The Opioid Crisis | *Interactive Toolkit*

MHA
MISSOURI HOSPITAL ASSOCIATION

EXECUTIVE SUMMARY

RESOURCES
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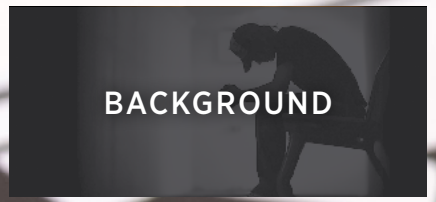
Understanding the Issue



Strategies to Reduce Opioid Misuse

- Missouri Prevention Resources
- Prescribing Guidelines: Emergency Department
- Managing Pain

- Assessment
- Treatment

- Addiction
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- Understanding Use and Disposal of Narcotics

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EXECUTIVE SUMMARY

In every community and in every social and economic strata, opioid abuse is a reality. Young athletes who are prescribed an opioid following a sports injury or wisdom teeth extraction may suddenly face the devastating spiral of addiction. What begins as a prescribed opioid for acute pain may devolve into heroin use. Younger adolescents are experimenting with parents' and elders' prescribed medications hosting "Skittle or Pharm" parties. Addicted women struggle to stay clean during pregnancy to give their child a healthy start, but many fail.

Between 2006 and 2015, Missouri recorded a 138 percent increase in the rate of inpatient hospitalizations and emergency department visits because of opioid overuse. According to the Centers for Disease Control and Prevention, in 2014, 28,647 people in the U.S. and 1,067 people in Missouri died from opioids, quadrupling the rate since 1999 (Rudd, 2016).

In Missouri, hospital utilization data suggests a 538 percent increase since 2006 in the number of babies born dependent on an opioid or other narcotic. Yet, providers portend actual cases are much greater than data suggest.

Opioid overuse is complex and requires multifaceted solutions with two goals: 1) identify and help individuals already facing overuse and misuse; and 2) implement prevention strategies to reverse the alarming trends. Both the downstream turbulence and upstream opportunities must be addressed. There is no one action or policy change that suddenly will halt and reverse this crisis.

Research and changes to both practice and policy are important strategies currently being implemented in Missouri and throughout the U.S. However, Missouri is the only state without a statewide prescription drug monitoring program. Thus, providers such as physicians and pharmacists, are unable to verify suspicion that a patient is abusing or misusing prescribed pain medicine. This is the single largest strategy in reversing the trend in Missouri.

In response to this policy deficit, in 2016, St. Louis County, passed a county ordinance to establish a PDMP and allow other Missouri jurisdictions to join. Today, more than 60 percent of Missouri providers and pharmacists practice in counties that have joined the St. Louis County PDMP, thus establishing a critical network of information.

Although the trends of opioid overuse and associated deaths are known, more information is needed to guide policy and practice changes. There are many questions that we just now are beginning to answer. Who is affected by this epidemic? To what extent does access to prescribed versus illegal opioid narcotics contribute to the epidemic? Where are opioid overdoses occurring? When are the appropriate times and circumstances for early intervention?

For example, babies born to mothers who have used or abused opioids begin life in withdrawal. In Missouri, hospital utilization data suggest a 538 percent increase since 2006 in the number of babies born dependent on an opioid or other narcotic (Reidhead, 2017). Yet, providers portend actual cases are much greater than data suggest. Further understanding the magnitude of this problem will guide providers and policymakers.

It is imperative that data and research guide practitioners and policymakers in efforts to curb and prevent opioid-use disorder and misuse.

BACKGROUND

The opioid crisis is the result of a perfect storm that few, if any, saw approaching. In 1990, a seminal article, titled "The Tragedy of Needless Pain," spurred a new era of pain-related research, therapy and incentives to more aggressively treat pain (Melzack, 1990 as reported by Rosenblum, 2008). Research suggested providers were under-prescribing pain medications, in part because of addiction concerns (Rosenblum, 2008).

Nora D. Volkow, M.D. testified before the Senate Caucus on International Narcotics control on May 14, 2014, stating several factors, including the role pharmaceutical companies have contributed to the opioid epidemic (Volkow, 2014).

"…drastic increases in the number of prescriptions written and dispensed, greater social acceptability for using medications for different purposes, and aggressive marketing by pharmaceutical companies. These factors together have helped create the broad "environmental availability" of prescription medications in general and opioid analgesics in particular."

Research on pain and the availability of pharmaceuticals prompted regulatory agencies and policy actors to ascribe more stringent expectations upon providers. In 2002, the Centers for Medicare & Medicaid Services and Agency for Healthcare Research and Quality developed the Hospital Consumer Assessment of Healthcare Providers and Systems which was endorsed by the National Quality Forum in 2005. This survey was tied to payment programs beginning in 2005 and added to the value-based payment program through the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148) (CMS, n.d.). Consequently, hospitals and providers had payment reductions for low aggregate scores on patient experience, including how effectively a patient perceived their pain to be managed. The broad use of the pain scale was one of many assessment and treatment tools implemented by providers to more effectively treat patients experiencing pain.

Insurance companies and other payors also supported a new era of aggressive pain management. The relatively low-cost opioids were a treatment option that patients, providers and payors deemed effective and affordable. Pharmaceutical companies purported there was a very low risk of addiction with certain opioids, basing their claims on limited research of short-term use for acute pain. For example, between 1996 and 2000, Purdue Pharma aggressively marketed OxyContin stating the risk of addiction was extremely small, less than 1 percent (VanZee, 2009). As a result, this treatment option was used on many patient populations without assessment of risk and for a wide variety of minor injuries and treatments, including dental procedures, sports injuries and lacerations. Further, pharmacy co-pays are applied at the time prescriptions are filled, regardless of the length of regimen. It was more affordable and more convenient for both patients and providers if the prescription extended out to include possible prolonged discomfort. Thus, instead of a prescription for two to three days for immediate pain relief following a minor injury or procedure, prescriptions for 30 days were common.

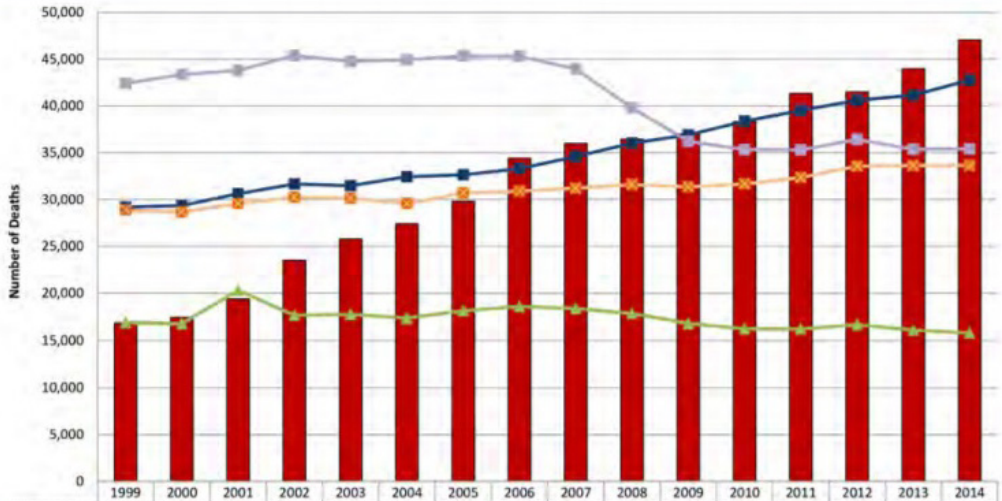
The trifecta of new pain medication, research and policy changes to more aggressively manage pain, and affordability and convenience, resulted in the emergence of a new public health crisis.

RESEARCH

The research is compelling. The trend of dramatic increases in opioid prescribing, consumption, misuse, overdose and death have not yet statistically stabilized or begun to decline.

Although the trends of opioid overuse and associated deaths are known, more information is needed to guide policy and practice changes. There are many questions that we just now are beginning to answer. Who is affected by this epidemic? To what extent does access to prescribed versus illegal opioid narcotics contribute to the epidemic? Where are opioid overdoses occurring? When are the appropriate times and circumstances for early intervention?

Number of Injury Deaths by Drug Poisoning, Suicide, Homicide, Firearms, and Motor Vehicle Crashes in the United States, 1999-2014[a,b]



	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Drug Poisoning	16,849	17,415	19,394	23,518	25,785	27,424	29,813	34,425	36,010	36,450	37,004	38,329	41,340	41,502	43,982	47,055
Suicide	29,199	29,350	30,622	31,655	31,484	32,439	32,637	33,300	34,598	36,035	36,909	38,364	39,518	40,600	41,149	42,773
Homicide	16,889	16,765	20,308	17,638	17,732	17,357	18,124	18,573	18,361	17,826	16,799	16,259	16,238	16,688	16,121	15,809
Firearms	28,874	28,663	29,573	30,242	30,136	29,569	30,694	30,896	31,224	31,593	31,347	31,672	32,351	33,563	33,636	33,674
MV Crashes	42,401	43,354	43,788	45,380	44,757	44,933	45,343	45,316	43,945	39,790	36,216	35,332	35,303	36,415	35,369	35,398

Source: Centers for Disease Control and Prevention

National Trends in Consumption, Utilization, Overdose and Death

Trends shown from the U.S. Department of Justice Drug Enforcement Administration 2016 National Drug Threat Assessment illustrates the magnitude of drug overdoses and death in comparison to other causes of violent death fueled by trafficking and abuse of prescription and illicit drugs (DOJ, 2016).

Today, prescription and illicit opioids are the primary source of drug overdoses and death in the United States. Since 1999, overdoses and deaths have quadrupled. The CDC provides extensive state-level opioid overdose data for multiple forms of opioids (CDC, n.d.a).

The opioid epidemic is evident throughout the community and the entire care continuum. Nationally, opioid-related ED visits and inpatient stays increased 99.4 percent between 2005 and 2015. In January 2017, the U.S. AHRQ Healthcare Cost and Utilization Project updated state-level utilization trends from 2009 to 2014 (Weiss, 2017). During the 10-year period evaluated, AHRQ researchers found that inpatient hospital utilization for opioid overuse increased by 64 percent, while ED utilization nearly doubled with a 99 percent increase.

Missouri Trends in Consumption and Misuse

During the same time period, Missouri also has experienced a significant increase in the rate of ED visits and inpatient stays for misuse of prescription-based opioids. In October 2015, *HIDI HealthStats* research was published. The data recently were updated and suggest an alarming increase continues, with a 138 percent increase in Missouri hospital utilization for opioid overuse between 2006 and 2015 (Reidhead, 2015).

Research continued

According to CDC data, three out of every four heroin users report that their opioid addiction was initiated by abusing prescription painkillers (CDC, n.d.b). The relatively low cost of heroin and recent expansion of heroin cut with deadly synthetic opiates, such as fentanyl, likely are contributing to the alarming increase in heroin overdose deaths in Missouri. A recent review of death certificates by the Missouri Department of Health and Senior Services found that recorded accidental heroin overdose deaths grew from 18 deaths in 2001 to 338 deaths in 2014 — this signals an annual average increase of 127 percent (MDHSS, 2015).

Missouri Trends in Overdose and Death

New research from the Hospital Industry Data Institute finds that drugs caused more than three-quarters of the increase in the overall mortality rates for Missouri white males since 1999. In 2015, populationwide, white males ages 25 to 55 had a drug-induced death rate 43 percent higher than the expected rate, while non-white males had a 16 percent higher rate. The 25- to 55-year-old male demographic was the only segment of the population to experience a higher than expected rate of drug-related mortality.

Missouri and Kansas Correlation Between Unemployment and Opioids

An analysis of county-level unemployment and opioid utilization, overdose and death, and prescribing variation in Kansas and Missouri suggest a very significant correlation between unemployment and opioid misuse. The analysis and policy implications are further detailed in a report from the Missouri and Kansas Hospital Associations.

Research Focus: Neonatal Abstinence Syndrome

Nationally, the incidence of infants born in withdrawal from neonatal abstinence syndrome — defined as fetal or neonatal addiction and withdrawal as a result of the mother's dependence on drugs during pregnancy — has grown at an alarming rate, higher than adult opioid consumption. Recent research found that the rate of NAS in the U.S. increased 500 percent between 2000 and 2012 (NCBI, n.d.). The extreme growth was attributed to prescribing analgesic opioids for pregnancy-related pain management and increased use of illicit opioids, such as heroin during pregnancy (McQueen, 2016).

Another recent national study evaluating birth records from 28 states with available data found an incidence of NAS in 1999 of 1.5 per 1,000 hospital births; by 2013, the rate had increased to six newborns with NAS out of every 1,000 hospital births, with a range of 0.7 in Hawaii to 33.4 in West Virginia (Ko, 2016). The study also found significant increases in all but two states evaluated during the study period.

In Missouri, research on the number of babies diagnosed with NAS follows the same alarming upward trajectory. In 2006, fewer than 100 newborns in Missouri were diagnosed with NAS; by 2016 the number grew to nearly 600 — an increase of 538 percent throughout 10 years (Reidhead, 2017). Anecdotal evidence suggests the number of infants born with NAS are significantly under-reported in hospital discharge data.

PREVENTION

ASSESSMENT & TREATMENT

PATIENT EDUCATION

POLICY CHANGES

The opioid crisis is the convergence of several changes in policy and practice occurring throughout a decade and requires a multifaceted approach to address this complex issue. In March 2016, the Missouri Hospital Association published a *Trajectories* edition describing the variations of opioid misuse and outlining strategies to reduce inappropriate use (Williams, 2016).

Changes begin with the patient and provider. Both understand that pain is real and treatment is required. Appropriate assessment and communication are necessary to ensure the best treatment and outcome. Opioids likely are an effective treatment option for many patients with short-term, severe acute pain, but other analgesic combinations and treatments may be more appropriate for some patients and other types of pain (Beubler, 2007; Bhamb, 2006; National Safety Council, 2014; Rauck, 2009). It is important to note that patients receiving treatment for cancer, palliative or end-of-life care are excluded from generalized opioid-reduction strategies.

Upstream. Policymakers and physicians must employ prevention strategies to reduce the likelihood a patient will become opioid dependent. This includes utilizing a PDMP and prescribing limited amounts of opioids only for conditions that respond effectively to opioids — short-term, severe acute pain.

Midstream. A change in policy and practice also requires assessment of every patient receiving opioids to determine risk or evidence of dependency. The PDMP and evidence-based assessment tools are available to providers. Further, physicians need resources and support to facilitate therapeutic communication if a patient is deemed to be at risk. There are various treatment options, including tapering the dosage (MMEq), alternative pain management and behavioral health support for those not yet dependent, but with indications of risk.

Downstream. For patients with known risk or history of dependency or overdose, more aggressive measures are available. Medication-assisted treatment through outpatient services, inpatient treatment facilities and behavioral health therapy are shown to be effective, although not readily available and accessible. Research suggests patients who receive initial therapy in the ED are more engaged in their treatment (D'Onofrio, 2015). Further, policies and use of naloxone to treat patients who overdose and subsequent aggressive treatment may help those most at risk.

The goal is to save lives today, identify those at risk and treat them to avoid overdose, preventing future deaths and dependency.

PREVENTION

- Missouri Prevention Resources
- Prescribing Guidelines: Emergency Department
- Managing Pain

The Substance Abuse and Mental Health Services Administration's Opioid Overdose Prevention Toolkit contains resources for many different audiences: health care practitioners, communities and workplaces, and patients and families.

Missouri Prevention Resources

In the St. Louis area, NCADA provides an abundance of resources, supplies and training to further opioid overdose prevention.

Prescribing Guidelines: Emergency Department

Although the emergency room is not the point of origination where most opioid addictions begin, it often is a location that those seeking additional opioids for dependency or other misuse and abuse may seek narcotics. A PDMP serves as a front-line assessment tool for any ED provider.

In December 2015, Missouri physician, dentist and hospital associations joined forces to develop a set of voluntary opioid prescribing guidelines and a policy brief for emergency room providers (Porth, 2015). In January 2017, nearly 80 percent of Missouri hospitals responding to a survey indicated the majority of these guidelines have been adopted.

Calculating MMEs – a CDC guide for prescribing safer amounts of opioids.

Managing Pain

Managing Acute and Chronic Pain

Managing pain requires comprehensive patient assessment and individualized patient treatment plans to ensure patients are effectively treated for pain without gradually developing an opioid dependency, or developing characteristics of addiction, abuse or other forms of misuse.

The increased rate and consequences of Opioid Use Disorder, including overdose and death, have prompted a difficult conversation for patients and providers to balance the need for therapy to manage chronic pain with the risk of adverse outcomes. The American Society for Pain Management Nursing launched the PAINS Project to better understand the needs of patients amidst this opioid crisis.

The 2018 Joint Commission Standards for Pain Assessment and Management will be revised to reflect changes in practice to prevent and manage Opioid Use Disorder.

Key national resources for pain management are listed below.

American Academy of Pain Management – Methadone for Pain Management: Improving Clinical Decision Making (2016)

American Academy of Pain Management Patient Clinical Support System for Opioid Therapy: Three CME Webinars (2016) on:

- Concurrent Management of Pain and Addiction
- Maintaining Balance Among Compassionate Prescribing, Ethical Clinical Strategies, and Societal Obligations
- Implementation of the National Pain Strategy and Safer Opioid Prescribing: A Military Perspective

The American Pain Society provides a series of evidence-based clinical guidelines for complex pain management including the following.

- Methadone Safety: A Clinical Practice Guideline from the American Pain Society and College on Problems of Drug Dependence, in Collaboration with the Heart Rhythm Society (2014) – There is no cost for this guidance or archived webinar.
- Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain (2009)
- Diagnosis and Treatment of Low Back Pain: A Joint Clinical Practice Guideline from the American College of Physicians and the American Pain Society (2007)
- Interventional Therapies, Surgery, and Interdisciplinary Rehabilitation for Low Back Pain: An Evidence-Based Clinical Practice Guideline from the American Pain Society (2009)
- Guideline for the Management of Acute and Chronic Pain in Sickle-Cell Disease (1999)

Federation of State Medical Boards Draft Guidelines for the Chronic Use of Opioid Analgesics (2016)

National Safety Council Evidence for the Efficacy of Pain Management (October 2014)

The Society of Hospital Medicine Improving Pain Management for Hospitalized Patients through support from Pfizer Pharmaceuticals.

CDC Guideline for Prescribing Opioids for Chronic Pain (March 2016)

The American Chronic Pain Association Chronic Pain Management An Integrated Guide to Medical, Interventional, Behavioral, Pharmacologic and Rehabilitation Therapies (2017)

Managing Cancer-Related Pain

MD Anderson Cancer Center Brief Pain Inventory for patients in pain with cancer. (n.d., for purchase)

Managing Palliative and End-of-Life Pain

American Academy of Family Physicians Pharmacologic Management of Pain at the End of Life (2014)

Managing Post-Operative Pain
American Pain Society Guidelines on the Management of Postoperative Pain (February 2016)

Managing Pain for Unique Populations
The American Pain Society provides the Guideline for the Management of Acute and Chronic Pain in Sickle-Cell Disease (1999)

Maternal Child Populations
American Academy of Pediatrics A Public Health Response to Opioid Use in Pregnancy (2017)

The American Congress of Obstetricians and Gynecologists Committee Opinion, No. 524: Opioid Abuse, Dependence, and Addiction in Pregnancy (2012)

Incarcerated Population
Brandeis University PDMP Training and Technical Assistance Center Assessing Risk for Overdose: Key Questions for Intake Forms (n.d.)

ASSESSMENT & TREATMENT

- Assessment
  - Providers Clinical Support System for Opioid Therapies
  - Screening and Assessment
  - Missouri Screening, Brief Intervention, Referral and Treatment (MOSBIRT)
- Treatment
  - Side Effects of Opioids
  - Medication-Assisted Treatment (MAT)
  - Overdose Interventions

Assessment

Providers Clinical Support System for Opioid Therapies

The Providers Clinical Support System for Opioid Therapies (PCSS-O) is a national training and mentoring project developed in response to the prescription opioid overdose epidemic. The consortium of major stakeholders and constituency groups with interests in safe and effective use of opioid medications offers extensive experience in the treatment of substance use disorders and specifically, OUD treatment, as well as the interface of pain and OUD. PCSS-O makes available, at no cost, CME programs on the safe and effective use of opioids for treatment of chronic pain, and safe and effective treatment of OUD.

Screening and Assessment

Screening and assessment tools fall into several categories dependent upon patient and provider needs, as well as timing in relation to prescribing opioids. The following are tools for clinical use prior to prescribing opioids; their efficacy is unknown.

Patient Directed Tools – Pre-Prescription

National Institute on Drug Abuse Opioid Risk Tool (ORT) (n.d.)

Brandeis University PDMP Training and Technical Assistance Center Assessing Risk for Overdose: Key Questions for Intake Forms (n.d.)

Canadian National Pain Center, McMaster University Screener and Opioid Assessment for Patients in Pain-Revised (SOAPP-R) (2010)

Patient Directed Tools – Post-Prescription

Canadian National Pain Center, McMaster University Current Opioid Misuse Measure (COMM)® (2010)

Clinician Directed Tools – Pre-Prescription

American College of Physicians, Physician Advisor. The Pain Assessment and Documentation Tool (PADT) (n.d.)

SAMHSA provides extensive screening tools for patients with a variety of conditions including depression, alcohol use, substance use, suicide risk, anxiety, trauma and bipolar conditions.

The University of Florida, School of Medicine - Jacksonville developed a medication dosing guide and training for pain management.

Clinician Directed Tools – Post-Prescription

University of Texas Southwestern Medical Center Pain Frequency, Intensity and Burden Scale (P-FIBS) (n.d.)

Missouri Screening, Brief Intervention, Referral and Treatment (MOSBIRT)

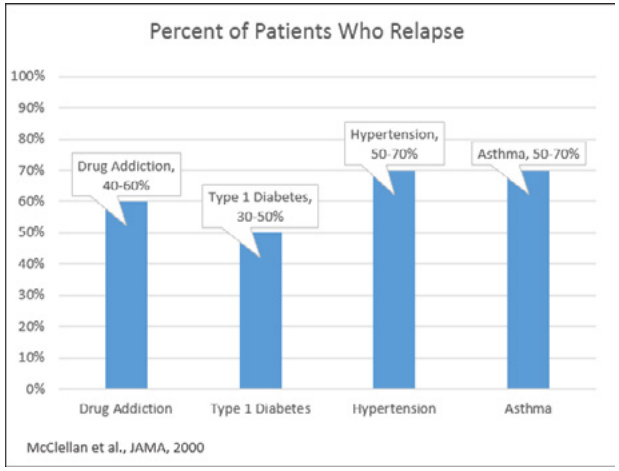
Evidence-based tools, including the screening and brief intervention, and the health and behavior assessment, provide an efficacious and systematic approach to systematically identify patients' risk of problematic use of alcohol and drugs, and initiate brief interventions. The prevention program is brief yet effective and thus, is recommended for use in many settings, including the ED and physician offices. In Missouri, the MOSBIRT program provides access to resources, training and funding support. A 2014 Missouri Institute of Mental Health report concluded these interventions would yield between $3.25 and $5.25 for every dollar spent in Missouri's Medicaid program (Adkins, 2014).

In addition to SBI, a Yale study concluded that administering buprenorphine treatment to opioid-dependent patients seeking medical care in the ED significantly increased engagement in addiction treatment at the two-month mark, and decreased inpatient addiction treatment services and self-reported illicit opioid use (D'Onofrio 2015). In this study, the treatment cohort received a 10-week follow-up treatment in a primary care setting and remained engaged. However, comparison of urine tests for illicit drug use between the treatment and controlled groups revealed no difference at the six- and 12-month mark (D'Onofrio, 2017).

Treatment

The evidence are convincing — addictions should be treated as a chronic condition and not episodic aberrant behavior. As stated in the Journal of Addiction Medicine, "Substance (alcohol and drug) dependence is a chronic disease for which many affected adults receive no intervention or detoxification without subsequent treatment. Like other chronic diseases (e.g., diabetes, congestive heart failure), substance dependence has no cure and is characterized by relapses requiring longitudinal care. Medical and psychiatric comorbidities are the rule rather than the exception" (Saitz, 2008).

The American Society of Addiction Medicine summarizes research, treatment and barriers of opioid addiction as a chronic condition.



The Missouri Hospital Association July 2017 Trajectories provides additional information and resources.

Side Effects of Opioids

American Academy of Pain Management Consensus Recommendations for Opioid-Induced Constipation (2015)

Medication-Assisted Treatment (MAT)

Medication-assisted treatment incorporates the use of FDA-approved medications and behavioral therapy in the treatment of OUD. SAMHSA serves as a primary source of information on MAT for patients and providers. NIDA and the AMA also endorse MAT as an effective treatment of OUD and serve as additional resources.

Methadone, buprenorphine and **naltrexone** are FDA-approved medications for treatment of OUD.

Methadone has been used for decades to treat patients who are addicted to heroin and other opioids. Methadone is a full agonist, and like heroin, it binds to opioid receptors and creates a response proportional to the dose. As noted by the National Institute on Drug Abuse, methadone has been shown to be effective in the treatment of heroin addiction, and taken as prescribed, it does not interfere with the performance of daily activities. Methadone can only be dispensed through SAMHSA-certified opioid treatment programs , and methadone is administered in pill, liquid and wafer form.

The Missouri Department of Mental Health shows 13 methadone (OTP) clinics in operation in Missouri, located in Breckenridge Hills, Cape Girardeau, Columbia, Hazelwood, Joplin, Kansas City, Poplar Bluff, Springfield, St. Joseph, St. Louis and West Plains. Private OTPs also exist in more rural areas of the state but are primarily private pay.

DMH provides additional information about Methadone Maintenance Myths and Resources.

Buprenorphine is a second option for medication-assisted treatment of OUD, and buprenorphine does not require administration through an OTP.

Treatment continued

Buprenorphine is a partial agonist that binds to opioid receptors, causes a limited reaction and prevents a euphoric effect. For treatment of OUD, buprenorphine is combined with naloxone and administered through film (Suboxone) or tablet form. In November 2017, the FDA approved the first monthly injectable form of buprenorphine (Sublocade).

Research from Yale demonstrated the effectiveness of ED induction of buprenorphine in a) increased engagement in treatment, b) reduced self-reported illicit opioid use and c) decreased inpatient addiction treatment use as compared to brief intervention and referral. Research from Boston University showed that buprenorphine induction (hospitalization) with linkage to office-based buprenorphine treatment (post discharge) is effective in engaging patients in treatment and reducing illicit opioid use at six months compared to inpatient detox protocol.

Prescribing buprenorphine for the treatment of OUD does require waiver training due to a provision of the Harrison Narcotics Tax Act of 1914. The Harrison Act allows for physicians to prescribe narcotics during the course of treating patients but not for the treatment of addiction. Under the Drug Addiction Treatment Act of 2000, physicians are eligible to obtain a SAMHSA waiver to prescribe buprenorphine as part of MAT for OUD. The waiver for physicians requires eight hours of training. The Comprehensive Addiction and Recovery Act of 2016 expanded the availability of the buprenorphine waiver to nurse practitioners and physician assistants. NPs and PAs must participate in 24 hours of training to become waivered.

The Missouri Opioid State Targeted Response partners with the Missouri Coalition for Community Behavioral Health to provide waiver training in Missouri. For more information on how to obtain a buprenorphine waiver, visit http://pcssmat.org/mat-basics/mat-waiver-training/ or https://docs.wixstatic.com/ugd/6dadf9_2f1f70528d124a6dbeedcfd00384d51a.pdf. Reimbursement for the cost of waiver training, as well as the prescriber's time to participate in waiver training is available for individuals who attend PCSS-MAT training on or after May 1, 2017.

Naltrexone provides a third option for medication-assisted treatment of OUD. Naltrexone does not require administration through an OTP, and no special waiver is required to prescribe naltrexone. Naltrexone is an antagonist. It binds to opioid receptors and blocks the receptors from being activated. A patient must be opioid free for 7 to 10 days prior to the administration of naltrexone. Administration prior to this period of abstinence will result in precipitated withdrawal from opioids. Naltrexone is administered in pill form but is most widely recognized in the monthly injectable form known as Vivitrol.

Research from NYU compared the effectiveness of buprenorphine and naltrexone in opioid relapse prevention. The findings demonstrated more difficulty initiating naltrexone (Vivitrol) compared to buprenorphine (Suboxone). Once initiated, both medications were found to be equally effective.

In May 2017, DMH received a grant from SAMHSA for $10,015,898 a year for two years to combat the opioid crisis. The Missouri Institute of Mental Health oversees the STR grant. A primary goal of the STR grant is to increase access to MAT for uninsured individuals with OUD. For more information, visit https://dmh.mo.gov/OpioidCrisisResponse.htm.

DMH and STR support a "Medication First" model of treatment for individuals with OUD because MAT addresses withdrawal symptoms, reduces cravings, enables patients to engage in behavioral therapy and social support groups, increases treatment retention, and saves lives. For more information on the "Medication First" model, visit https://static1.squarespace.com/static/594939ba197aea24a334ef60/t/59bab107f09ca461180d6429/1505407240927/Opioid+STR+Implementation+Guide_nonDMH.pdf.

DMH oversees the state-funded SUD treatment agencies in Missouri, which include Comprehensive Substance Treatment and Rehabilitation programs. CSTAR agencies are funded through MO HealthNet and DMH's purchase-of-service system. CSTAR agencies are required to either offer MAT or refer individuals to a provider who does. For information about CSTAR and SUD treatment agencies in Missouri, visit https://dmh.mo.gov/ada/progs/treatment.html.

Treatment continued

Overdose Interventions

Signs of an opioid overdose (NCADA, n.d.):

- shallow or no breathing
- pinpoint pupils
- blue/gray lips or fingernails
- cold and clammy skin

In Missouri, various organizations provide education, training and materials to professionals and laypersons at risk of witnessing or experiencing an overdose, including naloxone (Narcan®). Naloxone is an emergency overdose reversal medication that anyone in Missouri can legally purchase and possess. When administered properly, it can instantly revive someone who is experiencing an overdose and buy time until medical help arrives. Naloxone can be purchased at some pharmacies without a prescription.

Take-home naloxone refers to naloxone that is given to people to keep at their home or on themselves in case an overdose occurs (much like an EpiPen for allergies). Many hospital EDs and office-based providers are supplying their at-risk patients with take-home naloxone before they are discharged.

Grant-funded initiatives

Federal funding from SAMHSA is currently being used to reduce the number of opioid overdose-related deaths and adverse events among individuals 18 years and older. The Missouri Opioid-Heroin Overdose Prevention and Education (MO-HOPE) Project is run by the Missouri Department of Mental Health, with Missouri Institute of Mental Health-University of Missouri, St. Louis and NCADA leading implementation and evaluation. Key components of the grant include training emergency responders, substance use treatment providers, social service agencies and other key community sectors on the prevention of opioid overdose-related deaths. The primary focus is on secondary prevention strategies, including the purchase and distribution of naloxone to persons at risk of experiencing or witnessing an overdose. MO-HOPE training for diverse professional and community audiences focuses on evidence-based practices to reduce rates of overdose through public health and harm reduction strategies. Trainings include information on the background of opioid overdose trends and substance use disorder epidemiology; legislative protections for naloxone use and dispensing; and strategies for preventing, recognizing and responding to an overdose. Visit the project website to learn more or request a training.

Organizations

NCADA provides expertise, resources and one-on-one training specifically about overdose prevention and administration of naloxone. According to NCADA (n.d.):

NCADA also has a supply of Narcan which is available for free. If you need Narcan, call 314/962-3456 and schedule a time to meet with a counselor. You will receive brief training about how to use Narcan, and two doses free of charge.

Missouri Resources for Opioid Overdose Prevention

Located in South City, St. Louis, MO Network offers no-cost naloxone and harm reduction overdose education training to people who use drugs and their families.

FAQs regarding Narcan from NCADA

FAQs from MO-HOPE

Professional trainings provided by NCADA

MO-HOPE trainings

Treatment continued

PATIENT EDUCATION

- Addiction
- Pain Management
- Understanding Use and Disposal of Narcotics

It is important patients understand that as research on opioids has advanced, changes in pain management have followed. Communication with the patient and ensuring they understand the benefits and risks of opioids, requires diligent patient education and engagement. The following resources are specifically designed for patients and families.

The CDC has a campaign, *RxAwareness*, featuring real-life stories about the toll of the opioid crisis, from addiction through recovery, but also about lives lost.

The American Academy of Orthopedic Surgeons has a public service announcement on prescription safety.

The following resources are specifically designed for patients and families.

Addiction

American Society of Addiction Medicine Opioid Addiction Treatment: A Guide for Patients, Families and Friends (2016)

SAMHSA Opioid Overdose Prevention Toolkit: Recovering from Opioid Overdose – Resources for Overdose Survivors & Family Members (2016)

SAMHSA Opioid Overdose Prevention Toolkit: Safety Advice for Patients and Family Members (2016)

Information about Missouri substance-use treatment: https://dmh.mo.gov/ada/progs/treatment.html

For links to direct treatment facilities in different Missouri regions: https://dmh.mo.gov/ada/help.html

Pain Management

American Chronic Pain Association Consumers' Guide Practice Guidelines for Low Back Pain (2008)

MHA, Opioid Patient Education: Pain Management (2016); Spanish version (2017)

National Safety Council: Mathematics of Pain Relief (2015)

Pfizer Project Root: Rethink Opioids: Universal Precautions Implementation Tool (2013)

Understanding Use and Disposal of Narcotics

MHA, Opioid Patient Education Disposal of Narcotics (2016); Spanish version (2017)

MHA, Opioid Patient Education Prescribing Opioids (2016); Spanish version (2017)

Providers Clinical Support System – Opioids Pregnancy: Methadone and Buprenorphine (n.d.)

POLICY CHANGES

- Prescription Drug Monitoring Program
  - Authority to Implement a Jurisdictional PDMP Ordinance
  - Arguments Against a PDMP
  - Elements of an Effective PDMP
  - Participate in the St. Louis County PDMP
  - Action Plan to Subscribe to the St. Louis County PDMP
- Payers
- Access to Treatment

Policy and practice changes are needed to address this public health crisis.

Prescription Drug Monitoring Program

Every day patients present to physicians with complaints of pain. In all states except Missouri, physicians have the benefit of reviewing the patient's pain medication history to determine the best course of treatment or identify a patient at risk of opioid misuse — a simple search into a secure, web-based portal that compiles prescription history of controlled substances. Concerned Missourians must come together to advocate for a PDMP; a tool deemed essential by providers in every other state.

Today, the opioid crisis stands as a national call-to-action. In Missouri, the challenge is greater without a PDMP. Among the many notable strategies to reduce opioid overuse, none is more essential than a PDMP to inform physicians and pharmacists. For communities ready to address this issue, there is an option. Passing a county or municipal ordinance requiring pharmacists and physicians to use a PDMP would impart critical information into the patient assessment, thus enhancing the physicians' treatment options and enabling pharmacists to serve a role in reducing opioid abuse.

Authority to Implement a Jurisdictional PDMP Ordinance

Under the Missouri Constitution, counties are legal subdivisions of the state and only have those powers granted to them by the constitution or statute (or those necessarily implied to carry out such authority) [*Premium Std. Farms v. Lincoln Township*, 946 S.W.2d 234, 238 (Mo. 1997)]. A county's ability to exercise legislative or police powers to create a PDMP is dependent on the authority granted to it by the state.

Missouri counties are classified by the General Assembly as first through fourth class, with varying powers granted to each classification. Any county with a population exceeding 85,000 may adopt a charter form of government, which allows it to exercise police powers [*Mo. Const. Art. VI, §§ 18(a) & (c)*]. The constitution also allows first-class counties that do not adopt a charter to adopt a constitution that allows the exercise of police powers [*Mo. Const. Art. VI, § 18(m)*]. The city of St. Louis has similar authority under Article VI, Section 19 of the Constitution, and has organized as a charter city.

Missouri has four charter counties: St. Louis, St. Charles, Jackson and Jefferson. There are 15 first-class counties that have not elected to establish a charter form of government; four second-class counties; 89 third-class counties, and two fourth-class counties. This means the vast majority of Missouri counties lack general legislative powers that would allow them to mandate a PDMP.

However, another statute may authorize counties to mandate PDMPs. Section 192.300, RSMo, provides, in relevant part:

"The county commissions and the county health center boards of the several counties may make and promulgate orders, ordinances, rules or regulations, respectively as will tend to enhance the public health and prevent the entrance of infectious, contagious, communicable or dangerous diseases into such county, but any orders, ordinances, rules or regulations shall not be in conflict with any rules or regulations authorized and made by the department of health and senior services in accordance with this chapter or by the department of social services under chapter 198 . . ."

This statute provides **all** counties the power to enact public health ordinances, regardless of their classification or home rule status. Therefore, since research suggests an effective PDMP can reduce opioid misuse, a PDMP is deemed to "enhance the public health" and all counties should be able to mandate, by ordinance, a PDMP.

There is legal precedent for such action. A tobacco ordinance enacted by St. Louis County pursuant to Section 192.300 was upheld as a valid exercise of this authority [*Avanti Petroleum v. St. Louis County*, 974 S.W.2d 506 (Mo. Ct. App. 1998)]. This ordinance required retail vendors of tobacco products to be licensed by the county health department and pay a license fee to offset enforcement costs. It also prohibited the sale of tobacco to minors under the age of eighteen and subjected retailers to random compliance checks. Convenience store owners contested the validity of the ordinance.

The court upheld the ordinance based on evidence showing that the county's intent was to combat the known health hazards of tobacco use, especially among minors. The court found that Section 192.300 authorized the county to use any reasonable means to protect the public from a known health hazard. In so doing, it relied on a 1961 Missouri Supreme Court case involving an ordinance directing the fluoridation of the St. Louis County water supply [*Readey v. St. Louis County Water Co.*, 352 S.W.2d 622 (Mo. 1961)]. In *Readey*, the parties disputed whether the public health benefits of fluoridation outweighed the potential harms. Despite finding valid evidence on both sides, the court concluded that the county council acted reasonably in exercising its public health powers.

In both cases, the court upheld ordinances enacted under Section 192.300 where there was persuasive evidence of a threat to public health and the ordinance was reasonably calculated to address that potential threat. Existing evidence supports opioid abuse as an emerging public health issue. The fact that 49 other states have PDMPs in place supports the contention that a PDMP is one reasonable approach to addressing the opioid crisis. Such evidence likely would lead a court to uphold a county-mandated PDMP.

Arguments Against a PDMP

Opponents of a PDMP often will cite one of several reasons for their opposition. The following are common concerns and contrasting information to support a PDMP.

Opposition Position: A PDMP will restrict the ability for patients to be effectively treated for pain.

Managing pain to provide maximum functionality and quality of life should be a primary goal for every patient and provider. There are many different types of pain: short-term pain following an injury or surgery; long-term pain caused by a chronic condition, such as arthritis; long-term, intermittent pain caused by a specific condition, such as sickle-cell disease; pain while undergoing cancer treatment; and pain at the end of life.

Opponents of a PDMP often will refer generically to pain and not differentiate among type and cause of pain. Research shows that opioids generally are more effective than other analgesics at treating severe short-term acute pain, such as following a surgery

or a kidney stone, but do have greater risks. In 2014, the National Safety Council issued a report that concluded: (Teater)

"… opioid medications are often referred to as 'powerful painkillers.' In fact, the evidence shows that they are mild to moderate painkillers and less effective than over-the-counter ibuprofen. They have, however, powerful side effects that harm hundreds of thousands of individuals every year in the U.S. Even if one disregards the public health problems created by the use of opioid pain killers, these medications still are not a good choice for the treatment of acute pain — regardless of the severity."

Research also indicates opioids may not be the most effective method to treat chronic pain. Other non-addictive forms of pain management have shown better results for many patients. The CDC released guidelines for chronic pain management. (Dowell, 2016). Combinations of over-the-counter, non-addictive analgesics and anti-inflammatory medications, as well as physical therapy, may be very effective alternatives for many patients.

As providers, patients and communities gain understanding about opioids, more evidence-based resources are becoming available for patients and providers to ensure pain is managed appropriately and without excessive discomfort or risk of misuse.

Opposition Position: Patients demand opioids and physicians are financially penalized if their patient satisfaction scores are low.

Throughout the last several years, providers and health care systems have expressed concern about financial penalties in the federal Hospital Value-Based Purchasing Program for patient satisfaction scores related to pain management. Specifically, the pain management dimension in the HCAHPS is derived from the following questions.

- During this hospital stay, did you need medicine for pain? (Q12)
- During this hospital stay, how often was your pain well-controlled? (Q13)
- During this hospital stay, how often did the hospital staff do everything they could to help you with your pain? (Q14)

Beginning October 2017 (federal fiscal year 2018), CMS will remove the pain management dimension from the scoring formula used for payment adjustments in the hospital VBP program. The questions will continue to be asked and publicly reported on the Hospital Compare website, but will not be used in payment formulas. (Hospital Consumer Assessment of Healthcare Providers and Systems, n.d.)

Opposition Position: PDMPs are not effective at reducing opioid deaths or curbing the epidemic of use.

PDMPs alone will not reduce opioid deaths or halt the epidemic. It is one tool among many needed to address this issue. But, it is an essential tool. PDMPs have been in place since 1918, first started in New York, with most PDMPs implemented between 2000 and 2012 (Source: PDMP Training and Technical Assistance Center, Brandeis University (n.d.) History of Prescription Drug Monitoring Programs). Initially, PDMP legislation was enacted, but the systems developed lacked evidence-based structure, processes, training and participation to ensure the PDMP was appropriately established and used.

As a result, there are studies with conflicting results regarding the efficacy of PDMPs. One study by Meara et al., published in *The New England Journal of Medicine* in June 2016, cites a study analyzing the association of controlled substance laws, such as PDMPs, and opioid outcomes among disabled Medicaid beneficiaries between 2006-2012 (Meara, 2016). The study concludes that "adoption of controlled-substance laws were not associated with reductions in potentially hazardous use of opioids or overdose (Meara, 2016)." For example, the data concluded that the percentage of patients receiving high daily doses of opioids (greater than 120 morphine milligram equivalent dose) did not decrease after adoption of a PDMP. However, evidence-based practice recommendations only recently have concluded the need to reduce daily

maximum doses using 120 MME as an upper-limit threshold (Dowell, 2016). Prior to this, research questions about upper-limit thresholds only were being considered and limited recommendations to reduce the limit to 120 MME were being introduced. The study is imposing new, evidence-based recommendations on prior care delivered.

However, during a similar time period of 2001-2010, a study published in *Health Affairs* suggests that implementation of a PDMP was associated with a 30 percent reduction in the rate of prescribed Schedule II opioid analgesics (Bao, 2016). The probability of receiving a Schedule II opioid decreased from 5.5 percent to 3.7 percent, while prescriptions for non-opioid analgesics increased slightly (Bao, 2016). These data infer a PDMP is a tool to inform both the patient and provider in selecting appropriate pain therapy.

Another study from Florida cites a 16.7 percent decrease in drug overdose deaths and a 23.2 percent decrease in prescription drug overdoses between 2010 and 2012 following enactment of various policy changes, including enactment of a PDMP in 2009 (Johnson, 2014).

These are just two of many research studies that indicate PDMPs are effective. According to the Brandeis University PDMP Center of Excellence, "Accumulated research strongly suggests that PDMPs serve essential functions in combating the prescription drug abuse epidemic" (Brandeis Briefing, 2014). As PDMP policies have advanced from enactment and implementation to refinement and enhancement, the weight of recent studies support PDMPs, and future studies will better inform policy and practice.

Opposition Position: The only use of a PDMP is to identify patients motivated to "doctor shop" and research suggests less than 5 percent of patients actually are doctor-shopping. Therefore, this is an expensive overreach to identify a small number of patients.

Research supports the argument that "doctor shopping" occurs in less than 5 percent of the population. However, prevalence of this form of misuse varies, based on geography and ease of access, especially for at-risk populations, including youth seeking recreational drugs. A PDMP is one mechanism to reduce ease of access for those seeking multiple prescribers (McDonald, 2014; Stogner, 2014; Worley, 2012).

Further, this argument ignores the protection a PDMP offers for patients who may be developing an opioid dependency. A patient who receives a prescription for an opioid from his/her primary care provider for a chronic condition, a dentist for a tooth abscess, or an ED physician following treatment for a severe cut and sutures, suddenly is at risk of OUD without shopping for multiple prescribers.

Opposition Position: Patients should have their personal information protected; a PDMP is a violation of freedom from government.

Every day, personal medical information is shared electronically among appropriately designated health care providers. A PDMP is simply one additional element of medical information that must be shared among providers, including pharmacists, to ensure patients receive appropriate assessment and treatment.

The Health Insurance Portability and Accountability Act, passed in 1996, was designed to give patients greater protection and control over their medical information. The HIPAA Privacy Rule established national standards to protect individuals' personal health information, including medical records. The law sets boundaries on the use and release of health records; establishes appropriate safeguards; and, holds violators accountable, including civil and criminal penalties. Any information included in a PDMP must comply with HIPAA (HHS, n.d.).

Opposition Positon: A PDMP may curb the use of prescription opioids, but will increase the use of "street drugs" and heroin.

A PDMP is one of several key strategies to identify patients that may have, or be developing, a dependency on opioids. Earlier identification and intervention reduces the number of people that would be at risk of using heroin or other street drugs.

PDMP continued

Although it is commonly stated that reducing the amount of prescribed opioids will lead to an increase of heroin, new research from *The New England Journal of Medicine* suggests otherwise. The study concludes that "nonmedical use of prescription opioids is a strong risk factor for heroin use ... however, heroin use among people who use prescription opioids for nonmedical use is rare, and the transition to heroin use appears to occur at a low rate." This rise of all opioids, including heroin, has occurred at an alarming rate since 1999. Practitioners, public health officials, public safety officers and policymakers must continue diligent, multifaceted strategies to address this epidemic. Avoiding use of a PDMP will not curb the heroin problem (Compton 2016).

Elements of an Effective PDMP

The initial policies and practices of state PDMPs were varied and thus, the effectiveness was mixed. Comparative research among the various PDMP models suggests methods to enhance PDMP effectiveness. New guidance released by the PDMP Training and Technical Assistance Center at Brandeis University fully describes 11 recommendations to improve the efficacy of a PDMP.

- adopt uniform and the latest American Society for Automation in Pharmacy reporting standards
- collect positive identification for the person picking up prescriptions
- collect data on method of payment, including cash transactions
- reduce data collection interval; move toward real-time data collection
- integrate PDMP reports with health information exchanges, electronic health records and pharmacy dispensing systems*
- send unsolicited reports and alerts to appropriate users
  - authority to provide unsolicited/threshold reports
  - engaged in providing unsolicited/threshold reports
- mandate enrollment*
- mandate utilization*
- delegate access
- enact and implement interstate data sharing among PDMPs*
- secure funding independent of economic downturns, conflicts of interest, public policy changes and changes in PDMP policies*

** these elements currently are not included in the St. Louis County PDMP.*

Participate in the St. Louis County Prescription Drug Monitoring Program

The vision and strategy of St. Louis County enables every Missouri jurisdiction to participate in a PDMP designed for Missourians. In March 2016, using their jurisdictional authority, St. Louis County passed an ordinance to establish a PDMP. St. Louis County intentionally designed their proposal and PDMP architecture to accommodate every Missouri county and the City of St. Louis.

Developed by Appriss™, PMP AWARxE is a web-based platform that provides critical information to improve clinical decision-making. This system adheres to the Brandeis University national PDMP center-of-excellence criteria for an effective PDMP.

Jurisdictions subscribing to the PDMP will be responsible for an annual participation fee, proportionally based on the number of covered practitioners (dispensers, providers) within that jurisdiction. The annual participation cost is $7 per covered practitioner, plus an administrative fee proportional to the prescriber population. The participation fee is covered by the governing entity and not by dispensers or providers. There is no data

submission or retrieval cost charged to dispensers or providers by St. Louis County or Appriss. Thus, there is no fee to input data or retrieve information directly from the Appriss platform.

Already, this program has had a far-reaching effect in Missouri. As of March 2017, 14 jurisdictions in addition to St. Louis County, the greater St. Louis, Kansas City and mid-Missouri regions, have passed ordinances and signed agreements with St. Louis County to subscribe to the PDMP. In spring 2017, these jurisdictions will launch this new capability for nearly 60 percent of Missouri's pharmacies and providers.

Quarterly, from that point forward, additional counties and municipalities that have enacted legislation that aligns with St. Louis County Ordinance 26352 and have a signed user agreement with St. Louis County, will be able to subscribe to the PDMP.

Table 1 includes the onboarding timeline for all jurisdictions joining after March 1, 2017. Onboarding includes data submitters (dispensers) registering with Appriss, then moving from testing to production (successfully submitting data). Data for each jurisdiction will be visible to physicians and pharmacists by the first business day of the quarter following onboarding.

Table 1. Onboarding Timeline

Quarter A	Quarter B		Quarter C
Jurisdiction Legislation & User Agreement signed	Data Submitter Registration	Clearinghouse Testing → Production	PDMP (PMP AWARxE) live on first business day

Table 2. Subscribing County Onboarding Timeline

Initial Implementation		Second Implementation		Third Implementation	
Action	**Due Date**	**Action**	**Due Date**	**Action**	**Due Date**
Enact Legislation	03/09/2017	Enact Legislation	05/01/2017	Enact Legislation	08/01/2017
Sign User Agreement	03/31/2017	Sign User Agreement	06/01/2017	Sign User Agreement	09/01/2017
Go-Live!	04/25/2017	Go-Live!	07/01/2017	Go-Live!	10/01/2017

Action Plan

Subscribe to the St. Louis County PDMP

Specific questions should be directed to:

Contact: PDMP Coordinator
Email: PDMP.DPH@stlouisco.com
Phone: 314/615-0522

To learn more about the St. Louis County PDMP, the following resources provide detailed information and examples.

Passed Missouri Ordinances
Agreement to Participate
Letter to Pharmacists
Pharmacy Guidance for Data Submission
PDMP Test Data Submission
Frequently Asked Questions

Action 1: Convene Key Community Leaders

- ❑ Engage public health leaders — they have the authority to lead PDMP policy changes
- ❑ Seek input from health care professionals, including EMS and coroners
- ❑ Seek cooperation from law enforcement
- ❑ Seek local champions — citizens with a personal story
- ❑ Develop a unified strategy

Action 2: Inform to Raise Awareness

- ❑ Present to community leaders, government officials and interested citizens
- ❑ Present a realistic use and expectations of a PDMP
- ❑ Share difficult stories
- ❑ Allow time for additional education and presentations

Resources

- Missouri data on opioid-related hospital utilization and neonatal abstinence syndrome
- SAMHSA Opioid Overdose Prevention Toolkit: Facts for Community Members (2016)
- In the St. Louis area, NCADA provides an abundance of resources, supplies and training to further opioid overdose prevention.

Action Plan

Subscribe to the St. Louis County PDMP

Specific questions should be directed to:

Contact: PDMP Coordinator
Email: PDMP.DPH@stlouisco.com
Phone: 314/615-0522

Action 3: Advocate for PDMP Participation

- ❑ Use data and research to inform decision-makers
- ❑ Understand the concerns of those that suffer from pain
- ❑ Understand the concerns of those that worry about privacy
- ❑ Understand that a PDMP will not reverse the trend without other actions

Resources

- St. Louis County Department of Public Health PDMP Frequently Asked Questions
- St. Louis County Department of Public Health PDMP Budget for participating counties

Action 4: Facilitate Jurisdictional Authority using resources provided by the St. Louis County Department of Public Health

- ❑ User Agreement Template
- ❑ Passed Missouri Ordinances
- ❑ Agreement to Participate
- ❑ Letter to Pharmacists
- ❑ Frequently Asked Questions

Action 5: Facilitate Training

- ❑ Pharmacy Guidance for Data Submission
- ❑ PDMP Test Data Submission
- ❑ Web-based Tutorial: Registering (pending)
- ❑ Web-based Tutorial: Provider Dashboard (pending)

Payers

Throughout the last several years, providers and health care systems have expressed concern about financial penalties in the federal Hospital Value-Based Purchasing Program for patient satisfaction scores related to pain management. Specifically, the pain management dimension in the HCAHPS is derived from the following questions.

- During this hospital stay, did you need medicine for pain? (Q12)
- During this hospital stay, how often was your pain well-controlled? (Q13)
- During this hospital stay, how often did the hospital staff do everything they could to help you with your pain? (Q14)

Beginning October 2017 (FFY 2018), CMS will remove the pain management dimension from the scoring formula used for payment adjustments in the hospital VBP program. The questions will continue to be asked and publicly reported on the Hospital Compare website, but will not be used in payment formulas. (Hospital Consumer Assessment of Healthcare Providers and Systems, n.d.)

Private insurers also have a role in reducing opioid misuse. In 2012, Blue Cross and Blue Shield of Massachusetts implemented a comprehensive opioid utilization program for its 2.8 million members. CDC analyzed BCBSMA data and determined that during the first three years of policy changes to reduce prescriptions and limit quantities the average monthly prescribing rate decreased nearly 15 percent from 34 to 29 per 1,000 members (Garcia, 2016). Although additional research for any similar initiative is warranted to evaluate patient pain and function, payer involvement should be encouraged as part of the overall strategy to reduce opioids.

Access to Treatment

Access to clinically effective, evidence-based treatment for OUD (i.e., agonist and partial agonist medication assisted treatment and care coordination) is often limited, especially for poor and uninsured individuals.

The Missouri Department of Mental Health oversees the state-funded substance use treatment agencies in the state, which include Comprehensive Substance Treatment and Rehabilitation programs for individuals without insurance or covered by MO HealthNet. CSTAR agencies are required to directly offer MAT or refer individuals to a provider who can.

Information about Missouri substance use treatment: https://dmh.mo.gov/ada/progs/treatment.html

For links to direct treatment facilities in different regions:
https://dmh.mo.gov/ada/help.html

State-funded outpatient methadone clinics are based in St. Louis and Kansas City, and are referred to as opioid treatment programs. Private OTPs exist in more rural areas of the state but are primarily self or private pay. Methadone maintenance treatment has been shown to be clinically effective at increasing treatment retention and quality of life, and reducing rates of overdose among individuals with severe heroin dependence. A subset of these clinics are beginning to prescribe buprenorphine products as well.

Missouri anticipates receiving a two-year, multimillion dollar SAMHSA grant to conduct a State Targeted Response to the Opioid Crisis this spring. Planned project activities include developing and expanding efforts related to prevention, treatment and recovery of opioid use and consequences. The grant will be overseen by the Missouri Department of Mental Health, Division of Behavioral Health, and be administered and evaluated by a team at the Missouri Institute of Mental Health – University of Missouri-St. Louis.

The development and implementation of a standardized protocol for MAT for OUD will be a large focus of this grant, with an emphasis on treating OUD within a chronic care model and increasing utilization of maintenance medication.

Specific questions should be directed to:

Rachel Winograd, Ph.D.
Opioid STR Project Director
Assistant Professor, Research
Missouri Institute of Mental Health, University of Missouri-St. Louis
rachel.winograd@mimh.edu

RESOURCES

- Glossary of Terms
- Toolkit Links

Glossary of Terms

Opioid Misuse — Misuse of prescription drugs means taking a medication in a manner or dose other than prescribed; taking someone else's prescription, even if for a legitimate medical complaint such as pain; or taking a medication to feel euphoria (i.e., to get high). The term nonmedical use of prescription drugs also refers to these categories of misuse. The three classes of medication most commonly misused are:

- Opioids – usually prescribed to treat pain
- Central nervous system [CNS] depressants (this category includes tranquilizers, sedatives, and hypnotics) – used to treat anxiety and sleep disorders
- Stimulants – most often prescribed to treat attention-deficit hyperactivity disorder (ADHD)

Prescription drug misuse can have serious medical consequences. Increases in prescription drug misuse throughout the last 15 years are reflected in increased emergency room visits, overdose deaths associated with prescription drugs and treatment admissions for prescription drug use disorders, the most severe form of which is addiction. Among those who reported past-year nonmedical use of a prescription drug, nearly 12 percent met criteria for prescription drug use disorder. Unintentional overdose deaths involving opioid pain relievers have more than quadrupled since 1999 and have outnumbered those involving heroin and cocaine since 2002. https://www.drugabuse.gov/publications/research-reports/misuse-prescription-drugs/summary

Opioid Use Disorder – In the 2013 Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (Table 1, Diagnostic Criteria for an Opioid-Use Disorder.), an opioid-use disorder is defined as the repeated occurrence within a 12-month period of two or more of 11 problems, including withdrawal, giving up important life events in order to use opioids, and excessive time spent using opioids. A cluster of six or more items indicates a severe condition. NEJM

Opioid Use Disorder 2 – Symptoms of opioid use disorders include strong desire for opioids, inability to control or reduce use, continued use despite interference with major obligations or social functioning, use of larger amounts over time, development of tolerance, spending a great deal of time to obtain and use opioids, and withdrawal symptoms that occur after stopping or reducing use, such as negative mood, nausea or vomiting, muscle aches, diarrhea, fever, and insomnia. https://www.samhsa.gov/disorders/substance-use

Prescription Drug Monitoring Program – According to the National Alliance for Model State Drug Laws (NAMSDL), a PDMP is a statewide electronic database that 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. https://www.deadiversion.usdoj.gov/faq/rx_monitor.htm

Schedule I-IV Narcotics – Drugs and other substances that are considered controlled substances under the Controlled Substances Act are divided into five schedules. An updated and complete list of the schedules is published annually in Title 21

Code of Federal Regulations (C.F.R.) §§ 1308.11 through 1308.15. Substances are placed in their respective schedules based on whether they have a currently accepted medical use in treatment in the U.S., their relative abuse potential, and likelihood of causing dependence when abused. https://www.deadiversion.usdoj.gov/schedules/#define

Buprenorphine – Buprenorphine (Suboxone®, Subutex®3, Zubsolv®4, Bunavail™5, Probuphine®6) is an opioid medication used to treat opioid addiction in the privacy of a physician's office. Buprenorphine can be dispensed for take-home use, by prescription. This, in addition to the pharmacological and safety profile of buprenorphine, makes it an attractive treatment for patients addicted to opioids. https://www.naabt.org/faq_answers.cfm?ID=2

Suboxone – Suboxone is actually the combination of two different drugs: buprenorphine (a partial opioid agonist) and naloxone (a pure opioid antagonist). As a partial opioid agonist, buprenorphine's job is to deliver very diminished opioid doses to a patient who is addicted to a stronger opioid. It provides a way for the client to be gradually weaned off their pre-existing addiction, while minimizing the opioid withdrawal symptoms that would come from the process. http://americanaddictioncenters.org/suboxone/

Naloxone – Naloxone is a medication designed to rapidly reverse opioid overdose. It is an opioid antagonist — meaning that it binds to opioid receptors and can reverse and block the effects of other opioids. It can very quickly restore normal respiration to a person whose breathing has slowed or stopped as a result of overdosing with heroin or prescription opioid pain medications. https://www.drugabuse.gov/related-topics/naloxone

Medication Assisted Treatment (MAT) – Medication assisted treatment is the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders. A combination of medication and behavioral therapies is effective in the treatment of substance use disorders, and can help some people to sustain recovery. http://www.integration.samhsa.gov/clinical-practice/mat/mat-overview

Morphine milligram equivalents (MMEs) – Higher dosages of opioids are associated with higher risk of overdose and death — even relatively low dosages. It is important to calculate the MMEs.

Resources continued

Toolkit Links

Practice Guidelines

National

- Patient Assessment for Risk of Addiction or Overuse
- CDC Guideline for Prescribing Opioids for Chronic Pain (March 2016)
- National Safety Council Evidence for the Efficacy of Pain Management (October 2014)
- American Pain Society Guidelines on the Management of Postoperative Pain (February 2016)
- Brandeis University PDMP Training and Technical Assistance Center Assessing Risk for Overdose
- American Academy of Pediatrics A Public Health Response to Opioid Use in Pregnancy (February 2017)

Missouri

- Opioid Use in Missouri: Strategy for Reduced Use and Misuse
- Strategies to Reduce Opioid Misuse and Abuse (PowerPoint Presentation)
- Emergency Department Opioid Prescribing Guidelines (December 2015)
- Opioids: A Population Health Dilemma (March 2016
- DSS Clinical Practice Guidelines (pending)
- Hospital-specific with permission

Assessment and Treatment

- Substance Abuse and Mental Health Services Administration (SAMHSA)

Patient Education

- MHA: Opioid Patient Education Flyer #1: Disposal
- MHA: Opioid Patient Education Flyer #2: Prescribing
- MHA: Opioid Patient Education Flyer #3: Pain Management
- National Safety Council: Mathematics of Pain Relief

Policy Guidelines

- St. Louis County Department of Public Health PDMP
- St. Louis County PDMP Ordinance Language
- Missouri counties and municipalities that have enacted legislation
- Sample Policy

Prevention

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Opioid Overdose Prevention Toolkit includes resources for many different audiences including health care practitioners, communities and workplaces, and patients and families.

Missouri Prevention Resources

In the St. Louis area, NCADA provides an abundance of resources, supplies and training to further opioid overdose prevention.

Prescribing Guidelines: Emergency Department

Missouri Voluntary Emergency Department Prescribing guidelines and policy brief Calculating MMEs – a CDC guide for prescribing safer amounts of opioids.

Managing Acute and Chronic Pain

- American Academy of Pain Management Methadone for Pain Management: Improving Clinical Decision Making (2016)
- American Academy of Pain Management Patient Clinical Support System for Opioid Therapy: Three CME Webinars (2016) on:
  - Concurrent Management of Pain and Addiction
  - Maintaining Balance Among Compassionate Prescribing, Ethical Clinical Strategies, and Societal Obligations
  - Implementation of the National Pain Strategy and Safer Opioid Prescribing: A Military Perspective
- Federation of State Medical Boards Draft Guidelines for the Chronic Use of Opioid Analgesics (2016)
- National Safety Council Evidence for the Efficacy of Pain Management (October 2014)
- The Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain (March 2016)
- The American Chronic Pain Association Chronic Pain Management An Integrated Guide to Medical, Interventional, Behavioral, Pharmacologic and Rehabilitation Therapies (2017)

Toolkit Links continued

Managing Cancer-Related Pain

- MD Anderson Cancer Center Brief Pain Inventory for patients in pain with cancer. (n.d., for purchase)

Managing Palliative and End-of-Life Pain

- American Academy of Family Physicians Pharmacologic Management of Pain at the End of Life (2014)

Managing Post-Operative Pain

- American Pain Society Guidelines on the Management of Postoperative Pain (February 2016)

Managing Pain for Unique Populations

- Maternal Child Populations
  - American Academy of Pediatrics A Public Health Response to Opioid Use in Pregnancy (2017)
  - The American Congress of Obstetricians and Gynecologists Committee Opinion, No. 524: Opioid Abuse, Dependence, and Addiction in Pregnancy (2012)
- Incarcerated Population
  - Brandeis University PDMP Training and Technical Assistance Center Assessing Risk for Overdose: Key Questions for Intake Forms (n.d.)

Assessment and Treatment of Opioid Use and Misuse

Providers Clinical Support System for Opioid Therapies

The Providers Clinical Support System for Opioid Therapies (PCSS-O) is a national training and mentoring project developed in response to the prescription opioid overdose epidemic.

Screening and Assessment

- Patient Directed Tools – Pre-Prescription
  - National Institute on Drug Abuse Opioid Risk Tool (ORT) (n.d.)
  - Brandeis University PDMP Training and Technical Assistance Center Assessing Risk for Overdose: Key Questions for Intake Forms (n.d.)
  - Canadian National Pain Center, McMaster University Screener and Opioid Assessment for Patients in Pain-Revised (SOAPP-R) (2010)
- Patient Directed Tools – Post-Prescription
  - Canadian National Pain Center, McMaster University Current Opioid Misuse Measure (COMM)® (2010)
- Clinician Directed Tools – Pre-Prescription
  - American College of Physicians, Physician Advisor. The Pain Assessment and Documentation Tool (PADT) (n.d.)
- Clinician Directed Tools – Post-Prescription
  - University of Texas Southwestern Medical Center Pain Frequency, Intensity and Burden Scale (P-FIBS) (n.d.)
- Missouri Screening, Brief Intervention, Referral and Treatment (MOSBIRT)
  - In Missouri, the MOSBIRT program provides access to resources, training and funding support.

Treatment for Opioid Dependency and Overdose Interventions

- Side Effects of Opioids
  - American Academy of Pain Management Consensus Recommendations for Opioid-Induced Constipation (2015)
- Medication-Assisted Treatment (MAT)
  - SAMHSA serves as a primary source for information, resources and access to treatment for patients and training for providers.

    PCSS-MAT trainings are offered through sponsorship from the American Academy of Addiction Psychiatry (AAAP) and American Psychiatric Association (APA) and organized by the Missouri Department of Mental Health and Missouri Coalition for Community Behavioral Healthcare. Trainings will be offered monthly through 2017-2018 across the state.

    For more information on how to obtain your DATA 2000 buprenorphine waiver:
    Website: http://pcssmat.org/mat-basics/mat-waiver-training/
    Email: Katie Horstman
    KHorstman@mocoalition.org

Toolkit Links continued

Information about Missouri substance use treatment visit https://dmh.mo.gov/ada/progs/treatment.html

For links to direct treatment facilities in different Missouri regions visit https://dmh.mo.gov/ada/help.html

- Organizations
  - NCADA provides expertise, resources and one-on-one training specifically about overdose prevention and administration of naloxone. According to NCADA (n.d.):

    NCADA also has a supply of narcan which is available for free. If you need narcan, please call (314) 962-3456 and schedule a time to meet with one of our counselors. You will receive brief training about how to use narcan, and two doses, all at no-cost to you.
- Missouri Resources for Opioid Overdose Prevention
  - Located in South City, St. Louis, MO Network offers no-cost naloxone and harm reduction overdose education training to people who use drugs and their families.
  - FAQs regarding narcan from NCADA
  - FAQs from MO-HOPE
  - Professional Trainings provided by NCADA
  - MO-HOPE trainings

Patient Education

Addiction

- American Society of Addiction Medicine Opioid Addiction Treatment: A Guide for Patients, Families and Friends (2016)
- SAMHSA Opioid Overdose Prevention Toolkit: Recovering from Opioid Overdose – Resources for Overdose Survivors & Family Members (2016)
- SAMHSA Opioid Overdose Prevention Toolkit: Safety Advise for Patients and Family Members (2016)
- Information about Missouri substance use treatment visit https://dmh.mo.gov/ada/progs/treatment.html
- For links to direct treatment facilities in different Missouri regions visit https://dmh.mo.gov/ada/help.html

Pain Management

- American Chronic Pain Association Consumers' Guide Practice Guidelines for Low Back Pain (2008)
- MHA, Opioid Patient Education: Pain Management (2016)
- National Safety Council: Mathematics of Pain Relief (2015)

Understanding Use and Disposal of Narcotics

- MHA, Opioid Patient Education: Disposal of Narcotics (2016)
- MHA, Opioid Patient Education: Prescribing Opioids (2016)
- Providers Clinical Support System – Opioids Pregnancy: Methadone and Buprenorphine (n.d.)

Provider Education

MHA has partnered with physicians dedicated to reversing the opioid epidemic through a series of physician-to-physician videos.

- The Opioid Epidemic's Impact on Expectant Mothers & Babies: Dr. Randy Tobler, Scotland County Hospital
- Opioid Overuse Reduction Strategies: Dr. Randall Williams, Director, Missouri Department of Health & Senior Services
- Emergency Department Opioid-Prescribing Guidelines Implementation: Dr. Darin Haug, Fitzgibbon Hospital
- The Value Of A Prescription Drug Monitoring Program For Physicians: Dr. Sam Page, Mercy

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