Northern Light Health

Northern Light Blue Hill Hospital

September 2018 Updates: Northern Light Health Controlled Substance Management Policy

10.02.2018 | Zoe Tenney, MSN, APRN

Introduction & Overview

New System policy replaces prior local policies & aligns with current Maine law and Boards of Licensure rules

All prescribers should familiarize themselves with the full policy, this slide show presents an overview only. Links below.

Controlled Substance Prescriptions and Medications with the Potential for Diversion (29-020)

Controlled Substance Prescriptions and Medications with the Potential for Diversion ATTACHMENT Informed Consent for Controlled Substances (29-020)

Controlled Substance Prescriptions and Medications with the Potential for Diversion ATTACHMENT Informed Consent for Benzodiazepines (29-020)

Controlled Substance Prescriptions and Medications with the Potential for Diversion ATTACHMENT Treatment Agreement for Controlled Substances (29-020)

General reminders

- Use electronic prescribing
- Prescriptions for ACUTE pain shall be limited to a 7 day supply within a 7 day period
- When prescribing controlled substances for the treatment of CHRONIC pain, clinicians shall present it as a therapeutic trial for a defined period of time, and for no more than 30 days. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation.
- Medical hx, risk assessments, PE, & tx plan requirements are intense & specific: Northern Light Health enhancements to the ambulatory Cerner platform have been designed to prompt & support required documentation in compliance with policy and State law.
- Cerner screen shots & references are included here in a limited fashion to illustrate components of the Policy. *Formal workflow guidance available in a separate document*.

Medications included in this policy

- Controlled pain medications
- Benzodiazepines

Note that stimulants are NOT addressed in this policy

Detailed overview

Informed consent & treatment agreements
PMPs
Monitoring
Visit frequency
Palliative and hospice considerations
CME

Informed Consents

Before prescribing any controlled substances to a patient for 90 days or more:

- Obtain a signed Informed Consent (use the standard NLH System consent form specific to opioids or benzodiazepines, see link, slide 3)
- If Opioid Medication and Benzodiazepines must be prescribed concurrently, use a *separate* Informed Consent Form for each medication
- Keep IC on paper in exam rooms, scan into Cerner when signed
- Give copy to patient

Treatment Agreements

- Treatment agreements are due annually
- Keep blank agreements on paper in exam rooms, scan into Cerner when signed (use NLH standard forms, see link slide 3)
- *Note that we use same Treatment Agreement form for opioids & benzodiazepines*
- Give copy to patient
- Document your plan if violations occur

- NOTE: The NLH Treatment Agreement form contains language for stimulants. *Use this if you choose to have a patient prescribed stimulants sign an agreement* (note that this is not required per Policy, it is at prescriber discretion)

PMP

- Prescribers (or their authorized designee) must check the PMP before initially prescribing
  (1) a Benzodiazepine for any diagnosis
  (2) a Controlled Substance to a person for the treatment of Acute or Chronic Pain
- The PMP must be checked at the time the prescription is written. *It must be checked again on the day that a new prescription is written/renewed, even if that prescription is within the 90-day window of the previous PMP check.*
- More frequent checks are encouraged for high risk patients, at the discretion of the Prescriber
- Policy stipulates that review of the three required elements (MME, prescribers, pharmacies) must be “noted in record”, but does not require scanning the printed PMP report into the chart.

Urine or serum drug screens & pill counts

Clinicians who prescribe controlled substances to a patient for 90 days or more for chronic non-cancer/non-hospice/non-end-of-life pain shall

- Perform toxicological (e.g. urine or serum) drug screen prior to the initiation of treatment
- Periodic random screening shall be done at least annually, but frequency should be based on the patient's level of risk.

Pill counts are an additional, optional tool

Visit frequency

Level of Risk	Recommended Frequency
Initial prescription/dose escalation	1-4 weeks
Low risk and doses < 30 mg daily MME	Every 6-12 months
Low risk	Every 6 months
Moderate risk	Every 3 months
High risk or Opioid doses > 90 mg/day daily MME	Every 1-3 months

Palliative care

- Prescriptions for opioids that are prescribed for “palliative care” which will cause the patient to exceed the 100 MME aggregate daily limit must contain a diagnosis code (ICD-10) and an exemption code B.

- *NOTE: All controlled substance monitoring requirements (informed consents, treatment agreements, PMPs, UDS etc.) DO apply to non-hospice/non end-of -life patients receiving palliative care.*

Hospice

- “Hospice” or “end of life care” should be added to the active problem list along with the relevant medical diagnosis(es)
- MME dose limits do not apply
- Use Exemption Code C: Hospice/end of life care
- Requirements for treatment agreements, drug screens, and PMP checks do not routinely apply to patients receiving hospice care

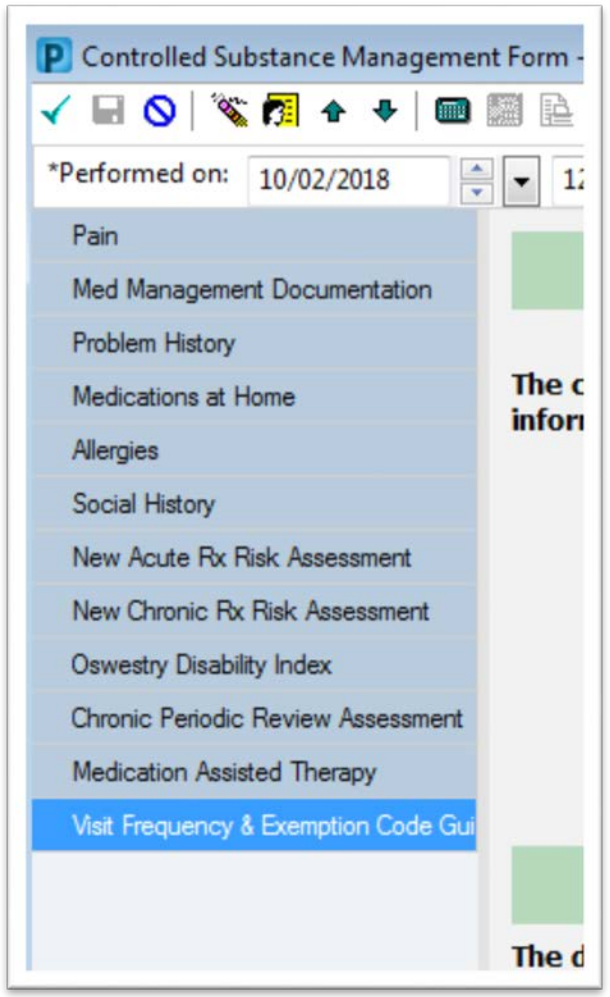
Opioid-related CME

No change from prior requirements:

Three hours of CME are required every two years for anyone with a DEA license that allows them to prescribe controlled substances.

Assessing and documenting risk

Controlled substance management visit guidance/prompts are embedded in the Cerner EHR “controlled substance management form”



General Opioid risk tool

Right click over "opioid risk score" box for score for scoring information

Additional acute Rx risk assessment questions (limited assessment)

New Acute Rx Risk Assessment

In risk assessment of the patient, prior to treating for acute pain, the following elements were considered as appropriate:

Patient has evidence or risk of significant adverse events, including falls or fractures	☐ Yes ☐ No ☐ Other:	**Patient has significant psychiatric conditions**	☐ Yes ☐ No ☐ Other:
Patient has comorbidities that may affect clearance and metabolism of the opioid medication	☐ Yes ☐ No ☐ Other:	**Patient recieves opioids from more than one prescribing practitioner or practitioner group**	☐ Yes ☐ No ☐ Other:
Patient currently uses substances including tobacco	☐ Yes ☐ No ☐ Other:	**Patient has aberrant behavior regarding opioid use, such as repeated visits to an emergency department ("ED") seeking opioids**	☐ Yes ☐ No ☐ Other:
Patient regularly uses benzodiazepines, alcohol, or other central nervous system medications	☐ Yes ☐ No ☐ Other:		

Documenting acute rx plans using autotext prompts

/pcp_controlled_substance_a&p_acuteRx

Medical indication for the ACUTE (<90 days total, 7 day supply per Rx max) use of this controlled substance:_

In evaluating this patient, appropriate physical examination, medication history, and medical/social history (including substance use) have been performed, including past treatments for this pain where applicable, and consideration of the effect of pain on this patient's function.

Relevant diagnostic results including imaging, lab, and specialty consult reports have been reviewed.

Short term risks vs. benefits have been considered, and in my professional opinion the potential benefits outweigh potential risks.

I have reviewed the following PMP information: MME, number of prescribing providers, and number of filling pharmacies.
Concerns based on PMP review, if any:_

New Chronic Rx risk assessment questions (detailed assessment)

New Chronic Rx Risk Assessment

In risk assessment of the patient, prior to treating for chronic pain (rx>90 days) the following elements were considered as appropriate:

Patient has possible pregnancy: Assess pregnant women taking opioids for opioid use disorder. If present, refer to a qualified specialist	☐ Yes ☐ No ☐ Other:	**Patient has psychiatric conditions; especially poorly controlled depression or anxiety**	☐ Yes ☐ No ☐ Other:
Patient has evidence or risk of significant adverse events, including falls or fractures	☐ Yes ☐ No ☐ Other:	**Patient has personal or family history of addiction or substance abuse/misuse**	☐ Yes ☐ No ☐ Other:
Patient has comorbidities that may affect clearance and metabolism of the opioid medication	☐ Yes ☐ No ☐ Other:	**Patient has history of physical or sexual abuse**	☐ Yes ☐ No ☐ Other:
Patient has history of sleep apnea or other respiratory risk factors	☐ Yes ☐ No ☐ Other:	**Patient receives opioids from more than one prescribing practitioner or practitioner group**	☐ Yes ☐ No ☐ Other:
Patient regularly uses benzodiazepines, alcohol, or other central nervous system medications	☐ Yes ☐ No ☐ Other:	**Patient has aberrant behavior regarding opioid use, such as repeated visits to an emergency department ("ED") seeking opioids**	☐ Yes ☐ No ☐ Other:

Chronic periodic Rx review assessment

Chronic Periodic Review Assessment

NOTE: This form is for patient currently being treated for chronic pain within this practice/by this clinician. If a clinician is continuing treatment of chronic pain on a patient who was previously treated with long term controlled substances by another clinician, that patient requires re-assessment of the prior work up, non-pharmacologic treatment and appropriateness of the controlled substance dosing.

Is continuation or modification of medications necessary based on the clinician's evaluation of progress towards treatment objectives?	☐ Yes ☐ Other: ☐ No
New or ongoing comorbidities (such as COPD, liver or renal failure, sleep apnea) or medications that may increase the risk for adverse effects such as overdose?	☐ Yes ☐ Other: ☐ No
Patient adherence to the treatment plan?	☐ Yes ☐ Other: ☐ No
Is the patient's progress or compliance with the current treatment plan is unsatisfactory? If so, consider tapering, changing or discontinuing treatment with controlled substances.	☐ Yes ☐ Other: ☐ No

Documenting chronic Rx plans using autotext prompts

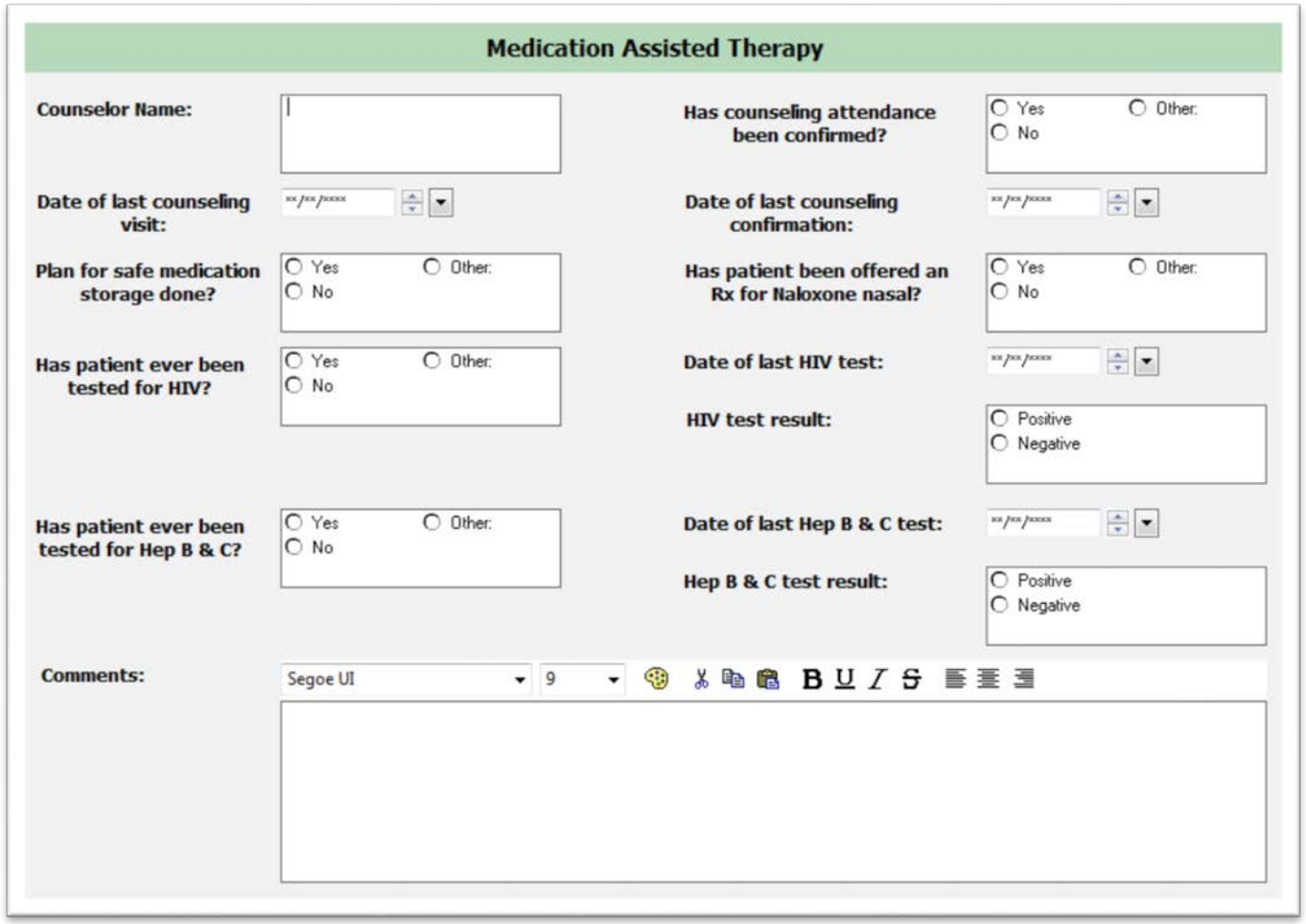
/pcp_controlled_substance_a&p_chronicRx

Treatment plan for this patient's use of controlled substance is as follows:

- Realistic goals & objectives which will indicate treatment success (other than report of pain reduction) have been discussed with the pt and include:_
- Specific functional goals include:_
- Further diagnostic evaluations needed:_
- Other treatments planned:_
- Regular physical activity was encouraged as appropriate to patient's health status.
- Treatment plan violations and response/changes in treatment plan if applicable:_
- Relevant diagnostic results including imaging, lab, and specialty consult reports have been reviewed.
- Risks benefits have been assessed and in my professional opinion the potential benefits outweigh possible risks. Other treatment modalities including non-pharmacological treatments, and non-opioid alternatives up to a maximum recommended by the CDC or dictated by patient safety, have been inadequate to address this patient's pain and functionality.

MAT

The controlled substance monitoring form prompts important MAT monitoring questions, although this is not specifically articulated in the Policy.



Medication Assisted Therapy

Counselor Name:

Has counseling attendance been confirmed? ○ Yes ○ Other: ○ No

Date of last counseling visit: **/**/****

Date of last counseling confirmation: **/**/****

Plan for safe medication storage done? ○ Yes ○ Other: ○ No

Has patient been offered an Rx for Naloxone nasal? ○ Yes ○ Other: ○ No

Has patient ever been tested for HIV? ○ Yes ○ Other: ○ No

Date of last HIV test: **/**/****

HIV test result: ○ Positive ○ Negative

Has patient ever been tested for Hep B & C? ○ Yes ○ Other: ○ No

Date of last Hep B & C test: **/**/****

Hep B & C test result: ○ Positive ○ Negative

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