8th District Branch, Council Report
Edward Kelly Bartels, MD
March 2019

The MSCE has received increased negative comments regarding what some members believe to be 'non-action' by MSSNY on the Reproductive Health Act which was recently signed into law. Although the members who called understand that the current scope of practice was not expanded, they question how MSSNY will monitor the implementation of law to assure that all practitioners act within their scope.

It appears that a meeting of the Niagara County Medical Society will take place on March 25, 2019. It appears that the current leadership would like to explore, using MSSNY Legal Counsel or the "Bylaws Division", how to dissolve the Society without exposing any of the leadership or membership to any liability. They have also advised Ms. Skelly that during that meeting, all current leadership plan to retire from all leadership positions. At a recent meeting of District officers, a unanimous decision was made the District's administrative staff had exceeded their expectations of assistance to the leadership of NCMS, but it would be best to let Ms. Skelly work directly with Dr. Christodoulides (secretary/treasurer, NCMS) to contact all members about the meeting and its agenda.

Primary Care members are expressing their concern as to the required documentation that is being mandated or requested by payors and NYS and see that these requirements will have increased difficulty in recruiting or retaining physicians. Physicians are increasingly angry about the recent letter, attached, from the DOH advising of the need to have a written plan in a patient's EMR when prescribing opioids for more than three months as well as the increased "prior authorization" documentation that insurers are requiring for older patients. The documentation is based the *Beers Criteria* for potentially inappropriate medication use in older adults. Physicians state that that many patients have been successfully monitored on many of these medications for "decades" but the carriers are now demanding the additional documentation, and in most cases the authorization is given and the medication is then approved for continuance.

The MSCE in conjunction with the Bar Association of Erie County and the Womens' Bar Association will be hosting its second womens leadership event on Saturday, April 27, 2019 at the Science Center at Canisius College. The event entitled ***Professional Bravery: Define and Achieve Your Goals*** will have as panel participants: Doctors Rose Berkun, Kristen Robillard, Davina Moss-King; Attorneys Lisa Coppola, Paulette Ross; Clinical Psychologist Dr. Melinda Scime; Financial Advisor Lisa Walsh, VP/CIO of Integer Holding, Mary Holler, and CEO of Leadership Buffalo, Althea Luehrsen. The program will explore how to define personal success using effective communication strategies, the creation of a personal strategic plan, how to work effectively and minimize burnout syndromes, how to make effective life plans when faced with being part of a sandwich generation or considering transition to a new position, vocation, retirement.

The MSCE Annual Meeting and Installation of Officers will be held on Wednesday, May 1, 2019 at the recently renovated historic Sheas' Seneca Complex. Further information to follow.

Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

February 13, 2019

Dear Practitioner/Facility/Institution:

This letter is to advise you of an important addition to the Public Health Law affecting many patients who have been prescribed, or may be prescribed, opioids for pain that has lasted more than three months or past the time of normal tissue healing.

Effective April 1, 2018, legislation signed by Governor Cuomo with the 2018-2019 State Fiscal Year Budget amends Public Health Law §3331 by adding subparagraph (8), as follows:

> 8. No opioids shall be prescribed to a patient initiating or being maintained on opioid treatment for pain which has lasted more than three months or past the time of normal tissue healing, unless the medical record contains a written treatment plan that follows generally accepted national professional or governmental guidelines. The requirements of this paragraph shall not apply in the case of patients who are being treated for cancer that is not in remission, who are in hospice or other end-of-life care, or whose pain is being treated as part of palliative care practices.

In short, **a written treatment plan in the patient's medical record is required if a practitioner** prescribes opioids for pain that has lasted for more than three months or past the time of normal tissue healing. There are exceptions for patients being treated for:

- cancer that is not in remission
- hospice or other end-of-life care and
- palliative care.

The treatment plan must follow generally accepted national professional or governmental guidelines, and shall include (but is not limited to) the documentation and discussion of the following clinical criteria within the medical record:

- ✓ goals for pain management and functional improvement based on diagnosis, and a discussion on how opioid therapy would be **tapered to lower dosages or tapered and discontinued** if benefits do not outweigh risks;
- ✓ a review with the patient of the risks of and alternatives to opioid treatment; and
- ✓ an evaluation of risk factors for opioid-related harms.

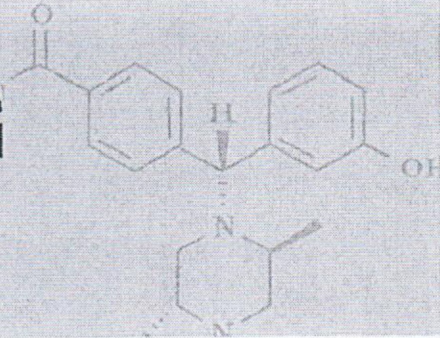
Such documentation and discussion of the above clinical criteria shall be done, at a minimum, on an annual basis.

For an example of a generally accepted national governmental guideline for prescribing opioids for chronic pain from the Centers for Disease Control and Prevention (CDC), visit https://www.cdc.gov/media/modules/dpk/2016/dpk-pod/rr6501e1er-ebook.pdf. Thank you for your attention and anticipated compliance with this important new aspect of the Public Health Law.

Very truly yours,

Joshua S. Vinciguerra
Director
Bureau of Narcotic Enforcement
New York State Department of Health

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN



IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

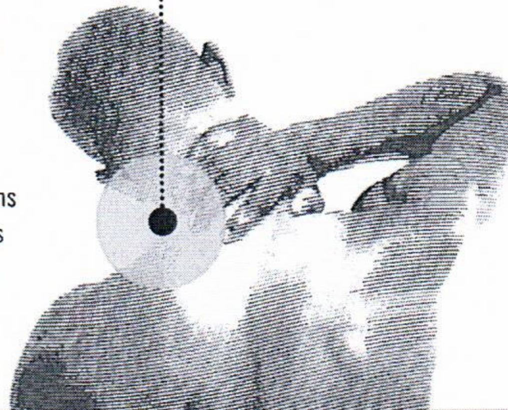
1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CLINICAL REMINDERS

- **Opioids are not first-line or routine therapy for chronic pain**
- **Establish and measure goals for pain and function**
- **Discuss benefits and risks and availability of nonopioid therapies with patient**



U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

CLINICAL REMINDERS

- **Use immediate-release opioids when starting**
- **Start low and go slow**
- **When opioids are needed for acute pain, prescribe no more than needed**
- **Do not prescribe ER/LA opioids for acute pain**
- **Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed**

4 When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

5 When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

6 Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

7 Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

8 Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

9 Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10 When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11 Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

12 Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

CLINICAL REMINDERS

- **Evaluate risk factors for opioid-related harms**
- **Check PDMP for high dosages and prescriptions from other providers**
- **Use urine drug testing to identify prescribed substances and undisclosed use**
- **Avoid concurrent benzodiazepine and opioid prescribing**
- **Arrange treatment for opioid use disorder if needed**

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html