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Substance Abuse Services Commission Report on:

LD 1501 Resolve

Prepared By: LD 1501 Workgroup

Substance Abuse Services Commission

11 State House Station
41 Anthony Avenue
Augusta, ME 04333-0011

Paul R. LePage
Governor

(207) 287-6342

Robert Long
Chair

Commission Members

Debbie Dettor
Orrington

David J. Faulkner
Portland

Patricia Hickey
Bangor

Rebecca Ireland
Gorham

Margaret Jones
Old Orchard Beach

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Freeport

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Gorham

Rep. Linda F. Sanborn
Gorham

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Chelsea

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Scarborough

Dr. Marcella Sorg
Orono

Veronica Wiegman
Leed

December 14th, 2011

Committee on Health and Human Services
100 State House Station
Room 210, Cross Office Building
Augusta, ME 04333-100

Joint Standing Committee on Health and Human Services and the Legislature

Honorable Senator Earle L. McCormick and Representative Meredith N. Strang Burgess,

The Substance Abuse Services Commission convened a work group, comprised of commission members and public and private stakeholders as directed from LD 1501 and submits the **LD1501 Workgroup Report** to the Joint Standing Committee on Health and Human Services as requested.

Through a thoughtful and collaborative process over the past four months, the LD1501 Workgroup has reached a consensus on specific recommendations related to each of the four tasks outlined in LD1501. The **LD1501 Workgroup Report** includes these recommendations along with detailed findings and related supportive information. In addition, as part of its review of current efforts in the State of Maine, the workgroup developed and conducted a survey that received responses from over 800 prescribers. The report provides information related to the survey, highlights of the results and the complete survey document.

The workgroup members recognize the signficance and importance of improving prescribing and dispesing practices to reduce the addiction to and diversion of controlled substances to treat noncancer related pain without unduly restricting access to adequate pain control. The workgroup members want to support the Joint Standing Committee on Health and Human Services and the Legislature as a whole in taking the next steps to achieve the intent of RESOLVE Chapter 81, LD 1501.

It is in this spirit that the Substance Services Commision's LD1501 Workgroup respectfully requests an oportunity discuss the **LD1501 Workgroup Report** with the Joint Standing Committee on Health and Human Services.

Sincerely,

Robert M. Long, Chair
Substance Abuse Services Commission

Cc: Clerk

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Workgroup Membership

Chairman:

Bob Long, LCPC, LADC, CCS
Substance Abuse Services Commission

Members:

Jeffrey Austin, Esq.
Maine Hospital Association

Douglas Carr, Esq.
Rite Aid of Maine and retail pharmacy

Mark Cooper, MD
Medical Director, Board of Licensure in Medicine

Guy Cousins, LCSW, LADC, CCS
Director, Office of Substance Abuse Services; Acting Director, Office of Adult Mental Health Services; DHHS

Scott Davis, M.D., M.A., FASAM
Director of Addiction Medicine, Penobscot Community Health Care, representing the Maine Primary Care Association

James Douglas, DO
Inland Hospital

Kevin Flanigan, MD
Medical Director, MaineCare; DHHS

Noel J. Genova, MA, PA-C
Maine Medical Association, Board of Licensure in Medicine, Chronic Pain Project

Stevan Gressitt, MD
Founding Director, International Institute of Pharmaceutical Safety

Eric Haram, LADC
Addiction Resource Center Director, Midcoast Health System

Rep. Jon Hinck, Esq.
House of Representatives, Maine

Stephen Z. Hull, MD
Mercy Pain Center

Brenda Kielty
Office of the Attorney General

Patricia Lapera, MPH, CHES
PMP Coordinator, Office of Substance Abuse, DHHS

Bonnie Lundquist, NP
Director, Pain Program, Mount Desert Island Healthcare System

Rep. Richard Malaby
House of Representatives, Maine

Randal Manning, MBA
Executive Director, Board of Licensure in Medicine

Tamas Peredy, MD
Maine Medical Center

Melissia Petro, MPH, J.D.
Regional Director, State Government Affairs, Purdue Pharma

Kandyce Powell RN, MSN
Executive Director, Maine Hospice Council and Center for End of Life Care

Mark Publicker, MD
Mercy Addiction Medicine

Tom Lewis
Administrative Secretary to Director, Office of Substance Abuse, DHHS

Rep. Linda Sanborn, MD
House of Representatives, Maine

Rep. Deborah Sanderson
House of Representatives, Maine

Rep. Heather Sirocki, RDH
House of Representatives, Maine

Gordon Smith, Esq.
Executive Vice President, Maine Medical Association

I. Executive Summary

I. Executive Summary

Up until three decades ago physicians were taught that there was no indication for the use of chronic opioids in the management of chronic, non-cancer pain. This was driven by the perception that the rate of addiction to these medicines was high. Studies in the 1980's, however, suggested that the risk of true addiction, defined as psychological dependence, to opioids was actually quite low, less than 1%. At about the same time medical literature, much of which focused on the frequency of the use of opioids as the standard of care, suggested that American physicians were undertreating pain.

Based on these two pieces of data a change in the accepted wisdom towards the prescription of opioid analgesics to non-cancer pain patients has resulted in the current epidemic of over prescription, overuse, and abuse. Additional important factors that have played a role in the shift to utilizing opioids have included:

- The, at times strident influence by pain advocacy groups,
- Professional pain organizations guidelines based on consensus statements without adequate scientific evidence to support efficacy,
- Regulations from healthcare regulatory bodies, stressing the importance of pain management, by the Joint Commission on Accreditation of Healthcare Organizations adoption of "pain as the fifth vital sign",
- Federal and state implementation of guidelines for the prescription of controlled substances for the treatment of pain including the Federation of State Medical Boards' Model Policy Statement and Maine's Use of Controlled Substances for Treatment of Pain,
- Very successful and at times misleading and assertions about safety and efficacy, in treating chronic non-cancer pain, and
- Recent insurance payment initiatives, for quality patient care linking patient satisfaction with their pain management with healthcare reimbursement, epitomized by the adoption of HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) patient survey results as a measure of quality.
- The efforts made to move the current system to a more patient-centered, community engaged approach, may also constitute a barrier to effectively responding to overprescribing leading to opioid diversion and abuse. On the other hand, engaging patients and consumers in this effort is also essential if success is to be achieved.

All of these factors have resulted in a shift from the initially proscriptive attitude towards prescription of opioids for non-cancer pain to a permissive attitude and, finally, to an attitude of

expectation that opioids should form the backbone of appropriate chronic non-cancer pain management.

Community and patient expectations, along with the desire on the part of prescribing healthcare providers' to offer compassionate care and medical educations overemphasis on giving patients something, all too often a prescription for medications, so that the patient doesn't leave the clinical encounter empty-handed, have unfortunately outpaced the science of pain management. This has resulted in a shift in the drugs leading to addiction in this country from heroin and cocaine sold by drug dealers to pain medications, in many cases originating with the prescribing habits of well-meaning prescribers, misled into believing that good pain management equals opioid prescribing.

In the last two years, meta-analyses and systematic reviews of the literature have failed to provide convincing evidence that chronic opioids provide benefit for chronic non-cancer pain patients either in terms of pain reduction or improvement in function. Indeed, an emerging literature would suggest that taking patients who have become physiologically dependent upon opioids as a result of the treatment of their pain off opioids need not worsen their pain and may actually result in improvement in their pain and function. This supports a conclusion that opioids, initiated in an effort to manage pain, shifts into chronic use that maintains physiologic dependence. The paralleling increase in addiction and overdose are the tragic outcomes of misguided medical practices, governmental and regulatory policies, and unrealistic societal expectations.

Under treatment of chronic pain remains a problem. This results from:

- Imperfect and ever evolving science,
- A misunderstanding about what pain is,
- Society's unrealistic expectations that science can and should eliminate pain, and
- Insufficient financial support for multidisciplinary treatments that have good scientific evidence for their efficacy.

To stem the tide of over prescription, overuse and abuse of opioids we need to give attention to the following topics that serve as the foundation of the recommendations given by this workgroup:

- Prescriber, dispenser and community education:
    - About pain and the very real risks of psychological addiction and other serious adverse effects of opioids, and
    - About the proven effective pain and addiction treatments, and
- Governmental, regulatory and insurance policy and funding shifts supportive of:
    - Scientific methods and evidence based research as the basis for treatment of pain and addiction,

- Enhanced control over these controlled medications through:
  - Improved communication between providers of healthcare who co-treat pain patients,
  - Improved communication between healthcare providers and law enforcement,
  - Effective drug disposal programs and,
  - Continued use and enhancement of the Maine Prescription Monitoring Program.

The members of this workgroup are ready and willing to work with the legislature and other stakeholders on finding realistic solutions to this problem.

II. Introduction

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The misuse of prescription drugs, particularly controlled substances is reaching an epidemic rate, according to the Center for Disease Control[1]. The estimated cost of nonmedical use of prescription opioids alone, nationally, was $53.4 billion in 2006[2]. Maine is experiencing these similar and alarming rates of abuse, looking at statistics relating to treatment admissions[3], emergency department visits, nonmedical use of prescription drugs by high school students[4], prescription drug overdose deaths[5] and prescriptions dispensed per capital[6].

The Substance Abuse Services Commission has, as directed from LD 1501 (see Appendix C.7), convened a work group, comprised of commission members and public and private stakeholders (including representatives from licensing boards, clinicians specializing in the treatment of pain and addiction, as well as clinicians from primary care and emergency department settings, MaineCare, Maine Hospital Association, representatives from pharmaceutical industry, professional associations and Health and Human Services, as well as an appointed chair), to review and make recommendations for improvements in how physicians and other prescribers treat patients in chronic, non-cancer-related pain while minimizing risk of addiction or diversion. The workgroup has completed the four tasks outlined in LD 1501 and made relevant recommendations (see Section III):

Task 1. Review of current efforts in the State aimed at preventing addiction and diversion;
Task 2. Examination of similar efforts in other states, including Washington State;
Task 3. Consideration of additional tools that could lead to decreased abuse while not unduly restricting access to adequate pain control; and
Task 4. Consideration of enhancements to the Controlled Substances Prescription Monitoring Program established in the Maine Revised Statutes, Title 22, section 7248.

The workgroup has completed these tasks, and has included recommendations of additional tools and possible plans related to standards of care centered on evidence based research. The workgroup reached consensus on all recommendations made in this report. The workgroup has also developed a survey[7], completed by over 800 prescribers in the state of Maine, to enhance the perspective of the group and has collected these responses, incorporating them into the scope of the recommendations.

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[1] CDC, 2011. See Appendix C.1 for text.
[2] Ryan, Hansen et al., 2011. Economic Costs of Nonmedical Use of Prescription Opioids. See Appendix C.2 for text.
[3] Maine TDS, 2011. See Appendix C.3 for text.
[4] MYDAUS, 2011. See Appendix C.4 for text.
[5] Sorg, 2011. See Appendix C. 5 for text.
[6] Maine PMP, 2011. See Appendix C.6 for text.
[7] The prescriber survey was developed by the members of the 1501 workgroup. The survey was sent via contacts and through professional associations as well as posted on several websites including those for Maine Medical Association and the Office of Substance Abuse. Survey Results are available in Section V.

III. Recommendations

III. Recommendations

The LD 1501Workgroup recommendations have been divided by task group and within specific governmental and non-governmental bodies. The Workgroup recommendations are as follows:

Task 1: Statewide Efforts

The current efforts in the state of Maine, as well as other state and national initiatives, have been reviewed by the workgroup, resulting in the formulation of the following recommendations.

Office of Substance Abuse:

The World Health Organization has recommended collective statewide involvement and initiatives as a best policy and practice (see Appendix C.8). Therefore:

1. **The workgroup recommends that the Office of Substance Abuse develop and maintain a database for all current efforts that are evidenced based, from both statewide and national initiatives and research around the issues of controlled substances and addiction, diversion and misuse. Stakeholders statewide can collect and provide materials for the compellation of this resource. This database should be established over the next year, and be made available through its website.**

Office of the Attorney General

2. **The workgroup recommends that the Attorney General's Summit becomes an annual event, in which representatives from organizations working with prevention, treatment and addiction, as well as clinicians, government officials and other stakeholders can gather to discuss initiatives and current topics.**

Regulatory Boards:

3. **The workgroup recommends that all regulatory boards work with other agencies, such as the Maine Independent Clinical Information Service (MICIS) and the local chapter of American Society of Addiction Medicine (ASAM) to provide academic detailing and education (as outlined and recommended by World Health Organization, see appendix C.7) that addresses the issue of chronic pain to medical practices statewide. MICIS has already created its fifth module which addresses the issue of chronic pain. MICIS is operated by the Maine Medical Association, with financial support from MaineCare.**

4. **The workgroup recommends that the funding responsibility for the Chronic Pain Project[8] is expanded from the board of licensure in Medicine to all licensing boards for prescribers and dispensers. The current Chronic Pain Project contract with the Maine Medical Association is funded by the Board of licensure in Medicine. This contract expires Dec. 31, 2011.**

[8] The Chronic Pain Project was developed by the Maine Primary Care Association. See appendix C.9 for detailed information.

Professional Associations:

Health professional associations in Maine addressed in this document include the Maine Medical Association, Maine Pharmacy Association, Maine Veterinary Association, Maine Dental Association, Maine Nurse Practitioner Association, Maine Physician Assistant Association, and all other professional associations associated with healthcare, particularly those practitioners who prescribe or dispense controlled substances.

5. **The workgroup recommends that all professional associations involved in the prescribing or dispensing of opioids encourage the facilitation of groups and meetings such as the Mercy Integrated Pain Management Conference[9], in which current literature, best practices and challenges relating to the treatment of pain and opioid prescription drug misuse and diversion are discussed in the clinical setting.**

6. **The workgroup recommends that all professional associations involved in the prescribing or dispensing of opioids provide resources and/or toolkits, including guidance on clinical literature and best practices, such as the Maine Primary Care Association White Paper[10].**

Legislature:

The workgroup recommends enactment of these proposals on an emergency basis, because of the direct and positive impact the ability to share information between prescribers and law enforcement and, because they have the potential to immediately decrease deaths attributable to accidental overdose.

7. **The workgroup recommends that the legislature pass an emergency act to amend the State confidentiality of health care information law. The obligation of health care providers and dispensers to protect the confidentiality of a patient's personal health information emanates from several sources, including the Principles of Medical Ethics, the federal HIPAA regulations and the state's confidentiality law found in Title 22 MRSA section 1711-C. The state law was enacted in 1999, prior to the federal protections being established and in certain areas; the state law is more restrictive than the federal law. Therefore, the Work Group proposes that Maine law be amended to conform to the federal law in order to provide more protection to a prescriber or dispenser who wishes to report diversion or other illicit drug activity on the part of a patient to law enforcement. (See Appendix C.11 for proposed Legislation)**

8. **The workgroup recommends that the legislature enact an emergency Good Samaritan Law to Prevent Drug Overdose Deaths. Passage of such a law would facilitate the creation of an intranasal naloxone pilot project recommended elsewhere in this Report. A law of this type would save lives and save costs associated with untreated or inappropriately treated drug overdoses. This legislation would not protect people from prosecution for other offenses, including trafficking. The policy would also not protect those persons with outstanding warrants and would not interfere with law**

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[9] The format is similar to a journal club, but cases are also discussed. Recently, efforts have focused on moving away from opioid therapy for treatment of chronic, non-cancer pain.

[10] The White Paper was developed by the Maine Primary Care Association. See Appendix C.10 for detailed information.

<u>enforcement protocols to secure the scene of an overdose. (See Appendix C.12 for the proposed legislation language.)</u>

9. **<u>The workgroup recommends that the Department of Health and Human Services reviews and evaluates the efficacy of comprehensive pain management including physical and cognitive behavioral therapy and report findings to the Joint Standing Committee of Health and human Services in October 2012.</u>**

Task 2: Other States

The work group has reviewed efforts in other states, both similar to Maine and those who have other initiatives. This workgroup recommends a coordinated and cohesive statewide effort, working collectively to reduce prescription drug misuse and diversion. The workgroup encourages stakeholders in Maine to look to some efforts in others states as examples in best practices. Recommendations resulting from the review of efforts in other states are listed below:

A number of states have Medicaid programs aimed at reducing "doctor shopping" and "pharmacy hopping" including, but not limited to, Washington, North Dakota, New York, Pennsylvania, and Ohio.[11] Further investigation of these programs is needed to identify best practices and those most feasible for Maine.

1. **<u>The workgroup recommends that MaineCare create or utilize an existing group to review these initiatives and report findings to the SASC in July 2012</u>**.

The states of Washington (see Appendix C.14) and Ohio (see Appendix C.15) have recently mandated certain prescribing practices and education through legislation. The efficacy of these laws and policies, or any unintended consequences of these is not yet known, but these efforts were well intended to address problems in those states.

2. **<u>The workgroup recommends that specific prescription practices and education not be mandated at this time, but that these initiatives in other states are reviewed over the next year by the Prescription Monitoring Program Advisory Committee and a recommendation and/or impact assessment be submitted to the Substance Abuse Services Commission by December 2012.</u>**

Disposal Programs are needed in the state of Maine to address the growing problem of Prescription Drug Waste and illicit supply and to provide data to inform policy makers on ways to reduce and prevent this waste and supply.

3. **<u>The workgroup strongly recommends that the Commissioner of Public Safety appoint a permanent Drug Disposal Task Force within 15 days (of formal receipt of this recommendation), chaired by a representative from the International Institute of Pharmaceutical Safety, to provide recommendations and a status report following consultation with the recommended agencies. A mutually collaborative relationship</u>**

[11] KFF, 2010. See Appendix C. 13.

will be formed among the Task Force and named agencies. These named state agencies shall be instructed to collaborate with the Drug Disposal Task Force. (See Appendices 16-19.)

Task 3: Additional Tools

Regulatory Boards

1. **The Workgroup recommends that the five licensing boards which established the joint Chapter 21 Rule "Use of Controlled Substances for Treatment of Pain" (see Appendix) review the current rules and adopt any necessary changes consistent with evidence based medicine. Consideration should be given to the use of treatments such as Physical, Occupational and Cognitive Behavioral Therapies and non-opioid medications in rules dealing with the treatment of pain. The boards will also develop a process for on-going review and revision if necessary of Chapter 21 (see appendix C.20 for Chapter 21 Rule).**

2. **The Workgroup recommends that the various health licensing boards review the process followed for responding to complaints by patients against licensed prescribers, alleging that the prescribers have not provided adequate pain relief;[12] and, in conjunction with licensees and interested parties, consider actions to improve processes as appropriate.**

3. **The Workgroup recommends that the licensing boards endorse the use of universal precautions[13] when prescribing opioids as a treatment for acute and chronic pain.**

Education

4. **The Workgroup recommends that the current statewide association efforts cited in the resources educational programs for providers and dispensers, (on topics of risk, treatment, prevention and addiction) be expanded. The expansion is intended to bring to providers an educational course on treatment modalities other than opioids that can be used by patients to manage pain.**

5. **The Workgroup recommends that an educational process for the public be designed and implemented. This program[14] will educate the public on pain and addiction, proper expectations for successful treatment of pain and opiates including risks, proper use and proper disposal. The program should be supported by general funds.**

Legislative/Rulemaking

6. **The Workgroup recommends that all employers of health professionals and independently practicing health professionals who prescribe or dispense controlled substances be encouraged to provide access to the internet or intranet for the purpose of providing access to the Prescription Monitoring Program (PMP).**

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[12] Statements relating to the amount of complaints received can be found in the appendix C.21.
[13] (See Appendix C. 22)
[14] Model programs exist in the state of Maine, such as those for tobacco and alcohol abuse education.

7. **The Workgroup recommends that a picture ID be required of the individual picking up the written prescription for a controlled substance and at the time of controlled substance dispensing.**

8. **The Workgroup recommends statutory immunity for prescribing and dispensing intranasal naloxone kits this session on an emergency basis. Draft language for this statute can be found in Appendix C.11.**

Professional Associations

9. **The workgroup recommends that relevant professional associations convene to discuss ways in which prescribers and dispensers can assist one another in the effort to prevent diversion and abuse including pill counts, treatment agreements and medication therapy management and packaging.**

10. **The workgroup recommends that the appropriate state agencies and professional associations work with public and private health insurers to reduce the volume of pills dispensed on first opioid prescriptions and improve formal coverage of non-opioid pain consultation. These organizations should also work with insurers to improve coverage for evidence-based treatment for chronic pain, which can complement opioid therapy or replace opioid therapy (including Physical, Occupational and Cognitive Behavioral Therapies).**

11. **The workgroup recommends that professional associations representing prescribers work with the MDEA and other local law enforcement organization to establish collaborative efforts to improve communications between prescribers and law enforcement within the context of existing laws.**

Task 4: PMP Enhancements

The suggested enhancements for Maine's Controlled Substances Prescription Monitoring Program (PMP) were formulated by contributions from the 1501 workgroup, as well as the PMP Advisory Group's[15] recommendations to the 1501 workgroup. The recommendations are based on evidence based research as well as recommendations and endorsements from groups including but not limited to the American Society of Addiction Medicine, The Office of National Drug Control Policy, as well as the National Alliance for Prescription Drug Monitoring Programs.[16]

Office of Substance Abuse:

1. **The workgroup recommends, in recognition of its major importance in the treatment of pain and prevention of abuse, diversion and addiction, that the Prescription Monitoring**

[15] The PMP Advisory Group is composed of stakeholders, practitioners, members of state agencies and clinicians. This group meets bi-annually to discuss current efforts and improvements for the PMP.
[16] See Appendices C.23-26 for full reports)

program continues to be sustained by Federal and State efforts at levels that not only support its operation, but also its provision of education and registration efforts.

2. **The workgroup recommends that the Office of Substance Abuse review the threshold levels relating to the threshold reports[17] , which are a means of alerting prescribers and dispensers to possible doctor shopping and pharmacy hopping behaviors, potential misuse or diversion, distributed on a monthly basis by OSA. The work group also recommends that the PMP email threshold alerts to existing users in addition to postal service mail.**

3. **The work group also recommends that the PMP incur the cost of the upgrade to allow prescribers and dispensers to view payer source in the PMP report.**

4. **The workgroup recommends a stable platform for the Request for Proposal (RFP) process, relating to the PMP, for more than 2 years at a time. There was a call for a special exception to contracting regulations for the Office of Substance Abuse to make changes to allow for more renewals.**

5. **The workgroup also recommends the ability for prescribers and dispensers to "self-query", i.e. to be able to review their own prescribing and dispensing practices. The workgroup also recommends the ability of self query to enable the prescriber to be able to benchmark practices compared to other prescribers.**

6. **The workgroup recommends the PMP continues to prioritize and sustain research initiatives relating to aggregate PMP data. (See Appendix C.27)**

7. **The workgroup recommends that the PMP Advisory Committee review the practices and policies by which PMP data is reviewed and utilized and look to other states for best practices.**

8. **The workgroup recommends that the PMP Advisory Committee; including representatives from the PMP, as well as law enforcement, both local, state and the drug enforcement agency, research current laws relating to HIPAA, patient confidentiality and law enforcement access to PMP information at the level of an investigation. The task force should also look to other states who allow for law enforcement access at the level of investigation for best practices and outcomes to date. If the recommendation from this task group is in favor of changing PMP rules to allow law enforcement access at the level of investigation, a procedure for access (based on current procedure for law enforcement access), should be included in the report. This report should be given to the Substance Abuse Services Commission.**

Regulatory Boards

9. **The workgroup recommends that PMP education be endorsed by all health licensing boards as part of the ongoing licensure renewal requirements.**

[17] Threshold reports are automatic notifications sent to prescribers and dispensers alerting them to those patients of theirs who have surpassed certain "thresholds".

Legislative and Rulemaking

10. **The workgroup recommends that state legislature pass a resolve or write a letter of recommendation encouraging congressional legislation for the Veteran's Administration, federally regulated Methadone Clinics and Indian Health Service to emphasize and advocate for participation in the PMP.**

III. Summary

Improving prescribing and dispensing practices is as important as it is challenging. The LD 1501 Workgroup members recognized that thoughtfully addressing the four tasks outlined in LD 1501 and developing recommendations could provide a significant contribution towards achieving the balance between reducing the addiction to and diversion of controlled substances without unduly restricting access to adequate pain control in treating non-cancer related pain. Maintaining this perspective has enabled the LD 1501 Workgroup members to provide recommendations in this report that have been reached through the agreed upon consensus process established by the workgroup members at the outset of their deliberations in August of this year.

The LD 1501 Workgroup appreciates the opportunity to participate in a thoughtful process and to provide meaningful recommendations to support the Joint Standing Committee on Health and Human Services and the Legislature as a whole in achieving the intent of LD 1501.We would also like to thank the Substance Abuse Services Commission and the Office of Substance Abuse, for their facilitation and support. OSA provided not only a location for meeting, but staff and support for facilitation of meetings and the development of the final report. In particular, the workgroup would like to thank Tom Lewis, Deb Doiron and Patricia Lapera for their efforts of facilitation of meetings and materials.

In addition, the LD 1501 Workgroup appreciates the efforts of Representative Hinck in developing RESOLVE Chapter 81, LD 1501 and for his participation in the LD 1501 Workgroup process.

IV. Detailed Findings

IV. Detatiled Findings

In addition to the initiatives described by the many organizations involved, there are many projects, programs and efforts going on around the state aimed at preventing prescription drug abuse and addiction. In this portion of the report, we will highlight some of those efforts with the understanding that these are just a few of the efforts and no attempt has been made to complete an inventory of all such efforts.

Three themes emerged from our review of these efforts that influenced our recommendations. First, Maine can do a better job of collecting and disseminating all that is going on already. While many prescribers and dispensers have expressed a desire for more information, it is clear to us that much information exists already. What Maine needs is a concerted effort to collect and disseminate the existing information on an ongoing basis. Second, many of these efforts have unreliable or shaky financial underpinnings. From the PMP, to drug disposal to statewide education efforts, the ongoing funding sources for these efforts are in jeopardy. It was hard for us to propose significant new efforts that had a fiscal cost knowing that ongoing efforts need to be stabilized first. Third, there are some significant efforts today (some of which are highlighted in section A.) that are being done in limited fashion that the Legislature should be aware of and should explore for feasibility to take statewide. The Legislature is uniquely suited to decide whether and how to expand them.

A final note on efficacy. It was simply beyond the purview of this effort to be able to determine with the kind of certainty necessary to influence legislative action whether the existing efforts in the state are making a meaningful difference. Obviously, many of us believe in the importance of education, training and information sharing. Yet, if asked whether these things truly "work" in Maine, we would not be able to provide you with definitive answers. Nevertheless, the strong consensus of the group is that these efforts are important and, based upon the information we have at hand, that they should continue. Additionally there is strong support cited in the literature for the efficacy of these initiatives in other states, and nationally.

A. Statewide Efforts (Task 1)

As part of our review of statewide efforts, we surveyed the participating associations for their ongoing efforts and we received these brief summaries in response.

Current Efforts

The following outlines a portrait of current, statewide efforts including programs, policies, and other initiatives dedicated to prescription drug misuse prevention, treatment and education. This list highlights statewide efforts, as well as those in other states. This list is in no way exclusionary, as there is significant work that has and continues to be done on this current and relevant public health issue.

Statewide Associations

Maine Nurse Practitioner Association. At the annual NP association spring conference held in April 2011 there were 4 separate presentations about opioids and pain. These included: Dan Eccher former director of the Maine PMP who provided education about the PMP and assisted anyone to complete the application; a speaker on management of chronic low back pain; a speaker on the topic of pain in primary care; and a speaker on management of fibromyalgia (each of these presentations included a discussion on opioids and other pharmacologic and nonpharmacologic treatments.) Content from each of these 4 presentations was available on

Maine NP Association website for any NPs who could not attend. The Maine NP association quarterly newsletter in 2010 had article about the Maine PMP and information about how to apply. The Maine NP list serve has had active group discussions in 2010 and 2011 about importance of Maine PMP with information shared several times about how to apply.

Maine Medical Association. Over the past eight years, MMA has presented approximately 40 CME programs around the state on the topic of appropriate treatment for chronic pain, preventing diversion and avoiding abuse of prescription drugs. Many of these were funded by annual grants from OSA (those grants are no longer available, unfortunately). These programs have run from one hour to four hours. The typical faculty includes a local DEA agent, the OSA PMP coordinator, a physician and the MMA Executive Vice President. The programs are generally well attended, but the attendance at the five programs sponsored by the American Academy of Emergency Physicians and presented by the Maine Chapter ACEP was disappointing. However, despite this poor attendance, the group should be given credit for focusing on this issue in the ER and at least putting the programs together.

While this list is not intended to be exhaustive, the MMA has presented the education at programs presented in York, Sanford, Portland, Manchester, Augusta, Waterville, Bangor, Ellsworth, Dover-Foxcroft, Fort Kent, Presque Isle, Caribou, Machias, Calais, Northport (Saturday session for Pen Bay physicians), Lewiston and Auburn.

The MMA has also frequently have been asked to present the topic at other group's meetings, such as the annual educational program presented by the Downeast Association of Physician Assistants.

In addition to the CME programs, the MMA has featured the topic of prescription drug abuse at a number of its Annual Practice Education Seminars (each May or June) at the Annual Session each September. Articles in the MMA's quarterly publication, *Maine Medicine* also include information on these relevant topics.

In addition, with financial support by the Board of Licensure in Medicine the MMA has led a project focused on the issue of prescription drug abuse. It involved three elements, including individual office consultations (performed ably by Noel Genova, PA-C, the creation of resources on the MMA website (www.mainemed.com) and the establishment of a 2-hour home study CME course. All of these elements have been well received, particularly the in-office consultations. The funding for the program ends on Dec. 31 of this year and the MMA does not intend to continue to project at this point. The MMA particularly wants to acknowledge Noel Genova's efforts as the MMA has had many positive comments on her work around the state.

Maine Association of Substance Abuse Programs (MASAP) has worked with OSA to obtain Technical Assistance (TA) grants to assist providers of addiction treatment in the technology needed to adopt and implement Evidence Based Practices for the treatment of opioid addiction. This resulted in a clinical learning collaborative between Acadia Hospital, Mid Coast Hospital, Maine General, and Aroostook Mental Health Center, as facilitated by national experts from UW Madison, Dept. of Engineering; College for Health Enhancement Studies and the RWJ Foundation. We further expanded the effort for spread and sustainability by adding St. Mary's Hospital, Tri-County Mental Health, Catholic Charities and York Hospital to the collaborative. OSA can quantify the improved access to this standard of care through its Treatment Data Set. Furthermore, the grant resulted in the publishing of a TA Guide to assist providers in adopting these standards of care for the treatment of opiate addiction.

The MASAP has also secured funding from the Addiction Technology Transfer Center at Brown University to deploy a trained trainer across the state to deliver the NIDA endorsed training curricula for the Evidenced Based Practice Buprenorphine Assisted Treatment for opiate addiction. This training curriculum was developed to support and spread the overwhelming efficacy of the Buprenorphine Assisted Treatment clinical trials

completed in 2000-2004. To date, 120 clinicians have been trained across Maine. These trainings have taken place in Machias, Lewiston, Rockland, Portland and Augusta.

Down East Association of Physician Assistants (DEAPA). DEAPA members receive communications not only from DEAPA, but from MMA, and are invited to participate in any educational offerings being offered by MMA. DEAPA sponsors an annual CME conference in February, and have had a session on appropriate opioid prescribing, and related issues, during the last few conferences. Members who work in substance abuse have written articles for our newsletter. DEAPA had the previous Director of the PMP come to our last conference to notarize PA's PMP registration forms.

The Maine Chapter of the American College of Emergency Physicians (ACEP). ACEP awarded Maine a Chapter grant to produce specific educational programs regarding opioid prescribing practices. Five live events were done and the summary is posted on the Maine ACEP website which can be viewed for CME credit.

Maine Osteopathic Association. The MOA holds two CME programs each year and include at least one pain management/ treatment/ medication management and diversion related topic per program. The MOA would also refer our practices wanting additional training/assistance to the MMA.

Maine Hospice Council. The MHC has done/is doing a lot with education around issues of pain and prescription abuse. This started in 1993 when we convened the Maine Cancer Pain Initiative, now known as the Maine Pain Initiative. Additionally, we do/have done the following:

1. Annual Pain Symposia featuring nationally known speakers, including no less than four individual conferences addressing Prescription Drug Use, Mis-use and Abuse.
2. In June 2006, at the request of the Judiciary Committee, MHC published, ***Pain Management at the End of Life: A Physician Self-Study Packet.*** This was done as a collaborative effort with MMA, MOA, Board of Licensure in Medicine, and ACS with a grant from the American Alliance of State Pain Initiatives.
3. In 1998 we hosted the American Alliance of Pain Initiatives Conference in Portland. Part of the conference addressed the issue of balancing pain management with drug mis-use and abuse.
4. 2009-2010 we invited Dr. Publicker to speak with Hospice Providers before convening workshops to develop standardized policies for safe medication disposal.
5. In partnership with UMA, the MHC produced an education series for the ITV - addressing, "An Interdisciplinary Approach to Pain Management".
6. In partnership with researcher Barry Fortner, the MHC did a study looking at the effectiveness of pain management within Hospice Programs.
7. The MHC has hosted Town Hall Meetings with Attorney General Steven Rowe assessing perspectives of end of life care in Maine.
8. In 2004 MHC hosted a "Listening Conference" in partnership with Steve Rowe entitled, "Consumer Protection and End of Life Care".

Maine Primary Care Association. The Maine Primary Care Association has developed the *White Paper*. In developing the *White Paper* (see Appendix C.10), The MPCA engaged in extensive research and collaboration to identify resources, educational opportunities and best practices being utilized across Maine's Federally Qualified Health Center system, with a goal of better utilizing and monitoring the use of opioids for chronic, non-cancer pain .

State Agencies

Department of Health and Human Services, Office of Substance Abuse. DHHS, through the Office of Substance Abuse (OSA), has supported many significant initiatives, policies, resources and research dedicated to prescription drug abuse treatment, prevention and education. Including, but not limited to:

Maine Prescription Drug Monitoring Program. See Part D. PMP Enhancements

Treatment Data Systems. The Treatment Data System (TDS) was legislatively mandated by the State Legislature in P.L. 1983 c. 464. It is also required by the Federal Government that the Office of Substance Abuse submit substance abuse treatment data to them on a monthly basis. OSA uses the information from TDS for a variety of purposes in addition to the requirements noted above. TDS aggregate data are used to monitor and track trends in substance use for new or changing patterns. The system allows OSA to monitor contracted agencies for utilization and effectiveness. In addition, TDS is used for needs assessment planning and workforce development. TDS collects de-identified admission and discharge data on clients in substance abuse treatment. It is a secure system requiring a user ID and password to log on. Data is only disseminated from TDS in aggregate form. TDS has several different levels of reporting by agencies. Those levels have been consolidating over time so that eventually TDS will contain all or nearly all the substance abuse treatment information for the state. This will allow a complete picture of the substance abuse treatment community. (See Appendix C.3)

Maine Youth Drug and Alcohol Survey. Since 1993, Maine has been one of several states partnering with the University of Washington for the purpose of developing research-based substance abuse prevention strategies. The Maine Youth Drug and Alcohol Use Survey (MYDAUS) was a product of that collaboration. The purpose of the survey is to quantify the use of alcohol, tobacco and other substances (including prescription drugs) among middle and high school students in Maine, and to identify the risk and protective factors that influence a student's choice of whether or not to engage in these and related harmful behaviors. These influences are found in the different domains of the student's social environment: peer group, family, school, and community. Identification of specific populations in which the risk factors are high and the protective factors are low, permits the targeting of interventions where they are most needed. This survey is produced every other year. (See Appendix C.26)

Community Epidemiology Surveillance Network. Organized by the State of Maine Office of Substance Abuse (OSA) within the Department of Health and Human Services and based on a national model from the National Institute on Drug Abuse (NIDA), the Community Epidemiology Surveillance Network (CESN) is a multi-agency work group that studies the spread, growth and development of substance use in Maine and its communities. The CESN aims to provide updated trend reports twice a year. OSA received funding from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to perform epidemiological work as part of the Strategic Prevention Framework State Incentive Grant (SPF SIG), currently in its fourth year. The SPF SIG aims to use public health research and evidence-based prevention programs to build capacity within states and the prevention field. To better address the need for statewide information about substance use and abuse, the CESN and SPF SIG joined efforts in 2008. The network is a multi-agency work group which studies the spread, growth and development of drug abuse in Maine and its communities. Network members contribute information they routinely collect. Also, qualitative data is collected from a variety of key informants to particularly identify emerging trends. The CESN meets periodically to assess information from the multiple sources comprising the network and draw conclusions about drug abuse. Note:SPF SIG funds are no longer available.

Maine Integrated Youth Health Survey. In 2009, the Maine Youth Drug and Alcohol Use Survey (MYDAUS) was replaced by the Maine Integrated Youth Health Survey (MIYHS). The MIYHS is a joint effort of OSA, the Maine Center for Disease Control and Prevention (DHHS-Maine CDC), and the Department of Education. The MIYHS covers a broad array of health topics, including substance use, unintentional injury, suicide/depression, physical activity and nutrition, and sexual behaviors, and includes a module administered to parents of kindergarten children or third graders, a module for 5/6 the graders and 4 modules each for 7/8th graders and high school students. The next MIYHS will be administered in February of 2013. Online reports currently available include (See Appendix C.4):
Local Summary Reports
Full Reports by Grade Level
Public Health District Highlights
2009 Methodological Summary

Healthy Maine Partnerships. The Office of Substance Abuse (OSA) has contracted, on numerous occasions, with Healthy Maine Partnerships (HMPS), who are *a collaborative effort of the Maine Department of Health and Human Services Maine, Center for Disease Control and Prevention, Maine Office of Substance Abuse, and the Maine Department of Education*. These efforts include, but are not limited to: Assisting schools to adopt a parental notification policy regarding substance use, assisting schools to adopt and implement a written substance abuse policy consistent with recommendations in OSA's School Substance Abuse Policy Guide and communicate to staff , parents, and students through multiple channels, helping schools to provide consistent enforcement of the school substance abuse policy, using the OSA Parent Media Campaign materials to build a social marketing campaign to raise awareness of the importance of positive role modeling through channels within the local service area, assist in officer training on best practices, model policy implementation, and the importance for prevention, through the Worksite Framework, assist workplaces in developing policies that include offering personalized assessment-feedback to every employee, and/or require all employees to take evidence-based course as part of general orientation, assist colleges to develop policies that require those who violate school substance abuse policy to participate in assessment-feedback and/or educational program, through the worksite framework, educate employers on consistently enforcing their Drug-Free Workplace policy (through the communication of the policy, education, assessment and referral to treatment as important supporting components), through the Worksite Framework, assist workplaces to develop policies that require those who break business substance abuse policy to participate in assessment-feedback and/or educational program, through the Worksite Framework, educate employers that as part of Drug-Free Workplace program a review the Drug-Free Workplace policy is part of general employee orientation, and through the Worksite Framework, assist the employer in developing a policy and procedures that require those employee who break Drug Free Workplace policy to participate in an assistance program and/or educational program.

Substance Abuse Prevention Program, City of Portland, HHSD, Public Health Division. OSA works with the Substance Abuse Prevention Program on several initiatives, but we will highlight the three major projects. One Maine One Portland was developed to support development and implement positive youth development programs. We currently support the Life Skills Training Program at Lyman Moore Middle School and have also supported Lions Quest for Adolescents and Reconnecting Youth at several other schools in Portland. The mission statement of the Overdose Prevention Project is to "prevent drug overdoses by providing support, advocacy, education and outreach to the Portland community through positive collaborations and partnerships." Activities of this project include: bi-monthly Advisory Committee meetings, provide education and outreach to high-risk populations and groups (jail, shelters, clinics), conduct quarterly workshops at shelters and clinics, coordinate printing and distribution of “Call 911, Save a Life” wallet cards and posters, conduct at least one weekly All-Recovery groups within a community setting. This is an ongoing support group for people recovering or

seeking recovery from all addictions and in partnership with MAAR's Maine Recovering Communities Coalition, provide staff development workshops for agencies, departments and community groups, coordinate the annual Portland Wellness and Recovery Resource Fair, provide technical assistance to local programs, make treatment referrals, maintain and coordinate the activities of a speakers bureau, extend overdose prevention outreach and education into immigrant and refugee communities, participate in CESN, Coordinate with other overdose prevention programs throughout the state, Coordinate and facilitate the Portland Women's Task Force to focus on opiate-addicted mothers and mothers-to-be, collaborate with Maine Alliance of Addiction Recovery (MAAR) to coordinate recovery-oriented services and activities in Greater Portland. Finally, the Portland Women's Task Force, which is a group of over fifty agency staff, medical staff and providers who work together to create a bridge between agencies to provide opioid addicted women with better access to services and support.

Annual Reports produced by OSA include*: Office of Substance Abuse Annual Report, Substance Abuse Trends in Maine (which is now including some mental health indicators), and done every 3 to 5 years, and the Substance Abuse Treatment Client Satisfaction Survey – State of Maine*

Department of Health and Human Services, Substance Abuse Services Commission. The Substance Abuse Services Commission (SASC) was established via Legislation on June 30, 1993 and consists of 21 members. All members have education, training, experience, knowledge, expertise, and interest in drug abuse prevention and training and reflect experiential diversity and concern for drug abuse prevention and treatment in the State of Maine, as well as active participation in drug abuse programs such as prevention, treatment, rehabilitation, training or research in drug abuse and alcohol abuse. The mission of the SASC is to serve as a bridge between the Office of Substance Abuse, the public, and elected officials, regarding the issues of substance abuse prevention, research, identification, and treatment. The SASC meets in a public meeting monthly at the Office of Substance Abuse. In addition to the continued evaluation of state and federal programs and policies, the SASC educates the public by collecting and disseminating information, by conducting or commissioning studies and publishing the results of those studies, by issuing publications and reports and by providing public forums, including conferences and workshops. The SASC reports annually to the joint standing committee of the Legislature on developments and needs related to drug abuse prevention, including alcoholism and intoxication, and significant policy matters relating to substance abuse.

Reports (See Appendices C.28-31) include but are not limited to:

- *2010 Report Card on Maine Substance Abuse Services from the Maine Substance Abuse Services Commission*
- *SASC Substance Abuse Report Card 2008*
- *The Largest Hidden Tax: Substance Abuse in Maine*
- *Oxycontin Abuse: Maine's Newest Epidemic*

Board of Licensure in Medicine. The Board of Medicine has distributed at no cost the book Responsible Opioid Prescribing by Scott M. Fishman, M.D. to all licensees. The plan is to distribute an updated version when available. For many years, all new applicants for licensure by the Board of Medicine have been required to take and pass a written examination on Board rules, statutes and expectations. Beginning in May 2011, all licensees will be required to take and pass this examination every 4 years. Treatment of chronic pain and responsible opioid prescribing are a part of this examination. The Board of Licensure in Medicine has provided financial support the Maine Medical Association's project focused on prescription drug abuse. The details of this project are discussed in the section on the Maine Medical Association's educational efforts and will not be repeated here. (See Appendix C. 32 for citation only).

In 1999 the allopathic and osteopathic licensing boards promulgated a joint rule regarding best practices in the treatment of non-cancer pain. Even then, the difficulty of establishing detailed, specific prescribing guidelines that did not interfere with individual patient needs and treatment plans, was recognized. That challenge has grown more difficult as drugs and treatment modalities have become ever more complex. The Rule was revised and re-released in 2010 as a Joint Rule regarding the treatment of non-cancer pain, which provides sound guidance to the professions of medicine, dentistry, advanced nursing, and podiatry.

Private Organizations

Inland Hospital. Inland Hospital System has developed a comprehensive policy relating to prevention and treatment with respect to controlled substances. Inland primary care practices have adopted policy PPA: PC:207, dated 12/3/2010 based on State of Maine Board of Licensure and DEA rules/ regulations which addresses the issue of control substance management. This policy was adopted from EMMC's existing policy, created by a working group composed of 5 physicians representing EMMC primary care practices and approved by the EMMC Primary Care Leadership Committee. EMMC's centricity committee designed the EMMC Medication Monitoring form to help the practices comply with the "Chronic Pain Management, Controlled Substance Prescriptions and Use of Medication Contracts". (See Appendix C.33)

International Institute for Pharmacy Safety. There are four methods of collecting unused drugs from the community: drop off, event driven, pickup, and mail back. Maine leads the nation in the mail back area and serves as a model for both Federal legislation and replication under appropriate Federal regulations and law. Maine has led the nation for amount collected by weight per capita during each of the three DEA-sponsored community collections too. From these data, this is an issue that requires attention in order to create a permanent solution for proper medication disposal.[18] At some point in the next few months, the US DEA will be issuing proposed final regulations in response to S3397 which directs the US DEA to promulgate regulations to make it easier for the public to dispose of their unused medication. These Federal regulations will supersede State regulations and so there is a natural hold period for initiating any new program other than those above which we have been told will all be permitted to continue. A table of disposal efforts in Maine can be view in Appendix C.16.

Brandeis Center for Excellence. The Brandeis Center for Excellence has participated in significant research using PMP data, as well as other Maine data, contributing extensively to research around prescription drug addiction, treatment misuse and diversion.

University of Southern Maine. Researcher, Susan Payne from the University of Southern Maine, Muskie School has used de-identified data from the Maine PMP to develop the *Epidemiological Analysis of the Maine Prescription Monitoring Program (PMP) Data, 2005-2008*. The goal of the project was to "support OSA's policy development, strategic planning, and public health initiatives. The aims are to measure trends over time in the use of prescription drugs tracked by the PMP and to identify potential problem areas for monitoring or intervention. The focus is on changes in use rates over time by patient characteristics and by category of drug." (See Appendix C.27) Dr. Payne is beginning a continuation of the analysis for data for 2006-2010. This report is anticipated to be completed July 2012.

Maine Medical Center. Research Dr. Christina Holt, from Maine Medical Center, has contracted with the Office of Substance Abuse to use de-identified PMP data, with research specifically focused on overdose deaths.

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[18] Gressit, Stevan and Jayne Harper. 2011. Ongoing Medication Activates Throughout Maine.

MaineGeneral Hospital. Another example of a hospital-based approach is the CLIPP program currently under development at MaineGeneral in Augusta. CLIPP stands for "Compassionate Limits Prescription Program." A summary of the program is included in Appendix C.34. They are attempting to create a comprehensive program that includes prescribers, dispensers, patients, law enforcement and community providers.

Enhancing Existing Efforts in Maine

The Naloxone Pilot Project is designed to reduce overdose deaths due to opioids. One factor that interferes with the ability of drug overdose prevention specialists to motivate people to call 911 during a drug overdose is fear of arrest as a result of an investigation into the overdose. International studies, out-of-state research, and qualitative data from central Maine all confirm this is one of the main reasons people do not call 911 during an overdose emergency. To address this concern, the states of New Mexico, Washington and Rhode Island have passed Good Samaritan laws providing limited immunity (from charges or prosecution for possessing controlled substances) to victims or witnesses of overdose during which Emergency Medical Services (911) are called. Proposed Legislation can be found in Appendix C.11.

The Diversion Alert Program. The Diversion Alert Program provides a monthly emailed or mailed document to registered health care providers and pharmacists. The document consists of a list of individuals charged with prescription or illegal drug related crimes (other than marijuana) in the previous month. The data included is the same data published by newspapers and includes a photograph of each individual. The goal of the Diversion Alert Program is to prevent prescription drug abuse and diversion by providing health care providers with information that assists them in determining whether patients are legitimately in need of controlled substance prescriptions.

Drug Disposal Task Force. The guidelines recommended by the workgroup for the drug disposal task force can be found in Appendix C.7.

B. Other States (Task 2)

Berkshire Health System, MA. Significant initiatives are being accomplished and implemented in other states. For examples, many hospital systems have developed specific and detailed policies, centered around evidence based research. The Berkshire Health System Plan (see appendix C.35), for example, emphasizes provider education, integration of care, community awareness, safe disposal of medications and partnership in the formation of their *Pain Care Resource Manual*. Even in early stages, this program has seen significant impact. Looking at PMP data in Masechusetts, since the program implementation, there are reductions in presctiptions per patient and doses per prescription for schedule II opioids[19]. Individual patient successes with coordinatd planned care also increased.

West Virgina has developed a policy outline in which current statewide efforts were reviewed and suggested policies were outlined. (See appendix C.36)

[19] The Massachusetts PMP only collects data for schedule II controlled substances.

Wisconsin has also developed a Prescription Drug Reccommendations Report, which (similarly to the 1501 group in Maine) was created by a Controlled Substances Workgroup. The puporpose of the workgroup was to produce "a report that represents the full breadth and scope of the prescription drug abuse epidemic"[20]. This report also recognized the needs for safe disposal and a Prescription Drug Monitoring Program. Similar to this report, Wisconsin outlined current state initiatives as well as recommendations (See appendix C.37).

Other. Other organizations, such as the Veteran's Administration and the World Health organization (see appendix C.38), have developed recommended policies and guidelines for local and federal government, providers and other stakeholders. Iowa has also dedicated a certain portion of Continuing Medical Education Credits provided in the state to chronic pain and opioid use.

Washington and Ohio. Some state governments have choosen to mandate prescribing practices, such as Washington and Ohio. The implications of these mandates are unknown, however the initial pushback from providers is a strong one. Washington has also enacted policies very specific to their Emergency Departments[21] to curb misuse, diversion and addition of opioids. These policies center around dosage, treatments and regulator policies around these medications. This type of program is in its infancy, therefore impact is still unknown.

C. Additional Tools (Task 3)

This section identifies resources that were highlighted by the Task 3 group.

White Paper. The White Paper was created by the Maine Primary Care Association. "To locate common ground, the Maine Primary Care Association has engaged in extensive research and collaboration to identify resources, educational opportunities and best practices being utilized across Maine's Federally Qualified Health Center system, with a goal of better utilizing and monitoring the use of opiates for chronic, non-cancer pain." (See Appendix C.10.)

Mercy Health System Pain Pathway The Mercy Health System Pathway outlines goals of treatment, treatment options, opioid and non, potential impacts, and chronic management. (See Appendix C.40.)

SAMHSA Guidance. The Director of the Center for National Substance Abuse Treatment Centers encourages the use of state PMP programs in a formal letter sent to colleagues. (See Appendix C.24.)

WHO Guidance. The World Health Organization has put forth a guidance of 21 items to ensure availability, affordability and control of controlled substances. (See Appendix C.8.)

ASYM Guidance. The American Society of Addiction Medicine put forth a letter encouraging the use of the PMP in combination with other initiatives to reduce prescription drug misuse. (See Appendix C.23.)

VA Clinical Practice Guideline. The Veteran's Administration put forth a clinical practice guideline for the management of chronic pain. (See Appendix C.38.)

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[20] State Council on Alcohol and Other Drug Abuse, Controlled Substances Workgroup. 2011. Wisconsin Prescription Drug Recommendation Report.

[21] This program is entitled "Oxy Free ED". See Appendix C.39.

Naloxone Presentation (overdose Prevention Project). The presentation outlines the Overdose Prevention Project, encouraging the use of Naloxone Kits as best practice in preventing overdose deaths. (See Appendix C.40.)

Inland – Medication Monitoring. Inland hospital has put forth a policy for practice with the goal of treating non-cancer pain, curbing misuse and diversion while still providing adequate care and appropriately treating pain. (See Appendix C.33.)

D. PMP Enhancements (Task 4)

Maine PMP in Brief

Maine's Prescription Monitoring Program (PMP) is a tool created to prevent and detect prescription drug misuse and diversion. The state legislature passed a law in 2003 that requires information about all transactions for Schedule II, III, and IV controlled substances dispensed in Maine to be reported to the state government. Pharmacies licensed in Maine– both in and out of the state (i.e. mail order pharmacies) – submit data weekly. The data is then cleaned and added to a relational database. Using patients' names and birth dates, registered users of the database can log on to the web site at www.maine.gov/pmp to look up their patients online. Clinicians have immediate access to a patient's history with controlled substances freely available at their fingertips. PMP continually maintains a database of all transactions for controlled substances dispensed in the State of Maine. This database is available online to prescribers and dispensers. A free service of the Office of Substance Abuse (OSA) in the Maine Department of Health and Human Services, the PMP database is quickly becoming a standard tool for clinicians to provide better care to their patients throughout the state and many other states as well. Forty eight states in the United States have legislation enacted for PMP programs. These patient reports, and the automatically sent threshold reports, enhance the ability of health care providers to coordinate care. The database is searchable online, so it is available anywhere one has Internet access. Clinicians can use the program to check the history of a new patient and to monitor on-going treatment. PMP is another tool clinicians can add to their toolkit for preventing and intervening against misuse and diversion of prescription drugs.

Maine PMP Initiatives

The PMP itself participates in many initiatives (both contracted and collaborative) with statewide and national partners centered on provider education, patient education, PMP advocacy and registration, as well as research. Most recently, for example, the PMP is participating (through OSA's contract with HMPS) in the PMP Promotion Project. The PMP is predominantly funded by the Bureau of Justice Assistance, NASCSA, NASPER and a small percentage of the PMP is supported by Maine General Fund. Since the PMP is one of several essential tools in address the prescription drug misuse problem in Maine, the workgroup recommended utilizing researchers who work with PMP de-identified data sets to outline statistically significant and indicative measures of the PMP program itself, as well as continue to sustain successful education initiatives. The next report will be available, and should be publicized statewide by July 2012. Brandeis Center for Excellence, University of New England and University of Southern Mane also do extensive research with Maine PMP data.

PMP Enhancements

The suggested enhancements for Maine's Prescription Monitoring Program (PMP) are centered on best practices and evidence based research, from examples in other states, internal initiatives in Maine, and as well

as suggestions from a scope of providers in Maine, via the provider survey, distributed by the workgroup. Continuing these existing initiatives, while continually enhancing the PMP will help reduce and prevent prescription drug misuse and diversion, improving public health, and consequently reduce the health and financial costs that Mainer's experience.

The prescription monitoring program has seen an increase in over ten percent of registered prescribers in recent months. Additionally, the amount of sub account users has increased. While still a major problem, Maine has seen a decrease in excessive rates of "doctor shopping" behaviors. Research shows that states with prescription monitoring programs are also "effective in reducing the supply of prescription drugs per capita[22]" and therefore reduce the propensity for abuse. This research is also indicative of the success of states in reducing abuse, for those states that are proactive.

The Maine PMP continues to be proactive in provider registration and education initiatives. The PMP has had several seminars, grand rounds, and continuing medical education opportunities in conjunction with medical institutions, hospitals, and local provider practices, statewide and national conferences. Additionally, OSA abuse has recently contracted with Maine Medical Association to provide a statewide initiative of presentations on the PMP, prescription drug misuse (presented by a clinician), legal implications (presented by an attorney) and law enforcement status and impact (presented by a Maine Drug Enforcement Agent). OSA has also contracted with Healthy Maine Partners, selecting PMP Promotion Champions from each district, including tribal regions, which are developing education materials and promoting the PMP throughout the state.

[22] Simone, Ronald and Lynn Holland. (2006) An Evaluation of Prescription Drug Monitoring Programs. See Appendix C. 44.

V. LD 1501 Survey Report

V. LD 1501 Survey Report

As part of our review of current efforts in the State, we decided to conduct a survey of prescribers.

Process

The stakeholder group spent a portion of three meetings drafting, editing and reviewing the survey instrument. Ultimately, the survey consisted of 15 multiple-choice questions and one open-ended question where recipients could provide additional information. The survey covered four topics: demographic of respondent, current assessment of the opioid problem, current practices, and, responses to possible changes. The survey was conducted online using the Survey Monkey tool. A paper-response option was also available. The survey was "linked" on both the Office of Substance Abuse website and the Board of Licensure in Medicine's website. Representatives of the Maine Hospital Association, Maine Medical Association, Maine Osteopathic Association, Maine Nurse Practitioners Association, Maine Primary Care Association (FQHCs), Maine Physician Assistants Association and Maine Dental Association all promoted the survey to their membership. See below for a more detailed description of how each group promoted the survey.

Highlights

Here are the highlights of the survey results:

- Over 800 responses were received including responses from 472 physicians, 230 nurse practitioners and 83 physician assistants (as of November 10);
- The responses were heaviest from hospital-based practitioners (38%) followed by small private practices (24%), large private practices (11%), FQHCs (10%) and solo practitioners (8%);
- 48% of prescribers would characterize the opioid abuse/addiction problem in their area as "severe" (compared to 46% who characterize it as moderate);
- 35% of respondents prescribe opioids for chronic, non-cancer pain regularly – several patients per week (compared to 34% who prescribe them a few times per month); however, many respondents worked in ERs and were prescribing frequently for acute pain rather than chronic pain.
- Half of prescribers regularly use the PMP usually, half do not;
- Two-thirds of prescribers say they do screen patients for possible addiction/diversion by reviewing the patient's history;
- 63% of prescribers use patient contracts/agreements and 75% try to educate the patient;
- 56% use drug testing and 40% use pill counts to monitor patient usage.
- Two-thirds of prescribers received training on opioids in the last year.
- 80% of prescribers would like to receive email alerts from the PMP.

Additionally, 348 "open-ended" responses were provided by respondents. The responses provided to the open-ended question are worth reading. They express a great deal of concern but also frustration. There is frustration with the PMP, with the relatively new, and heavy emphasis on patient satisfaction scores, with few alternatives to pills because of either nor insurance coverage or no pain specialists, with patients who are belligerent and abusive when providers say no to refills (including the hassle of dealing with baseless patient complaints to the Board of Medicine) and frustration with one another as providers. There does not appear to be much support for legislative establishment of protocols but there is substantial recognition of the problem.

All responses can be found on the Substance Abuse Services Commission website. See http://www.maine.gov/dhhs/osa/about/resolve1501.htm .

Limitations

This survey cannot be viewed as statistically valid. However, the total number of responses (over 10% of all prescribers) is a great sample size. We are not able to determine if the respondents are truly representative of all prescribers because they were not chosen at random. But most groups of prescribers are well represented as show in the results. Participant were members of associations and, more importantly, their participation was self-selected. While many surveys suffer this flaw (who wants to stay on the phone and answer poll questions?) we simply cannot say, with statistical confidence, that our respondents were representative. For example, 80% of our survey respondents are at least registered with the Prescription Monitoring Program, while only 50% of all prescribers are members. So, while our survey may over-represent prescribers who take precautions against addiction, we do strongly believe the survey is very informative.

Efforts to Publicize Survey

Maine Hospital Association. MHA alerted its membership generally to the survey in its weekly "Friday Report" email update. MHA also emailed a specific request to the Medical Directors at every hospital in the state, twice, encouraging them to have their hospitalists (approximately half of all physicians in the state) complete the survey.

Maine Osteopathic Association. The MOA publicized the survey in our electronic e-news brief (goes to about 250 of our 400 members) and I also sent it out to the 20 physician members on my Board of Directors with a direct request for them to complete it.

Maine Medical Association. We e-mailed the link to the survey and the accompanying message to all the MMA members that we had an e-mail address for. I believe that number is about 1500 physicians. We also included the link in *Maine Medicine Weekly Update* which we publish every Monday. The e-newsletter goes to over 4000 e-mail addresses and we regularly have about 1000 recipients open it. It includes a lot of practice managers so hopefully many of them would have forwarded it to the physicians and other prescribers in the practice. We do know that some practice leaders forwarded the link onto the entire medical staff at the institutions. I think we could have gotten it around to virtually everyone if we had had more time.

Down East Association of Physician Assistants. We send out a weekly e-news blast. As the survey was being constructed, our President Erika Snowman Pierce, sent out a highlighted notice that the survey would be arriving, encouraging all members to fill it out. We then sent out the survey on Sat, Oct 8th, asking recipients--only DEAPA members get this communication--to complete the survey, and also to pass it along to colleagues who might not be DEAPA members. Many PAs work for RHCs or hospitals, so some respondents may have gotten the survey from their employer.

Maine Nurse Practitioners Association. We sent an e-mail with survey link to all members of Maine Nurse Practitioner Association in early October and again October 22nd. I wrote an article about our Workgroup with information about the survey included in the October NP newsletter; an email and phone communication was held with the Maine State Board of Nursing informing them of the survey and giving the link; I emailed the chief of staff Dr Timothy Richardson at the Department of Veterans Affairs Togus facility who agreed to forward information about the survey with the link to all Togus providers (MD. DO, NP and PA) I spoke with and sent e-mail with survey info and link to local dentists.

Maine Pharmacy Association. Association president, Kenneth McCall, forwarded the survey to its members on the MPA list serve.

Survey Results

See Appendix C.45.

VI. Appendix

VI. Appendix

A. SASC-Workgroup

The Substance Abuse Services Commission (SASC) was established via Legislation on June 30, 1993 and consists of 21 members. All members have education, training, experience, knowledge, expertise, and interest in drug abuse prevention and training and reflect experiential diversity and concern for drug abuse prevention and treatment in the State of Maine, as well as active participation in drug abuse programs such as prevention, treatment, rehabilitation, training or research in drug abuse and alcohol abuse. The mission of the SASC is to serve as a bridge between the Office of Substance Abuse, the public, and elected officials, regarding the issues of substance abuse prevention, research, identification, and treatment. The SASC meets in a public meeting monthly at the Office of Substance Abuse.
The SASC, as directed by Legislative Document 1501 Resolve, appointed a member to act as chairman and facilitate this workgroup.

B. Process

The workgroup was composed of representatives from licensing boards, clinicians specializing in the treatment of pain, as well as clinicians from primary care and emergency department settings, MaineCare, Maine Hospital Association, representatives from pharmacies, professional associations and Health and Human Services, as well as an appointed chair), to review and make recommendations for improvements in how physicians and other prescribers treat patients in chronic, non-cancer-related pain without causing addiction or diversion. Task groups were formed to address each one of the four tasks. Members of the workgroup selected a task group to be a part of, based on interest and relevance. The chairman guided and collected the efforts of the task groups.

C. Identified Resources

The following are resources used by the workgroup and also included recommended resources.

1. CDC. (2011). Vital Statistics: Prescription Painkiller Overdoses in the U.S.
2. Ryan, Hansen et al. (2011). Economic Costs of Nonmedical Use of Prescription Opioids. Clinical of Pain, 23(7):194-202.
3. Maine Treatment Data Systems. (2011)
4. MYDAUS Data. (2011)
5. Sorg, Marci. (2011) Maine Drug Related Overdose Deaths.
6. Maine PMP Data. (2011)
7. LD 1501 Resolve
8. World Health Organization. (2011). Ensuring Balance in National Policies on Controlled Substances.
9. Maine Primary Care Association. (2011) Chronic Pain Project.
10. Maine Primary Care Association. (2011) White Paper.
11. Legislative Draft Language- Nalaxone Kits.
12. Legislative Draft Language- Good Samaritan Law.
13. Kaiser Family Foundation. (2011).

14. Washington State, Rules Governing the Prescription Monitoring Program. (Amended 2011).
15. Ohio State, Rules Governing the Prescription Monitoring Program. (Amended 2011).
16. Gressit, Stevan and Jayne Harper (2011). Guidelines for the development of the Drug Disposal Task Force.
17. Gressit, Stevan and Jayne Harper (2011). Ongoing Medication Collection Activities Throughout Maine.
18. Gressit, Stevan. (2011) Prescription Drug Abuse: A problem for the Community and Physicians.
19. Gressit, Stevan and Heather Stewart. (2011) Maine State Medication Take-Back Data.
20. Chapter 21: use of Controlled Substances for the Treatment of Pain.
21. Letters stating number of complaints from boards of medicine and nursing. (2011).
22. Universal Precautions.
23. American Society of Addiction Medicine. (2011). Public Policy Statement on Measures to Counteract Prescription Drug Diversion, Misuse and Addiction.
24. Letter Dated October 2011, SAHMSA.
25. ONDCP. (2011). Epidemic: Responding to America's Prescription Drug Crisis.
26. National Alliance for State Prescription Monitoring Programs. (2011).
27. Payne, Susan. (2010). Epidemiological Profile of Maine's Prescription Monitoring Program.
28. The Largest Hidden Tax: Substance Abuse in Maine
29. Oxycontin Abuse: Maine's Newest Epidemic
30. 2010 Report Card on Maine Substance Abuse Services from the Maine Substance Abuse Services.
31. SASC Substance Abuse Report Card 2008.
32. Fishman, Scott, (2010) Responsible Opioid Prescribing.
33. Inland Hospital –Medication Monitoring Policies. (Developed 2011).
34. Maine General Medical Center. (2011). Compassionate Limits Prescription Program.
35. Berkshire Healthcare Systems. (2010). Pain Care Resource manual: A practical Guide for Health Care Professionals.
36. West Virginia State Medical Association. (2011) Physician Leadership in Addressing Prescription Drug Diversion.
37. State Council on Alcohol and Other Drug Abuse, Controlled Substances Workgroup. (2011) Wisconsin Prescription Drug Recommendation Report.
38. Department of Veteran's Affairs and the Department of Defense. (2010). Clinical Practice Guideline: Management of Opioid Therapy for Chronic Pain.
39. Washington State Medical Association. (2011) Washington Emergency Department Opioid Guides.
40. Publicker, Mark et al. (2011) Mercy Health System Pathway Proposal.
41. Harper, Jayne. (2011) Rx Opiate Misuse, Options for a Policy Response.
42. Turk, Dennis and Kimberly Swanson. Efficacy and Cost Effectiveness Treatment from Chronic Pain: An Analysis and Evidence Based Synthesis.
43. Katz, Ronnie et al. (2011) The Overdose Prevention Project.
44. Simone, Ronald and Lynn Holland. (2006) An Evaluation of Prescription Drug Monitoring Programs
45. LD 1501 Survey Results.