

## West Virginia Board of Examiners in Counseling

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August 1, 2016

Attorney Patrick Morrisey  
Office of the Attorney General  
1900 Kanawha Blvd. East  
Building 1, Room E-26  
Charleston, WV 25305

Dear Attorney General Morrisey,

We first want to thank you for inviting us to collaborate with your Mr. Anthony Martin when we met on June 30, 2016 to discuss the alternative treatment methods to using opioids for pain management, specifically, the practice of counseling and Cognitive Behavioral Therapy. Also attending were Jim Bennett-Licensed Professional Counselor and Mike Brown-RPh & Executive Director of the Pharmacist & Dental Recovery Networks.

As discussed in our meeting, the effects of opioids are widespread and insidious. The addictive properties of opioids are so strong that it seems so many are blindsided by their effects. It is so common for individuals who have surgeries or serious accidents and where pain medication is often necessary for effective treatment. However, the warning signs of potential addiction to these medications may not be as well known. Educating the public on what effects to look for and stressing the importance of communicating the presence of those effects with their doctor is key. Additionally, by educating the public on the benefits of taking a holistic approach for pain management - one that includes multiple modalities such as medical treatment, spiritual support, family intervention and education, and evidence-based counseling practices - we can all be assured we are taking a well-educated, comprehensive, responsible approach to pain intervention that could replace sole reliance on the prescription of opioids.

Prescription drug abuse effects every resident in WV, directly or indirectly, and we are confident that Mr. Morrisey and his staff are moving in the right direction by partnering with the varied health professions and coordinating efforts to educate the public on alternative treatment methods for managing pain. We fully support the efforts and direction taken by you and your staff and we look forward to our continued work together.

Respectfully,



Lori Ellison, Ph.D.  
WVBEC Chair



Roxanne Clay  
WVBEC Executive Director



State of West Virginia  
Office of the Attorney General

Patrick Morrissey  
Attorney General

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September 1, 2016

Lori Ellison, Ph.D., WVBEC Chair  
Roxanne Clay, WVBEC Executive Director  
West Virginia Board of Examiners in Counseling  
815 Quarrier Street, Suite 212  
Charleston, WV 25301

Re: Best Practices Endorsement

Dear Dr. Ellison:

We would like to thank the West Virginia Board of Examiners in Counseling for its support and guidance in producing our office's best practices for prescribing and dispensing opioids. The credibility that comes with an endorsement from your organization is a mark of quality recognized by professionals across our state. The board is fortunate to have such strong leaders that are willing to step up and confront the overprescribing of opioids. You have been a tremendous help in our office's efforts to address the state's prescription drug epidemic. The WVBEC's input has been invaluable in our ability to finalize these documents. We thank you for this feedback and all that you have done over the years to fight opioid abuse.

The best practices make recommendations for prescribers and pharmacists on how to best prescribe and dispense opioids, and help ensure patient safety. A main goal of the best practices is to reduce the prescribing of opioids by at least 25 percent. In order to reach that goal the best practices must be distributed to any and all stakeholders. We would ask that this letter and the best practices be sent to all of the Board's members and licensees, and distributed at any appropriate events. Please feel free to carbon copy our office on any relevant email so that we may be able to answer questions or concerns your members or licensees may have regarding our collaboration to reduce opioid overprescribing.

Thank you again for partnering with us, your support and guidance make this fight much more manageable. If your members or licensees have any questions or concerns regarding the guidelines, or would like to implement the guidelines at their facility, please contact Chief Operating Officer and Senior Deputy Attorney General Anthony Martin at 304-558-2021 or [Anthony.P.Martin@wvago.gov](mailto:Anthony.P.Martin@wvago.gov).

Best Regards,



Patrick Morrissey  
West Virginia Attorney General



State of West Virginia  
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Consumer Protection and Antitrust Division

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## **Best Practices for Prescribing Opioids in West Virginia**

### **Background**

Prescription drug abuse is an epidemic in West Virginia. In 2015, there were approximately 686 drug overdose deaths, including 598 opiate-related fatal overdoses, in West Virginia. In 2014, West Virginia had the highest overdose death rate in the United States with 35.5 deaths per 100,000 people. This is more than double the national average of 14.7 deaths per 100,000 people. These guidelines are proposed to help reduce the misuse of prescription opioids while preserving legitimate patient access to necessary medical treatment.

One of our goals with these guidelines is to dramatically reduce the use of opioids as a first-line treatment option for patients with pain and significantly increase the use of non-opioid alternatives for these patients. We understand that there is no one-size-fits-all treatment plan for pain management and that individual plans of care may vary, but it is clear that our state is being flooded with far too many opioids than the population requires.

These guidelines provide recommendations for prescribers who are prescribing opioids for pain, including chronic pain lasting longer than three months or past the time of normal tissue healing. Applicable to adult patients that are at least eighteen years old, the guidelines exclude patients prescribed opioids for chronic pain related to active cancer treatment, palliative care, and end-of-life care.

The best practices are intended for (1) utilizing West Virginia's Controlled Substance Monitoring Program, (2) reducing risk of opioid misuse, (3) ensuring that the prescription medication, dose, and quantity is safe and appropriate, and (4) incorporating naloxone into opioid treatment discussions.

The Attorney General's Office obtained input from experts and stakeholders in drafting these guidelines. These guidelines balance the need for safe and effective pain management treatment for West Virginians while addressing the state's opioid epidemic. However, prescribers should use their professional judgment in treating patients and document their decisions.

## **Recommendations**

1. Prescriber or his or her authorized designate should check West Virginia's Controlled Substance Monitoring Program ("CSMP") every time the prescriber writes an opioid or benzodiazepine prescription or at least once every three months. Ensure the patient's controlled substance history is consistent with the prescribing record.
2. For patients starting or continuing opioid treatment for chronic pain and pursuant to an opioid pain care agreement, prescriber should conduct random urine toxicology screening and testing. If results reveal "red flags," such as the confirmed presence of cocaine, amphetamines, non-prescribed benzodiazepines, or any other drugs not consistent with provider's prescription history or patient's self-reported history prior to conducting the urinalysis, prescriber should discuss with the patient the importance of complying with the pain management treatment plan and be willing to accept assessment and treatment for both pain management and any concurrent disorders, such as drug abuse or addiction. To help prevent diversion, discontinue opioid prescriptions if urine toxicology screening fails to confirm the presence of opioids and patient does not provide an adequate explanation for the results. Prescriber should use his or her professional judgment in administering urine toxicology screening and testing and determining the best course of action after reviewing urine toxicology testing results.
3. When considering whether to prescribe opioids for pain, screen all patients for opioid misuse risk and adverse effects using the Opioid Risk Tool (ORT), Screener and Opioid Assessment for Patients in Pain (SOAPP-R), Diagnosis, Intractability, Risk Efficacy (DIRE), National Institute on Drug Abuse (NIDA) Quick Screen, CAGE-AID, or other validated screening tools. Review the patient's medical records and converse with the patient's support system to verify the results of the risk assessments.
4. Prior to prescribing opioids for chronic pain, conduct a physical examination of patient. Check for needle marks, signs of opioid intoxication, and signs of opioid withdrawal.
5. Prior to prescribing opioids, review the patient's medical records and, if possible, consult with the patient's previous prescriber.
6. Implement a tiered approach for prescribing opioids for pain and take every possible step to utilize non-opioid options first. Prescribers should discuss the value and effectiveness of alternative approaches to opioid treatment and outline other appropriate care pathways. In addition to medication, other treatment alternatives include cognitive behavioral therapy, physical therapy, occupational therapy, massage therapy, acupuncture, chiropractic services, and osteopathic manipulative treatment. Generally, opioids should not be prescribed on the first visit. When initially prescribing opioids, prescribers should prescribe the lowest effective dosage for the shortest duration. To determine the appropriate dosage, the prescriber should follow the CDC Guideline for Prescribing Opioids for Chronic Pain.

7. When contemplating opioid treatment, the prescriber should thoroughly review the risks with the patient so the patient may make an informed decision regarding treatment options. When patients are prescribed an opioid, the patient should sign and comply with an opioid pain care agreement governing his or her use of opioids.
8. When a prescriber prescribes an opioid, the prescriber should educate the patient about the safe use, storage, and disposal of opioid medications. Prescriber should also inform the patient about the risk of family members or household members improperly accessing the drugs.
9. Prescribers should understand and be familiar with opioid equivalents and conversions. Prescribers may utilize the total morphine milligram equivalents (MME) calculator available on the CSMP. The calculator was provided by the Board of Pharmacy and Attorney General's Office and uses conversion factors and formulas from the CDC to aggregate all opioids currently dispensed to a patient into a single comprehensible score.
10. Prescribers should avoid prescribing opioids with benzodiazepines, muscle relaxants, anticonvulsants, or sedative-hypnotics unless it is medically necessary and the benefits outweigh the risks.
11. Prior to beginning opioid treatment, the prescriber should collaborate with the patient to set expectations and create a plan to end opioid treatment. The treatment goals should not focus simply on the subjective goal of reducing pain, but should include objective, function-based treatment goals. Prescribers should also set clear expectations regarding pain management.
12. Prescribers should issue a prescription so that the supply does not end on a weekend.
13. Patients prescribed an opioid should be monitored as often as necessary or at least once every three months. Monitoring should be performed in an in-person setting and include documentation of pain intensity and functional ability, assessment of progress toward treatment goals, presence of adverse effects, and presence of aberrant drug-related behaviors or substance abuse.
14. Opioid therapy should be tapered and discontinued in patients who are known to be diverting opioids or engaging in aberrant drug-related behaviors. Aberrant drug-related behaviors include multiple unexplained dose escalations, non-adherence to the treatment plan, or use of a route of drug administration other than the prescribed method, such as injecting or inhaling oral formulations. If a prescriber tapers or discontinues opioid therapy in such a situation, prescriber should refer patient to a treatment or detoxification center and/or consider alternative treatment options.

15. Prescriber should discuss and consider recommending over-the-counter naloxone to any patient at risk of experiencing an opiate-related overdose or anyone otherwise at risk of experiencing or witnessing an opioid overdose. Educate family members and/or caregivers living with the patient to watch for warning signs of an overdose, such as sedation or impaired breathing. Also, educate the patient and the patient's family members and/or caregivers about proper administration, storage, and disposal of naloxone.



State of West Virginia  
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## **Best Practices for Dispensing Opioids in West Virginia**

### **Background**

Prescription drug abuse is an epidemic in West Virginia. In 2015, there were approximately 686 drug overdose deaths, including 598 opiate-related fatal overdoses, in West Virginia. In 2014, West Virginia had the highest overdose death rate in the United States with 35.5 deaths per 100,000 people. This is more than double the national average of 14.7 deaths per 100,000 people. These guidelines are proposed to help reduce the misuse of prescription opioids while preserving legitimate patient access to necessary medical treatment.

One of the goals with these guidelines is to dramatically reduce the use of opioids as a first-line treatment option for patients with pain and to significantly increase the use of non-opioid alternatives for these patients. We understand that there is no one-size-fits-all treatment plan for pain management and that individual plans of care may vary, but it is clear that our state is being flooded with far too many opioids than the population requires.

These guidelines provide recommendations for pharmacists who fill prescriptions for opioids for pain, including chronic pain lasting longer than three months or past the time of normal tissue healing. Applicable to adult patients that are at least eighteen years old, the guidelines exclude patients prescribed opioids for chronic pain related to active cancer treatment, palliative care, and end-of-life care.

The guidelines address best practices for (1) utilizing West Virginia's Controlled Substance Monitoring Program, (2) verifying the legitimacy of the patient, prescriber, and prescription, (3) ensuring that the prescription medication, dose, and quantity is safe and appropriate, (4) educating patients about the safe use, storage, and disposal of opioids, and (5) incorporating naloxone into opioid treatment discussions.

The Attorney General's Office obtained input from experts and stakeholders in drafting these guidelines. These guidelines balance the need for safe and effective pain management treatment for West Virginians while addressing the state's opioid epidemic. However, dispensers should use their professional judgment in determining whether to dispense medication to patients and should document their decisions.



## **Recommendations**

1. Pharmacist or his or her authorized designate should check West Virginia's Controlled Substance Monitoring Program ("CSMP") prior to dispensing benzodiazepines or opioids.
2. When individuals purchase naloxone without a prescription, dispenser, per protocol, must educate patient, family, and/or caregiver about the risks of opioid overdose and the signs or symptoms of an overdose.
3. When individuals purchase naloxone without a prescription, dispenser, per protocol, must consult with patients and/or their family members or caregivers on the proper administration of the opioid antagonist; the importance of contacting emergency services as soon as practicable either before or after administering the opioid antagonist; and the risks associated with failure to contact emergency services following administration of an opioid antagonist.
4. Record the dispensing of an opioid antagonist without a prescription in accordance with the Bureau of Public Health and Board of Pharmacy's protocol.
5. Validate the legitimacy of the identity of the person picking up a controlled substance through acceptable photo identification, such as a valid driver's license, similar state-issued photo identification card, a military identification card, or a passport. Document that the pharmacy obtained valid photo identification.
6. The dispenser should initiate communication with the prescriber to discuss the dispenser's concerns if he or she identifies any of the following potential red flags: (1) the prescriber writes the same or similar medications in the same strength and quantity for multiple patients without regard to a patient's individual characteristics; (2) the prescriber writes the prescription for a dangerous drug "cocktail," such as a prescription for an opioid, a muscle relaxant, and a benzodiazepine; (3) the prescriber is writing prescriptions for treatment outside his or her practice area; or (4) the prescriber is located outside the pharmacy's typical geographical area.
7. Verify the legitimacy of the patient by proactively recognizing suspicious prescriptions and identifying individuals who may be abusing controlled substances. Several red flag examples include patient travels in groups; patient presents prescriptions for controlled substances written in the names of others; patient shows physical signs associated with controlled substance abuse, such as needle tracks or scars; patient obtains similar prescriptions at different pharmacies; patient has insurance but insists on paying cash; patient requests early refills on controlled substances; patient presents prescriptions for highly abused drug cocktails (combination of opioids, benzodiazepines, muscle relaxants, sedative-hypnotics, and/or anticonvulsants); and patient presents a prescription from a prescriber who is prescribing outside the scope of his or her practice. If red flags are observed, dispenser should contact the prescriber. If dispenser is unable to satisfactorily resolve his or her suspicions, then the dispenser should not fill the prescription.

8. Dispensers should understand and utilize the total morphine milligram equivalents (MME) calculator available on the CSMP. The calculator was provided by the Board of Pharmacy and Attorney General's Office and uses conversion factors and formulas from the CDC to aggregate all opioids currently dispensed to a patient into a single comprehensible score.
9. If a prescriber has prescribed doses over the CDC's recommended limit in the CDC's "Guideline for Prescribing Opioids for Chronic Pain," then the dispenser should initiate communication with the prescriber to discuss the opioid prescription.
10. When dispensing opioids, educate patients on the safe use, storage, and disposal of opioids and other prescription drugs.
11. When an individual is identified who may be diverting or abusing opioids, refer the individual to treatment and other support resources by either directly counseling the individual or distributing educational material.