In addition to the recently released *CDC Guideline for Prescribing Opioids for Chronic Pain,* there is news at the state level with regard to guidance and policy on prescribing opioids. Within Vermont the General Assembly spent much of the session this year discussing a number of bills that presented proposed adjustments to the laws relating to opioid analgesics, and to some extent other controlled substances. The end result was Act 173, *An act relating to combating opioid abuse in Vermont.* (Some may have heard references to S.243, the designation used while this was discussed as a bill). For the most part, with a couple of notable exceptions, the law does not directly or immediately change the requirements for prescribers of controlled substances. However, as discussed in more detail below, it directs studies and rulemaking that may lead to some changes that all prescribers of controlled substances will need to follow when prescribing.

The full text of the law is available on the website of the General Assembly at: http://legislature.vermont.gov/assets/Documents/2016/Docs/ACTS/ACT173/ACT173%20As%20Enacted.pdf. Here, we will provide a short synopsis of each section, with focus on the parts of the bill that will most directly affect licensees of the Board.

Section 1- Reflects a change in the name of the council that provides input on prescribing issues. It will be the Controlled Substances and Pain Management Advisory Council.

Section 2- Adds to the mandate that currently requires authorities that license prescribers to make guidelines for use of opioids for treatment of chronic pain; they are instructed to add guidelines for use of opioids for acute pain. The requirement to begin rulemaking was effective July 1, but new standards for prescribers will not be seen until the new rules are created.

Section 2 also includes a requirement for every health care provider who dispenses any schedule II, III, or IV controlled substances to register to use the Vermont Prescription Monitoring System (VPMS), adding to the existing requirement that has been in place since 2013 for all who prescribe controlled substances to register to use VPMS). The requirement for all dispensers to register to use VPMS closing a small gap that previously would allow a health care provider who does not prescribe, but only dispenses controlled substances to not register) was effective July 1, 2016. That is the only requirement that applies to health care providers that is effective in the short term and without any other actions (e.g. rulemaking) to make it operative.

This long section also includes the requirement for every pharmacy or other dispenser to report all Schedule II, III, or IV controlled substance prescriptions dispensed within 24 hours or one business day, increasing the frequency, which used to be weekly. The 24-hour reporting standard will be effective only after the Commissioner Health finds that such reporting is practical, and then provides formal notice. Finally, this section directs the Commissioner of Health and the revised Council to consider additional circumstances in which to require checking VPMS before prescribing opioids.

Section 2a - Directs the Commissioner of Health, after consulting with the Council, to adopt rules governing the prescription of opioids. It directs consideration of numeric and

temporal limitations on opioids after minor medical procedures and directs that the rules shall require providing patients informed consent about the risks associated with taking opioids, as well as information about safe storage and disposal. It also directs rulemaking for use of VPMS by dispensers.

Sections 3 & 4 - Are directed toward opioid addiction treatment, addressing care coordination and coverage of telemedicine services associated with addiction treatment.

Sections 5 – 8 - Are directed toward pharmacy practice and looking at use of pharmacists to assist with verification of patient compliance by doing pill counts.

Section 9 - Requires every Vermont-licensed prescriber who holds a DEA to have at least two hours of CME in each two-year licensing period to complete at least two hours of CME on abuse and diversion, safe use, appropriate storage and disposal, use of VPMS, risk assessment, pharmacological and non-pharmacological alternatives to opioids, tapering and cessation of controlled substances, and State and federal laws and regulations on opioid prescribing. For Vermont MDs, this increases the requirement for CME on safe prescribing to two hours from one hour, and extends the list of subjects to be covered. For our PA and DPM licensees, this is an altogether new requirement. For MDs, this requirement will be effective beginning with the two-year licensing period that starts on December 1, 2016. MD licensees who are subject to the requirement will need to complete the required CME between December 1, 2016 and November 30, 2018. Physician assistants subject to the requirement will need to complete the CME during the licensing period that begins February 1, 2018; for podiatrists the first licensing period covered will be beginning on July 1, 2017.

Section 10 – Calls for the Commissioner of Health to work with medical educators to ensure that safe prescribing and dealing with drug misuse is made a core competency for graduate and undergraduate medical, dental, and pharmacy training.

Section 11 – Addresses regional prevention partnerships.

Sections 12 & 13 – Increase the existing fee paid by pharmaceutical manufacturers on drugs purchased for State of Vermont health coverage programs to provide funds for disposal of unused drugs, prevention efforts, treatment of substance use disorder, exploration of nonpharmacological pain management, and distribution of naloxone to EMS providers.

Section 14 – Renames and adjusts the composition of the Controlled Substances and Pain Management Advisory Council.

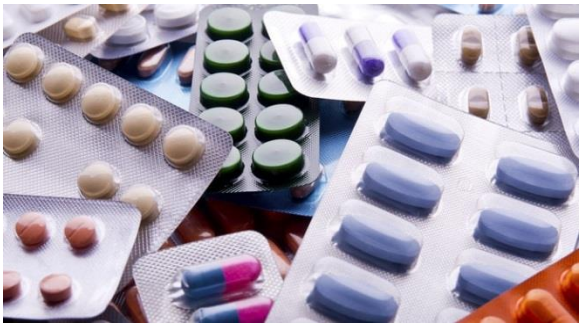
Section 14a – Concerns Health Department establishment of the drug disposal or “take-back” program.

Sections 15 – Asks hospitals and medical service corporations licensed in Vermont to provide input to the Legislature on the question of whether insurance should cover acupuncture as a treatment modality for pain.

Section 15a – Directs the Department of Vermont Health Access to develop a pilot project to offer acupuncture as a treatment for chronic pain.

It's often said that the problem the United States is experiencing with misuse and abuse of opioids has many facets and that there is no single solution. The variety of approaches seen in Act 173 reflects the multidimensional nature of the problem. While some of the measures offered by the law may seem small or incremental, none of these approaches should be discounted. Act 173 does not take on the illicit drug component of the problem, but it does target many different aspects of the problem on the healthcare side of the equation. The varied approaches seen in the bill include:

- Promotion of greater use of the tools that can support safer prescribing and deter diversion
- Make the tools more effective (e.g., 24-hour reporting to VPMS)
- Reduction of the overall amount of opioids entering our communities through medical channels
- Reduction of the amount of unused, excess opioids, which tend to be targets for diversion and misuse
- Promotion of alternative therapies for pain
- Efforts to make treatment for opioid use disorder more widely available



Our licensees are encouraged to join the discussion. Whether you disagree with some of these approaches or support them, please get involved. The expanded (and renamed) Controlled Substances and Pain Management Advisory Council has many new seats for those who want to play a more active role in taking on opioid misuse and abuse. For those who don't want to make that much of a commitment, the Council is sure to be seeking more public comment.

As indicated earlier, many elements of the Act are not immediately effective, but rather set into motion rulemaking or other processes that will result in further actions. The Board of Medical Practice will provide additional advisories as new standards are put in place.

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