Vermont Medical Society Comments
To the House Human Services Committee
S. 243 Draft 1.1
April 21, 2016

The Vermont Prescription Monitoring System is an extremely valuable clinical tool for prescribers. It was used more than 13,000 times per month as of February. (150,000 times a year) and its use appears to be increasing steadily month by month, with a big increase in October of 2015 after delegates could be registered with the system again.

Responsible opioid use is a very high priority for VMS. According to the CDC, Vermont has the eighth lowest number of painkiller prescriptions per 100 people. The Department of Health reports, however, that there were 76 opioid-related deaths in 2015 and while deaths from fentanyl and heroin are increasing in Vermont, prescription drugs were a factor in at least 32 of those deaths. Opioid misuse and addiction is a public health crisis in Vermont.

VMS has created a multi-disciplinary task force with more than 40 members including primary care physicians, emergency medicine physicians, surgeons, pain specialists, addiction specialists, nurse practitioners, physician assistants, pharmacists, other practitioners, and representatives of licensing boards to work on this issue. The goal of the taskforce is to improve safety and treatment for patients with chronic pain, acute pain, and addiction. The taskforce looks forward to working on rules with the Commissioner of Health. VMS communicates regularly to members and the task force about opioid-related issues, and serves as a clearinghouse for educational opportunities and for clinicians to share tools and updates.

VMS supports S. 243 as it passed the Senate, authorizing the Commissioner of Health to adopt rules that address the required frequency to check the VPMS and permits the Commissioner to adopt rules that include numeric or temporal limits on the number of pills prescribed, consistent with evidence-informed best practices for effective pain management. VMS strongly supports the requirement for consultation with the Controlled Substances and Pain Management Advisory Council, a group that includes many clinicians with expertise in prescribing and dispensing medication for pain and addiction. Input from this group will ensure that the clinical complexity of the issues considered in rulemaking will be addressed and unintended consequences will be avoided.

While VMS supports the most of the proposals in draft 1.1 we have two concerns which are outlined below.

Section 2. Standards and Guidelines for Health Care Providers and Dispensers
VMS opposes the change in subsection (c)(3) that would require prescribers to query the VPMS the first time an opioid is prescribed. VMS is particularly concerned that this change would require prescribers treating patients for cancer pain, or providing palliative care or hospice or other end-of-life care to query the VPMS when starting new opioid prescriptions, because patients' circumstances can change quickly and frequently, requiring new prescriptions for different drugs or drugs that use different routes of administration. While checking the VPMS is appropriate when prescribing opioids for many emergency department patients, particularly patients that prescribers are not familiar with who request treatment for chronic pain, it is not appropriate for all patients, such as accident victims or patients with trauma or other serious acute injuries, where checking the VPMS would take time and be likely to have a low yield. VMS also recommends that

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requirements to check the VPMS for post-operative patients should be developed in collaboration with clinicians because the intensity of procedures and patients' pain thresholds are highly variable. In addition to avoiding unintended clinical consequences, having clinician input into the rules will increase prescribers' confidence in the rules.

VMS recommends modifying the language in Section 2 (e) on page 4 as follows:

The Commissioner and the Council shall consider additional circumstances under which health care providers should be required to query the VPMS, including whether health care providers should be required to query the VPMS prior to wiring a prescription for any opioid Schedule II, III, or IV controlled substance or ...

The Commissioner and the Council shall consider when and whether prescribers from various professions and specialties should be required to query the VPMS, with respect to patients they are treating for addiction, chronic pain, end-of-life pain, acute pain, emergency pain, post-operative, or post-procedure pain. In creating new requirements to check the VPMS, the Commissioner and the Council shall avoid unnecessarily increasing administrative burden for clinicians. If available, the Commissioner and the Council shall review de-identified prescribing data from the VPMS for various types of practitioners.

Section 2. Rulemaking

VMS recommends authorizing the rules to include numeric or temporal limits consistent with evidence-informed best practices for effective pain management, and supports the provision for consultation with the Controlled Substances and Pain Management Advisory Council. Ensuring the involvement of a group of clinicians with expertise in chronic pain management, acute and emergency pain management, post-operative pain management, and addiction treatment will avoid unintended consequences.

VMS supports the recommendations for this section proposed by the Vermont Association of Hospitals and Health Systems.

Rationale for VPMS Rulemaking

The VPMS is a work in progress and improving steadily, but it is taking longer than we expected. VMS still hears reports of issues using the system. Delegates have only been able to register since September of 2015. The residents, physicians in training came on line around December and January. Clinicians should be able to check prescriptions filled in states in our region starting this month with Connecticut and Rhode Island. Massachusetts and New York are in process. EMR vendors are now able to connect to the prescription monitoring program hubs in other states and the Department of Health hopes to work with UVM Medical Center to pilot this effort in Vermont. The Department of Health is working on linking the licensing specialty and professional data to the VPMS data, which will enable the Department to analyze the data and identify issues.

Currently there is significant statutory guidance for prescriber queries.

- For patients receiving ongoing opioid therapy, must check annually
- When starting a patient on an opioid or non-opioid for chronic pain, must check
- The first time a provider prescribes an opioid for chronic pain, must check
- Prior to writing a replacement prescription, must check.
- Commissioner shall consider additional circumstances.

The Commissioner of Health has identified a number of additional circumstances and incorporated them in the VPMS rules. Professionals in Vermont are required to comply with state and federal laws and regulations and are subject to unprofessional conduct actions if they fail to do so. Current rules require VPMS checks:

- When prescribing for acute pain for longer than 3 weeks;
- In emergency departments or urgent care settings
    - When a patient requests a prescription for chronic pain
    - When a patient requests an extension of a prescription for acute pain
    - Before prescribing an opioid for longer than 10 days.
- When prescribing buprenorphine to treat addiction:
    - Before writing a prescription the first time
    - At regular intervals
    - At least twice a year
    - Prior to writing a replacement (lost/stolen) prescription
    - Prior to exceeding a dosage threshold set by DVHA
- The rules also clarify that "chronic pain" does not include pain from cancer or pain experienced during hospice or end-of-life care.

VMS has confidence that the Department of Health with input from the clinicians and others on the Controlled Substances and Pain Management Advisory Council will be able to identify appropriate additional circumstances for checking the VPMS and will include them in the VPMS rules which will have the force of law.

Rationale for Authorizing, but not Requiring Prescribing Limits

VMS recommends that the Department of Health should have the flexibility to take into account the voluntary efforts to limit opioid prescribing that are already underway and might preclude or limit the need for rulemaking. For example, as Dr. Plavin described in his testimony, BCBSVT, Vermont Medicaid, MVP Health Plans, and the Vermont Department of Health have formed a multi-payer task force to coordinate implementation of opioid safeguards. The group has agreed to coordinate implementation of a limit for new prescriptions of short acting opioids to no more than a 10 day's supply effective July 5, 2016, with exceptions for oncology and palliative care specialists.

Similarly, in his testimony, Dr. Mark Depman described how he used data and report cards to prescribers to reduce opioid prescribing in the emergency department. Maintaining the "may" will enable to Commissioner and the Controlled Substances and Pain Management Council to evaluate these initiatives and to determine if specific limits should be included in rules.

Resources:

Department of Health VPMS 2015 Report:
http://legislature.vermont.gov/assets/Documents/2016/WorkGroups/House%20Human%20Services/Bills/S.243/Witness%20Testimony/W~Dr.%20Harry%20Chen~Vermont%20Prescription%20Monitoring%20System%20Report%202015%20Progress~4-6-2016.pdf

Dr. Joshua Plavin, BCBS Commitment to Fighting Opioid Addiction and Death:
http://legislature.vermont.gov/assets/Documents/2016/WorkGroups/House%20Human%20Services/Bills/S.243/Witness%20Testimony/S.243~Dr.%20Josh%20Plavin~BCBSVT%20Commitment%20to%20Fighting%20Opioid%20Addiction%20and%20Deaths~4-13-2016.pdf

Dr. Mark Depman, sample report card for Opioid Prescribing:
http://legislature.vermont.gov/assets/Documents/2016/WorkGroups/House%20Human%20Services/Bills/S.243/Witness%20Testimony/S.243~Dr.%20Mark%20Depman~Sample%20'Report%20Card'%20Emergency%20Room%20Providers~4-7-2016.pdf

Department of Health – Drug Related Fatalities 2015
http://www.healthvermont.gov/research/documents/databrief_drug_related_fatalities.pdf