2019 NM Opioid Prescriber Survey

Results

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PIRE

Introduction

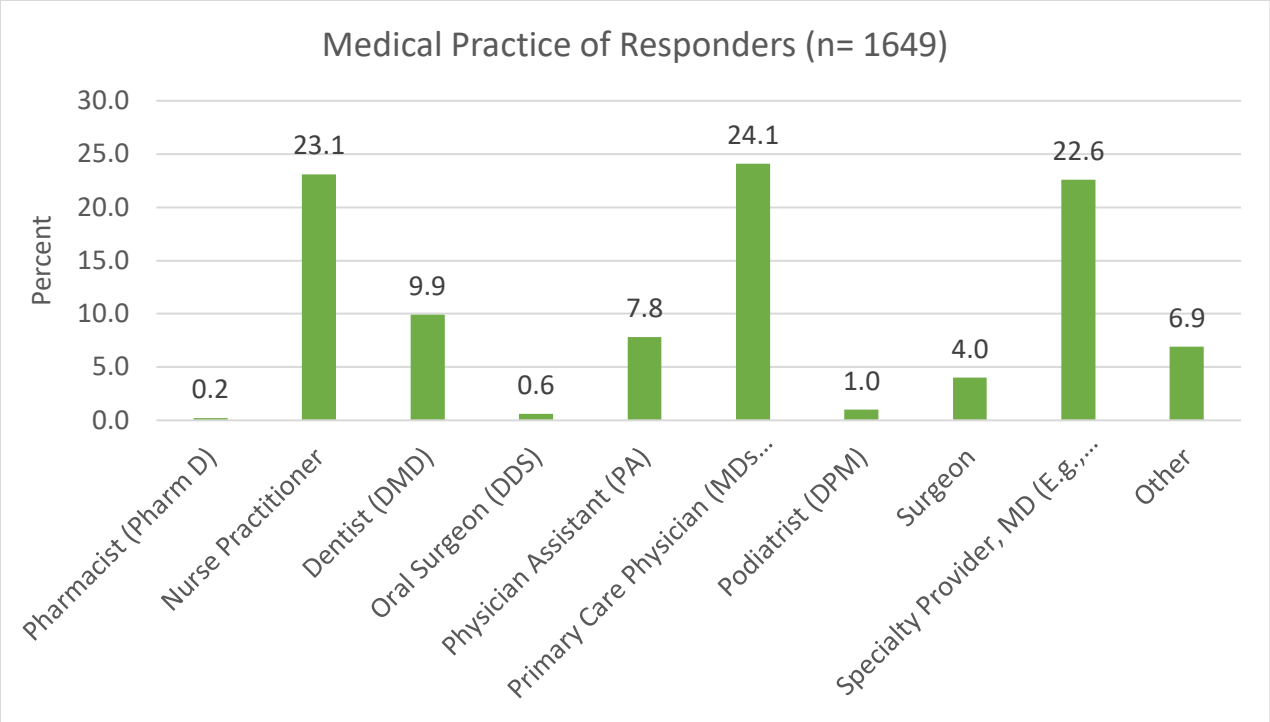
In July of 2017, the New Mexico Office of Substance Abuse Prevention in collaboration with the New Mexico Board of Pharmacy implemented the New Mexico Opioid Prescriber Survey as part of the requirements of the Strategic Prevention Framework- Prescription Drug (SPF Rx) grant. An emailed invitation to complete the survey on-line was sent to all registered users of the NM Prescription Monitoring Program (PMP) system from the Pharmacy Board. This included registered users who did not prescribe opioids (e.g., pharmacists), were retired, or no longer practicing in NM. The email invitation was sent to 9,485 registered users. A total of 1,672 people responded directly to the survey on-line. In addition, many other prescribers responded via email and phone calls. While the invitation letter specified that the survey was for opioid prescribers, many who received the invitation took the survey or contacted the Pharmacy Board and/or PIRE to confirm whether they needed to complete the survey. Overall, prescribers were very responsive to the request and positive about the survey.

Of the 1,672 responses, 1,380 (82.5%) indicated that they prescribe opioids in their practice. A response rate of 17.6% is calculated based on the entire number of invitations issued, however, this is a conservative estimate since we were unable to target our invitation to only opioid prescribers because of limitations of the PMP system.

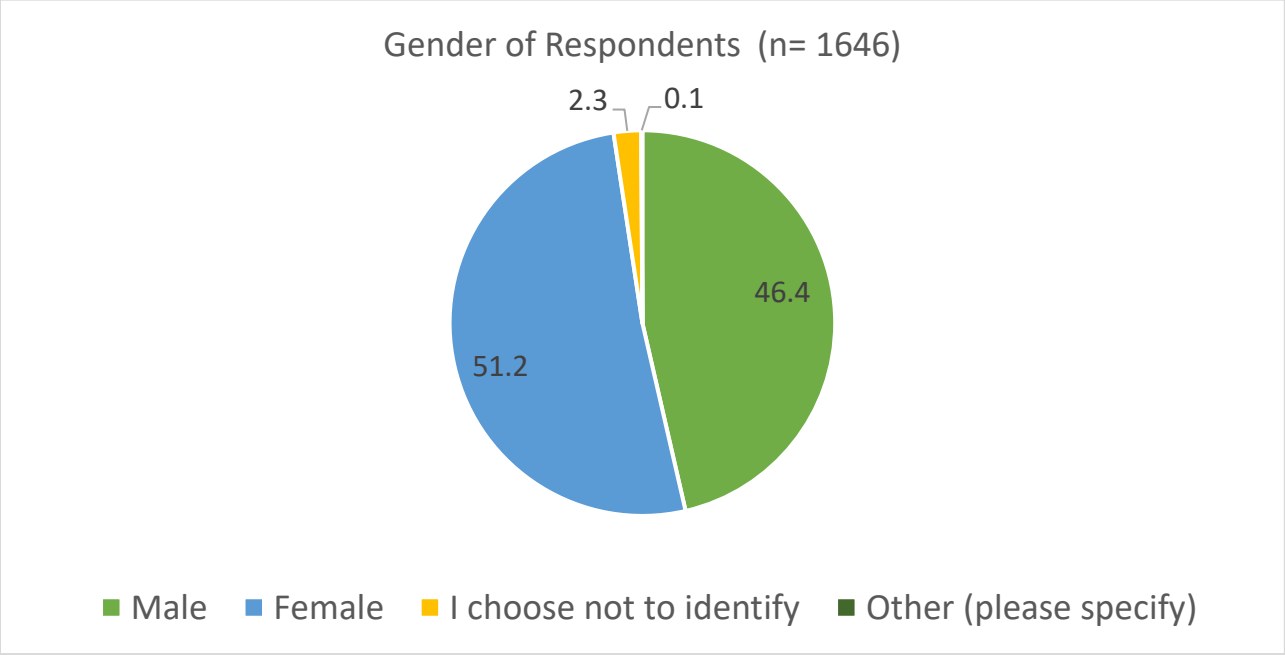
The initial screening questions of the survey excluded those who did not prescribe opioids or were not required to use the PMP from completing the entire survey since most questions would not apply to them.

Prescriber Characteristics

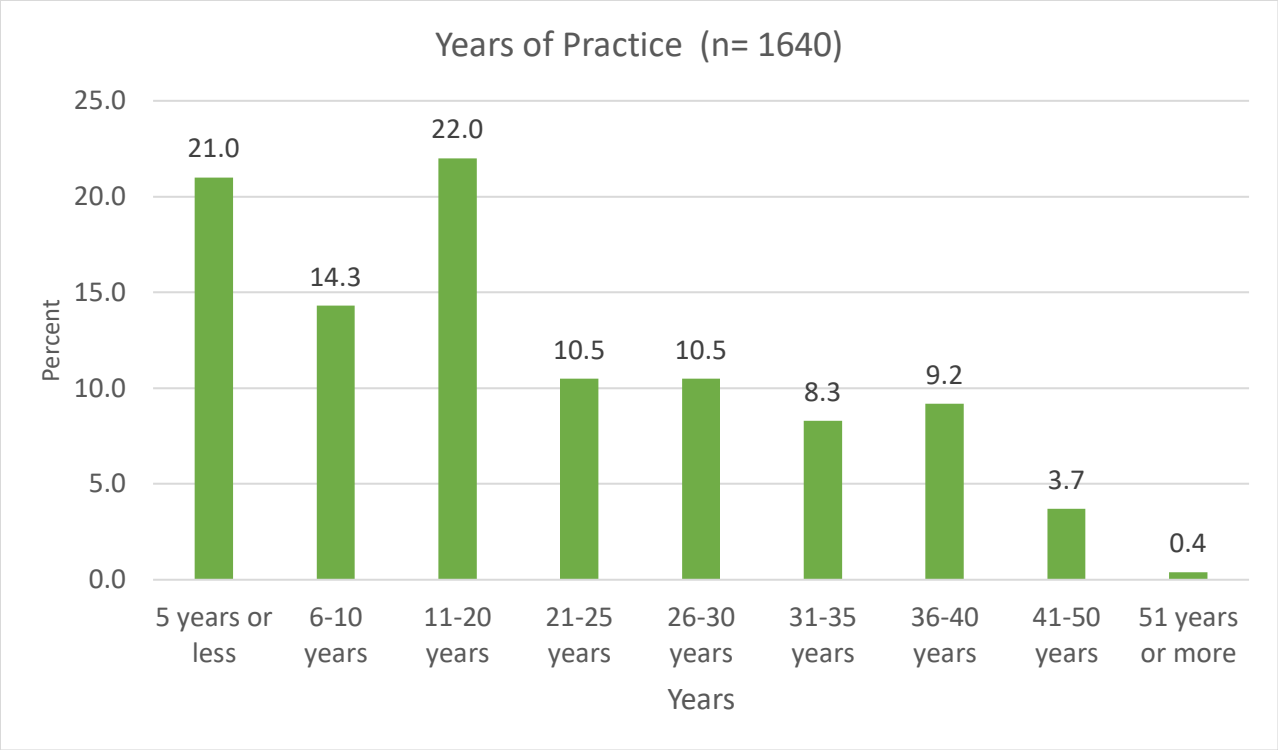
Who completed the survey? Most responders to the survey were nurse practitioners, primary care providers, and specialty medical providers such as oncologists, orthopedists, etc. Most primary care providers practiced Family Medicine (59%), followed by Internal Medicine (28%), and Pediatrics (13.5%).



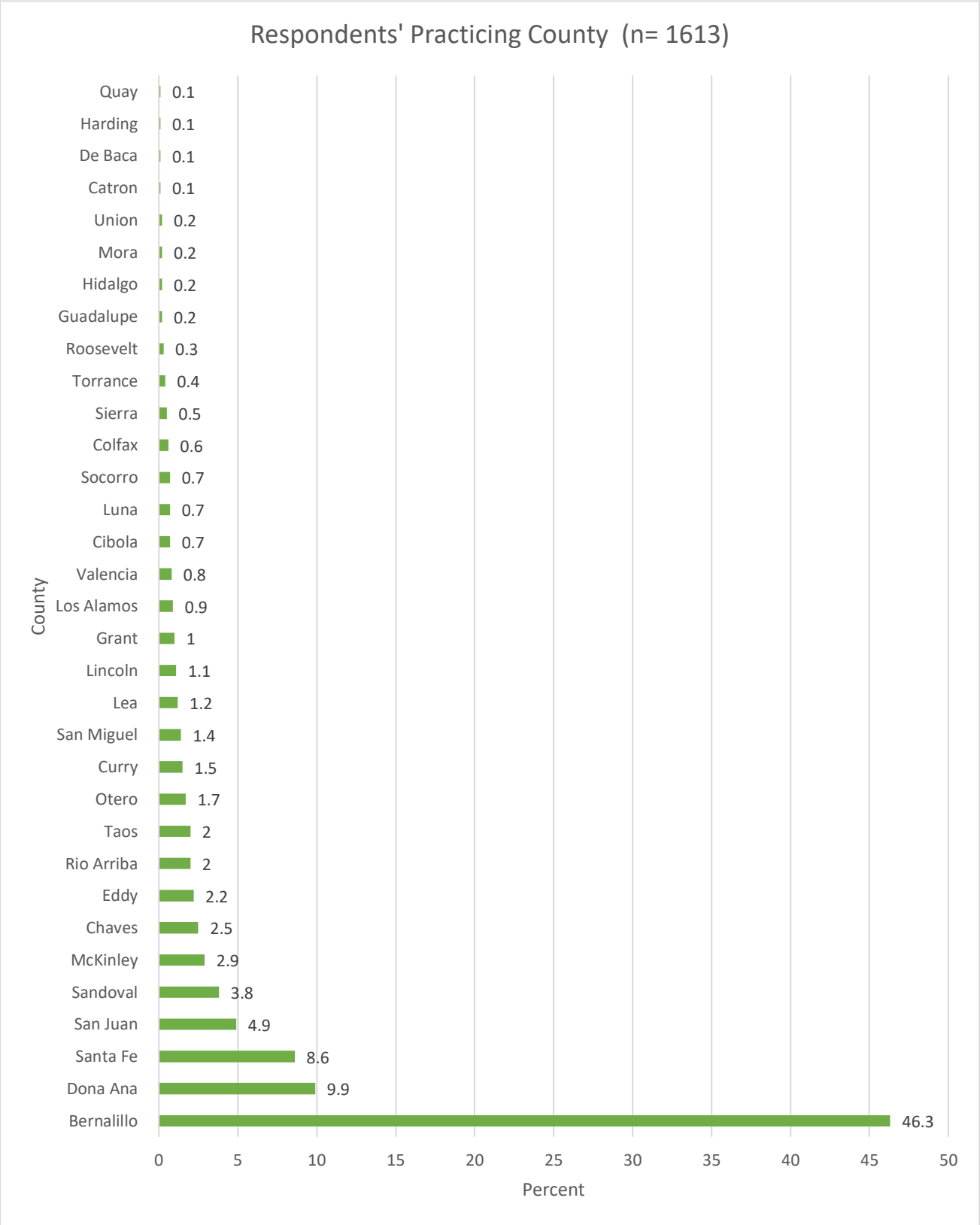
The sample was distributed fairly evenly between male (45.6%) and female (50.4%) respondents with 40 respondents not identifying a gender.



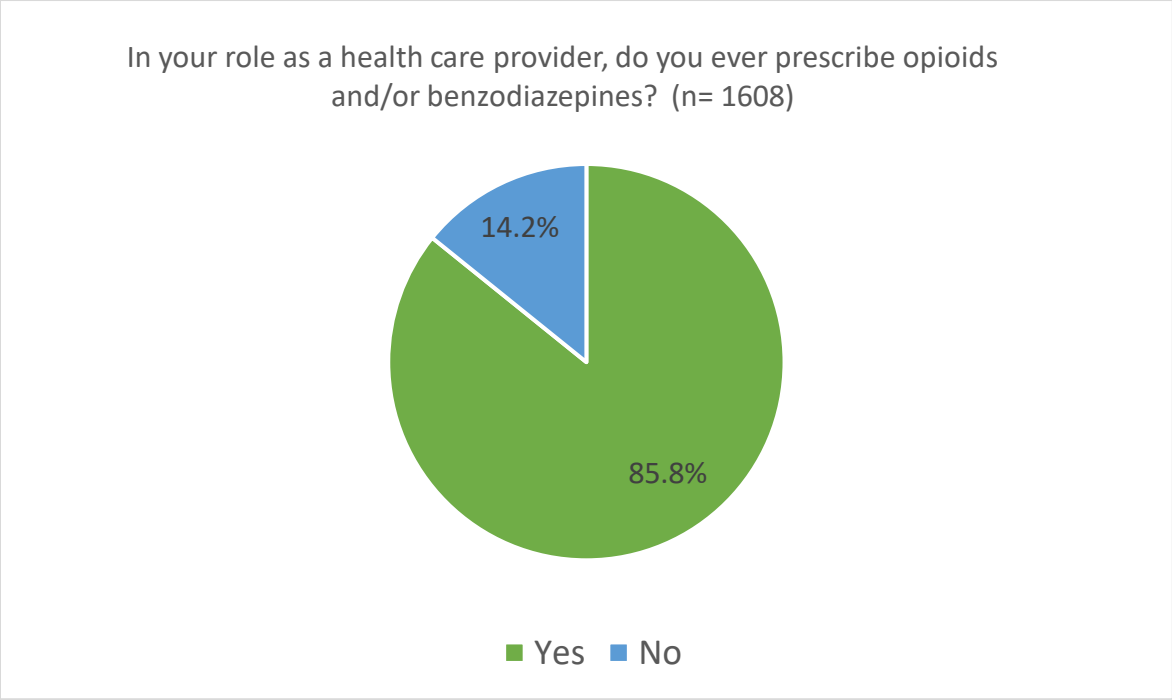
Respondents ranged from very new providers to well established providers. The average number of years in practice was 18.9 years.


Years of Practice (n= 1640)
Percent
25.0
20.0
15.0
10.0
5.0
0.0
21.0
14.3
22.0
10.5
10.5
8.3
9.2
3.7
0.4
5 years or less
6-10 years
11-20 years
21-25 years
26-30 years
31-35 years
36-40 years
41-50 years
51 years or more
Years

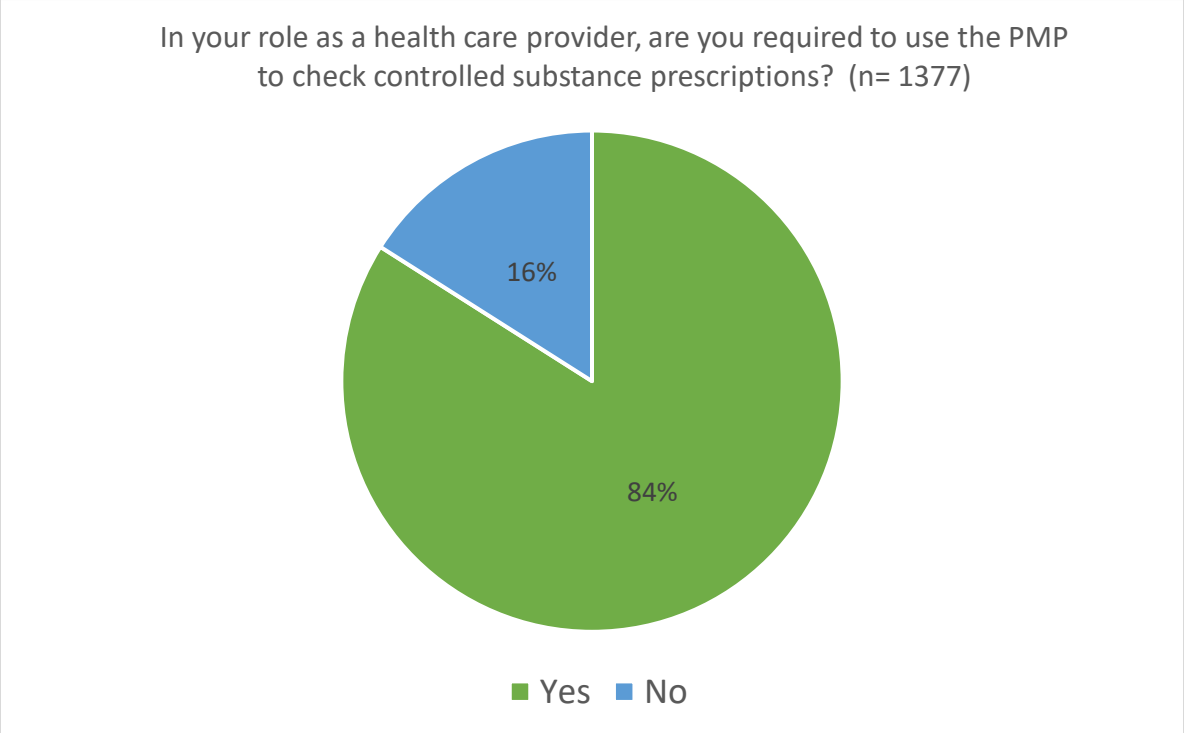
Respondents practiced in every county in New Mexico, although by far, the most respondents practiced in Bernalillo County.



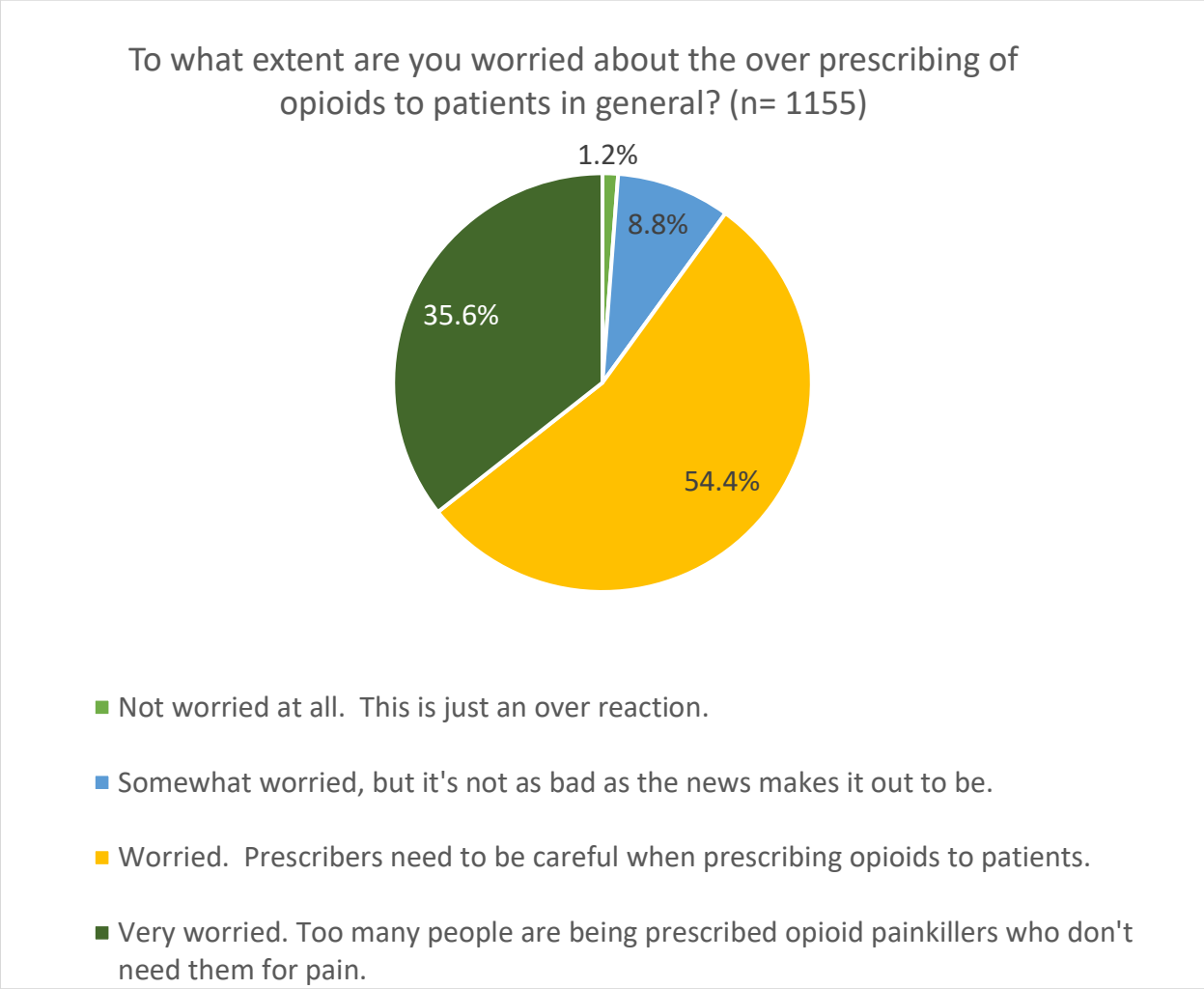
Most respondents to the survey indicated that they prescribe opioids and/or benzodiazepines.



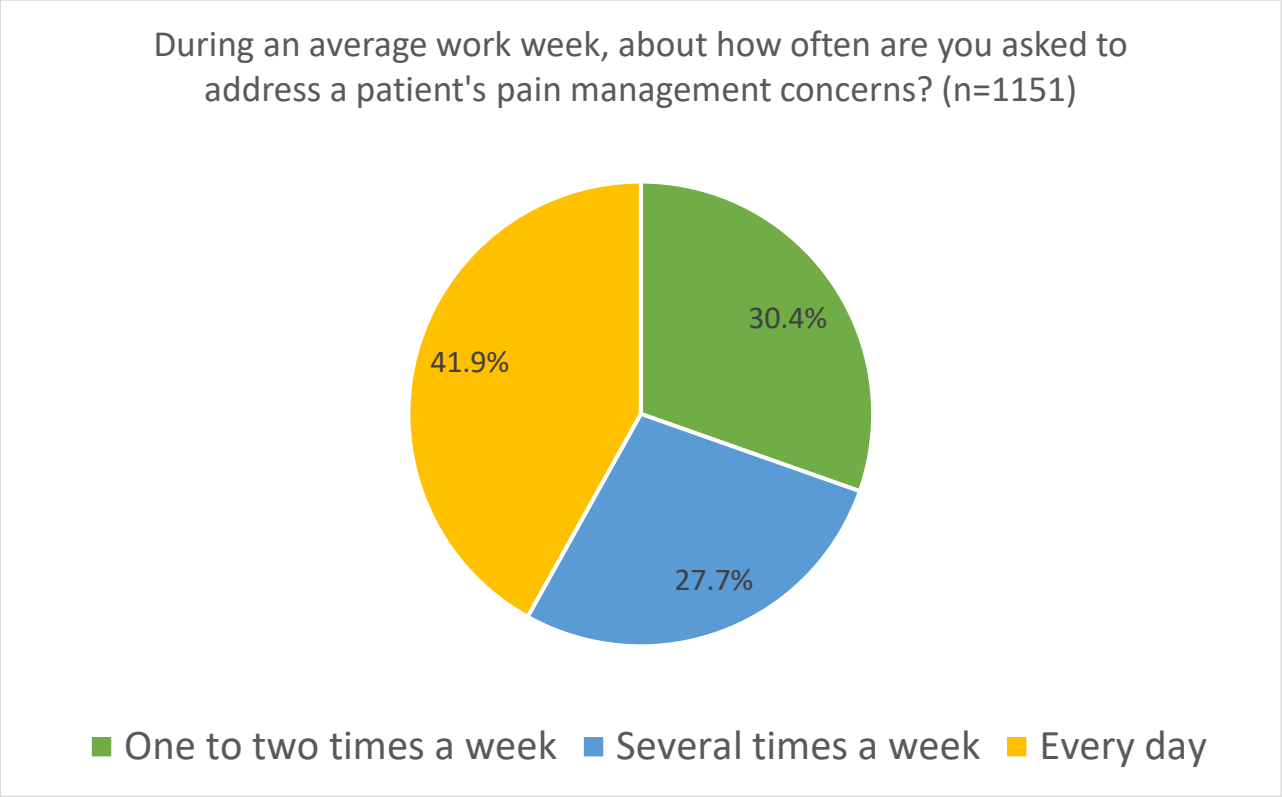
Most respondents indicated they were required to use the PMP to check controlled substance prescriptions.



Most prescribers (90%) indicated they are worried or very worried about the over prescribing of opioids to patients.



Most prescribers indicated they are treating patient pain daily in their practices.

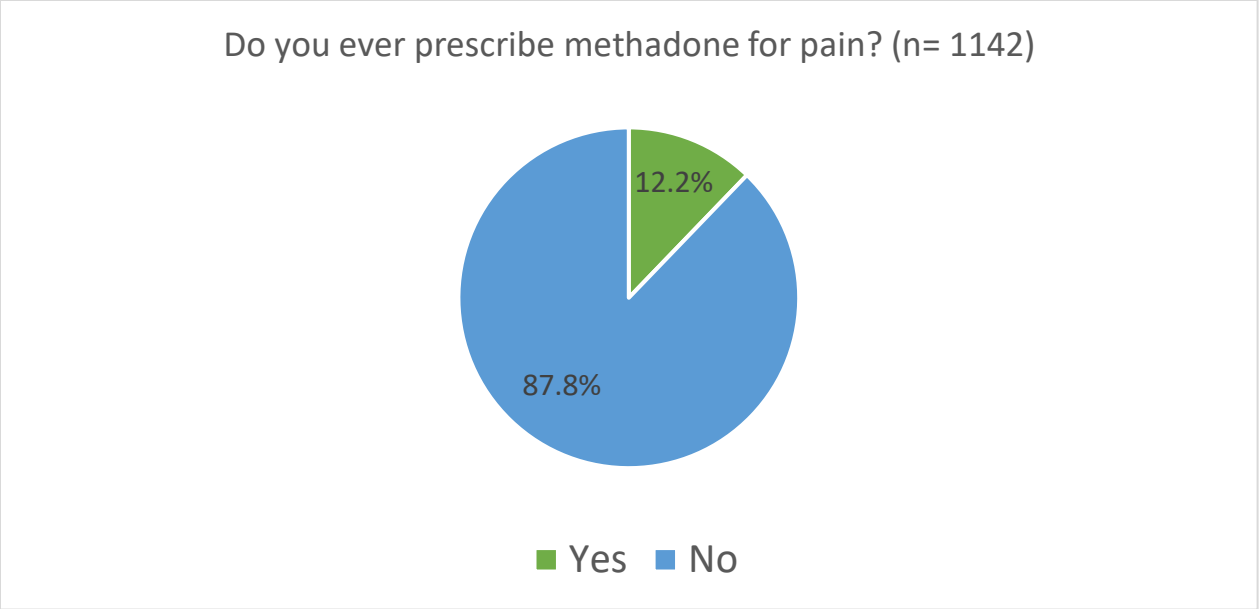


How do prescribers approach a patient in pain? Most start with recommending over-the-counter pain medications first before moving to opioids. More than half also recommend alternative pain management strategies such as physical therapy before prescribing opioids.

Prescriber Approaches	Percent			
	Very unlikely	**Somewhat unlikely**	**Somewhat likely**	**Very likely**
If a patient presents with pain concerns, how likely are you to suggest an over-the-counter pain medication such as ibuprofen or acetaminophen as the first option? (n=1149)	5.0	2.5	11.7	**80.9**
If a patient presents with pain concerns, how likely are you to prescribe an opioid painkiller as the first option? (n=1144)	**71.4**	20.2	5.5	2.9
If a patient presents with pain concerns, how likely are you to suggest alternative pain management (i.e., physical	7.2	7.7	18.5	**66.6**

therapy) before prescribing opioids? (n=1143)				

About 12% of the respondents indicated they also prescribed methadone for pain.

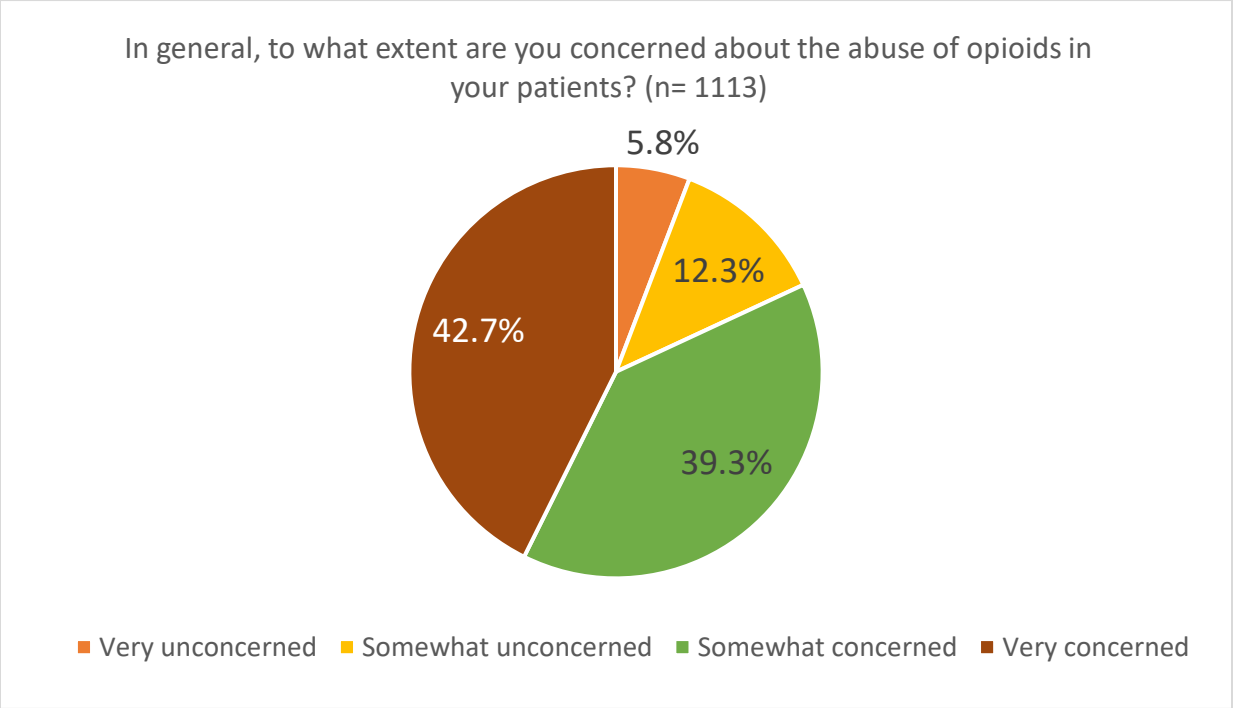


Over half of prescribers indicated that they always review the patients' charts, check the PMP database, and ask patients about previous addiction issues prior to prescribing an opioid.

In the context of your practice, when first prescribing opioids to a patient, how often do you…	**Percent**			
	Hardly ever	**Somewhat often**	**Often**	**Always**
... inquire about the patient's past opioid use (illicit and/or licit)? (n=1113)	7.7	10.7	25.6	**56.0**
... inquire about any past problems the patient may have with substance use or addiction? (n=1113)	10.1	15.4	24.3	**50.2**
... use an assessment tool to screen for any past or potential problems with a substance use disorder? (n=1113)	**52.4**	16.6	14.4	16.6
... review the patient's chart for previous opioid or benzodiazepine prescriptions prior to prescribing an opioid? (n=1113)	3.1	4.0	19.5	**73.3**
... avoid prescribing opioid pain medication for patients receiving benzodiazepines when possible? (n=1113)	4.2	11.1	30.9	**53.7**
... check the Prescription Drug Monitoring data base for previous opioid prescriptions given to the patient prior to prescribing an opioid? (n=1113)	12.0	10.7	26.9	**50.4**
... ask a delegate to pull/run a PMP report on a patient? (n=1113)	**57.5**	8.7	15.5	18.3

... ask a delegate to review the PMP report and let you know if there are concerns? (n=1113)	**70.8**	7.7	10.3	11.1
... require a urine test prior to prescribing opioids? (n=1113)	**47.8**	14.2	19.6	18.4
... provide a prescription for naloxone/Narcan at the same time? (n=1110)	**75.9**	10.7	8.1	5.2

Most prescribers (82%) indicated they were very or somewhat concerned about the use of opioids in their patients.

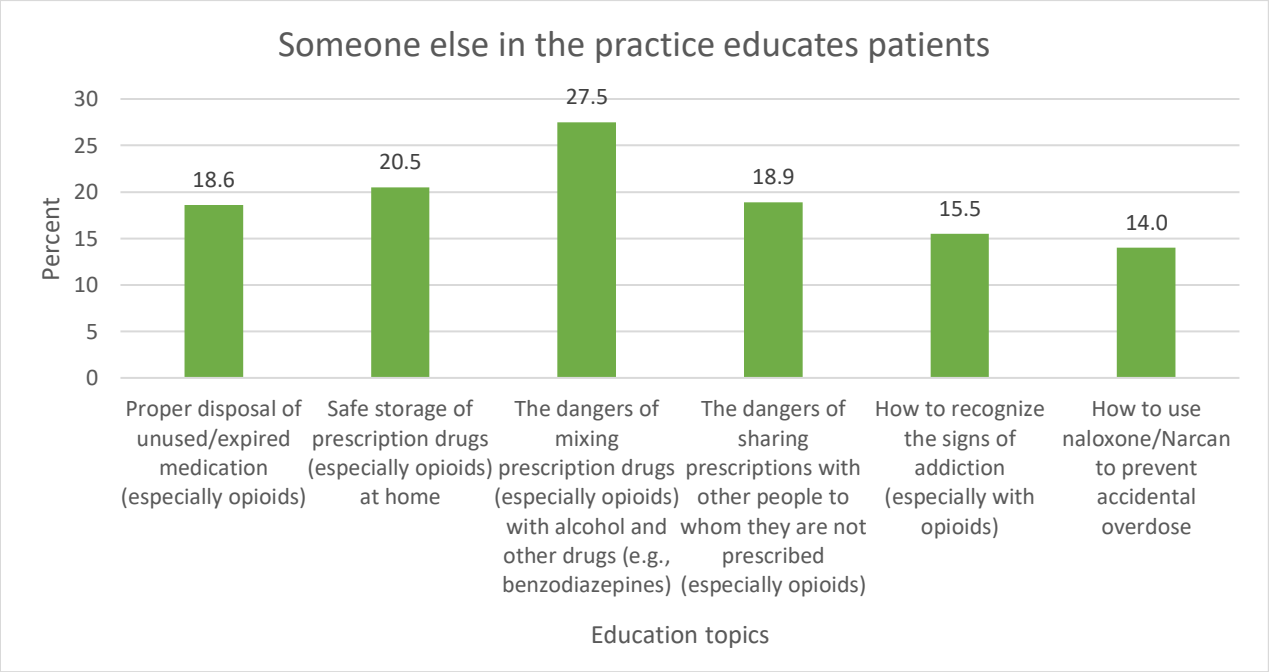


We asked prescribers if they spoke to their patients about specific topics related to opioid use. Prescribers often discussed the dangers of mixing opioids with alcohol and other drugs, the dangers of sharing opioids, and proper storage of opioids. Prescribers were less likely to discuss proper disposal of opioids, how to recognize the signs of addiction, or how to use naloxone.

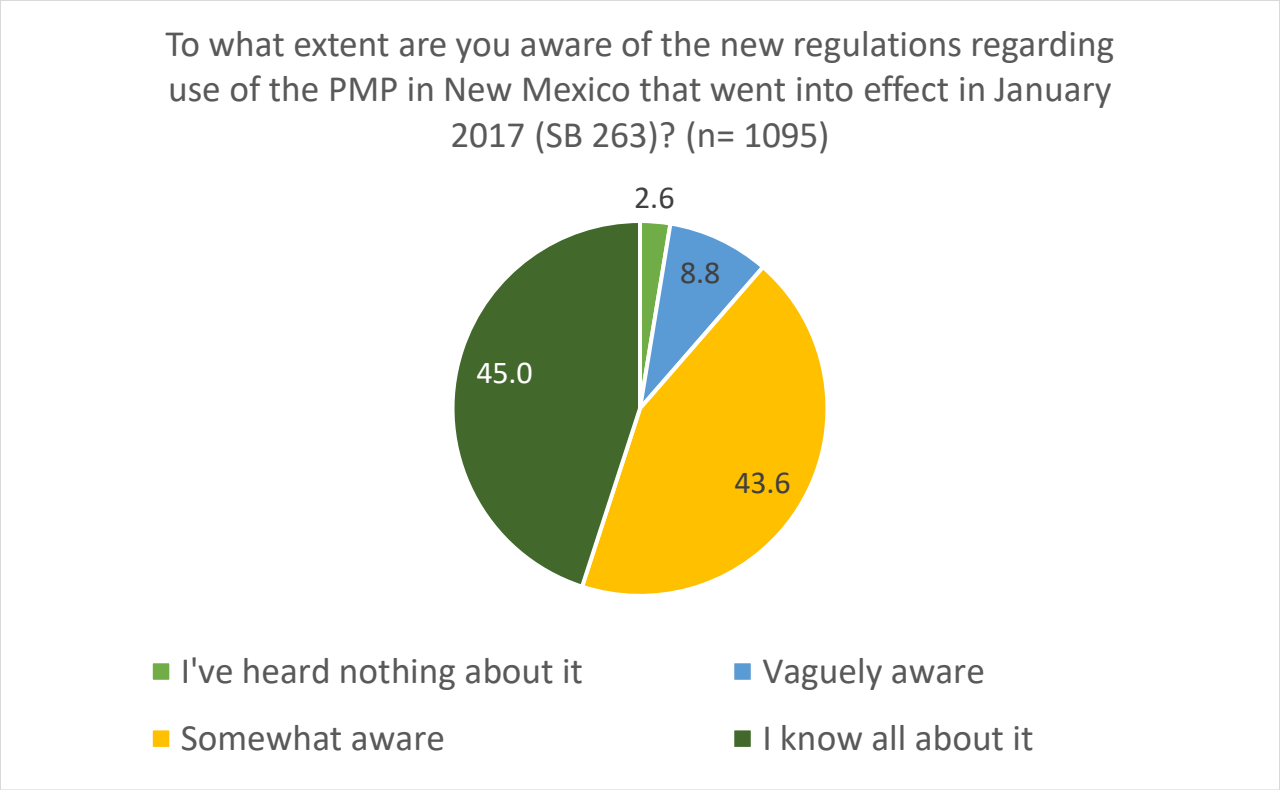
When prescribing opioids, how likely are you personally to talk to your patients about the following (n=1096)	**Percent**			
	Very unlikely	**Somewhat unlikely**	**Somewhat likely**	**Very likely**
Proper disposal of unused/expired medication (especially opioids).	21.4	20.3	28.3	**29.9**
Safe storage of prescription drugs (especially opioids) at home.	14.7	13.0	26.0	**46.4**
The dangers of mixing prescription drugs (especially opioids) with alcohol and other drugs (e.g., benzodiazepines).	4.1	4.2	17.5	**74.2**

The dangers of sharing prescriptions with other people to whom they are not prescribed (especially opioids)	11.4	9.4	21.1	**58.1**
How to recognize the signs of addiction (especially with opioids)	16.7	21.6	29.2	**32.5**
How to use naloxone/Narcan to prevent accidental overdose	**45.0**	22.9	18.7	13.4

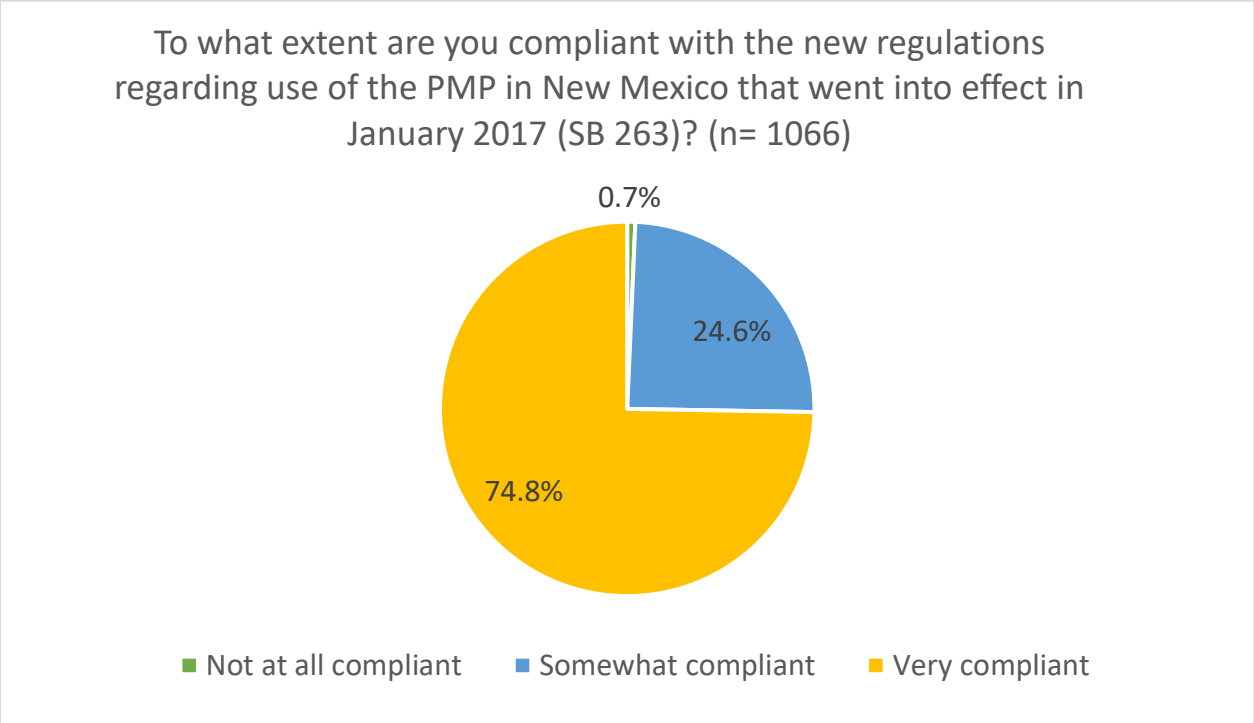
If the prescriber indicated that s/he was very or somewhat unlikely to discuss a topic, we asked whether someone else in the practice discussed the topic. In some cases, further discussion of opioids was handled by someone else in the practice.



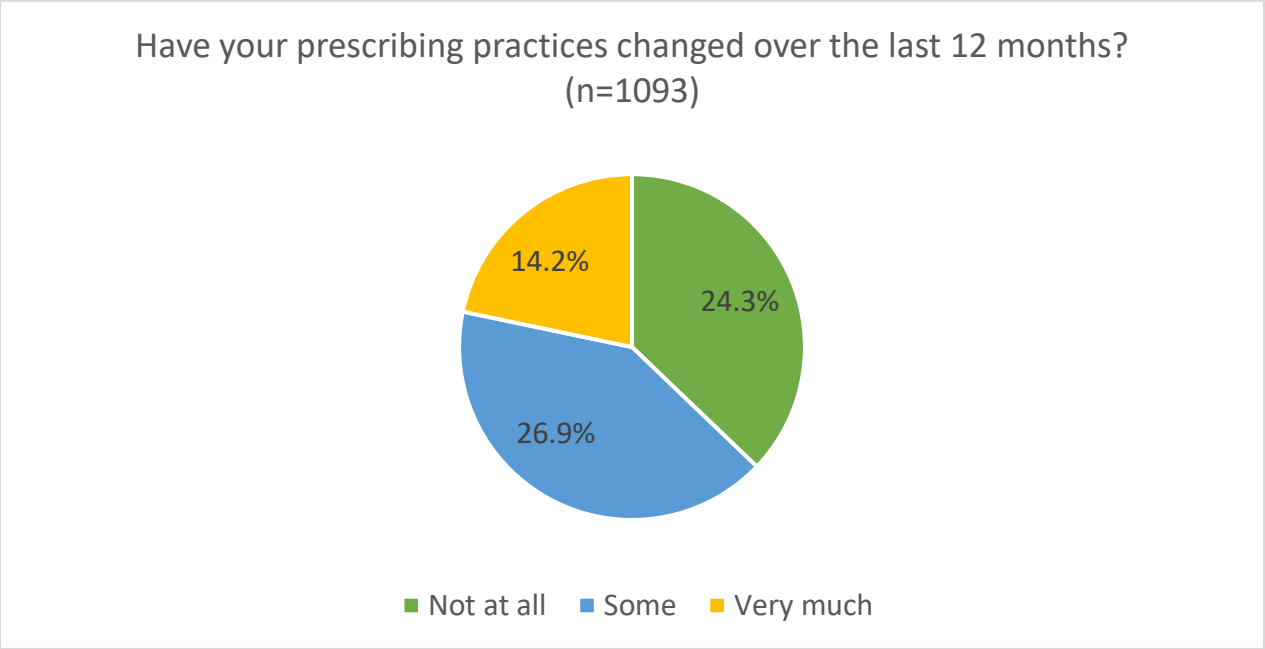
Most prescribers were very or somewhat aware of the new regulations regarding the use of the PMP (SB 263).



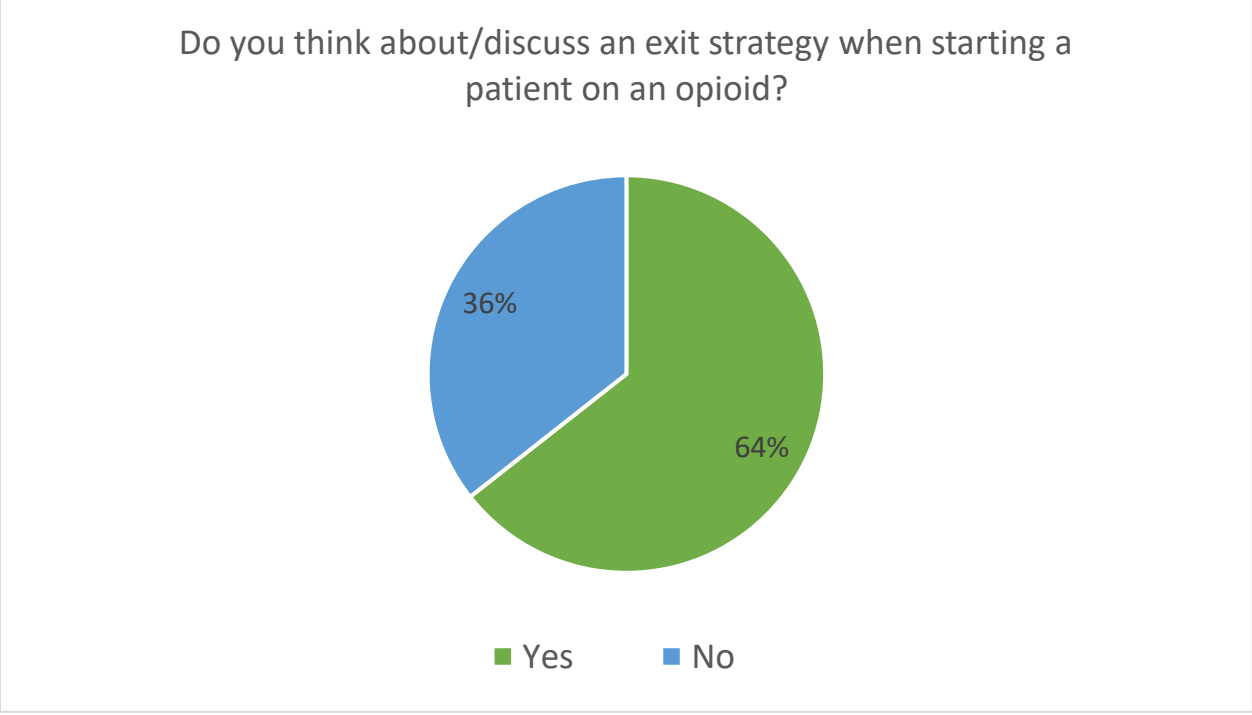
Not surprisingly, 75% of prescribers indicated they were very compliant with the state regulations that went into effect in January of 2017.



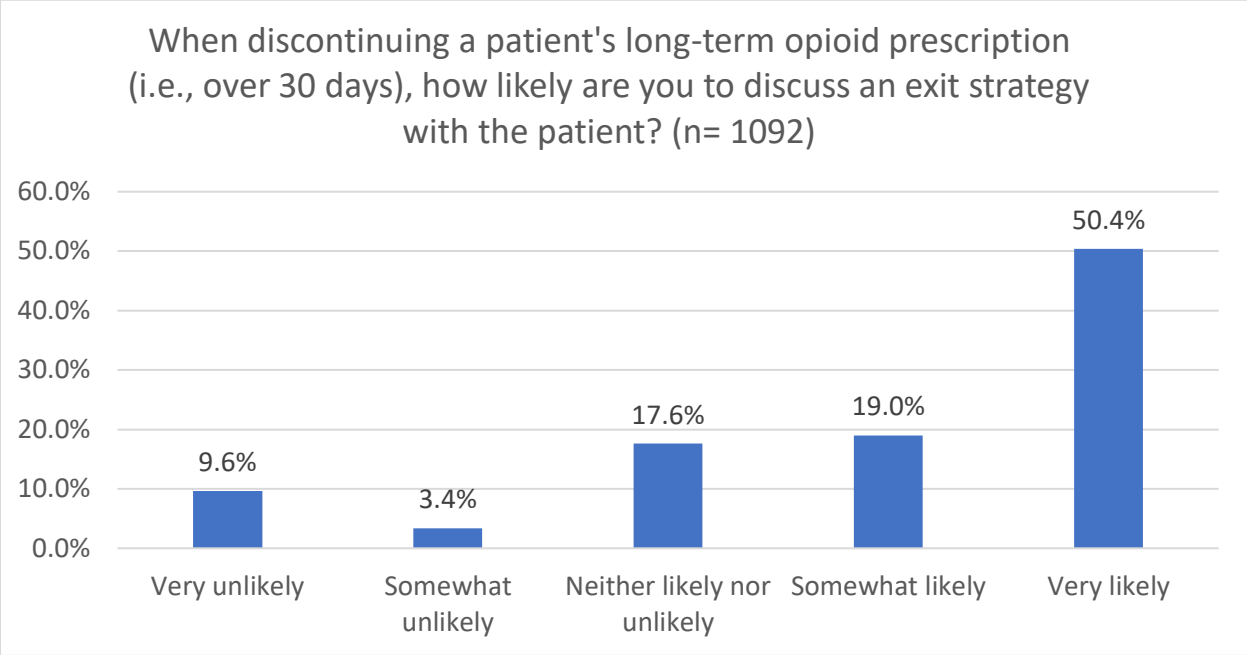
We asked prescribers if their prescribing behavior had changed at all in the past 12 months as tighter regulations have gone into effect and greater media coverage of the opioid crisis has occurred. Almost 15% indicated that their prescribing practices had changed very much while 27% indicated they had changed some, and 24% indicated they had not changed at all.



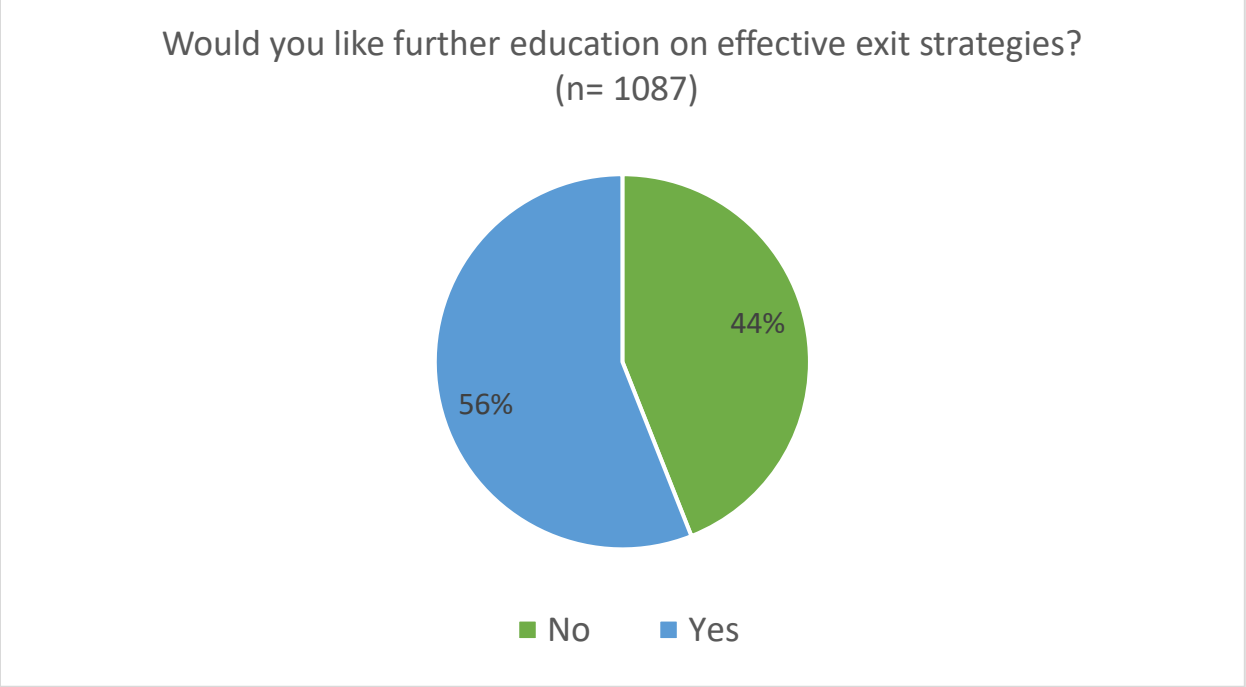
We asked prescribers if they discussed exit strategies with patients when starting them on opioids. Of respondents who answered the question, 64% indicated that they *do* discuss exit strategies with their patients.



Interestingly, fewer indicated discussing exit strategies with their patients with long-term opioid use, although half indicated they always discussed exit strategies.

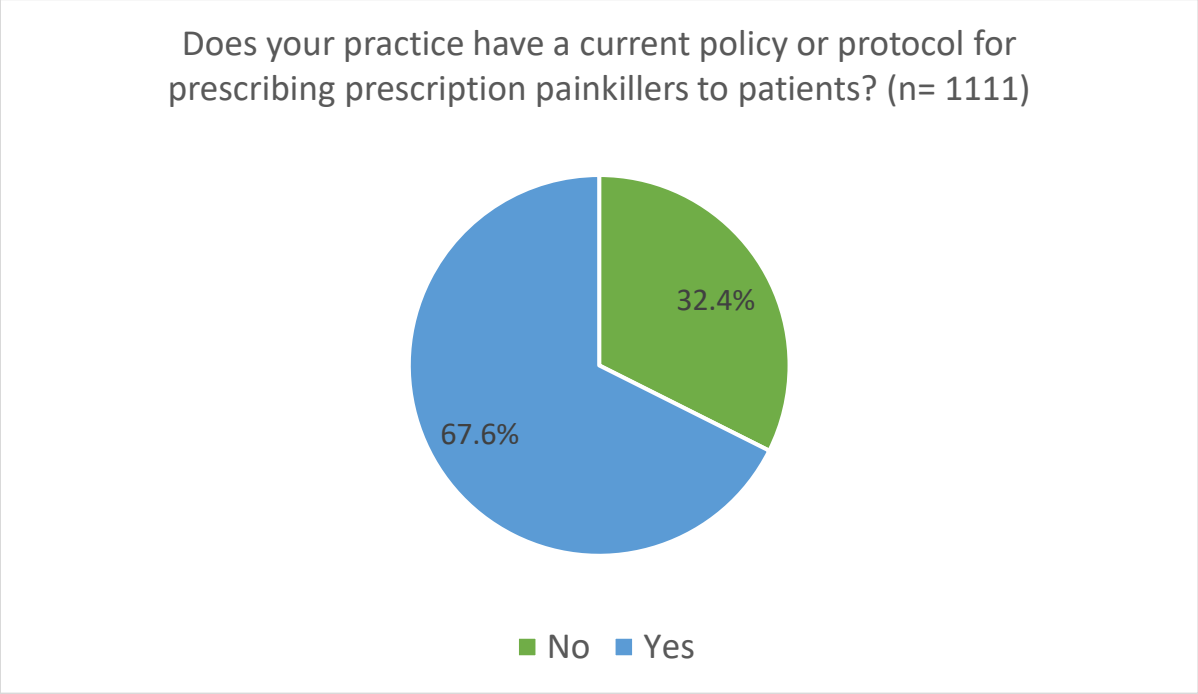


Over half of prescribers indicated they would like further education on exit strategies to help their patients.

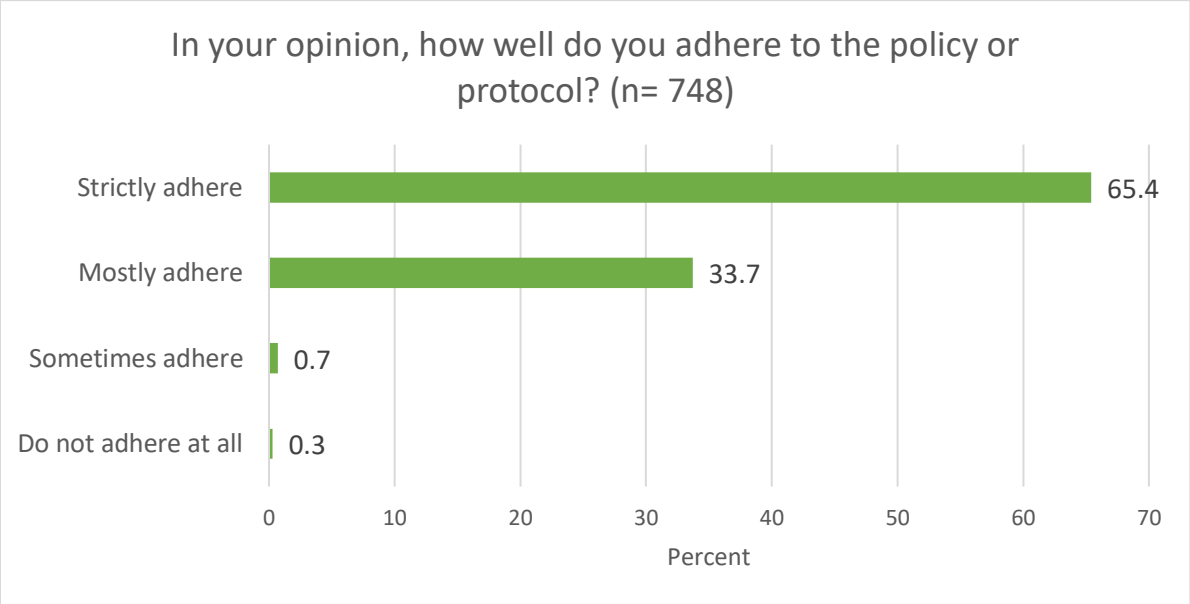


Practice Characteristics

Respondents were asked whether their medical practices have a current policy or protocol which guides prescribing prescription painkillers to patients. Over 65% indicated that their practice did have a policy or guidelines in place.



Of those who indicated their practices had current policies regarding the prescribing of opioids, most prescribers adhered to those policies all the time (65%), or most of the time (34%).



Prescribers reported that the policies and guidelines in place at the practice were mostly or very effective in protecting both doctors and patients.

Effectiveness of Opioid Prescribing Policies	Percent			
	Very ineffective	**Mostly ineffective**	**Mostly effective**	**Very effective**
How effective is the current policy or protocol at your practice in **protecting doctors from over prescribing Rx pain killers?** (n=747)	1.7	8.0	**53.4**	36.8
How effective is the current policy or protocol at your practice in **preventing patients from abusing Rx pain killers**? (n=746)	3.2	15.5	**57.8**	23.5

Qualitative Findings

The 2019 Prescriber Survey also asked respondents for short answers to enhance the understanding of their quantitative answers or to provide overall context to their prescribing practices. Answers were coded by the question asked and are listed here by question number and described by theme.

Q12a If a patient presents with pain concerns, how likely are you to suggest an over-the-counter pain medication such as ibuprofen or acetaminophen as the first option?

Most providers wrote that they begin with a conservative or step approach to treating pain. Respondents to the 2017 survey often used the phrase, "first line" when referring to NSAIDs in this question, and 2019 contained many "conservative" or "step" related words. Some respondents answered this question by writing something straightforward and short like "step therapy" or that they are following the WHO guidelines. Some added that they try to treat the issue causing the pain. This was especially true of dentists.

Others amplified the underlying question answering that NSAIDs work and are affordable and available. For example, one respondent said: "They work. Efficacy balanced with safety." Several providers specifically wrote that the combination of acetaminophen and ibuprofen are effective. Several added "unless contraindicated," such as the following statement: "I always offer over the counter medication as first line unless contraindicated." One said their patients respond better to non-opioid pain: "My patients typically have neuropathic pain and respond better to non-opioid medications in general."

Some respondents asserted that treating pain depends on the source of the pain. One person wrote that NSAIDs are insufficient for a fracture or kidney stones, for example. Others said cancer pain would also warrant a stronger response. However, even some oncology providers said they first suggest alternatives.

Several providers point to evidence in literature that shows opioids do not treat pain better than

NSAIDs. Illustrating this point, one said, “Multitude of studies for post-surgery and other showing opioids are no better than combination of ibuprofen and acetaminophen.” Another wrote, “Tylenol and Ibuprofen has been shown to work better then opioids in the literature.”

A significant group of providers wrote that they recommend alternative methods, including physical therapy, acupuncture, or heating pads. For example, one person wrote, “I typically recommend non-pharmaceutical methods like [a] chiropractor, massage, stretching, heat, ice, rest, movement, Epsom salt baths, etc.”

A few providers claim that OTCs are inadequate for some pain or that the patients have already tried alternatives to opioids. For example, one provider said, “Most of our patients have chronic kidney disease and can't take any NSAIDS. We use acetaminophen regularly, but this is often inadequate.” Two respondents asserted that patients claim NSAIDs do not work: “Always recommend least potent route of pain control first but unfortunately most patients claim Tylenol or Ibuprofen don't work.” However, about equal the number wrote that most people have not yet tried OTCs.

> “Most patients with chronic pain already have taken OTC pain relief medications and have not had adequate pain relief.”

Respondents noted the difficulties patients had with accessing pain specialists. After writing several paragraphs, a surgeon added, “It is very difficult to get patients in to see a chronic pain specialist in this state. This leaves practitioners in a difficult position stuck between patients and compliance with arbitrary metrics. Fear of ‘over prescribing’ is in my experience hurting patients.” This respondent also pointed out populations who cannot take NSAIDs: “Some patients are not able to take NSAIDs particularly those that I encountered with kidney disease, a common condition dealing with a largely Navajo population. NSAIDs also are particular concern with postoperative bleeding. Most importantly, there is no objective pain meter and appropriate pain management is a subjective issue. Surgical pain often lasts more than 3 days and I believe that the regulations while well-meaning actually have an opposite effect to that intended.”

Other providers also pointed out the continued practice that fearing patient satisfaction results in over-prescribing opioids. One person said, “In every place that I have ever worked (University of New Mexico Hospitals and Department of Veteran Affairs), my job security was threatened by medical leadership (Chief of Medicine or Chief of Staff) who fear patient complaints more than the consequences of inappropriate prescribing. “Another respondent echoed this sentiment stating, “Changes in rules and policy are reflecting on my decisions.”

Q13a If a patient presents with pain concerns, how likely are you to prescribe an opioid painkiller as the first option?

Respondents generally reported that opioids are not a first line to address pain. Some said it is unsafe, while others claimed that opioids do not address root cause of pain, or that opioids are not as effective as NSAIDs. A few providers said patients do not want opioids stating: “Opioids should be used for intractable pain with good objective evidence and should never be the first line of treatment with exception for cancer patients.”

A significant minority of respondents said that their prescribing practices reflect the kind of pain that a patient is experiencing. They sometimes prescribe short-term opioids for fractures or acute, post-operative pain. Others noted that they might prescribe opioids to oncology patients who are dying. Most of the respondents who said "it depends" noted that prescribing an opioid as first option is unnecessary and rare. For example, one person said, "Chronic opiates should be the last medication tried, unless there are other factors limiting NSAID and APAP use." Some said that their patients have already tried OTCs. One person said, "Mainly opioids are my go-to for kidney stones and fractures." Another said, "For trauma or deeper surgery, sometimes opioids are the best first choice." A couple of providers asserted that it is up to them to decide per individual patient.

> "Opioid medications should not be the first choice for pain relief."

As in the responses to Question 12a, some providers noted that they are not supported by administrators if they do not prescribe an opiate and the patient complains. One described the process saying: "I perform a history and physical exam [and] review prior treatment successes and failures. [I] provide extensive education of a variety of pain management modalities that are not opioid. I enlist the support of other disciplines including psychiatry, physiatry, PT, OT, and a pain management specialist who might provide interventional pain management procedures. Nine of 10 patients will immediately go to the front office to file a complaint. Management will sum the complaints until a secret limit is reached and the provider will be warned, threatened, [and then] terminated."

Q14a If a patient presents with pain concerns, how likely are you to suggest alternative pain management (e.g., physical therapy, chiropractic) before prescribing opioids? Please provide an explanation for your response.

Some respondents said they are likely to recommend alternative pain management first. Physical Therapy (PT) was the most common alternative listed, and respondents often pointed out the evidence of effectiveness for PT. One responded, "I prefer to steer patients towards rehabilitation and empower them to give self-care rather than rely on addictive medications that only mask the problem. Many alternative therapies address the problem by promoting healing." Another wrote, "I always refer patients with pain to PT, acupuncture, massage and other healing modalities." A third person wrote, "I believe physical treatments are often underused, and they address functional status as well as pain."

Another group of respondents pointed out that insurance does not always cover alternative therapies. Illustrating the point, one provider said that IHS does not cover it: "Tooth pain cannot be solved with alternate therapy. However, jaw pain often can-but Indian Health Service doesn't recognize that as a payable option for our patients." Another respondent pointed out that in underserved counties, it takes too long to assess a patient for physical therapy. "I don't use chiropractors, It takes a very

> "Finances must also be considered in this picture. Can a patient afford alternative treatments?"

long time to access Physical Therapy here in Las Cruces. We are so terribly underserved in Doña Ana County"

As with the previous questions, many providers pointed out that certain issues cannot be solved with alternatives. Many dentists pointed out the ineffectiveness of alternative pain management for their situations Although one dentist mentioned cold and elevation: "Not sure those things help for dental extractions, but I suggest cold and head elevation."

Q16 In what situations do you prescribe methadone for pain?

Very few providers responded to this question. Those that did typically said they would prescribe methadone for new patients who are already using it. Illustrating this point, a provider said, "In-patients who were already established patients and were started on this by another provider." The second most common answer related to patients with chronic pain and co-occurring addiction concerns, with one provider telling us "in patients who have constant pain and have developed tolerance to opioids or intolerance to other forms of narcotic analgesia." Cancer was the third highest reason. One person wrote, "Cancer related pain most often: when it is not responsive to other opioids or s/e from other opioids are greater than benefits."

> "Hospice patients - less constipating and [fewer] other side effects."

Q17a In what situations do you prescribe buprenorphine for pain

Providers noted that they might prescribe buprenorphine in patients with opioid use disorder/ another substance use disorder, in people transitioning off opioids who still have pain, or people already on buprenorphine. They also would consider it in when all other methods have failed.

> "When previously on opioids for chronic pain and a safer option is required."

Q18a In what situations do you prescribe naloxone?

Most people wrote that they prescribe naloxone by law with every opioid Rx, for example: "I am forced by law to prescribe it along with opioid prescriptions in all patients." However, respondents did not all know the length of an opioid prescription for which they must co-prescribe. There were about equal groups writing for 4 days or 5 days and more rarely, 3 or 7 days. One person noted that patients get mad if they must pay for the prescription, and another wrote that uncertain insurance coverage mean many patients do not fill the prescription. A nearly equal number of people did not mention any law; they wrote that they prescribe naloxone for all patients taking opioids.

> "[I prescribe naloxone] when a patient is taking prescribed opiates or if I know they are using illicit forms of opiates."

Some providers noted that they will prescribe naloxone for people with family members who have OUD, patients at risk for overdose, patients on suboxone, alcohol abuse, or those who present with opioid overdose. A few people said their prescriptions of naloxone have jumped.

For example, one person wrote, “Rarely before, now frequently.”

Q19tx_1 In the context of your practice, when first prescribing opioids to a patient, how often do you… inquire about the patient’s past opioid use (illicit and/or licit)?

This question was answered only by a small number of respondents. Most of those respondents said they do it when they take the patients’ histories. For example, it is “essential to know history of use of medications, quality of pain, complete history of medications.” Many people said they check the PMP. One person mentioned HERO Trails.

Several people also wrote that asking helps guide dosage. “It’s always good to know if the patient is opiate naive or not,” and “This gives an idea of how tolerant or naive they may be to guide dosing.” One specified that they ask about addiction.” I inquire is the patient has ever had an addiction problem with opioids.”

> “Past usage does not pertain to acute postsurgical pain. A patient deserves pain medication after a surgery as they will be in pain from the operation. Past opioid use only matters if they have tolerance or dependency, which is reviewed with medication reconciliation and addressed in the preoperative setting.”

A group of providers noted that they do not ask their patients because they are pediatric, geriatric, or dying. One person wrote that they did not want to answer for fear of legal troubles and another wrote, “Time constraint.” A third asked, “Would they really tell me?”

Q10tx_2 In the context of your practice, when first prescribing opioids to a patient, how often do you… inquire about any past problems the patient may have with substance use or addiction? Like Q10tx_1 above, only a few respondents answered this question. Most respondents said that they ask when they take the patients’ histories. A couple of these respondents wrote that taking this information was part of a new update to patient records. One provider wrote, “This is routinely done for every pre surgery evaluation.” Another noted, “Based on answer to previous inquiry.”

Q10tx_3 In the context of your practice, when first prescribing opioids to a patient, how often do you… use an assessment tool to screen for any past or potential problems with a substance use disorder?

Thirteen respondents to this question wrote that a screen is not used for the patients they see. For example, one person explained they see post-op patients already on opioids from the surgery.

> “It depends upon the situation. Time limits in visits are difficult for acute pain issues. For chronic pain issues, I agree this should be done.”

Another noted that acute hospital stay patients are not screened. One person said, “Even if they are addicted, patients with cancer deserve pain control.”

Two people wrote in that they check the PMP, another said they screen for risk assessment.

Q10tx_4 How In the context of your practice, when first prescribing opioids to a patient, how often do you… review the patient's chart for previous opioid or benzodiazepine prescriptions prior to prescribing an opioid?

Most providers who answered this question wrote that their situation does not require checking a chart (i.e., do not prescribe, prescribe only to children, acute care, post-surgical; n = 11). About equal numbers (n=10) wrote that they check the PMP. Among them, one wrote, "I'm using the PMP more than the chart," and another wrote they review the chart and the PMP.

Q10tx_5 In the context of your practice, when first prescribing opioids to a patient, how often do you… avoid prescribing opioid pain medication for patients receiving benzodiazepines when possible?

Most providers who responded wrote about specific cases or situations (end of life, cancer, post-op; n= 11) in which they have patients on both opioid and benzodiazepines. Two respondents said they inherited patients but are in the process of weaning them, and one said they have prescribed both in the past but no longer do so.

Among the group who avoids prescribing opioids for patients receiving benzodiazepines, reasons included: to avoid drug interactions, standard of care, and one person listed "PMP, History, Rx history." (n = 7)

Q19_11_2_1 When first prescribing opioids to a patient, how often do you inquire about current cannabis use? - Would you like to provide an explanation for your response?

Most people who responded wrote that they ask (n= 16). One wrote, "I inquire about this with every patient. My experience is that those people utilizing cannabis actually have a lower demand for opioids. This is particularly important in my breast reconstruction patients after mastectomy for cancer." One person wrote that they inquire as part of history, not necessarily related to opioid Rx. Another said they ask during pre-op because they are going to give them anesthesia.

Six respondents wrote favorable comments about cannabis use. For example, one person wrote, "I'm less inclined to inquire about cannabis use because it is such a frequent positive." However, another person wrote, "Cannabis has a medicinal role, but it is rarely useful for the extremely wide variety of symptoms that patients proport to use it for."

There appeared to be some difference in opinion as to whether cannabis should be used with opioids. One person wrote, "Safest drug to co-use with opioids," while there was another group who felt cannabis should/could replace opioid use. For example, one provider wrote, "Often cannabis is prescribed for pain. If that's the case, then supplemental opioids should not be indicated. Also, I require a current cannabis card." Another wrote, "I have suggested cannabis as an alternative to opioid and had patients be successful with this transition."
One person wrote that they encourage cannabis when tapering.

A few people wrote unfavorably about cannabis. One person said that too many people want it, while another wrote, "Cannabis use prescribed or non-prescription often clouds response to

medical management."

Of the smaller group of respondents who wrote that they do not inquire about cannabis use, most explained that they treat pediatric or geriatric patients, or post-op (n = 6).

Q19_12_2_1 When first prescribing opioids to a patient, how often do you check the PMP for multiple provider encounters (i.e. multiple prescribers and pharmacies)

An equal number of respondents (25) wrote that they check the PMP and that they did not because of their patient panel/situation. Some pointed out that it is the law to check, while others said they would check if they are required by law. Some wrote that they check only if they suspect the patient is abusing. A group of people have a pharmacist who checks for them. One said, "That would be better left to the pharmacist."

> "If the PMP were available [in] 1 click without a separate log in it would be easier to use it every time."

A group of respondents wrote that they check their in-house EMR. Among them, some noted a prescription from one of their colleagues in the same clinic, so the PMP shows multiple providers. Another said that they would check the PMP if it was as fast as checking their EMR: "I always check our EMR external RX history which is not as complete as the PMP but is quick and easy to access within the chart. If the PMP were available [in] 1 click without a separate log in it would be easier to use it every time."

Q19_6_2_1 When first prescribing opioids to a patient, how often do you check the PMP for previous opioid prescriptions given to the patient prior to prescribing an opioid

The biggest group was of people who said the question did not apply to them or their patient panel (n = 15). A small group of people (4) explained that they keep the quantities they prescribe very small, ostensibly so that they do not have to check the PMP.

> "Consuming more of MY resources: At some point it will be too costly to practice. We have had to hire an extra person in the practice just for PMP, naloxone research, [and] keeping up to date on regs."

Q19_13_2_1 When first prescribing opioids to a patient, how often do you check the PMP for current benzodiazepine prescriptions given to the patient prior to prescribing an opioid?

Seven respondents reported that they check because it is the law, for risk assessment, and because they must check the PMP for opioids anyway.

Q19_14_2_1 When first prescribing opioids to a patient, how often do you check the PMP for current opioid, benzodiazepine and carisoprodol prescriptions given to the patient prior to prescribing an opioid?

Again, the biggest group of respondents (14) wrote in that the question did not apply to them for the same reasons listed above: they do not prescribe opioids or only for post-op/acute care hospital setting. Seven respondents noted that they checked PMP.

> "We have to check the PMP anyway, so I do not sign out and get back on to check for benzos."

Q19_15_2_1 When first prescribing opioids to a patient, how often do you check the PMP to review the dose of an opioid prescription previously dispensed to the patient?

Most respondents (n=21) who do not check the PMP don't check because they do not prescribe opioids, or they only prescribe a very brief/ small quantity (post-surgical, acute hospital stay). One respondent said "I look at patient medical records and their pill bottles and interview patients and their families for this information." Another said that they have the patient bring the bottle in. The second largest group of respondents checks the PMP (n=8) because it is standard of care, it's the law, for risk assessment, a window pops up to remind them, and/or a delegate does it for them.

Q19_16_2_1 When first prescribing opioids to a patient, how often do you check the PMP to see when the patient last filled their controlled substance prescriptions?

> "I usually rx less than amount requiring review, but often check anyway or if suspicious or concerned. If someone has documented acutely painful condition not likely to managed by OTC meds, I do not always check if rx'ing a small amount because checking will not change what I do."

Nineteen respondents report that they do not check the PMP. Of the people who do not check, most wrote that it is because they prescribe so little or do not prescribe. For example, "This is not a concern in my general practice. The 5 tabs given along with the knowledge of the patient's background leaves this a nonissue." Two people said they check internal databases. For example, "In the VA this information is easily accessible for all VA filled prescriptions." Some people check situationally. "If indicated; usually prescribing such a short course that this is not required." One person commented on the access: "Sometimes access is not available, making it hard to check 100%" Another person questioned the accuracy of the PMP for this.

The second largest group of respondents (N=15) check the PMP for the same reasons as discussed in earlier questions: it's the law. One person commented, "Rarely do patients' attitudes change when presented with PMP data. In fact, some patients become agitated or aggressive if the PMP is checked because of a perception of "lying." I have found the approach of being a "hard ass" to get narcotics, benzos, and/or muscle relaxers from has a salubrious effect of disentangling drug-seekers from legitimate patient requests."

Q19_17_2_1 When first prescribing opioids to a patient, how often do you check the PMP to see if the patient obtained medication for other states?

Twenty-six respondents wrote they check other states, at least situationally. For example, respondents told us that they check other states if the patient comes from out of state or is traveling. Some respondents wrote that not all states are available, another said they were unaware this was an option. A few respondents thought it was automatic. A fourth person wrote, "The federal pharmacies are not included in the reporting, I only collect Texas and NM."

> "Whenever I check PMP I look at the bordering states as well."

Q19_7_2_1 When first prescribing opioids to a patient, how often do you ask a delegate to pull/run a PMP report on a patient? and Q19_8_2_1 When first prescribing opioids to a patient, how often do you ask a delegate to review the PMP report and let you know if there are concerns?

By far, most respondents (n=65) wrote in that they pull the PMP themselves. Some explained that it is their responsibility, to ensure patient privacy, or that others do not have time to pull it (or it takes longer to find someone else to pull it than doing it on their own). Some people said their EMR automatically pulls it now. One provider explained, "I used to have a delegate pull the PMP always. Now our new EMR pulls the PMP automatically so I can view it myself without having to log in." Several respondents said simply that they do not have a delegate. Of the people who delegate (n = 6), one person said they have the medical assistants pull, but they always review it.

Q19_9_2_1 When first prescribing opioids to a patient, how often do you… - Q19_3#2 - ... require a urine test prior to prescribing opioids?

Equal numbers of respondents indicated that they would require a urine test (usually situational) and would not (mainly because it was not applicable to their setting). Some providers said they do not work in a setting that requires a urine test. For example, one provider wrote, "in a school-based setting, the need for opioid prescriptions are minimal otherwise a urine test would be something I'd use often if frequently prescribing opioids." One person said patients can get around urine tests: "Taking OTC H2 blockers (e.g., cimetidine) will invalidate a urine drug test. Opioids have a duration of 1-3 days in human urine; I have not found it practical to screen for opioids."

Q19_10_2_1 When first prescribing opioids to a patient, how often do you provide a prescription for naloxone/Narcan at the same time?

Most respondents began prescribing naloxone because of the new law. Several people who prescribe naloxone at the same time as opioids noted the exact date the law requiring them to do so took effect but noted some limitations in implementation. "Now required, someone should let the insurance companies know." Respondents reflected confusion about the number of days a prescription is for before they must co-prescribe naloxone. Some expressed a desire for improvements to the new law. One person felt that including Tramadol did not make sense and another felt it should not apply to hospice patients.

> "Never have been required until 6/14."

Q21 In general, to what extent are you concerned about the abuse of opioids in your patients?

This question elicited many responses. Most respondents expressed concern about the abuse of opioids in patients, commenting on the size of the crisis or epidemic and noting the prevalence in their geographic location. One provider wrote succinctly, "I'm concerned about the potential for opioid abuse or misuse in all of my patients. I work in NM."

> "I am concerned about the widespread use of controlled substances in general, and addiction, not just in my patients."

Some respondents expressed concern about prescribing practices of other providers, perceiving them to not follow the recommended guidelines. For example, one person observed their colleagues, "Other providers in my practice prescribe opioids without following guidelines with no penalty." Another wrote, "The 2 doctors in [location withheld] County have created an environment of opioid abuse and dependence. It is well known that if anyone wants to "party" they just need to see one of the 2 doctors at [location withheld]."

Some providers noted the challenge of assessing mental health as a co-occurring issue: "It is important I know what medication the patient is taking so that there are no or few contraindications, i.e.: benzos and opioids if possible. Sometimes an individual with chronic pain also has anxiety which presents challenges as a prescriber." One provider stated a desire for patients to try alternative pain management, writing, "I worry some patients don't try other ways to relieve pain."

> "Opioid use in NM is out of control. The culture and the laws have changed. As a provider, I feel that by prescribing less opioids and benzodiazepines, I will be doing my part to reduce abuse."

Several providers were worried about diversion; they were comfortable with their elderly/ hospice/ cancer patients' usage but concerned about their patients' families taking the meds. One wrote, "Even though I see the oldest old, I worry about abuse and misuse, and families or caregivers stealing their meds or elder abuse such as diversion, coercion, or withholding or neglectful management of these substances."

Alternately, there was pushback among a group of providers on the stricter guidelines around opioid prescription. Some stated that the guidelines hinder their ability to treat their patients effectively. One provider wrote, "Look, the pendulum has swung too far in the opposite direction. Yes, too many narcs are rx'd, but most post-surgical patients are having too much pain." Another wrote, "I do not assume that everyone using opioids is abusing them, nor that pain should only be treated with medication as a last resort, which unfortunately seems to be the dominant paradigm now." A third person noted, "I practiced for many decades including when we (went overboard) were tested by Joint Commission on the "fifth" vital sign- addressing pain. Now I SEE we are again going "overboard" in the other direction, not prescribing APPROPRIATELY 1-4 days of narcotics for acute conditions. With appropriate usage,

appropriate discussion, education, with the patient, [we can] relieve pain and suffering...do no harm."

Q23 Does your practice have a current policy or protocol for prescribing prescription painkillers to patients? Please briefly describe the policy

Most respondents listed a combination of policies when prescribing opioids, commonly: check PMP, drug screens, assess patient's history, pain contracts, pain clinics, patient education, naloxone prescription, do not give refills/lost prescription, and prescribing a limited quantity. Within the policies, providers also varied regarding how many strategies they require and how often they implement some of them. For example, some respondents randomize drug screens while others screen every 3 months. While many providers check the PMP, some only provide patient education. Several providers wrote in that it is policy that they avoid prescribing opioids or start with conservative measures/alternatives first. Some do not accept any long-term pain patients.

Generally, providers appear to trust their experience/expertise when deciding to prescribe an opioid. For example, one person wrote, "New patients can get a weekend dose depending on the day of their appointment. but Doctor shopping/ abuse signs are understood and if they present then we do not Rx opioids."

"I don't want my license taken away for some jackass to get high!"

Q24a In your opinion, how well do you adhere to the policy or protocol? Would you like to provide an explanation for your response?

Most providers reported compliance with the policy and often have a template to follow. Medical assistants or nurses help ensure compliance, or the pharmacy enforces the pain contract. One provider explained it this way: "I try to adhere to all policies at each site where I work for consistency of policy, to avoid undermining usual provider-patient relationship, community values, or patient well-being." Several people shared ethical or patient safety comments, that following the policy helps them and is best for their patients. One wrote, "I adhere to policy as it is state of the art, and it helps me." A second person wrote a lengthy paragraph on the risks and side effects of prolonged opioid use on quality of life to explain their adherence to policy. A third stated, "It would be unethical to do anything but that which is policy."

Some providers noted very rare slips in compliance. For example, one wrote, **"**99% compliance with rare exceptions...MUST leave room for humanity." Another wrote, "I try really hard to adhere 100%, but sometimes things do slip through. Nurses are taught to look out for the missing annual contracts so we can fix it ASAP." Similarly, another wrote, "I do my best to adhere. Sometimes, you're in a hurry and realize you haven't checked a urine drug screen in more time than the policy says, or you forgot to have the patient sign the agreement and it's been fourteen months since the last time."

Q25a In your opinion, how effective is the current policy or protocol at your practice in protecting doctors from over prescribing prescription opioids?

Overall, respondents felt their policy was effective or that they had not encountered problems. There were frequent expectations of self-regulation among providers. Illustrating this point, a provider wrote, “While as a leader I can give people tools and educate them, as some point they are medical providers who have free will. Luckily we have some ability to self-regulate and monitor.” A few people noted that they work as a team to meet and ensure effectiveness. Others said they have an independent practice and/or are the sole prescriber. One person perceived the PMP to help prevent patients from accessing excess opioids: “Some patients will always figure out a way to fool us, sometimes. Thanks to PMP they now can do this for no more than a couple of months, rather than a couple (or more) years prior to PMP being widely available.” A different provider felt the “no refill” policy helps, while others said the pharmacy helps enforce their policy.

Several providers noted concerns with the language of this question (e.g., Why only doctors? How to define over-prescription? Pain is subjective.). Others stated that patients need protection, not doctors. One person wrote, “The question is biased as phrased. I would have preferred ‘prescribing opioids safely’ instead of "protecting doctors from over prescribing prescription opioids." I believe it is patients who need protection more than doctors.” Another said, “while over prescribing is an issue, under managed chronic pain is also an issue.”

Some people commented on the system being broken. For example, “The DEA requires me to have multiple DEA numbers for each state each practice location such as a hospital or a clinic a private office and the office is in the various states. It is possible for me to hold up to 10 DEA numbers. It would be very easy to run a prescription mill. Eventually I would be caught but the system is broken.”

Q26a In your opinion, how effective is the current policy or protocol at your practice in preventing patients from abusing, misusing, and diverting prescription opioids?

Most respondents noted that there is no way to control for diversion, or “where there’s a will, there’s a way”. Representing this group, a provider wrote, “If a patient wants opioids, they will get them.” Another stated, “Patients will divert in spite of efforts to reduce.” A third wrote, “Patients will still divert or overuse because they think they can get away with it. When they are caught, I switch mine to buprenorphine. Most take it, some find another provider who will prescribe oxycodone.” One respondent perceived diversion to be a unique characteristic of New Mexico, stating, “Abuse and misuse or diversion is a commonly accepted social phenomenon in New Mexico. Bucking this trend is seen by patients as the Dr is just making trouble for me.”

“Where there’s a will, there’s a way!”

The other group of respondents listed steps they take to control for preventing patients form abusing opioids, including checking the PMP, drug contracts, urine screens, and patient education. For example, “by checking the PMP and only prescribing 3 days of low dose narcotics and referring for further evaluation and treatment; we treat the acute pain and also protect the patient.” Several said they just prescribe for acute pain or do not prescribe opioids.

Some people felt their policy or parts of their policy needed improvement. One respondent wrote "The policy is irrelevant." One person said the new VA guidelines are having deleterious effects, saying, "I have Veterans that have told me they are turning to street heroin rather than deal with the new rules at VA for painkillers."

Another provider observed that following the policy is a challenge: "If it is followed - it is very effective. My observation is that many of the primary care providers are so overwhelmed with the demands of their practice, they cannot follow the recommended guidelines or VA policy."

Q29a_11_TEXT Have your prescribing practices changed over the last 12 months? How have they changed?

Very few responded to this question. Those that did said they now prescribe shorter scripts and co-prescribe with naloxone. Some providers no longer prescribe at all: "I have decided that prescribing opioids chronically for pain relief is not something I wish to do. The only exception is for terminally ill patients."

Some providers feel the new guidelines are not helpful. One provider stated, "Leaving patient to deal with their pain -being under prescribed in fear of retaliatory action by the state bureaucracy."

"Protecting my license by refusing to see any new pain patients. Current regulatory climate is too punitive for me to risk newcomers."

Q29b_10_TEXT Have your prescribing practices changed over the last 12 months? What has influenced those changes?

Most providers who answered this question (n=32) cited the new law or SB221. Others said that evidence in the medical literature and national awareness has influenced them (n = 22). Ongoing education and focusing on best practices were also cited. Related, personal experience or observation of opioid addiction has influenced providers' changes (n=7). Three respondents asked for a definition of academic detailing.

Q32 When discontinuing a patient's long-term opioid prescription…. As part of your exit strategy, what methods have you used?

Tapering was the most common answer with providers describing how they taper ("slow" and "gradual" were commonly used words but how slow varied). For example, "I taper them down over a few months to build trust in themselves that they can come off and in me they can trust me to go slow with them," Some respondents used percentiles: "25% dose reduction per week depending on length of time patient has been on opioids." Many providers also listed methods they use in combination with tapering, including counseling, family/friend support, close monitoring/in person visits. "Encourage patient to seek therapy, expand social support networks, natural/alternative methods of healing including exercise, yoga, meditation. Understanding that titration down is inevitable so it must be taken seriously as a certain outcome of care. Patient will be transferred to pain management or another provider if they are not compliant."

"Tapering every 3-4 days by 1 pill per day and if using as needed but daily the same mechanism."

Some respondents also detailed discussing/creating a plan with the patients so that they are accountable. "Have the patient acknowledge a specific time frame. Discuss support measures. i.e., psychological referral, discuss support medications for withdrawal Rx etc." Another wrote, "Letting the patient know up front that the prescription is for temporary relief of pain, and for long-term recipients, I address the goal of tapering at each visit."

Some providers wrote that they refer to pain management. One said, "I don't initiate opioids, will inform them I am referring to pain management or another primary provider." Another wrote, "Consult to co-occurring pain clinic." A few providers wrote that they try alternative therapies. One wrote, "Try to use all the non-narcotic medications, PT, CBT and reassurance. I have not been very successful in decreasing or discontinuing chronic pain med patients." Another wrote, "Prescribing Lucemyra, referring to other pain management, recommending non opiate medications, encouraging different or more PT."

Q36 Do you prescribe buprenorphine products? = No Why are you not prescribing?

There were only a few responses to this question and most respondents explained that it is simply out of the scope of their practice (n=12): "I am a hospice doctor. Focus is on being able to aggressively treat pain at end of life." Some respondents (n=9) cited credentialing or capacity issues: "No clinical capacity in current specialty care."

Two respondents wrote that it is difficult to monitor buprenorphine." Have not done the induction process on my own and don't feel confident." Another respondent told us about the "risks of diversion and patient noncompliance."

Q38 Approximately how many patients are you currently treating under your DATA Waiver Registration to prescribe buprenorphine products to treat opioid use?

Most respondents have between 1 and 10 patients that they treat under the DATA waiver (n = 41). Within this group, one respondent clarified that if they added their residents' patients, the number would be much higher. The second largest group of respondents wrote in zero patients (n = 37). Two people in this group said they had just received their Waivers, so their number will change. Others explained they practice in settings outside the scope of the waiver. One person said they only use it for discharge, "so no ongoing patients."

Q42 How would you improve the PMP program to make it more efficient or useful to you for clinical purposes?

This question received a high volume of responses. Broadly, respondents' ideas relate to saving time, more easily preventing abuse, and clarifying information. There is immense variation under these three categories.

Time saving suggestions include improving the interface overall (employ UX researchers do improve, reformat prescription page). Suggestions to save time include: reduce frequency of

password resets (most common), integrate PMP to EMR and EPIC systems (some have this and said how helpful it is), improve the delegation process (increase number of patients allowed for NPs and PAs/ allow providers to look up and save time/all multiple logins), make reports easier to print, summarize or email "red flags" to avoid having to search for them, not "agree" so often/scroll to accept, search last name first as is standard in medicine (improve search function overall; populate info upon typing), lengthen time instead of every 3 months (at least for sleep meds), provide a backup when system is down, and provide an app to use.

Suggestions **to more easily identify abusers** include: Make the database nationwide/get other states to buy in/more pharmacies/VA (most common), flag suspected abusers (show that other providers looked the patient up, let providers add notes on patients; second most common), include methadone, alert when a patient has an overdose, require reviewing PMP for all controlled substance Rx, provide referral system for providers who are not pain management specialists, greater pharmacy requirements to prevent abuse, more resources (latest research, seminars, CMEs, education for patients too). One person suggested that a PMP be run for every triage patient who has pain higher than zero and that report be placed in the chart before the provider sees the patient.

Desire for **clearer information**: Desire to see number of pills, not number of days to better determine abuse, separate statistics regarding buprenorphine for OUD and opioids agonist, include type of doctor and the VA medications, see when a PMP is not reviewed on Rx logs, and connect computer generated narcotics orders to PMP site. Two respondents reported receiving inaccurate emails from the program and are concerned about accuracy of data.

A group of providers commented that they are pleased with the system, with several commenting on how it has been improved. One person said, "It's refreshing to have the current model after being berated during the 80's by JCHO to prescribe more pain medication."

Several respondents noted concerns with harsher laws withholding drugs from patients who really need them, such as cancer patients, and that the burden is placed upon providers who do not receive any support from the State or from guidelines. Elderly patients should also be considered related to difficulties complying, diversion, coercion, and urinalysis; pediatric, AHDH, post-op, and sleep patients should also be considered specially/excluded from requirements. Regarding support for providers, one explained, "If a patient comes to me from the Reservation, she may have been to 2 facilities in 2 different states before I see her and she is indicated for surgery. This means that she may have had prescriptions from 2 providers in 2 states as a usual course. I will still provide her with appropriate pain management despite the PMP giving me this information. The State should develop safe harbor guidelines for each common surgery. This would provide clarity as well as help such that patients do not feel a physician is not being caring and helpful. There should be better access for referring a patient for chronic pain management. Patients in pain are not happy and unhappy patients are much more likely to sue. This is a big reason physicians have 'overprescribed'."

Summary

Prescribers note a variety of barriers to safe prescription practices. Many respondents perceive very high stakes prescribing opioids. Prescribers note that there are no truly objective pain meters. Assessing pain and deciding on appropriate pain management are subjective and different doctors may interpret the same symptoms differently. Patients claim that other pain medications like ibuprofen are inappropriate or do not work for them. Often, insurance does not cover alternative therapies, nor does the Indian Health Service. In addition, providers note difficult getting patients into see chronic pain specialists in the state. Checking the PMP and other misuse prevention efforts take time and coordination and making the wrong decision for a patient has real consequences for them legally and in terms of their licensure. Medical providers must balance humanity and their training to minimize pain with the responsibility for ensure "right dosage." Providers are concerned about diversion of unused opioids to loved ones, particularly youth.

Despite these barriers, most prescribers are complying with state regulations related to checking the PMP and opioid prescribing guidelines like co-prescribing naloxone. Furthermore, most respondents reported that their medical practices had policies or protocols in place regarding opioid prescribing to protect both prescribers and patients. In addition to the PMP and co-prescribing naloxone, these policies include drug screens, assessing the patient's history, pain contracts, pain clinics, patient education, not giving refills/lost prescription, and prescribing a limited quantity at a time.

Additional education efforts might focus on patient/caregiver education about opioid risks, storage, sharing, and disposal, co-prescribing naloxone with opioid prescriptions, which in turn will work toward reducing stigma associated with naloxone, and opioid exit strategies. In addition, training on when opioids are not indicated for certain types of pain may be useful. As cannabis becomes more available in the State, providers will need to know more about how to properly assess pain and need for opioids in conjunction with cannabis use. Finally, education on how the PMP may be helpful for some providers who are less clear about the regulations. This is particularly true for providers working in Indian Health Services, where it is encouraged, but not required that they use the PMP.

Generally, providers appear to trust their experience and expertise when deciding to prescribe an opioid. The public health attention, laws, and regulations appear to have significantly raised the issue of opioid misuse. While the State of New Mexico has made great progress, more prevention education for providers and patients can help clarify the State's expectations and will reinforce that safe opioid prescribing practices continue.