2/28/18 Senate Health and Welfare Committee

Over the past several days I've talked to most of the prescribers in our practice, including physicians, but more importantly our PAs and NPs who do most of the prescribing and fielding of patient phone calls. The overwhelming consensus is that we are able to control our patient's pain under these rules, and that we were likely prescribing more opioids than necessary prior to their implementation. My subspecialty training is in orthopaedic trauma, taking care of patients that have complex fractures. I started with Mansfield Orthopaedics in August of 2016, and the NP I work with and I adopted these rules well ahead of the go live date to see how it went. There were of course a few exceptions, but we were pleasantly surprised with how few patients were calling back requesting more pain medications. Now, I had the benefit of a developing practice, with a little more time to talk to our patients and manage expectations, which I feel was a huge benefit.

There are certainly times where I prescribe less, but most of my fracture patients are prescribed an amount of opioid that falls into the "severe" pain category in addition to recommending other medications such as Tylenol and Advil. My colleagues that perform joint replacement surgeries, such as total hip and total knee replacements, prescribe an amount of opioid that falls into the "extreme" category, and this was a significant cut from what they were used to. The PAs that work closely on that service tell me less than half of patients call back asking for more pain medications, but some still do. My colleagues that specialize in hand surgery, shoulder surgery, and foot and ankle surgery also feel they are able to control their patient's pain under the current rules.

A point that was brought up by many was that we can use these regulations to help us limit the amount of opioids given to patients we do not feel really need them, but are requesting them. In essence, we can blame the rules and the burden does not fall on the provider.

There are concerns amongst physicians in my group about legislation directing medical practice. We must be allowed to use our clinical judgement when determining how many opioids are prescribed on an individual basis. We do not feel that it is up to lawmakers to decide if our patients fall into the minor, moderate, severe, or extreme pain categories. Although good as guidelines, we should be allowed to place our patients into which category we feel will adequately, and safely, control our patient's pain so they can successfully recover from their orthopaedic procedure.

The most common complaint I received from our practice was with VPMS. We all appreciate the need to know if other prescribers are providing our patients with regulated medications, but the prescribers and delegates that use it most find it cumbersome and time consuming to use. One provider suggested being provided with a reference number for each query that can be placed in the patient's chart to confirm on our end that a query had been done. Another has found the customer service hours inconvenient while trying to get a password reset. We have also talked about a requirement to check VPMS before the first prescription is given, but then the system notifies us, for example by email, when another provider prescribes a controlled substance to this patient outside of our practice. Then instead of having to spend time rechecking VPMS in the rare circumstance a patient needs a refill, we can either quickly provide a refill knowing we are the only provider prescribing for them, or be able to have a conversation with that patient about the other prescription we are aware has been filled under their name. Most of us think there is certainly room for improvement with VPMS.

The consent form does add time to our preoperative routine, but the majority of the providers in our group don't find it to be a nuisance, and with a few exceptions, we feel patients appreciate the discussion. A few patients have even taken this opportunity to tell us they don't want a narcotic prescription following their procedure.

In our group, we have decided to prescribe Narcan to all patients that receive a narcotic prescription. This saves the hassle of having to figure out who needs one and who doesn't. To save time we had a stamp made for our Narcan prescriptions that lives in our perioperative area. However, we have noticed that the majority of our patients do not fill this Narcan prescription.

Initially, the morphine milligram equivalent requirement was confusing. We worked with our pharmacy department who put together a table to help guide how much of each specific narcotic medication could be prescribed to comply with these rules. This was extremely helpful in determining our new prescribing habits. I encourage the other providers here today to do the same if they haven't already.

In conclusion, I want to thank this committee on behalf of Mansfield Orthopaedics for being given the chance to testify today, and for your continued interest in making these rules as operational and functional as possible, while not inhibiting our ability to practice medicine in a thorough and efficient manner.