths: Rural Concentration

Rate of Fatal Prescription Opioid (Excluding Fentanyl) Overdoses by Locality of Overdose, 2017

Fentanyl and Heroin Overdose Deaths: Urban/Ex-Urban Concentration

Rate of Fatal Fentanyl (Rx, Illicit, or Analogs) and/or Heroin Overdoses by Locality of Overdose, 2017

Source: Virginia Department of Health, Office of the Chief Medical Examiner
Virginia Approach to Crisis

- State Health Commissioner declared a public health emergency in 2016
- Previous Governor’s Task Force on Prescription Drug and Heroin Abuse
- Coordinating body: Governor’s Executive Leadership Team on Opioids and Addiction
  - Co-chaired by Secretary of Health and Human Resources and Secretary of Public Safety and Homeland Security
  - Supplemented by stakeholder group
  - Led by 5 work groups to facilitate interagency work

State Agency Organization

- Prevention and Community
- Harm Reduction
- Supply Prevention
- Public Safety Treatment Engagement
- Treatment and Recovery
Supporting Provider Education

- 2016 legislation to authorize mandatory CME on pain management, appropriate prescribing, and addiction
- 2017 legislation directing prescriber curriculum development for emerging health professionals
  - Allied health professions added
  - Collaborative approaches
  - Includes psychology of pain
  - Includes history of opioid prescribing
  - Core competencies developed for schools

Challenges in Pain Management

- Chronic pain and SUD co-occurrence
- Social determinants: economic and social factors contributing to pain incidence and perception
- Disability and chronic pain, especially in Appalachia
- Combatting decades of prescribing practices AND patient expectation
Virginia Prescribing Regulations

- Developed by licensing boards legislative direction in 2017
- Both Medicine and Dentistry regulations
- Regulations for both acute and chronic pain
- Informed by CDC Guidelines
- Emergency regs passed in March 2017, revised August 2017

Acute Pain Regulations

- Nonpharmacologic and non-opioid treatment considered first
- If opioids considered necessary, prescribe short-acting opioid in the lowest effective dose for the fewest possible days.
- Must perform history and physical exam appropriate to the complaint, query the PMP, and conduct assessment of patient's history and risk of substance misuse
- No more than a 7-day supply (also applies to opioid prescriptions upon ER discharge)
- Document reasons to exceed 50 MME/day.
- >120 MME/day requires referral or consultation with pain management specialist
- Must co-prescribe Naloxone when risk factors of prior overdose, substance misuse, doses in excess of 120 MME/day, or concomitant benzodiazepine is present
- Limit co-prescribing of benzos, sedative hypnotics, carisoprodol, and tramadol to extenuating, documented circumstances, and document tapering plan if co-prescribed
- Buprenorphine primarily indicated for addiction treatment as opposed to pain treatment
- Include in medical record: description of pain, presumptive diagnosis for origin of pain, examination appropriate to complaint, a treatment plan, and medication prescribed or administered to include the date, type, dosage, and quantity prescribed or administered
Chronic Pain Regulations

EVALUATION
- Full medical history and physical exam performed and documented prior to opioid prescription – to include a mental status evaluation
  - Document nature and intensity of pain
  - Current and past treatments for pain
  - Underlying or coexisting diseases or conditions
  - Effect of pain on physical and psychological function, quality of life, and activities of daily living
  - Psychiatric, addiction, and substance misuse history of patient and any family history of addiction or substance misuse
  - Urine drug screen or serum medication level;
  - Query of PMP
  - Assessment of history and risk of substance abuse
  - Request for prior applicable records
- Must "discuss with the patient the known risks and benefits of opioid therapy and the responsibilities of the patient during treatment to include securely storing the drug and properly disposing of any unwanted or unused drugs. The practitioner shall also discuss with the patient an exit strategy for the discontinuation of opioids in the event they are not effective."

TREATMENT
- Nonpharmacologic and non-opioid treatment considered first
- Document reasons to exceed 50 MME/day.
- >120 MME/day requires referral or consultation with pain management specialist
- Must co-prescribe Naloxone when risk factors of prior overdose, substance misuse, doses in excess of 120 MME/day, or concomitant benzodiazepine is present
- Document the rationale to continue opioid therapy every three months.
- Buprenorphine mono-product in tablet form shall not be prescribed for chronic pain
- Limit co-prescribing of benzos, sedative hypnotics, carisoprodol, and tramadol to extenuating, documented circumstances, and document tapering plan if co-prescribed
- Must regularly evaluate for opioid use disorder and initiate specific treatment for opioid use disorder, consult with an appropriate health care provider, or refer the patient for evaluation and treatment if indicated
Chronic Pain Regulations (cont’d)

TREATMENT PLAN
- Document treatment plan stating measures to be used to determine treatment progress, including pain relief and improved physical and psychosocial function, quality of life, and daily activities
- Include further diagnostic evaluations and other treatment modalities or rehabilitation that may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.
- Document the presence or absence of any indicators for medication misuse or diversion and take appropriate action.

INFORMED CONSENT AND TREATMENT AGREEMENT
- Document informed consent to include risks, benefits, and alternative approaches, prior to opioid prescription
- Provide documented, written treatment agreement signed by patient addressing parameters of treatment, including those behaviors that will result in referral to a higher level of care, cessation of treatment, or dismissal from care.
- Include notice that practitioner will query and receive reports from the PMP and permission for practitioner to:
  - Obtain urine drug screens or serum medication levels when requested; and
  - Consult with other prescribers or dispensing pharmacists for the patient.
- Document expected outcomes including improvement in pain relief and function or simply in pain relief; and document discussion of limitations and side effects of chronic opioid therapy.

THERAPY and CHRONIC PAIN
- Review course of pain treatment and any new information about the etiology of the pain and the patient's state of health at least every 3 months
- Continuation must be supported by documentation of continued benefit and if unsatisfactory, assess appropriateness of continued opioid treatment, consider other therapeutic modalities
- Check PMP every 3 months
- Order and review urine drug screen or serum medication levels upon initiation and at least every 3 months for the first year of treatment and at least every 6 months thereafter
- Regularly evaluate for opioid use disorder and initiate specific treatment for opioid use disorder, consult with an appropriate health care provider, or refer the patient for evaluation for treatment if indicated

ADDITIONAL CONSULTATIONS
- When necessary, refer patient for additional evaluation and treatment
- When diagnosis of opioid use disorder is made, OUD treatment initiated or the patient shall be referred for evaluation and treatment
Impact of Prescribing Regulations

The Virginia Prescription Monitoring Program recorded 530,907 Virginia Residents received an opioid prescription in FY Q4 2018. This is a modest decline from the previous quarter and is part of a general downward trend in the number of Virginia residents who receive opioid prescriptions.

Treatment and Recovery

- Medicaid Addiction Recovery and Treatment Services (ARTS) benefit through 1115 waiver
  - Expand short-term SUD inpatient detox to all Medicaid/FAMIS members
  - Expand short-term SUD residential treatment to all Medicaid members
  - Increase rates for existing Medicaid/FAMIS SUD treatment services
  - Add Peer Support services for Individuals with SUD and/or mental health conditions
  - Require SUD Care Coordinators at DMAS contracted Managed Care Plans
  - Organize Provider Education, Training, and Recruitment Activities

- Virginia Medicaid expansion 2019
- Implemented Medicaid prescribing guidelines building on ARTS momentum and collaboration
Medicaid Prescribing Guidelines

- Developed alongside Medicaid MCO medical directors, the Virginia Department of Health, the Virginia Department of Health Professions, and the Medical Society of Virginia
- Aligns CDC prescribing guidelines and new PA rules
- Created uniform PA for all members
- Implemented in FFS July 1, 2016 and in Managed Care December 1, 2016

Medicaid Guideline Implementation

- Uniform, Stream-lined Prior Authorization forms
  - All Short acting opioids > 7 days or 90 MME and long-acting opioids
  - Requires PMP check and urine drug screen
- Increase access to Naloxone
  - Naloxone injection and Naloxone nasal spray (Narcan®) available without PA and no quantity limits
- Include non-opioid pain relievers on all MCO formularies without PA
  - Lidocaine patches
  - Capsaisin topical gel
  - SNRIs including duloxetine
  - Gabapentin and pregabalin (Lyrica®)
  - NSAIDs including oral and topicals (diclofenac gel)
  - Baclofen
  - Tricyclic antidepressants (TCAs)
Results of Medicaid Guidelines

Medicaid FFS opioid utilization post implementation (7.1.16)

- **Total Pills Dispensed**
  - January-June 2016: 3,750,000
  - July-December 2016: 2,500,000
  - January-June 2017: 2,500,000
  - 43% decrease

- **$ Spend**
  - January-June 2016: $700,000
  - July-December 2016: $500,000
  - January-June 2017: $200,000
  - 38% decrease

- **Members with Opioid Rx**
  - January-June 2016: 14,000
  - July-December 2016: 12,000
  - January-June 2017: 10,000
  - 16% decrease

Questions and Contact info

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Virginia Prescribing Regs:
https://townhall.virginia.gov/L/viewchapter.cfm?chapterid=2929