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MHA SUDPTTF Guidelines for Prescription Opioid Management within Hospitals Executive Summary and Table of Contents

The Massachusetts Hospital Association’s Substance Use Disorder Prevention and Treatment Task Force (SUDPTTF) provide the following recommendations related to prescribing opioid and/or opiate medications within a hospital setting, including hospital owned/affiliated clinics or physician practices. The goal is to develop a general standard for limiting the use of or finding alternatives to prescription opioids. We encourage all hospitals to adopt the following six provider and eight operational recommendations.

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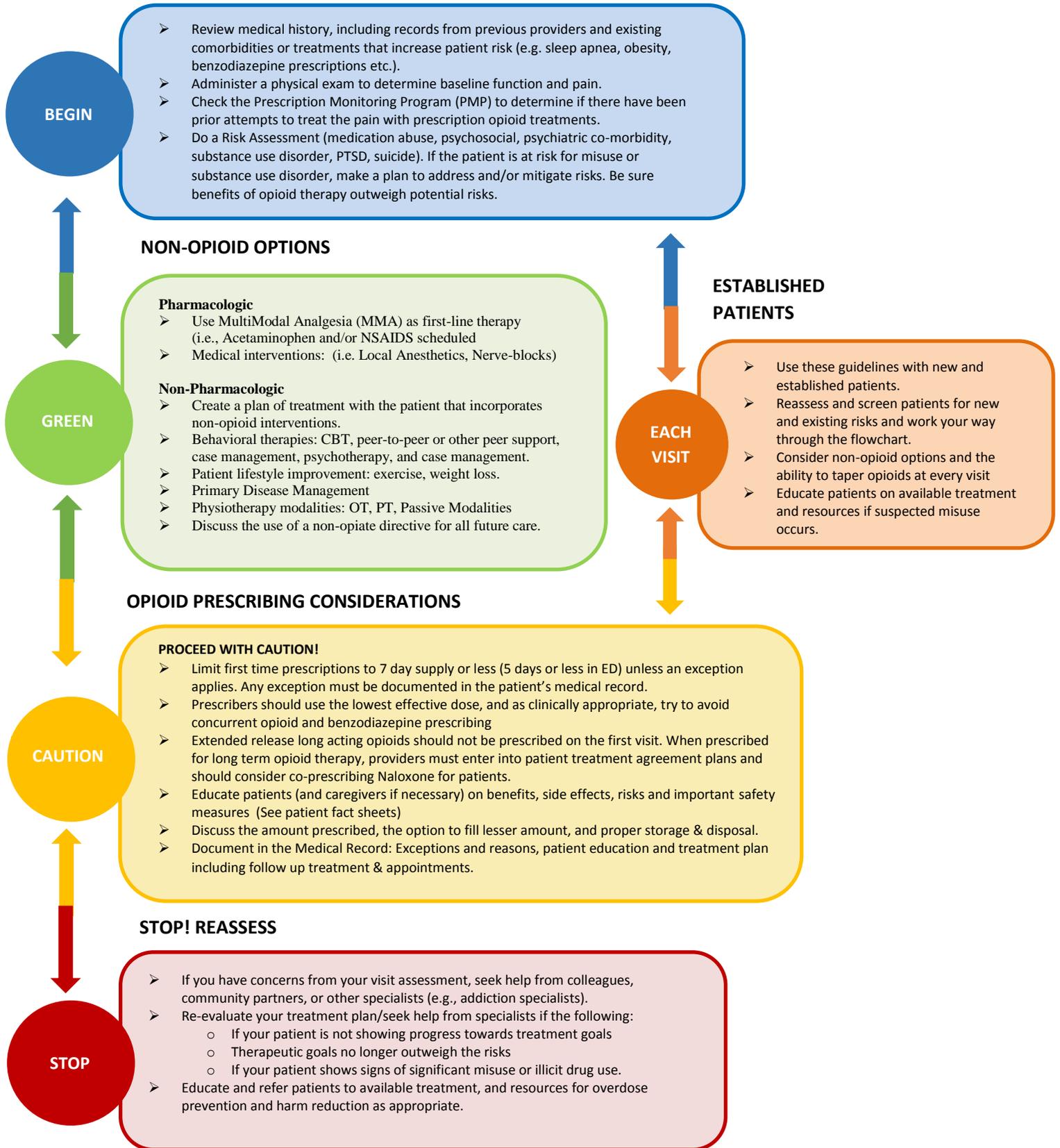
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Suggested Opioid Prescribing Guidelines FLOWCHART

The following flow chart offers a suggested process for evaluating each patient to determine if prescription opioids are appropriate for their pain management

ASSESSMENT



BEGIN

- Review medical history, including records from previous providers and existing comorbidities or treatments that increase patient risk (e.g. sleep apnea, obesity, benzodiazepine prescriptions etc.).
- Administer a physical exam to determine baseline function and pain.
- Check the Prescription Monitoring Program (PMP) to determine if there have been prior attempts to treat the pain with prescription opioid treatments.
- Do a Risk Assessment (medication abuse, psychosocial, psychiatric co-morbidity, substance use disorder, PTSD, suicide). If the patient is at risk for misuse or substance use disorder, make a plan to address and/or mitigate risks. Be sure benefits of opioid therapy outweigh potential risks.

NON-OPIOID OPTIONS

Pharmacologic

- Use MultiModal Analgesia (MMA) as first-line therapy (i.e., Acetaminophen and/or NSAIDS scheduled)
- Medical interventions: (i.e. Local Anesthetics, Nerve-blocks)

Non-Pharmacologic

- Create a plan of treatment with the patient that incorporates non-opioid interventions.
- Behavioral therapies: CBT, peer-to-peer or other peer support, case management, psychotherapy, and case management.
- Patient lifestyle improvement: exercise, weight loss.
- Primary Disease Management
- Physiotherapy modalities: OT, PT, Passive Modalities
- Discuss the use of a non-opiate directive for all future care.

ESTABLISHED PATIENTS

- Use these guidelines with new and established patients.
- Reassess and screen patients for new and existing risks and work your way through the flowchart.
- Consider non-opioid options and the ability to taper opioids at every visit
- Educate patients on available treatment and resources if suspected misuse occurs.

EACH VISIT

OPIOID PRESCRIBING CONSIDERATIONS

PROCEED WITH CAUTION!

- Limit first time prescriptions to 7 day supply or less (5 days or less in ED) unless an exception applies. Any exception must be documented in the patient's medical record.
- Prescribers should use the lowest effective dose, and as clinically appropriate, try to avoid concurrent opioid and benzodiazepine prescribing
- Extended release long acting opioids should not be prescribed on the first visit. When prescribed for long term opioid therapy, providers must enter into patient treatment agreement plans and should consider co-prescribing Naloxone for patients.
- Educate patients (and caregivers if necessary) on benefits, side effects, risks and important safety measures (See patient fact sheets)
- Discuss the amount prescribed, the option to fill lesser amount, and proper storage & disposal.
- Document in the Medical Record: Exceptions and reasons, patient education and treatment plan including follow up treatment & appointments.

CAUTION

STOP! REASSESS

- If you have concerns from your visit assessment, seek help from colleagues, community partners, or other specialists (e.g., addiction specialists).
- Re-evaluate your treatment plan/seek help from specialists if the following:
 - If your patient is not showing progress towards treatment goals
 - Therapeutic goals no longer outweigh the risks
 - If your patient shows signs of significant misuse or illicit drug use.
- Educate and refer patients to available treatment, and resources for overdose prevention and harm reduction as appropriate.

STOP

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Recommendations and Guidance for Provider Specific Practices

The goal of the provider specific guidance is to ensure that all treating providers and prescribers follow a general standard of care regarding the use of prescription opioids. Each recommendation is intended to cover equally all prescriptions that use an opioid and their derivatives. While this guidance provides recommended practices, the Massachusetts Hospital Association and the Massachusetts Medical Society have developed a quick checklist (*see Appendix 1*) that outlines the steps that prescribers should follow when issuing a prescription opioid. It should also be noted that while the terms “opioid” and “opiate” may be defined and used differently, providers should use the term similarly when considering how to incorporate the guidance below within their clinical practices.

1. Adopt appropriate screening and assessment of patient risks associated with prescription opioids including but not limited to the risk of opioid misuse and substance use disorders.

Patient screening and risk assessment for substance use prior to prescribing an opioid can help providers deliver better care to patients while also identifying those at risk for opioid misuse or substance use disorder, and assisting or referring patients with active substance use disorder to find appropriate evidence-based addiction treatment options.

At a minimum, all providers should follow general standards for evaluating and screening a patient’s level of risk for opioid misuse or substance use disorder. A medical history evaluation is necessary which should include prior attempts to treat pain with non-opioid modalities, psychiatric conditions or co-morbidity, personal and family history of substance use disorders, and health factors that could put the patient at increased risk for adverse outcomes (i.e. sleep apnea, benzodiazepines). As clinically appropriate, patients should be screened for, PTSD, suicide risk (prior suicide attempts, current suicidal ideation, and planning), and existing substance use disorder. In addition, a recent physical examination, current medication usage review, and appropriate diagnostic testing and pain assessment should be conducted as needed to determine baseline function and to ultimately determine whether pharmacologic pain management is appropriate.

Proper screening and assessment should be conducted to help providers not only customize treatment plans according to screening results, but also to refer patients with substance use disorders to evidence based addiction treatment and enhance safety and reduce harm for patients accessing addiction treatment as well as those not interested or unable to access addiction treatment. This can provide opportunities for education and early intervention for patients with active substance use disorder, risk for misuse or developing substance use disorder, or patients suspected of doctor shopping and diversion.

In addition to screening tools, prescribers are required to review information (including a patient’s prior prescription history) available through the Massachusetts prescription monitoring program (PMP) prior to issuing a prescription for a Schedule II or III narcotic drug. It is strongly encouraged that prescribers also consult the PMP before writing any prescription opioid in another schedule or for a prescription that has a high risk of misuse (e.g., benzodiazepine). The state’s Department of Public Health (DPH) [PMP Resource Website](#) provides information on how to use the PMP to determine a patient’s prior prescriptive history.

The following recommended tools can help assess the potential risk of opioid misuse or substance use disorder based on patient characteristics:

- MA DPH Recommended tool: [SBIRT](#)
- National Institute on Drug Abuse: [Screening Tools](#)

- Screener and Opioid Assessment for Patients with Pain (SOAPP)
- Revised SOAPP (SOAPP-R)
- Opioid Risk Tool (ORT)
- Diagnosis, Intractability, Risk, Efficacy instrument (DIRE)
- Details on suggested screening tools and resources can be found in the “Screening Tools Resource Packet”, that is available on the [MHA Substance Use Disorder Prevention and Treatment Task Force Website](#).

2. *Incorporate within the treatment options the use of multimodal medications and alternative non-opioid options to limit unnecessary prescription opioids.*

In accordance with the Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain, providers should first consider alternative non opioid treatments prior to prescribing opioids as well as consider information obtained in initial evaluation and assessments to determine whether the patient is at risk of misusing opioids and/or developing a substance use disorder, or is suspected to have an existing substance use disorder. Alternative treatments that should be considered include:

- :

Pharmacologic

- Use MultiModal Analgesia (MMA) as first-line therapy
- (i.e. Acetaminophen and/or NSAIDS scheduled
- Medical interventions: (i.e. Local Anesthetics, Nerve-blocks)

Non-Pharmacologic

- Create a plan of treatment with the patient that incorporates non-opioid interventions.
 - Behavioral therapies: CBT, peer-to-peer or other peer support, case management, psychotherapy, and case management.
 - Patient lifestyle improvement: exercise, weight loss.
 - Primary Disease Management
 - Physiotherapy modalities: Physical Therapy, occupational therapy, orthotics, alternative therapies (e.g., acupuncture)
 - Providers should consider the development of an internal chart or guidance document for prescribers, such as the flow chart available on page 3 of this document.
- *Non-Opiate Directives* may also be used for individuals with active substance use disorder or for those in recovery. The voluntary non-opiate directive form indicates to all providers that an individual should not be administered or offered a prescription or medication order for an opioid. Patients can revoke the non-opiate directive form for any reason through written or oral means. Additional information will be provided on or after December 1, 2016 from the Department of Public Health in regarding the development of a standard form, including the form as part of the clinical operations, legal concerns (including dealing with guardians and health care proxies as well as compliance with state and federal confidentiality laws), and exemptions for emergency medical services personnel.

3. *Limit prescription opioids as medically appropriate following state standards.*

Treatment and prescribing guidelines should be developed with the distinct goal of limiting and lowering dosage and supplies of prescription opioids circulating among patient populations whenever possible, and of adhering to prescribing practices that are within the best interest of patient and public safety.

Prescription Opioids: following current state law, all prescribers who issue a prescription for an opioid or opiate within a schedule II through VI, **must** consider the following as part of their prescribing practice.

- ***For an adult age 18 or over, first-time opioid prescriptions must be limited to a seven day supply***, unless one of the following exceptions outlined below apply. This should apply to each new/first-time prescription for each new condition or treatment.
- ***For minors under the age of 18, every prescription opioid must be limited to a seven day supply***, unless one of the following exceptions outlined below apply. This applies to all prescriptions regardless of how often the child is treated for a specific condition or treatment.
- ***Please note, that prescription opioids issued from the Emergency Department should be limited to a five day supply***. The Massachusetts Hospital Association and the Massachusetts College of Emergency Physicians continue to support and encourage all ED clinicians to limit prescription opioids to no more than five (5) days pursuant to the MHA SUDPTTF Guidelines for ED Opioid Management that were issued in 2015. For more details, please go to the [MHA Substance Use Disorder Prevention and Treatment Task Force Website](#)

Exceptions to the seven day Prescription Limit:

- The seven day limit would not apply to any prescription opioid that is provided to a patient who is currently being treated for a substance use disorder or opioid dependence (e.g., methadone, buprenorphine/naloxone products, or other such medications used to address withdrawal symptoms as determined by the treating clinician). However, providers should document in the medical record each and every time an outpatient opiate prescription is provided to a patient for such treatments to demonstrate (if audited) that the prescription qualifies for this overall exception to the prescribing limits. (For example, note: “This prescription is for the purpose of substance use disorder or opioid dependence treatment”)
- Prescriber may issue a prescription to an adult or minor for more than seven days, provided that they document in the medical record the information listed below. While this information does not have to be documented on the prescription, it is recommended to prevent unnecessary questions or confusion between pharmacy and prescriber. The patient’s medical record **must** include the following:
 - For an adult:
 1. Document that the prescription is for either: (1) an acute medical condition (as determined by the treating clinician pursuant to his or her medical judgment), (2) chronic pain management, (3) pain associated with a cancer diagnosis, or (4) palliative care; and
 2. Provide a brief description of the actual condition or treatment that necessitates more than seven days; and
 3. Indicate that there are no known or available non-opioid alternatives appropriate to address the patient’s specific medical condition.
 - For a minor (under age of 18):
 1. Document that the prescription is for either: (1) an acute medical condition, (2) chronic pain management, (3) pain associated with a cancer diagnoses, or (4) palliative care; and
 2. Provide a brief description of the actual condition or treatment that necessitates more than seven days; and
 3. Indicate that there are no known or available non-opioid alternatives appropriate to address the patient’s specific medical condition; and
 4. Document that there was a discussion with the parent/guardian of the known risks with the specific prescription and why it is necessary for that condition/treatment (which may occur before or after the prescription was issued).

Other Prescriptive Practice Requirements:

- **Extended-release long-acting opioid** prescriptions should be used only when medically necessary and with documented diagnosis related to chronic pain, cancer, or palliative care. If an extended-release long-acting opioid is prescribed for the first time, providers *must* conduct the following services, and while not required to, should document in the patient’s medical record the occurrence and findings of the services below:
 - Evaluation of the patients current condition, risk factors for substance misuse or abuse, history of substance abuse, and current medication usage; and
 - Discussion with the patient, documented in their medical record, that the prescribed medication is an appropriate course of treatment based on the medical need of the patient.
 - Please note that if the extended-release long-acting opioid is prescribed during the course of long-term pain management, the prescriber *must* enter into a written pain management treatment agreement that are filed in the patient’s medical record or included in the patient’s electronic health record and include the following:
 - Benefits of prescription, and
 - Risk factors for misuse or abuse
- Prior to issuing any **Schedule II prescription opioids**, prescribers *must*:
 - Include a note on the prescription that it may be filled at a lower amount (partial-fill) than prescribed. Please note that we recommended that providers also inform the patient that if they choose to partially fill their prescription, the remaining prescription will be void and the patient will need to make a subsequent appointment with the provider to obtain further prescription opioids,
 - have the following discussions with their patients:
 - Any known risks associated with the specific opioid prescription, and
 - The amount to be prescribed and the option to fill the prescription in a lesser amount
 - Prescribers *must* use the PMP (prescriptions monitoring program) prior to issuing a narcotic drug that is contained in schedule II or III.
 - While not required, it is recommended that prescribers document these discussions in the patient’s medical record.
- Prescribers should be aware that opioid selection, initial dosing, and titration should be individualized according to patients’ health status, previous exposure to opioids, attainment of therapeutic goals, and predicted or observed harms
- Subsequent prescriptions should also be for limited day supplies and minimal refills to allow for continued monitoring to ensure that potential therapeutic benefits outweigh any potential harm of continued use. There is limited evidence to the effectiveness of long term or chronic opioid analgesic treatment in significant pain relief and improvement in function. In fact, long term opioid use increases the risk of tolerance and the need to continuously increase dosage.

4. Provide continuous education through the treatment continuum including prior to prescribing and during active treatment

For patients where the therapeutic benefits outweigh or are likely to outweigh potential harms of prescription opioids for pain management, the following should be included into practice by each prescriber:

Prior to prescribing, providers should educate and discuss with patients so they fully understand risks and set realistic goals and expectations. Discussions should include the patient’s view about opioids which can help formulate appropriate treatment plans and set appropriate expectations.

- **Minimize Side Effects**
 - Educate on potential side effects and risks associated with chosen treatment.
 - Educate on the general risks associated with treatment using prescription opioids, as outlined in the MHA SUDPTTF template “Patient Fact Sheet - Prescription Opioid Risks and Treatment Resources” (*see Appendix 2*)
- **Goals & Expectations**

- Pain Reduction:
 - Total pain relief is rare
 - Goal is to take the “edge off” and reduce pain 20-30%
 - Expect a 2-3 point reduction on a 10 point pain scale where “10” is the worst pain imaginable.
- Improve function
 - Ultimate goal to improve quality of life (QOL)
 - Degree of pain that interferes with QOL is person dependent
 - Measure improvement with a QOL scale

Patient Treatment Agreement Plans for extended-release long-acting opioids: Patient treatment agreement plans are required in the event that a practitioner recommends that an extended-release long-acting opioid be used during the course of **long term pain management**. Treatment plans should address the benefits and risk factors for misuse and should be included in the patient’s medical record or electronic health file.

Patient Treatment Agreement Plans for all other opioids: Treatment plans can ensure both patient and provider are in agreement on treatment plan as well as the management of the plan during the course of treatment. If the prescribing provider and the treating provider are different, there should be discussion between the providers as to who would be the most appropriate provider to manage this aspect of the patients care and sign the management agreement with the patient. Treatment plans should include:

- Expected and realistic benefits of treatment
- Guidelines for safe and appropriate use
- Monitoring practices for treatment progress including risk screenings as appropriate
- Ongoing/Random Urine Drug Screening
- Benchmarks to stop treatment, tapering procedure, and plan to approach withdrawal symptoms

After prescribing has occurred, providers have a responsibility for ensuring patients are provided the necessary information to help make the best health care decisions during the course of their treatment. Provider driven education should include:

- Option to pick up a partial fill at the pharmacy for Schedule II prescription opioids. Patients should be notified that the remainder of a partial fill prescription will be voided and the patient should contact their provider if they need additional medication.
- The quantity, proper dosage, and usage of the medication.
- Proper Storage and Disposal Information as outlined in the template “Storage & Disposal Fact Sheet”
- Treatment and substance use services available:
 - Information and Referrals for Substance Abuse Services: 1-800-327-5050 TTY: 800-439-2370 or online at Massachusetts Substance Abuse Information and Education Helpline <http://helpline-online.com/>
 - The Massachusetts Behavioral Health Partnership operates the Massachusetts Behavioral Health Access (MABHA) website (www.mabhaccess.com) which provides a statewide resource of substance use services available to the general public. The MABHA website provides information on capacity for 24 hour levels of care, diversionary services, as well as emergency service programs. The website also provides the insurance carriers that providers/facilities will accept.

5. Consider options for pain management treatment follow up and best practices for ending prescription opioid treatment that are in the best interest of the health and wellbeing of patient populations.

Providers should schedule follow up appointments in accordance with the treatment plan agreement between provider and patient. Follow up should include an evaluation of the patient's health status, the patient's treatment plan, any new medications or medical services received, and any adverse side effects experienced by the patient. In addition, provider should follow provisions detailed in the patient agreement associated with drug testing.

Providers should consider terminating treatment plans if:

- Patient is not showing progress towards treatment goals
- Therapeutic benefits no longer outweigh the risks
- Person is presenting with active substance use
- Suspected misuse or handling of prescription opioids

If the decision to terminate treatment is made, the provider should determine whether appropriate care includes opioid agonist therapy, tapering, or discontinuation of opioid therapy as appropriate for the patient. A person who develops (or is suspected of) substance use disorder should be referred for substance use disorder treatment. .

For patients at low risk, not presenting with active substance use, and not suffering from adverse reactions to opioid medication, prescribers should discuss tapering options. These discussions should include the appropriate setting and time frame based on patient specific factors including but not limited to risk of withdrawal, duration of opioid therapy, medical and psychological comorbidities, and the clinical need for rapid taper.

Regardless of the reason for stopping treatment, providers are responsible for continuing to assist their patient in the tapering process, withdrawal process, or connecting their patient to substance use treatment and resources when appropriate.

Continuing to follow patients or oversee their care means not denying them the medically necessary treatments for their pain, substance misuse, or substance use disorder. If internal services are not available, providers can use resources listed with the Massachusetts Substance Abuse Information and Education Helpline at <http://helpline-online.com/> to assist patients in finding necessary programs.

6. Develop a comprehensive pain stewardship program to ensure proper internal controls to appropriately manage patient populations

Hospitals should work with their medical staff to implement a comprehensive pain stewardship program to ensure proper internal controls are in place to best provide pain stewardship services to patient populations. MHA will be working with members to develop best practices which will be released at a later date. In general, the program components should include a multi-disciplinary pain committee to oversee all aspects of program development within the hospital to accomplish the following:

- Suggest opioid prescribing parameters based on evidence-based guidelines consistent with new federal and state regulations
- Utilization of multimodal analgesia as a foundation for acute pain management
- Ensure components of the program are modified to accommodate specific patient populations; (i.e. Surgical, Obstetrics, Geriatrics, acute injury)
- Implement educational initiatives for executive senior leadership, providers, ancillary clinicians, and patients around redesigned approach to acute and chronic pain management
- Utilize elements of the tool kit which include; web based initiatives, educational pain brochures, mini-presentations for specific audiences (i.e. nurses, pharmacists, providers)
- Track compliance with recommendations of Comprehensive Pain Stewardship Program to ensure adoption of a standardized approach among providers

Hospital Organizational Guidance/Recommendations

In addition to working with clinical staff to ensure that prescribers are following common standards for treating patients using prescription opioids, hospitals should also consider the development of standardized patient educational materials as well as internal policies to monitor use and disposal of prescription opioids by hospital staff.

- 1. *Provide patients with standard patient fact sheets that outline the risks associated with the use of prescription opioids as well as guidance on storage and disposal.***
 - The patient fact sheet “Prescription Opioid Risks and Treatment Resources” was developed and endorsed by the Massachusetts Hospital Association and the Massachusetts Medical Society to provide a general template, based on national and local resources, to ensure providers are communicating risks in a consistent manner. This fact sheet will be updated based on guidance that may be issued from regulatory agencies (*see Appendix 2*)
 - The “Recommendations for Medication Storage” and “Local Disposal Options for Prescription Medications” were also developed as common templates that use national and local guidance on easy to read one page documents on how to safely store prescriptions as well as locations in local communities to dispose of unused prescriptions that have a high risk of misuse. (*see Appendix 3*)

- 2. *Implementing a Standing Order Prescription for Naloxone***
 - The “Implementing a standing order prescription for Naloxone” guidance document was developed to provide a short form that outlines the key requirements and provider education resources for outpatient pharmacies that are looking to adopt a Naloxone standing order. (*see Appendix 4*)

- 3. *Implement internal processes to monitor for appropriate opioid prescribing based on clinical and departmental best practice standards.***
 - Consider the development of an internal analytical report that monitors and alerts certain internal staff if a prescriber is routinely issuing prescription opioids with a high risk of misuse beyond seven days. Report should be analyzed for appropriateness based on patient condition/diagnosis, department specific best practices, and used to implement training and educational action plans for necessary staff.
 - As an alternative, hospitals should consider using state available data through the PMP to determine if there are prescribers who are inappropriately prescribing opioids. Pursuant to state law, on or after March 2017, the Department of Public Health is required to issue reports to individual prescribers that analyzes if the quantity and volume of their schedule II and schedule III opioid prescriptions are an outlier from similar providers in the same specialty. MHA will be working with members to determine an appropriate process for facilities to request copies of this report from each provider, and, should the individual provider receive such a report, to determine if further education should occur with those providers.

- 4. *Develop internal policies to reduce the potential for opioid diversion within the hospital setting by providers and other employees***
 - Hospitals should create a multidisciplinary diversion oversight committee (Controlled Substance Diversion Prevention Committee) responsible for reviewing root causes of diversion incidences, preventative solutions, existing internal policies and procedures for both efficacy and compliance, and ensuring proper alignment of necessary resources to oversee diversion preventatives initiatives.
 - Broad-based educational efforts must be instituted that focus on the nature and scope of the problem, signs and symptoms of possible diversion and substance use disorder, and proper ways to respond if diversion is suspected. This effort should include the following discussion/education with all staff that have access to prescriptions with a high risk of misuse:
 - The entire workforce with ready access to controlled substances should be informed of the threats to life and career presented by drug diversion.

- Employees should be made aware that procedures are in place to facilitate detection, with the objective of preventing patient harm, diversion-related addictive illness, and drug-related deaths.
- Employees also should be taught how to access available resources if they suspect diversion is occurring.
- Hospitals should update internal procedures on appropriate chain of custody for prescription opioids from ordering and receipt, to administration, waste and disposal including the use and documentation of witness accounts of disposal and waste.
- The hospital should maintain records in accordance with law and regulations, licensure and professional standards of practice. This includes surveillance system reporting from automated dispensing systems or vaults as well as hard copy records when automated systems are not in use.
 - Records of usage are appropriately reviewed, maintained and discrepancies are resolved within the hospitals defined time.
 - Procedures should be in place defining the resolution process and what happens when the discrepancy cannot be reconciled.
- Hospitals have policies and procedures in place on reporting incidents of diversion or loss of controlled substances that are in accordance with the following state and federal requirements:
 - **DEA** - <https://www.deadiversion.usdoj.gov/webforms/dtlLogin.jsp>
 - **DPH** - <http://www.mass.gov/eohhs/docs/dph/quality/drugcontrol/drug-incident-report-form.pdf>
 - **MA Board of Registration in Pharmacy** - <http://www.mass.gov/eohhs/docs/dph/quality/boards/pharmacy/borp-report-loss-controlled-substance.pdf>

Please note that there are several best practices and sample policies that are currently in development by national organizations and MHA is committed to developing a forum for hospitals to review and discuss ways that members can uniformly adopt such policies and practices once they are issued.

5. *Develop capacity for screening, treating and referring patients with substance use disorders for evidence-based addiction care.*

- To ensure appropriate referrals and improved communication/sharing of information following acute-level care to a post-acute or primary care provider hospitals should, at a minimum, work with medical staff and case management to ensure that the patient is adequately prepared for a safe transition from an acute care hospital to follow up care for substance use disorder treatment. The key information that all staff should ensure are included with the patient discharge/transfer documentation includes:
 - For patients transferred from the ED directly to inpatient or community based substance use disorder treatment service:
 - Discharge Summary – including past medical and psychiatric diagnosis, presenting issue, physical examination findings and diagnosis within the ED;
 - Reconciled medication list (include last doses for all meds);
 - Copy of most recent labs as well as pending lab and test results; and
 - Copy of recent radiology, imaging, or other diagnostic services (i.e. MRI, EKG).
 - For patients transferred from the Acute Medical Service to an inpatient or community based substance use disorder treatment service:
 - All of above PLUS 72 hour medication administration record;
 - Discharge medication reconciliation;
 - Blood glucose over the past 72 hours if diabetic;
 - Specialist consultant notes; and
 - List of aftercare or other follow up appointments (date/time/clinician/phone number).

6. Hospitals should ensure providers are aware of and in compliance with new pain management education requirements as part of their licensing, credentialing, or renewal process.

- Following the guidance and instructions from the Board of Registration in Medicine, practitioners applying to renew their license or obtain a new license must complete at least three credits of education and training in pain management and opioid education. This applies to all practitioners who prescribe controlled substances (schedule I through VI).
- The pain management training required in M.G.L. c. 94C, § 18(e) includes the following elements:
 - Effective pain management
 - Identification of patients at risk for substance use disorders
 - Counseling patients about the side effects, addictive nature and proper storage and disposal of prescription medications
 - The risks of abuse and addiction associated with opioid medication
 - Appropriate quantities for prescription medications that have an increased risk of abuse; and
 - Opioid antagonists, overdose prevention treatments and instances in which a patient may be advised on both the use of and ways to access opioid antagonists and overdose prevention treatments.
- Local courses that would qualify under the M.G.L. c. 94C, § 18(e) criteria include: (1) “[Managing Pain Without Overusing Opioids](#)”, (2) “[Evaluating and Treating Pain: Principles and Practice of Pain Medicine 2016](#)”, (3) “[Extended-Release and Long- Acting Opioids, Assessing Risk, Safe Prescribing](#)”, (4) “[The Safe and Competent Opioid Prescribing Education \(Scope of Pain\) Program](#)”.
- Courses/Classes and resources for CME credits can be found by visiting:
 - Massachusetts Medical Society [Courses on Pain Management](#) or [Prescriber Education](#)
 - Bureau of Substance Abuse Services (BSAS) Sponsored [Training & Continuing Education](#)
 - American Society of Addiction Medicine [Educational Resources](#)
 - [Providers Clinical Support System for Opioid Therapies: treatment of pain \(www.pcass-o.org\) or opioid use disorder \(www.pcassmat.org\)](#)

7. Work with appropriate residency and fellowship programs to adopt these Core Opioid Prescribing Competency Requirements to train prescribers

- MHA, joined by the Massachusetts Medical Society, the Conference of Boston Teaching Hospitals, and the Department of Public Health, strongly recommends the adoption of opioid prescribing core competencies as a critical framework in which any prescribing practice occurs. While all prescribers should be aware of and be provided with resources to ensure adoption of these competencies as part of their practice, appropriate residency and fellowship programs should specifically ensure the following standards are part of any training program:
 - Adopt the attached “Core Opioid Prescribing Competencies” that have been *endorsed by all Massachusetts Medical, Dental, Physician Assistant and Advance Practice Registered Nurse professional societies and schools. (see Appendix 5)*
 - Require each resident/fellow, within applicable programs, to complete (prior to completion of the residency/fellowship program) a medical education course on substance use disorder and pain management consistent with the themes identified in M.G.L. c. 94C, § 18(e) criteria: (1) “[Managing Pain Without Overusing Opioids](#)”, (2) “[Evaluating and Treating Pain: Principles and Practice of Pain Medicine 2016](#)”, (3) “[Extended-Release and Long- Acting Opioids, Assessing Risk, Safe Prescribing](#)”, (4) “[The Safe and Competent Opioid Prescribing Education \(Scope of Pain\) Program](#)”. Additional pain management training courses are available online at MMS [Courses on Pain Management](#) or [Prescriber Education](#). Future additional courses may be available at a later date that meet the theme identified in this guidance and within M.G.L. c. 94C, § 18(e).
 - Hold at least one **annual** resident/fellow meeting or training (as part of orientation, grand rounds, computer based training, or other appropriate delivery method) discussing the core competencies and how to adopt them as part of their practice.

8. *Hospitals should determine the ability and capacity for increasing the number of prescribers with DEA-X license:*

- Hospitals should use existing resources such as credentialing offices and pharmacy records to identify DEA X-licensed providers, those actively prescribing buprenorphine, and adherence to prescribing panel sizes. This information should be used to analyze the need for additional providers, including incentives that may be used to encourage participation in or expanding existing prescriber's panels. This includes the following:
 - Create internal consulting process for learning opportunities among both new and experienced staff
 - Identify external training opportunities to increase knowledge and skills for medication assisted treatments
 - Consider using residency programs to increase the number of providers with DEA-X licenses and as a systematic way to provide supportive training for buprenorphine prescribing.
- Patients with opioid use disorders often have a range of unmet psychosocial needs. Therefore, to support the use of medication-assisted treatment for hospitalized patients, hospitals should develop multi-disciplinary treatment programs that use pharmacy, nursing, social work, and/or case management services to facilitate the smooth transition of patients to the community. Hospitals should establish functional referral relationships with community agencies and providers that offer medication-assisted treatments and other specialty services.

Appendix 1: Physician/Prescriber Reminders when Prescribing Opioids

Before Prescribing Opioids, Remember to:

1. CHECK the PMP *
2. Determine goals of using prescription opioids.
3. DO a Risk Assessment. If the patient is at risk for misuse or substance use disorder, make a plan to address and/or mitigate risks. Be sure benefits of opioid therapy outweigh potential risks.
4. Prescribe for NO longer than seven days for any first-time prescription unless an exception applies. Within the Emergency Department prescribe for no longer than 5 days. Any exceptions must be documented in the medical record. * Prescribe the lowest dose for the least number of days.
5. EXPLAIN the expected benefits, side effects, risks and important safety measures to patients (and caregiver if necessary). *
6. DISCUSS the amount prescribed, appropriate dosing, and the option to fill a lesser amount. *
7. DOCUMENT in the Medical Record: Goals, exceptions and reasons, patient education and treatment plan. *
8. Special precautions should be taken when prescribing long term opioid therapy. Check the Opioid Prescribing Guidelines adopted by the Massachusetts Board of Registration in Medicine. Some considerations:
 - Consult with a pain specialist as deemed clinically appropriate by the treating prescriber
 - Prescribers must enter into a pain management agreement with patients when prescribing extended-release long acting opioids in non-abuse deterrent form.*
 - Prescribers should consider entering into a pain management agreement for patients who are being prescribed opioids for long term pain management, as the treating provider determines to be clinically appropriate
 - Consider co-prescribing Naloxone for patients on long-term opioid therapy.
9. PLAN follow-up

* Required by MA State Law

Approved by and jointly issued by the Massachusetts Medical Society and the Massachusetts Hospital Association

Appendix 2: Prescription Opioid Risks and Treatment Resources

You have been prescribed an opioid as part of your pain treatment, which may be used following injury, surgery, or arising from other health conditions. All patients taking opioids are at risk for unintentional **overdose, addiction, or death**. Therefore, you should discuss with your prescriber all treatment options available to you.

Common side effects of opioids include:

- Constipation
- Breathing problems
- Low Sex Drive, Energy, and Strength
- Sleepiness/drowsiness
- Confusion
- Nausea

Opioids are powerful painkillers, and if misused can have serious side effects including addiction. Your risk increases if:

- You are also **taking other drugs** like antihistamines, barbiturates, or antidepressant/anxiety medications (e.g., Benzodiazepines)
- You **consume alcohol** while taking opioids
- You or a family member have a **history of substance use disorder** or overdose
- You have a **mental health condition**, such as depression or anxiety
- You have **sleep apnea**
- You take **more than** the recommended prescribed amount

Know your options

- Read all instructions for your medication, take your medication exactly as prescribed, do not adjust your doses, and keep track of when you take your medication.
- If you have any questions about your medication ask your prescriber or pharmacist, including information about possible side effects as well as options for seeking a partial fill of the prescription. If you decide to partially fill your prescription opioid, you will need to contact your prescriber if additional medication is needed.
- Talk to your prescriber about non-opioid treatment options or if you don't want to be treated with opioids.
- Ask your prescriber about having an antidote (e.g., Naloxone) in case of an accidental overdose.

Protecting family, friends, and others

Storage: Medications should be kept in a **locked cabinet or box** when not in use. Medications should be placed in a location hard for children and pets to reach

Disposal: For the safety of others and the environment, patients are encouraged to take advantage of **drug take-back programs and safe drop sites**, which are available on the Massachusetts Prescription Dropbox Location website.¹ When these programs are not accessible, other secondary methods including flushing the medication down the toilet should be considered

Addiction Resources:

Be aware of the signs of addiction, which include uncontrollable cravings and inability to control opioid use even though it is having negative effects on personal relationships or finances. If you suspect or are concerned about addiction, the following resources may help:

- **For Youth, Young Adults (up to age 24), and Pregnant Women:** Massachusetts Central Intake & Care Coordination: 1-866-705-2807 or 617-661-3991
- **For all Massachusetts residents:** Information and Referrals for Substance Abuse Services: 1-800-327-5050 TTY: 800-439-2370 or online at www.helpline-online.com

¹ <http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/prevention/prescription-dropbox-locations.html>

Appendix 3: Recommendations for Medication Storage

Medications can be an important part of any treatment but also come with serious risks. Prescription opioids in particular are used to treat moderate or severe pain following injury, surgery, or for other health conditions. To avoid accidental or illegal use of prescriptions by others, it is critical that you properly store medication in areas least likely to be found or accessible by children, family members, and guests

Commonly Abused Prescription Medications:

- **Pain Medications** prescribed for people with serious, long-term pain, and sometimes short term pain: Vicodin®, OxyContin®, Percocet®, and codeine
- **Stimulants** used to treat attention deficit hyperactivity disorder (ADHD), or other disorders: Ritalin®, Concerta®, Adderall®, Dexedrine®, and Meridia®
- **Sedatives, Tranquilizers, and Barbituates** prescribed to treat stress, anxiety, panic attack, insomnia and seizures: Valium®, Xanax®, Ativan®, Klonopin®, Ambien®, Lunesta®

Keeping others Safe:

It is important to store your medication in a place that is not likely to be found by children, family members, and guests.

- Keep your prescriptions in a secure location to make sure kids, family, and guests don't have access to them, preferably in a locked box which you can purchase at your local pharmacy.
- Know where your prescription medications are at all times.
- Keep prescription medications in the original bottle with the label attached and the child-resistant cap secured.
- Keep track of how many prescription pain pills are in your bottle so you are immediately aware if any are missing.

Additional Best Practices for Proper Storage:

- Don't leave the cotton plug in a medicine bottle.
- Check the expiration date each time you take a drug.
- Never use a medication that has changed color, texture, or odor, even if it has not expired. Safely dispose of capsules or tablets that stick together, are harder or softer than normal, or are cracked or chipped.
- Ask your pharmacist about any specific storage instructions for your medications.

Why this information is important:

According to recent statistics, approximately 71% of obtained prescription drugs are gifted, purchased, or stolen from friends and relatives. In fact, survey results from 2010-2011 suggest that 6.1 million people have used prescription drugs for non-medical purposes in a given month. Proper storage and keeping commonly abused medications out of reach of children, family members, and guests can prevent others from illegally or accidentally taking your medications and prevent harmful risks such as overdose or death.

Local Disposal Options for Prescription Medications

Medications used to treat pain, ADHD, Seizures, Anxiety, and sleep disorders are just some of the medications that are dangerous if taken accidentally or illegally. These medications should be disposed of in a way that makes it difficult for other people to take them. There are various ways to simply and safely dispose of drugs through programs available in many communities.

Commonly Available Disposal Programs in Massachusetts: You should discuss with your pharmacist or your provider, the programs available to you through any of these programs listed below.

- **Drug Take-Back Programs: Drug take-back programs approved by federal and state agencies are free.** Take-back programs can be found at many drug treatment programs, retail pharmacies, or hospitals/clinics. There are two ways to find a location near you:
 - The federal Drug Enforcement Agency has several drug disposal locations that are available on its website (<https://www.deadiversion.usdoj.gov/pubdispsearch/spring/main?execution=e2s1>);
 - Within Massachusetts, there are several safe and secure locations within community pharmacies or local law enforcement, and are available at: <http://www.productstewardship.us/page/1051>
- **Prescription Dropbox Locations:** Many local communities also have drop box locations where people can dispose of unwanted, expired, or unused medications in a safe and secure manner. To find a location close to you, please visit <http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/prevention/prescription-dropbox-locations.html>.
- **Mail Back Programs:** Patients can use a prepaid and preaddressed packaging to mail back unused medications to be properly and safely destroyed. Please talk to your pharmacist if there is an available program for your prescription.

Disposal Options within the Hospital: This hospital also provides a safe and secure location for disposing of unused and unwanted medications. For more information, please talk to your treating provider or the department you are visiting for details on the location within the hospital:

- Locations at this hospital can be found at **(insert hospital specific locations, hours, etc.)**

Other Methods: Many people may not be able to use one of the programs listed above because of mobility, inability to leave the house, or if a program is not available in their community. In these circumstances, providers should educate patients/consumers about possible secondary disposal methods, which include:

1. Disposing medications on the following list provided by the FDA, down the sink or toilet* : http://www.fda.gov/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/EnsuringSafeUseofMedicine/SafeDisposalofMedicines/ucm186187.htm#Flush_List
2. A patient/consumer can also dispose of the unused medication in the trash by covering the medication in an undesirable substance such as kitty litter or coffee grinds, and using an unmarked, sealed container that is neither colorless/clear nor opaque.*

*Please note - Flushing or disposing medications in the trash may negatively affect our environment and our water systems. The best way to dispose of drugs is through take-back programs, mail-back programs, and disposing of medication at dedicated drop off sites in the community. When these programs are not available or accessible by the patient, other secondary methods including flushing the medication down the toilet should be considered.

Appendix 4: Implementing a Standing Order Prescription for Naloxone

Importance of Standing Order prescriptions for Naloxone Rescue Kits

Naloxone and other opioid antagonist medications reverse the effects of an opioid overdose, providing time for emergency responders to arrive. When coupled with education on how to recognize and intervene in cases of overdose, community members with medications such as naloxone rescue kits have helped prevent many deaths. Therefore hospitals are encouraged to coordinate with appropriate staff to provide a Naloxone standing order within the hospital's outpatient pharmacy, if available.

Who are these for?

Naloxone or other opioid antagonist medications should be dispensed to anyone who the treating clinician has determined is at risk of an opioid related overdose, a family member or friend of an at-risk person, or any person who may be in a position to assist an at-risk person in the event of an overdose.

Recommended practices for a Naloxone standing order policy within hospitals:

The goal is to enable a pharmacist to dispense Naloxone or other FDA-approved opioid antagonist medications without the need for an individual prescription for every order filled. The Department of Public Health has outlined the following criteria that must be followed for developing a Naloxone Standing Order Policy:

- **Identify a licensed and actively practicing prescriber** to agree to write the standing order to be provided to and securely kept at the hospital pharmacy.
- **Ensure completion of pharmacy participation requirements**
 - The standing order must be signed by a prescriber licensed in Massachusetts and kept on pharmacy premises, and must be renewed and updated annually
 - Standing order must be submitted to Board of Registration in Pharmacy via email naloxonestandingorders@MassMail.State.MA.US
 - Pharmacist must complete a commissioner-approved training program; this is available at this [Prescribe to Prevent Website](#).
 - The pharmacist should have knowledge of and should provide a copy of this [Naloxone information Pamphlet](#) with each Naloxone rescue kits. Full details on all requirements that a pharmacist and prescriber should follow are available at this DPH approved [MassTAPP Website](#)
 - Naloxone rescue kits must be labeled and include expiration date
- **Ensure patient/consumer education.** Pharmacists are strongly encouraged to counsel the patient/consumer at the point of sale to ensure successful use of Naloxone and to best prepare any person who may need to administer Naloxone. This may include providing information from the second page of the Naloxone Information Pamphlet or following other resources available from this [DPH Naloxone Access Website](#)
- **Pharmacies with Existing Naloxone Standing Orders:** Please note that there are several pharmacies in Massachusetts that have existing standing orders on file and providers may want to refer patients to these locations: [Pharmacies with standing orders](#)

Additional Information/Resources

- The Department of Public Health has provided several resources to assist with setting up a standing order, which are available at the bottom of this [MassTAPP Website](#).
- [Get Naloxone Now](#) is an online resource to train people to respond effectively to an opioid-associated overdose emergency.
- www.prescribetoprevent.org is a website for providers with general information about naloxone dispensing.

APPENDIX 5: CORE COMPETENCIES FOR THE EVALUATION, SCREENING, AND TREATMENT OF OPIOID PRESCRIPTION DRUG USE AND MISUSE

The following cross-institutional core competencies are framed from the perspective of an encounter with a patient who typically presents with pain and/or other medical symptoms for which a prescription opioid may be indicated. The goal of the stated core competencies is to ensure sound opioid prescribing by all prescribers regardless of level of training or education. The following competencies are not intended to be wholly exclusive but should be applied broadly to direct care specialties who may prescribe opioid medications to enhance a resident's ability to prevent prescription opioid drug misuse.

Preventing Prescription Drug Misuse: *Through Appropriate Screening, Evaluation, and Prevention*

1. Evaluate a patient's pain using age, gender, and culturally appropriate evidence-based methodologies.
2. Evaluate a patient's risk for substance use disorders by using age, gender, and culturally appropriate evidence-based communication skills and assessment methodologies, supplemented with relevant available patient information, including but not limited to health records, family history, prescription dispensing records (e.g. the Prescription Drug Monitoring Program or "PMP"), drug urine screenings, and screenings for commonly co-occurring psychiatric disorders (especially depression, anxiety disorders, and PTSD) and suicide risk screenings.
3. Identify and describe potential pharmacological and non-pharmacological treatment options including opioid and non-opioid pharmacological treatments (including the use of a non-opioid directive for all current and future treatment options) for acute and chronic pain management, along with patient communication and education regarding the risks and benefits associated with each of these available treatment options.
4. If non opioid alternatives are not appropriate as the sole treatment option and schedule II narcotics are clinically warranted, discuss the options of requesting a partial fill with the patient.

Treating Patients At-Risk for Substance Use Disorders: *Engage Patients in Safe, Informed, and Patient-Centered Treatment Planning*

5. Describe evidence based treatment options, including medication-assisted treatment, and demonstrate the ability to appropriately refer patients to addiction medicine specialists and treatment programs for both relapse prevention and co-occurring psychiatric disorders.
6. Prepare evidence-based and patient-centered pain management and substance use disorder treatment plans for patients with acute and chronic pain with special attention to safe prescribing and recognizing patients displaying signs of aberrant prescription use behaviors.
7. Demonstrate the foundational skills in patient-centered counselling and behavior change in the context of a patient encounter, consistent with evidence-based techniques.
8. Offer strategies to optimize safety such as designated driving, overdose prevention, and needle syringe access for people who use substances.
9. Utilize appropriate internal resources, coordinating appropriate treatment referral and discharge planning based on the individual patient need.

Managing Substance Use Disorders as a Chronic Disease: *Eliminate Stigma and Build Awareness of Social Determinants*

10. Recognize the risk factors for, and signs of, opioid and polysubstance overdose, intoxication, and withdrawal, refer the patient for an appropriate substance abuse evaluation, and educate patient and social networks in overdose prevention and the availability and correct use of naloxone rescue.
11. Recognize substance use disorders as a chronic disease by effectively applying a chronic disease model in the ongoing assessment and management of the patient.
12. Recognize their own and societal stigmatization and biases against individuals with substance use disorders and associated evidence-based medication-assisted treatment.
13. Identify and incorporate relevant data regarding social determinants of health into treatment planning for substance use disorders.