At the conclusion of this webinar, participants will be able to:

- Describe new state legislation impacting opioid addiction treatment.
- Describe limitations on initial prescriptions for acute pain management.
- Describe coverage requirements of insurers related to opioid addiction treatment services.
- Verbalize ways in which best practice are driving changes in law and vice versa.
The years of 2018 to 2028 shall hereby be designated as the "Show-Me Freedom from Opioid Addiction Decade"
Post-Partum Treatment Benefit

• Authorizes as much as 12 additional months of Medicaid coverage of substance abuse and mental health treatment for post-partum women who receive substance abuse treatment within 60 days of giving birth and who adhere to the treatment program.

• The added coverage is contingent on appropriations and federal approval.
Post-Partum Treatment Benefit

- Department of Mental Health and Social Services are directed to
  - work to secure waivers and state plan amendments from CMS
  - establish regulations surrounding treatment plan adherence

- **HB 2280**
- **RsMo 208.152**
Buprenorphine Prescriptions

- Revises standards for the prescribing of buprenorphine in medication-assisted treatment of opioid addiction under collaborative practice arrangements.
- Subject to appropriations.
- **SB 951, SB 718**
- SAMHSA training and waiver for NPs and PAs
- American Society of Addiction Medicine training and waiver information
Buprenorphine

• Assistant Physicians
  ➢ Schedule III controlled substances and Schedule II
    – hydrocodone prescriptions shall be limited to a five-day supply without refill, except that buprenorphine may be prescribed for up to a thirty-day supply without refill for patients receiving medication-assisted treatment for substance use disorders under the direction of the collaborating physician.

• RsMo 334.037
Buprenorphine

• Advanced Practice Registered Nurse
  ➢ An advanced practice registered nurse may prescribe buprenorphine for up to a thirty-day supply without refill for patients receiving medication-assisted treatment for substance use disorders under the direction of the collaborating physician.
Buprenorphine

- Physician Assistant
  - Schedule III controlled substances and Schedule II
    - hydrocodone prescriptions shall be limited to a five-day supply without refill, **except that buprenorphine may be prescribed for up to a thirty-day supply without refill for patients receiving medication-assisted treatment for substance use disorders under the direction of the supervising physician.**
- **RsMo 334.747**
Initial Prescription Limits

- **RsMo 195.080**
  - Limit initial prescriptions of opioids to a duration of seven days, with specified exceptions:
    - The prescription is issued by a practitioner located in another state according to and in compliance with the applicable laws of that state and the United States and dispensed to a patient located in another state; or
    - The prescription is dispensed directly to a member of the United States Armed Forces serving outside the United States.

- **SB 826**
Initial Prescription Limits

• Prior to issuing the initial prescription, the practitioner shall
  ➢ discuss risks, quantity to be prescribed and the patient's ability to fill a lesser quantity

• Upon any subsequent consultation for the same pain, the practitioner may issue any appropriate renewal, refill, or new prescription in compliance with the general provisions of this chapter and chapter 579.
Valid Prescription Changes

- The two line prescription format is no longer required in Missouri (SB 826) RsMo 338.056
Disposal of Controlled Substances

- **RsMo 195.265**
  - By August 28, 2019, the department of health and senior services shall develop an education and awareness program regarding drug disposal, including controlled substances.
  - CS may be accepted from ultimate users, from hospice or home health care providers on behalf of ultimate users to the extent federal law allows, or from any person lawfully entitled to dispose of a decedent's property if the decedent was an ultimate user who died while in lawful possession of a CS.
Disposal of Controlled Substances

- Collection receptacles, drug disposal boxes, mail-back packages, and other means by a Drug Enforcement Agency-authorized collector in accordance with federal regulations, even if the authorized collector did not originally dispense the drug; or
- Drug take-back programs conducted by federal, state, tribal, or local law enforcement agencies in partnership with any person or entity.
Quality data, patient satisfaction scores, and pain scoring

- In defining data standards for quality of care and patient satisfaction, the director of the department of insurance, financial institutions and professional registration shall not require patient scoring of pain control.

- Beginning August 28, 2018, the director of the department of insurance, financial institutions and professional registration shall discontinue the use of patient satisfaction scores and shall not make them available to the public to the extent allowed by federal law.

- RsMo 374.426
Opioids and Insurers

• Requires health insurers to offer their enrollees coverage of medication-assisted treatment of substance use disorders, including opioid use and heroin-use disorders.

• Services subject to the same coinsurance, copayment and deductible factors as apply to physical illness.

• **SB 951**

• **RsMo 376.811**
Improved Access to Treatment for Opioid Addictions Program (IATOA)

- **RsMo 630.875**
  - Disseminate information and best practices regarding opioid addiction.
  - Facilitate collaborations to better treat and prevent opioid addiction.
  - Facilitate partnerships between assistant physicians, physician assistants, and advanced practice registered nurses practicing in federally qualified health centers, rural health clinics, and other health care facilities and physicians practicing at remote facilities located in this state.
  - Implementation: as soon as reasonably possible.
IATOA

• Shall provide resources that grant patients and their treating assistant physicians, physician assistants, advanced practice registered nurses, or physicians access to knowledge and expertise through means such as telemedicine and Extension for Community Healthcare Outcomes (ECHO) programs established under section 191.1140.
IATOA

- Assistant physicians, physician assistants, and advanced practice registered nurses who participate in the IATOA program shall complete the necessary requirements to prescribe buprenorphine within at least thirty days of joining the IATOA program.

- A remote collaborating or supervising physician working with an on-site assistant physician, physician assistant, or advanced practice registered nurse shall be considered to be on-site.
IAOT

- An assistant physician, physician assistant, or advanced practice registered nurse collaborating with a physician who is waiver-certified for the use of buprenorphine, may participate in the IATOA program in any area of the state and provide all services and functions of an assistant physician, physician assistant, or advanced practice registered nurse.
IATOA

- Department may develop curriculum and benchmark examinations, which upon passing, result in a certification by the appropriate department or institution.
- An assistant physician, physician assistant, or advanced practice registered nurse may serve as a recovery coach in an emergency department meeting with overdose patients to provide treatment options and offer support.
Translating Opioid Research and Policy into Practice
Emergency Department Guidelines: Recommended Policy Brief Changes

- Title change to reflect hospital versus ED
- Specifically reference the CDC Chronic Pain Guideline
- Refer to Senate Bill 826
- Revise naloxone statement from policy to practice – consider discharging patients with a prescription for naloxone, if at risk of overdose
- PDMP query and medication-assisted treatment should be policy statements but not guidelines.
CDC Guideline for Chronic Pain

GUIDEINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC's Guideline for Prescribing Opioids for Chronic Pain is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

1. Nonpharmacologic therapy and nonpharmacologic therapy with opioids for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonpharmacologic therapy, as appropriate.

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CLINICAL REMINDERS

- Use immediate-release opioids when starting
- Start low and go slow
- When opioids are needed for acute pain, prescribe no more than needed
- Do not prescribe ER/EIA opioids for acute pain
- Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed

ASSESSING RISK AND ADDRESSING HARM OF OPIOID USE

8. 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 (>40 MME/day), or concurrent benzodiazepine use, are present.

9. Clinicians should review the patient’s history of controlled substance prescriptions using state prescription drug monitoring program (PMP) data to determine whether the patient is receiving opioid doses or combinations that put him or her at high risk for overdose. Clinicians should review PMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11. Clinicians should avoid prescribing opioid medication and benzodiazepines concurrently whenever possible.

12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with counseling) for patients with opioid use disorder.

Opioid Use Disorder

A problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two of the following criteria, occurring within a 12-month period.

Source: DSM-5 Diagnostic and Statistical Manual of Mental Disorders
<table>
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<th>Category</th>
<th>Criteria</th>
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| Impaired control               | • Opioids used in larger amounts or for longer than intended  
• Unsuccessful efforts or desire to cut back or control opioid use  
• Excessive amount of time spent obtaining, using, or recovering from opioids  
• Craving to use opioids                                                                 |
| Social impairment              | • Failure to fulfill major role obligations at work, school, or home as a result of recurrent opioid use  
• Persistent or recurrent social or interpersonal problems that are exacerbated by opioids or continued use of opioids despite these problems  
• Reduced or given up important social, occupational, or recreational activities because of opioid use                                                                 |
| Risky use                      | • Opioid use in physically hazardous situations  
• Continued opioid use despite knowledge of persistent physical or psychological problem that is likely caused by opioid use                                                                                     |
| Pharmacological properties     | • Tolerance as demonstrated by increased amounts of opioids needed to achieve desired effect; diminished effect with continued use of the same amount  
• Withdrawal as demonstrated by symptoms of opioid withdrawal syndrome; opioids taken to relieve or avoid withdrawal                                                                                      |
Identifying OUD in Health Care

Clinical Assessment:

Poor Functioning
- Emotional
  - Depression/Anxiety
- Physical
  - Sedation/in bed/ED
- Social
  - Patient or family concern
- Aberrant Behaviors
  - Running out early
  - Rx from another provider
  - Use of illicit drugs

Screening Scales:
- NIDI Quick Screen
- COMM: Current Opioid Misuse Measure
- DAST: Drug Abuse Screen Test
- SOAPP: Screener and Opioid Assessment for Patients with Pain
- ORT: Opioid Risk Tool

Sources: DSM-5; https://store.samhsa.gov/shin/content/SMA18-5063PT2/SMA18-5063PT2.pdf SAMHSA TIP 63
Missouri STR — Medication First Model

• Patients with OUD receive timely pharmacotherapy treatment – prior to lengthy assessments or treatment plan development;

• Maintenance pharmacotherapy is delivered without contraindicated tapering or time limits;

• Individualized psychosocial services are offered, but not required;

• Medicines are meant to address withdrawal symptoms, cravings and increase treatment retention.
ED-Initiated OUD Treatment And Community Linkage

- Patient overdoses and arrives in the ED.
- An ED buprenorphine-waivered physician is contacted. (SB 718, SB 660)
- Buprenorphine induction occurs in the ED. (SB 951)
- A Recovery Coach is contacted and meets with the patient in the ED.
- The ED physician provides the patient with a bridge prescription of 3-5 days of buprenorphine. (SB 951)
- The Recovery Coach assists the patient with a timely referral to outpatient pharmacotherapy, behavioral therapy and support groups. (HB 2280, SB 951, SB 718)
Resources

- CDC Guideline for Prescribing Opioids for Chronic Pain
- DEA Authorized Collector website
- SAMHSA training and waiver for NPs and Pas
- American Society of Addiction Medicine training and waiver information
- SAMHSA Medication Assisted Treatment website
Contact Information

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