Addressing the Opioid Use Issue

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It seems that you can't go a day without seeing or hearing something about the opioid epidemic, whether in trade publications or mainstream media. Now that everyone is paying attention to it, what happens? The Centers for Disease Control and Prevention (CDC) published guidelines, Congress wants new laws, the DEA is focused on diversion, providers want to take care of patients, and the adage about "following the money" continues to be true.

While we wait for Congress, or maybe, instead of waiting for them, there are steps that the healthcare industry can take today.

Prescription Drug Monitoring Program (PDMP)

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.

Some states refer to a PMP — prescription monitoring program. Regardless of the name, the programs are designed to address inappropriate uses of controlled substances. Almost every state (Missouri has been a holdout) has a PDMP in place. The NAMSDL is a good resource (http://www.namsdl.org/prescription-monitoring-programs.cfm), as is the PDMP Center of Excellence at Brandeis University (http://www.pdmpexcellence.org/). Every state is using the Standard for Prescription Monitoring Programs developed by the American Society for Automation in Pharmacy (ASAP) to enable the exchange of information via the dispenser and the PMP, and nearly half are using the most recently published version (4.2). ASAP developed the first PMP reporting standard in 1995, and it has worked closely with PMP directors in enhancing the standard over the years.

As of May 2016, 30 states have some form of prescriber mandate in place, whether registration or checking. The checks may be required for an initial opioid or benzodiazepine prescription, subsequent fills, those with duration exceeding a specified number of days or that are more subjective, e.g., when the prescriber suspects misuse.

Other states are tying licensure to PDMP access to facilitate enrollment/registration. As an example, Ohio requires that pharmacists, and pharmacy interns, must have an account with the Ohio Automated Rx Reporting System (OARRS) when renewing their license.

If your third-party payer contracts don't already address this issue, don't be surprised

continued on next page

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to see that included when you next negotiate the agreement. Payers may require, at a minimum, enrollment with the PDMP; others may go further and require checking of the PDMP in certain cases. Failure to do so could result in clawbacks.

Pharmacist Activity

Be sure you're connected to your state's PDMP. If you aren't connected, that should be at the top of your to-do list! Work with your vendor to ensure streamlined access to the PDMP. As much as they're able to integrate the PDMP data into workflow, the more effective you can be. Once you're connected, make sure you have consistent policies for checking the database and subsequent action. Some states have requirements for when prescribers and pharmacists have to check, as often as every prescription or fill. Vendors are starting to develop ways to automate that check so that it's integrated into workflow. This functionality will allow for consistency, which will improve practice. ASAP has also developed a standard in this area, the ASAP Prescription Monitoring Program Web Service Standard Version 2.1A. Some states have implemented an enhanced methodology that allows for a score to be associated with the patient's records. This score can offer providers a sense of the potential risk associated with a patient's use, as it uses an algorithm to analyze opioid and sedative fill data. Scoring the data allows you to more efficiently identify those situations where additional action (counseling, prescriber notification) might be needed.

If you aren't currently receiving controlled substance prescriptions electronically, contact your vendor immediately to begin implementation of this functionality. Electronic prescribing of controlled substances (EPCS) is legal in all 50 states and supported by the electronic prescribing standard (NCPDP SCRIPT). EPCS is a great tool to combat fraud and reduce the inefficiencies associated with maintaining multiple workflows for the same process. The implementation burden is heavier on prescribers, as they must complete certification and enable two-factor security authentication protocols. According to Surescripts, 90,000-plus prescribers and 53,000-plus pharmacies are active for EPCS on their network. They've seen recent growth, some of which may be attributed to the New York legislation requiring electronic prescribing for all prescriptions.

Benefits of a Monitoring Program

Appropriate access to legitimate medical use of controlled substances.

Identifying and deterring or preventing drug abuse and diversion.

Facilitating and encouraging the identification, intervention with, and treatment of persons addicted to prescription drugs.

Informing public health initiatives through outlining of use and abuse trends.

The CDC opioid prescribing guidelines that were published earlier this year should be reviewed by every care provider (http://www.cdc.gov/media/dpk/2016/dpk-opioid-prescription-guidelines.html). Although these are primarily targeted toward prescribers, several (such as the risk assessment recommendations) can be applied by other care providers.

Use Strategies to Mitigate Risk

Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every three months.

Lowell Anderson, a pharmacist in Minnesota, recently

wrote an article for MinnPost (https://www.minnpost.com/community-voices/2016/05/pharmacist-how-our-policies-enable-opioid-addiction-epidemic). In the article, he acknowledges the complexity of our current legal and financial systems surrounding narcotics, and proposes pharmacist-forward approaches to managing opioids. These include allowing pharmacists to manage the quantities dispensed and getting the payers to adjust their claims-processing methodologies accordingly. There may be ways to work with the prescribers and payers in your community to implement some of his suggestions while remaining in compliance with all regulatory requirements.

Clearly, one of the great fears associated with opioid use is the risk of overdose. Until some of the other recommendations are implemented that would reduce the risk potential, we must consider how to address the inevitable overdose situation. There are efforts underway in many states to allow for the dispensing of naloxone without a prescription; contact your state pharmacist association or board of pharmacy to validate what's allowable in your jurisdiction. Both entities may also be a good resource for other activities that would benefit from pharmacist participation.

Community Activity

While presenting at the Minnesota Rural Health Conference in June, Joseph Bianco, M.D., chief of primary care at Essentia Health, stated that since prescribers helped create the situation, they need to be part of the solution. Essentia has implemented new processes related to opiate prescribing, including use of evidence-based guidelines, treatment agreements, limits on daily morphine dose equivalents, and new metrics to monitor the impact of these changes. They've seen tremendous progress, with 12% fewer primary care patients on chronic opioid treatment in 2016 alone.

If you're participating in collaborative practice agreements or in accountable care organizations, talk with your prescribing partners about how you can assist them in managing their chronic opioid patients. Understand the messages they're sharing with the patients so that you can reinforce those. Even if you're not operating under a formal agreement, prescribers may be receptive to your professional observations and recommendations.

Payers are also taking action. Aetna recently contacted

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931 prescribers who they "identified as falling within the top 1 percent of opioid prescribers within your specialty," according to the text of Aetna's letter to prescribers. Aetna's hope is that by providing the physicians with data that compares them to their peers, their prescribing patterns will change. According to Aetna CMO Harold Paz, M.D., if the 931 physicians aligned their average opioid refill rate — 4.5 per prescription — with the overall average — 0.3 per prescription — the amount of pills dispensed annually would decrease by 1.4 million. Extrapolating this approach across multiple payers could ultimately result in a significant decrease in the volume of prescriptions written and the number of pills dispensed, leading to lower rates of abuse and addiction nationwide.

There are likely community-based activities, either through care systems or county public health departments, where additional involvement is needed. These activities could include participating in panel discussions, engaging with drug abuse task forces, and partnering with law enforcement for educational programs such as DARE (Drug Abuse Resistance Education). **CT**

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