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NYU Langone Health

Select State Strategies to Improve Opioid Prescription Safety

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Panelists

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IMPACTS OF STATE-LEVEL OPIOID REVIEW PROGRAMS ON INJURED WORKERS AND THEIR HEALTHCARE PROVIDERS

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Background and Motivation

Workers' compensation agencies in both Washington and Ohio launched opioid review programs (ORPs) to protect the health and safety of patients

Policy and advisory changes have effectively curtailed unsafe prescribing

Concerns have been raised about potentially negative secondary effects

Our interviews with 48 patients (21 WA, 27 OH) and 32 providers (18 WA, 14 OH) allow us to investigate directly whether feared negative impacts have come to pass, focusing on three core concerns

OBJECTIVE: To understand the impact of state-level opioid review programs (ORPs) on patient and provider experiences

WASHINGTON
Department of Labor & Industries

Prospective ORP stops paying for opioids after 6 weeks unless pre-approved. Covers more workers and providers.

OHIO
Bureau of Workers' Compensation

Retrospective ORP letters bring most providers into compliance, BWC rarely stops paying for prescriptions. Covers fewer workers and providers.

That – as a result of limitations on opioid prescribing instituted by WC agencies – patients would have unmanaged pain, reduced function, more disability, or reduced ability to return to work

CONCERN 1

Neither unmanaged pain nor functional losses due to pain were commonly reported

Most patients described their opioid medication as a useful, well-managed tool used to navigate recovery.

Some patients did struggle to get access to opioid medications, resulting in unmanaged pain. This was most often due to delays in approving prescriptions.

> Here I am just waiting. It's just a big waiting game...all the red tape, because the doctor will prescribe one thing, then it takes about four or five submissions to workers' comp to get anything to go through ....

Patients and providers were frustrated by approval delays, which could cause delays or reductions in healing.

> [WC required] all these extra steps when [the doctors have been] dealing with these kinds of injuries for...basically their whole careers. That's what they do. They... know what the injury is, but they can't get me the surgery that I needed until I [got all the] clearances.

That patients would be angry about or resistant to the reduced availability of opioid pain medication under ORPs, or that providers would resist the requirements to reduce their opioid prescribing

CONCERN 2

Neither patients nor providers had these responses. In contrast, they generally accepted or approved of precautions about opioid prescribing

Patients felt cautious; many had experience with addiction.

> It broke my heart. [A] good friend of mine had an accident, was on medication. A year or two into [his addiction, he] loses his wife, his life, everything around him… to see something life altering in a good friend, you know, it really hurts you…. I'm just at the point of, "Okay, I gotta do this. I'll [take my meds] and I'll do it regimented, like I'm supposed to."

Providers generally had positive views of opioid regulations; many noted positive impacts on patients.

> Nationally, there's been a push against too many pain pills, and so I think we all are writing for smaller numbers of pain pills. I'd rather…write a smaller number and make…the patient have to come back and specifically ask for more as opposed to giving everybody a higher number and then you get more pills floating around in the marketplace.

That relationships between patients and providers would be damaged by limits on opioid prescribing imposed by ORPs, or that providers would feel their clinical autonomy was eroded

CONCERN 3

Patients remained happy with their providers, and providers felt they continued to have good relationships with their patients and autonomy over clinical practice

Providers felt prescribing regulations helped them protect patients and were beneficial for their relationships with patients.

> I think the state policies help support the provider in justifying why we're not giving out so much [sic] opioids…Being able to tell patients [about the policies] is actually really helpful.

Patients felt good about collaborating with providers to make pain management decisions.

> The physician's assistant and I have always worked together about deciding when I should take something and when I shouldn't, or why I should take them and why I shouldn't. [He's] been very thorough going through all that. The last doctor's appointment…he says, "Well, do you think you still need it, or do you think you want to try to go off of it?"

Providers and patients both described frustration with WC processes and procedures, as well as the resulting impacts on care and recovery.

Conclusions

Feared negative impacts of ORPs have largely *not* come to pass. Instead, consequences of ORPs and related policies have been generally positive:

- providers prescribe in more limited ways,
- patients have satisfactory pain control and positive relationships with providers.

Both patients and providers comment frequently on the difficult aspects of interacting with WC agencies – from inconvenience to substantial delays and reduced potential for physical recovery.

Patient Interviews

What patients knew and how they felt about opioid-related policies of WC agencies

How ORPs (and other opioid-related policies) affected pain management, function, disability, ability to return to work, and relationships with healthcare providers

Experiences and feelings about WC more broadly

Provider Interviews

How and why prescribing practices have changed since the start of the opioid epidemic

Perceived legitimate role of opioids in pain management

How ORPs (and other opioid-related policies) have affected prescribing behavior and experiences of patient care

Opinions about how state policies are helpful and how they should be revised or improved

WHAT ARE WE AGREEING TO? OPIOID TREATMENT AGREEMENTS AND THE PHYSICIAN-PATIENT RELATIONSHIP

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ACCESS TO PAIN MANAGEMENT IN AN ONGOING OVERDOSE CRISIS

- Patients on Long-Term Opioid Therapy (LTOT) encounter a number of barriers to care, including stigma associated with opioids.
  - 81% of primary care physicians are reluctant to take on new patients currently prescribed opioids.[1]
  - 41% of primary care practices refused to schedule a first visit.[2]
- Clinician hesitancy may further stigmatize a larger and already marginalized population of patients with chronic pain.[3]

OPIOID TREATMENT AGREEMENTS

- Federally recommended, but not mandated in both the US and Canada
- Required in ≈ 27 states in the US, no Canadian provinces
- Not merely informed consent documents, enumerate clinical policies and monitoring requirements for Long-Term Opioid Therapy
- Patients must agree to the terms of the agreement in order to access and continue on LTOT.
- If the patients do not comply with these terms, many OTAs claim that the physician has discretion to end the clinical relationship or change their prescribing practices.

SAMPLE OPIOID TREATMENT AGREEMENT

Worker's Name _____ Claim Number _____

Opioid (narcotic) treatment is used to reduce pain and improve what you are able to do each day. Along with opioid treatment, other medical care may be prescribed to help improve your ability to do daily activities and reduce the need for pain medication. This may include exercise, use of non-narcotic analgesics, physical therapy, psychological counseling, or other therapies or treatment. Vocational counseling may be provided to help your efforts to return to work.

I, _____ understand that I must comply with this agreement for continued pain treatment with Dr. _____ .

1. I have the following responsibilities (check boxes):

- [] Take my medications only at the dose and frequency prescribed.
- [] Won't increase or change my medications without the approval of this provider.
- [] Actively participate in Return to Work (RTW) efforts and in any program designed to improve function (including social, physical, psychological and daily or work activities).
- [] Won't ask for opioids or any other pain medicine from another provider. This provider will approve or prescribe all other mind- and mood-altering drugs.
- [] Inform this provider of all other medications that I am taking.
- [] Fill all medications from one pharmacy, when possible. By signing this agreement, I give consent to this provider to talk with the pharmacist. Pharmacy: _____ Phone: _____
- [] Protect my prescriptions and medications. I will keep all medications away from children. **Medications may not be replaced if they are lost or destroyed. If medication has been stolen and a police report is completed regarding the theft, an exception may be made.**
- [] Agree to participate in psychiatric or psychological assessments, if necessary.
- [] Won't use illegal or street drugs, or alcohol. This provider may ask me to follow through with a program to address this issue. Such programs may include the following:
  - ☐ 12-Step program
  - ☐ Individual counseling
  - ☐ Inpatient or outpatient treatment
  - ☐ Other:

2. In the event of an emergency, I or my representative will contact this provider who will discuss the problem with the emergency room or other doctor. I am responsible for requesting a record transfer to this provider.

3. I consent to random drug testing and pill counts.

4. This provider will check the state's prescription monitoring program database to verify my opioid prescription history.

5. I will keep my scheduled appointments, or if necessary, cancel my appointment at least 24 hours before the appointment.

6. This provider will stop prescribing opioids or change my treatment plan if:

- I don't show any improvement in function.
- I behave in a way that is not consistent with my responsibilities outlined in #1.
- I give away, sell, or misuse the opioid medications.
- I develop rapid tolerance or loss of improvement from this treatment.
- I get opioids from another provider.
- I don't cooperate when asked to get a drug test.
- I develop an addiction problem from opioid use.
- I experience a serious adverse outcome from this treatment.
- I don't keep my follow-up appointments.

I have read and understand both sides of this agreement. My questions have been answered satisfactorily. I agree to the use of opioids to help control my pain, with treatment to be carried out as described above.

Worker's signature _____ Date _____ Provider's signature _____ Date _____

Provider: Keep a signed copy on file. Give a copy to the patient. You should renew this agreement every 6 months.

SAMPLE OTAS

Appendix B-5: Sample Opioid Medication Treatment Agreement

I understand that I am receiving opioid medication from Dr. _____ to treat my pain condition. I agree to the following:

1. I will not seek opioid medications from another physician. Only Dr. _____ will prescribe opioids for me.
2. I will not take opioid medications in larger amounts or more frequently than is prescribed by Dr. _____.
3. I will not give or sell my medication to anyone else, including family members; nor will I accept any opioid medication from anyone else.
4. I will not use over-the-counter opioid medications such as 222's and Tylenol® No. 1.
5. I understand that if my prescription runs out early for any reason (for example, if I lose the medication, or take more than prescribed), Dr. _____ will not prescribe extra medications for me; I will have to wait until the next prescription is due.
6. I will fill my prescriptions at one pharmacy of my choice; pharmacy name: _____
7. I will store my medication in a secured location.

I understand that if I break these conditions, Dr. _____ may choose to cease writing opioid prescriptions for me.

Source: Modified from Kahan 2006.

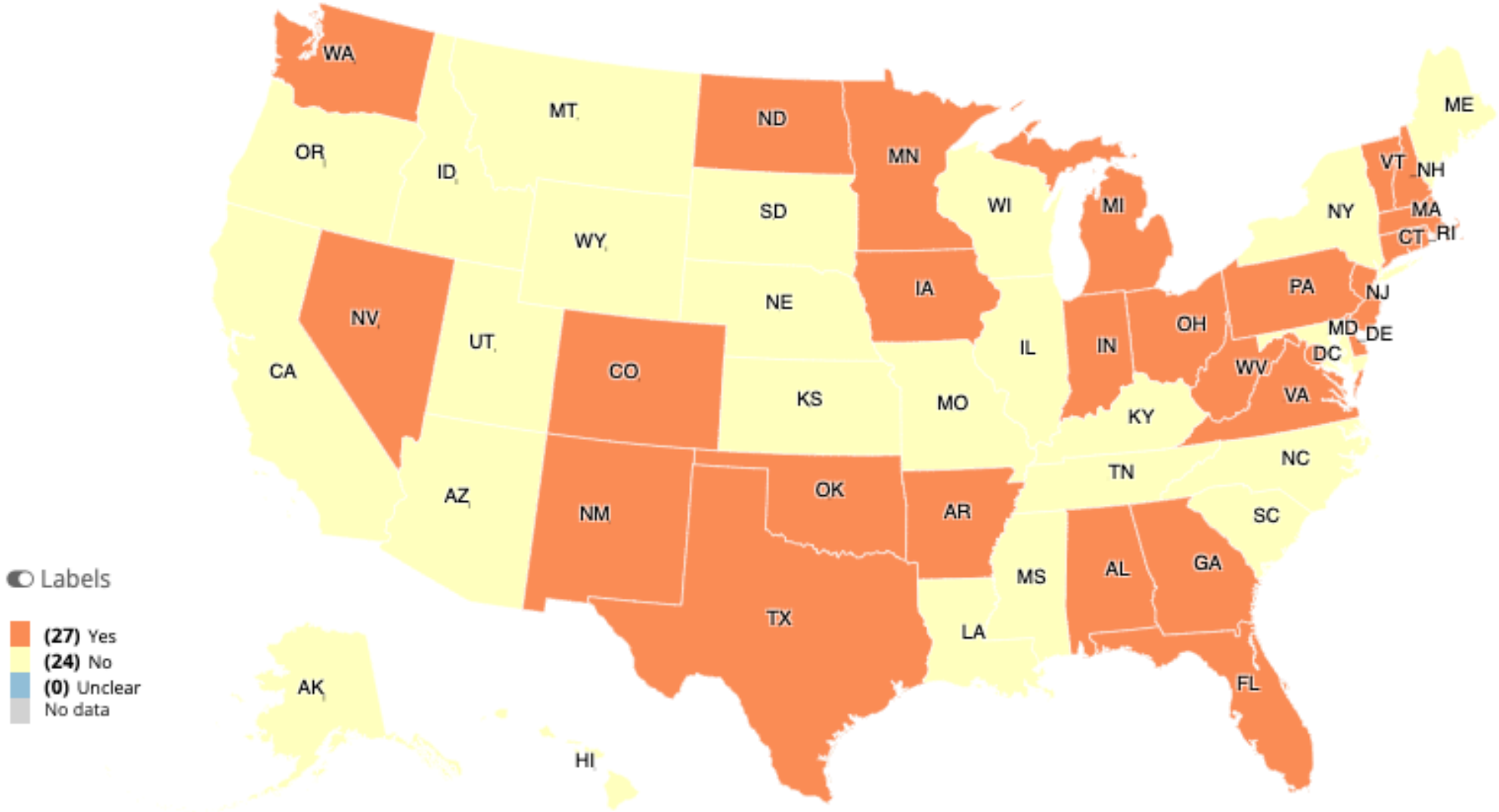
SOME ETHICAL CHALLENGES

- Little evidence that implementing OTAs improves patient health outcomes or guards against diversion [4]
- Concerns about the impact of OTAs on trust between physicians and patients [5]
- OTAs potentially punitive and or legalistic in language/focus on legal liability for the physician rather than patient welfare [6]
- Contributing to the stigmatization of patients with chronic pain and other vulnerable populations [6, 7]

THE LEGAL LANDSCAPE FOR OTAS [8]

- OTAs are controversial because of the lack of evidence that their use reduces opioid-related harms and the risk of increasing stigma.
- Even so, their use is now required in most US jurisdictions and their use is influencing the outcomes of civil and criminal lawsuits.
- Policymakers in jurisdictions where OTAs are required should consider eliminating OTA mandates or providing flexibility in the legal requirements to make room for clinicians and healthcare institutions to implement best practices.

10/5/22 Does the state require the use of an opioid treatment agreement (OTA)?



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THE LEGAL LANDSCAPE FOR OTAS [8]

- We looked at these dimensions of OTA requirements:
  - Does the requirement to use a treatment agreement also apply to non-opioid drugs?
  - Does the requirement only apply to opioid prescriptions with a certain duration or dosage?
  - Does the requirement also apply to patients with cancer?
  - Does the requirement also apply to patients with non-cancer terminal conditions?
  - Does the legal requirement specify at least one term that must be included in that jurisdiction's OTAs?

Jurisdiction	Requirement also applies to non-opioid drugs	Requirement is only for certain duration or dose	Requirement applies to patients with cancer	Requirement applies to patients with non-cancer terminal conditions	Requirement includes at least one term that must be included
Alabama	Yes	Yes	Yes	Yes	Yes
Arkansas	Yes	Yes	No	No	No
Colorado	No	Yes	Yes	Yes	Yes
Connecticut	No	Yes	Yes	Yes	Yes
Delaware	Yes	Yes	Yes	Yes	Yes
District of Columbia	Yes	Yes	Yes	Yes	Yes
Florida	Yes	Yes	No	Yes	Yes
Georgia	Yes	Yes	No	No	No
Indiana	No	Yes	Yes	Yes	Yes
Iowa	No	Yes	No	No	Yes
Massachusetts	No	Yes	Unclear	Unclear	Unclear
Michigan	No	Yes	Yes	Yes	Yes
Minnesota	No	Yes	Yes	Yes	Yes
Nevada	Yes	Yes	No	No	Yes
New Hampshire	No	Yes	No	No	Yes
New Jersey	Yes	Yes	No	No	Yes
New Mexico	Yes	Yes	Yes	Yes	Yes
North Dakota	No	Yes	No	No	Yes
Ohio	No	Yes	No	No	Yes
Oklahoma	No	Yes	No	No	Yes
Pennsylvania	No	Yes	Yes	Yes	Yes
Rhode Island	No	Yes	Yes	Yes	No
Texas	Yes	Yes	Yes	Yes	Yes
Vermont	No	Yes	No	No	Yes
Virginia	No	Yes	No	No	Yes
Washington	No	Yes	No	No	Yes
West Virginia	No	Yes	Yes	Yes	Yes

THE LEGAL LANDSCAPE FOR OTAS [8]

- OTA requirements and OTA use are already shaping the outcomes of both criminal and civil lawsuits.
- Some takeaways from surveying both the requirements and the lawsuits:
  - 48% of jurisdictions requiring OTAs exclude from their requirements patients with cancer or non-cancer terminal conditions who would otherwise qualify.
  - Even if exemptions for cancer patients were dropped, health policy makers should consider whether people who are at greatest risk of opioid misuse deserve disproportionate criminal liability.
  - Clinicians perceive OTAs to be legally protective,[8-10] and they are sometimes but not always.

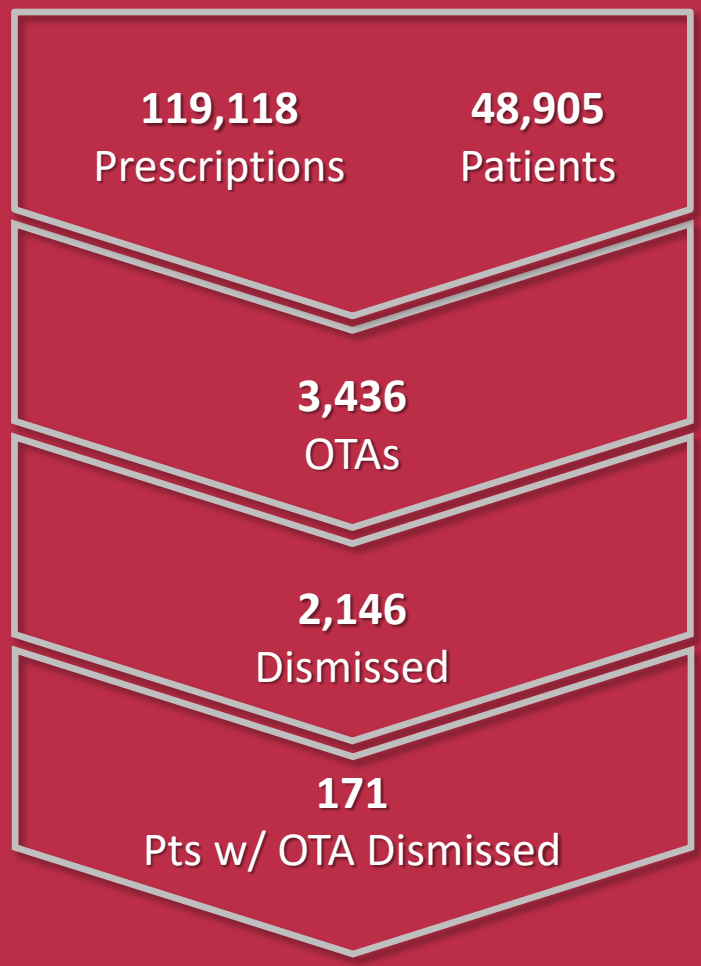
FUTURE EMR DATA STUDY: HOW ARE CLINICIANS ACTUALLY USING OTAS?*

*all data are preliminary

Research Question

How are clinicians actually using these documents?

Methods:
EMR Chart Review



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THANK YOU!

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Moderated Discussion and Q&A

Thank you for listening