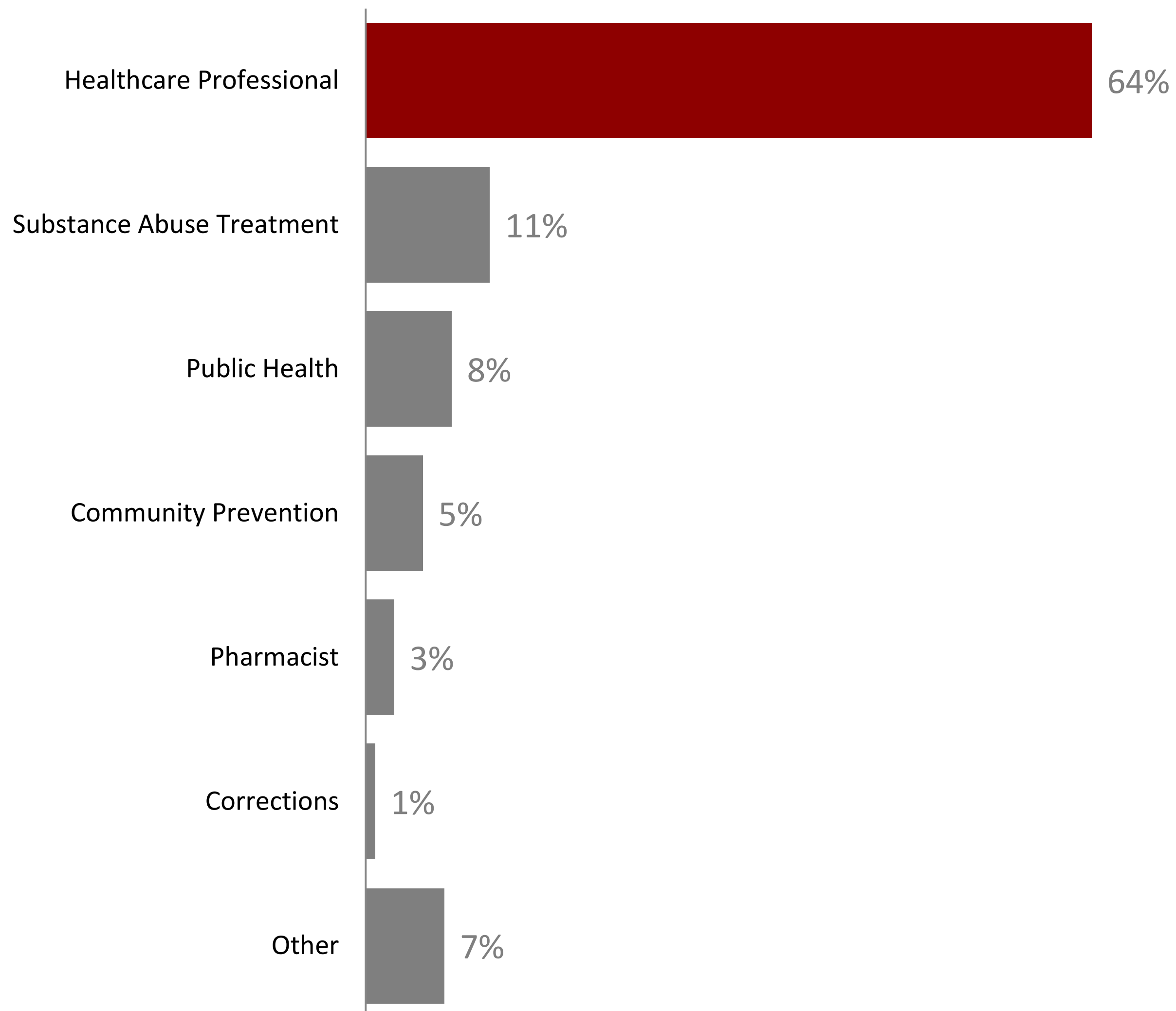
Feedback: Opioid Legislative Recommendations Brief

From November 21, 2017 through December 1, 2017, partners, stakeholders, and Goal Council 3 subgroup members were invited to provide feedback on the preliminary ideas in the Arizona Opioid Action Plan proposed to enact legislative solutions to impact the ongoing opioid emergency. A total of 118 individuals and organizations responded through the online survey.

The majority of survey respondents were healthcare professionals, including physicians, nurses, nurse practitioners and physician assistants.



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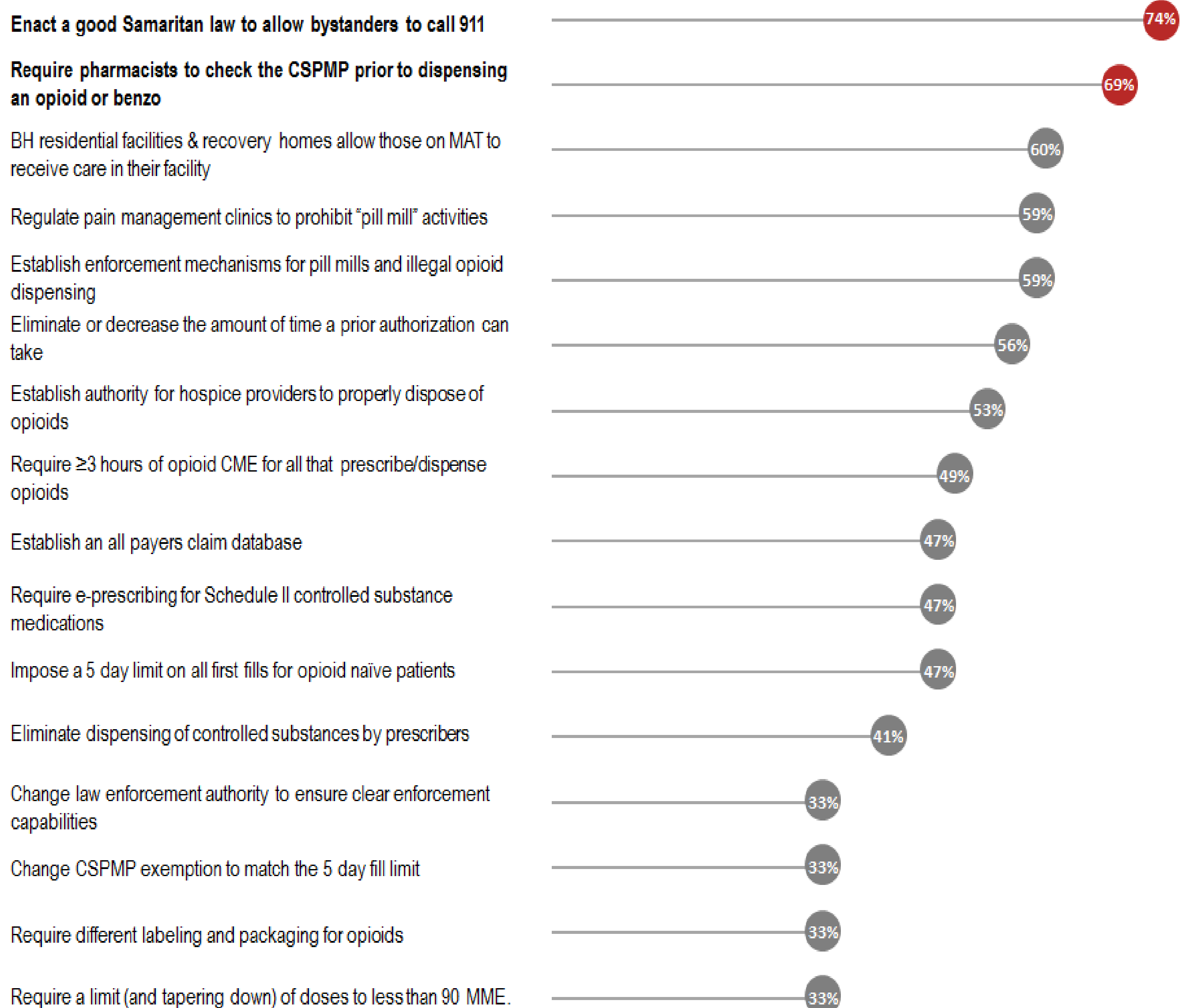
A total of 16 legislative proposals were included in the Opioid Action Plan. Respondents were asked to identify which of these proposals they viewed as being effective at addressing the opioid crisis in Arizona and what suggestions they had to improve each of the 16 proposals.

Legislative proposals respondents most frequently identified as being effective at addressing the opioid crisis were enacting a Good Samaritan law and requiring pharmacists to check the CSPMP before dispensing.



Summary of suggested improvements to legislative proposals:

Proposal	Theme	Selected Examples
Impose a 5 day limit on all first fills for opioid naïve patients for all payers	Allow exceptions to the limit for certain situations (n=15)	We ask that provision be made for appropriate, evidence based exceptions for certain surgical procedures that allow up to 7 days supply.
		We must develop a comprehensive list of exemptions for conditions and situations. Some examples include hospice and palliative care, oncology, post-surgical discharge, neonatal abstinence syndrome patients and patients with limited ability to receive follow-up care.
		Restrict this limitation to ER visits and Acute non-surgical pain (inpatient or outpatient)
		The postoperative exemption needs to be flexible enough to say five days for less painful surgery but longer more painful surgery
	General increase to the day limit (n=6)	We believe that a national standard would be better in order to not confuse part year residents. We would suggest a 7 day limit.
		The 10 day limit seems sufficient
	General decrease to the day limit (n=2)	Impose a 3 day limit
	Eliminate this requirement (n=8)	The day limit needs to be removed, you cannot create a hard and fast rule on a complex issue like pain management.
	Exceptions for access to care issues (n=3)	We want to be careful that we don't create an access to care issue for patients who have had traumas, recent surgeries or who have legitimate pain and are not able to see or contact their prescriber during office hours
Require a limit (and tapering down) of doses to less than 90 MME. (Taper down would occur over years, exemptions for specific situations would be made in statute)	Eliminate the requirement (n=17)	It is virtually impossible to specifically legislate an appropriate taper
		Determination of appropriate dosages and tapering recommendations should be left to clinicians and be based on the clinical nature of the patients condition
	Offer exceptions (n=16)	Some patients with chronic pain may need to have dosages over the 90mg of mme.
		Must make an exception for buprenorphine products. A dose of 8 mg BID is 480 MMEs.
	Taper down over years is too long (n=6)	This taper down needs to change from over years to over a set months span for instance 9-10 months.

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<tr><td></td><td>Include more provider education (n=4)</td><td>For those of us who are trying to get people weaned down sometimes it is difficult because of comfort levels with tapering schedules so possibly having some sort of guideline would be helpful to follow.</td></tr>
<tr><td rowspan="3">Require e-prescribing for Schedule II controlled substance medications</td><td rowspan="2">Expand or restrict the impacted substances (n=4)</td><td>We believe that e-prescribing should be required for all controlled substance medications</td></tr>
<tr><td>Schedule 2 drugs that are not opiates should not be included, particularly stimulants used for ADHD.</td></tr>
<tr><td>Consider exemptions for rural areas (n=4)</td><td>We are concerned about the inconsistent availability of this technology through the different vendors to all physicians, especially in rural areas.</td></tr>
<tr><td rowspan="3">Require different labeling and packaging for opioids (“red caps”)</td><td>Alternatives to red cap (n=4)</td><td>Bubble pack card; different colors for higher schedules of drugs; child proof caps; black box warning on bottle</td></tr>
<tr><td rowspan="2">Increases risk of theft/diversion (n=16)</td><td>This will allow kids and abusers to know the first thing to grab or steal from medicine cabinets or strangers.</td></tr>
<tr><td>The different color caps only alerts people who would steal, abuse, or divert medication as to which medicines they should target.</td></tr>
<tr><td rowspan="5">Eliminate dispensing of controlled substances by prescribers</td><td rowspan="2">Allow exceptions to prevent access to care issues (n=6)</td><td>We must avoid unintended consequences of prohibiting dispensing in remote rural communities, home visits to vulnerable patients, or other special circumstances where dispensing a medication is the most viable option for the patients with limited or no mobility.</td></tr>
<tr><td>Schedule 2 drugs that are not opiates should not be included, particularly stimulants used for ADHD.</td></tr>
<tr><td rowspan="3">Allow exceptions for certain procedures or class of medication (n=6)</td><td>Exceptions for schedule 3, 4 and 5</td></tr>
<tr><td>Be specific if this does not apply to Methadone.</td></tr>
<tr><td>Allow dispensing of 1 day supply out of urgent care clinics</td></tr>
<tr><td>Require pharmacists to check the CSPMP prior to dispensing an opioid or benzodiazepine</td><td>Provide clarity about pharmacists’ next steps after checking the CSPMP (n=4)</td><td>What would be their responsibility for action, if they see multiple prescriptions, or prescribing patterns that seem problematic?</td></tr>
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<tr><td rowspan="8">Require at least 3 hours of opioid-related CME for all professions that prescribe/dispense opioids</td><td rowspan="3">Increase or decrease required number of hours (n=14)</td><td>Our members request that flexibility be allowed in specifying the number of hours of mandatory CME related to Opioid education.</td></tr>
<tr><td>Perhaps consider 'tiering' specific populations that engage in opioid prescribing to longer CME requirements.</td></tr>
<tr><td>would require more than this other states require 8 hours annually</td></tr>
<tr><td rowspan="2">Include or exempt certain categories of professionals (n=6)</td><td>It is unnecessary and unfair to impose this mandate on physicians who do not have a DEA registration or have never prescribed Schedule II medications and should be exempt</td></tr>
<tr><td>This should be reserved for prescribers that are not pain fellowship trained and board certified.</td></tr>
<tr><td rowspan="2">Include specific topics in the continuing educations (n=6)</td><td>also teach alternative pain treatment.</td></tr>
<tr><td>3 hr of substance use disorder and harm reduction for CMEs not just anything to do with opioids</td></tr>
<tr><td>Consider a sunset date or review period (n=3)</td><td>We recommend a policy like this have a sunset date so its need can be reevaluated in the future and modified if necessary.</td></tr>
<tr><td>Establish an all payers claim database</td><td colspan="2">No specific improvement themes noted</td></tr>
<tr><td>Regulate pain management clinics to prohibit “pill mill” activities</td><td>Ensure clear definitions (n=6)</td><td>It is important that any criteria used to subject physicians to additional regulations is carefully designed so responsible physicians, who by virtue of the type of medicine they practice treat higher numbers of patients who suffer from pain, are not unduly and unnecessarily impacted.</td></tr>
<tr><td>Change CSPMP exemption to match the 5 day fill limit; exempt for prescriptions of 5 days or less.</td><td>Check CSMP for all prescriptions (n=5)</td><td>There should be no limit, any prescribing of controlled substances should require a check</td></tr>
<tr><td>Change law enforcement authority to ensure clear enforcement capabilities</td><td colspan="2">No specific improvement themes noted</td></tr>
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<tr><td>Establish authority for hospice providers to properly dispose of opioids to prevent diversion</td><td colspan="2">No specific improvement themes noted</td></tr>
<tr><td>Eliminate or decrease the amount of time a prior authorization can take</td><td colspan="2">No specific improvement themes noted</td></tr>
<tr><td>Establish enforcement mechanisms for pill mills and illegal opioid dispensing</td><td colspan="2">No specific improvement themes noted</td></tr>
<tr><td rowspan="3">Enact a good Samaritan law to allow bystanders to call 911 for a potential opioid overdose</td><td>Include other substances in addition to opioids (n=4)</td><td>Include all substances in this good Samaritan law not just opioids.</td></tr>
<tr><td>Allow the affected person to call 911 without fear of reprisal (n=3)</td><td>Always allow bystanders and please allow the people themselves to call 911 without fear of reprisal if they are dying.</td></tr>
<tr><td>Add syringe access (n=5)</td><td>Include a recommendation to enact a law that would decriminalize the distribution of needles for SUD persons.</td></tr>
<tr><td>Require licensed BH residential facilities and recovery homes to develop policies & procedures that allow individuals on MAT to continue to receive care in their facilities</td><td colspan="2">No specific improvement themes noted</td></tr>
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