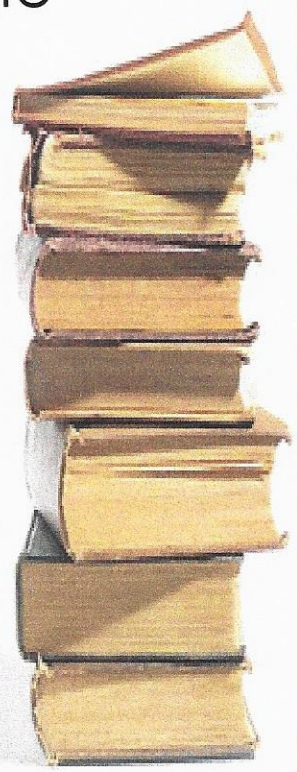
# Ad Hoc Committee on Controlled Substances Continuing Education

Virginia Board of Medicine
November 27, 2018
2:00 p.m.



# Ad Hoc Committee on Controlled Substance Continuing Education

**Tuesday, November 27, 2018 @ 2:00 p.m.**
**9960 Mayland Drive, Suite 200**
**Richmond, VA 23230**
**Hearing Room 3**

**Page**

**Call to Order of the Executive Committee**—Kevin O'Connor, MD, President, Chair



**Roll Call**



**Adoption of Agenda**

**Public Comment on Agenda Items**

**NEW BUSINESS:**



**Announcements**

**Next scheduled meeting:** TBA

**Adjournment**

---DRAFT UNAPPROVED---

**Ad Hoc Committee on Controlled Substances Continuing Education**

Friday, October 28, 2016 Department of Health Professions Henrico, VA

**CALL TO ORDER:** The meeting was called to order by Lori Conklin, MD at 1 PM.

**MEMBERS PRESENT:** Lori Conklin, MD, Committee Chair, Board of Medicine
Barbara Allison-Bryan, MD, President, Board of Medicine
David Taminger, MD, Board of Medicine
Ralph Orr, Prescription Monitoring Program
Stephanie Willinger, Board of Nursing
William Harp, MD, Executive Director, Board of Medicine

**MEMBERS ABSENT:** None

**OTHERS PRESENT:** None

**EMERGENCY EGRESS INSTRUCTIONS**

Dr. Conklin provided egress instructions in case of an alarm or emergency.

**ROLL CALL**

The roll was called and a quorum declared.

**ADOPTION OF THE AGENDA**

David Taminger moved that the agenda be accepted; it was seconded and passed.

**PUBLIC COMMENT ON AGENDA ITEMS**

There was no public comment.

**NEW BUSINESS**

1. **Review of the statute authorizing the Board to require continuing education**

   Dr. Conklin reviewed the law with the Committee.

2. **Review of FSMB document on states requiring controlled substances continuing education**

   Dr. Conklin led the discussion regarding the FSMB map of states and the table of states and their respective requirements. It was noted that 32 states and the District of Columbia did not require

continuing education on proper prescribing of controlled substances, and 18 states do. The hours required ranged from 1 hour every 2 years to 20 hours every 2 years.

**3. Recommendations from the Prescription Monitoring Program**

Ralph Orr presented PMP data for the Committee's consideration and made the recommendation for "baseline continuing medical education for all current active Board of Medicine licensees with a Virginia address." He added that more specific criteria could be considered for future biennia given that that an anticipated upgrade to the PMP system will support greater research capability. He also displayed VAAWARE and its resources for professionals.

**4. Suggestions for parameters from Board of Medicine staff**

These were reviewed and discussed by the Committee.

**5. Discussion and recommendations to the Board for the next biennium**

After a full discussion of all options, Dr. Allison-Bryan moved that the Committee recommend to the Board it require licensees with prescriptive authority to obtain 2 hours of continuing education on pain management, the responsible prescribing of controlled substances, and the diagnosis and management of addiction in the next biennium. The motion was seconded and passed. Dr. Harp said the recommendation will be presented to the Executive Committee on December 2, 2016.

**Adjournment**

There being no further business, Dr. Conklin announced adjournment.

Lori Conklin, MD
Chair

William L. Harp, M.D.
Executive Director

Code of Virginia
Title 54.1. Professions and Occupations
Chapter 25.2. Prescription Monitoring Program

# § 54.1-2523. Confidentiality of data; disclosure of information; discretionary authority of Director.

A. All data, records, and reports relating to the prescribing and dispensing of covered substances to recipients and any abstracts from such data, records, and reports that are in the possession of the Prescription Monitoring Program pursuant to this chapter and any material relating to the operation or security of the program shall be confidential and shall be exempt from the Virginia Freedom of Information Act (§ 2.2-3700 et seq.) pursuant to subdivision 2 of § 2.2-3705.5. Records in possession of the Prescription Monitoring Program shall not be available for civil subpoena, nor shall such records be disclosed, discoverable, or compelled to be produced in any civil proceeding, nor shall such records be deemed admissible as evidence in any civil proceeding for any reason. Further, the Director shall only have discretion to disclose any such information as provided in subsections B and C.

B. Upon receiving a request for information in accordance with the Department's regulations and in compliance with applicable federal law and regulations, the Director shall disclose the following:

1. Information relevant to a specific investigation of a specific recipient or of a specific dispenser or prescriber to an agent who has completed the Virginia State Police Drug Diversion School designated by the superintendent of the Department of State Police or designated by the chief law-enforcement officer of any county, city, or town or campus police department to conduct drug diversion investigations pursuant to § 54.1-3405.

2. Information relevant to an investigation or inspection of or allegation of misconduct by a specific person licensed, certified, or registered by or an applicant for licensure, certification, or registration by a health regulatory board; information relevant to a disciplinary proceeding before a health regulatory board or in any subsequent trial or appeal of an action or board order to designated employees of the Department of Health Professions; or to designated persons operating the Health Practitioners' Monitoring Program pursuant to Chapter 25.1 (§ 54.1-2515 et seq.).

3. Information relevant to the proceedings of any investigatory grand jury or special grand jury that has been properly impaneled in accordance with the provisions of Chapter 13 (§ 19.2-191 et seq.) of Title 19.2.

4. Information relevant to a specific investigation of a specific recipient, dispenser, or prescriber to an agent of a federal law-enforcement agency with authority to conduct drug diversion investigations.

5. Information relevant to a specific investigation, supervision, or monitoring of a specific recipient for purposes of the administration of criminal justice pursuant to Chapter 1 (§ 9.1-100 et seq.) of Title 9.1 to a probation or parole officer as described in Article 2 (§ 53.1-141 et seq.) of Chapter 4 of Title 53.1 or a local community-based probation officer as described in § 9.1-176.1 who has completed the Virginia State Police Drug Diversion School designated by the Director of the Department of Corrections or his designee.

C. In accordance with the Department's regulations and applicable federal law and regulations, the Director may, in his discretion, disclose:

1. Information in the possession of the program concerning a recipient who is over the age of 18 to that recipient. The information shall be mailed to the street or mailing address indicated on the recipient request form.

2. Information on a specific recipient to a prescriber, as defined in this chapter, for the purpose of establishing the treatment history of the specific recipient when such recipient is either under care and treatment by the prescriber or the prescriber is consulting on or initiating treatment of such recipient. In a manner specified by the Director in regulation, notice shall be given to patients that information may be requested by the prescriber from the Prescription Monitoring Program.

3. Information on a specific recipient to a dispenser for the purpose of establishing a prescription history to assist the dispenser in (i) determining the validity of a prescription in accordance with § 54.1-3303 or (ii) providing clinical consultation on the care and treatment of the recipient. In a manner specified by the Director in regulation, notice shall be given to patients that information may be requested by the dispenser from the Prescription Monitoring Program.

4. Information relevant to an investigation or regulatory proceeding of a specific dispenser or prescriber to other regulatory authorities concerned with granting, limiting or denying licenses, certificates or registrations to practice a health profession when such regulatory authority licenses such dispenser or prescriber or such dispenser or prescriber is seeking licensure by such other regulatory authority.

5. Information relevant to an investigation relating to a specific dispenser or prescriber who is a participating provider in the Virginia Medicaid program or information relevant to an investigation relating to a specific recipient who is currently eligible for and receiving or who has been eligible for and has received medical assistance services to the Medicaid Fraud Control Unit of the Office of the Attorney General or to designated employees of the Department of Medical Assistance Services, as appropriate.

6. Information relevant to determination of the cause of death of a specific recipient to the designated employees of the Office of the Chief Medical Examiner.

7. Information for the purpose of bona fide research or education to qualified personnel; however, data elements that would reasonably identify a specific recipient, prescriber, or dispenser shall be deleted or redacted from such information prior to disclosure. Further, release of the information shall only be made pursuant to a written agreement between such qualified personnel and the Director in order to ensure compliance with this subdivision.

8. Information relating to prescriptions for covered substances issued by a specific prescriber, which have been dispensed and reported to the Program, to that prescriber.

9. Information about a specific recipient who is a member of a Virginia Medicaid managed care program to a physician or pharmacist licensed in the Commonwealth and employed by the Virginia Medicaid managed care program or to his clinical designee who holds a multistate licensure privilege to practice nursing or a license issued by a health regulatory board within the Department of Health Professions and is employed by the Virginia Medicaid managed care program. Such information shall only be used to determine eligibility for and to manage the care of the specific recipient in a Patient Utilization Management Safety or similar program. Notice shall be given to recipients that information may be requested by a licensed physician or pharmacist employed by the Virginia Medicaid managed care program from the Prescription Monitoring Program.

10. (Expires July 1, 2022) Information to the Board of Medicine about prescribers who meet a certain threshold for prescribing covered substances for the purpose of requiring relevant continuing education. The threshold shall be determined by the Board of Medicine in consultation with the Program.

11. Information about a specific recipient who is currently eligible for and receiving medical assistance from the Department of Medical Assistance Services to a physician or pharmacist licensed in the Commonwealth or to his clinical designee who holds a multistate licensure privilege to practice nursing or a license issued by a health regulatory board within the Department of Health Professions and is employed by the Department of Medical Assistance Services.

Such information shall be used only to determine eligibility for and to manage the care of the specific recipient in a Patient Utilization Management Safety or similar program. Notice shall be given to recipients that information may be requested by a licensed physician or pharmacist employed by the Department of Medical Assistance Services from the Prescription Monitoring Program.

D. The Director may enter into agreements for mutual exchange of information among prescription monitoring programs in other jurisdictions, which shall only use the information for purposes allowed by this chapter.

E. This section shall not be construed to supersede the provisions of § 54.1-3406 concerning the divulging of confidential records relating to investigative information.

F. Confidential information that has been received, maintained or developed by any board or disclosed by the board pursuant to subsection A shall not, under any circumstances, be available for discovery or court subpoena or introduced into evidence in any medical malpractice suit or other action for damages arising out of the provision of or failure to provide services. However, this subsection shall not be construed to inhibit any investigation or prosecution conducted pursuant to Article 1 (§ 18.2-247 et seq.) of Chapter 7 of Title 18.2.

2002, c. 481; 2004, c. 690; 2005, cc. 637, 678; 2009, cc. 158, 162, 472; 2012, cc. 21, 71; 2013, c. 739; 2014, cc. 12, 97; 2015, cc. 118, 507; 2016, cc. 309, 410, 447, 568; 2017, cc. 186, 778; 2018, c. 108.

The chapters of the acts of assembly referenced in the historical citation at the end of this section may not constitute a comprehensive list of such chapters and may exclude chapters whose provisions have expired.

11/20/2018

Code of Virginia
Title 54.1. Professions and Occupations
Chapter 25.2. Prescription Monitoring Program

# § 54.1-2519. Definitions.

As used in this chapter, unless the context requires a different meaning:

"Administer" means the direct application of a controlled substance, whether by injection, inhalation, ingestion or any other means, to the body of a patient or research subject by (i) a practitioner or, under the practitioner's direction, his authorized agent or (ii) the patient or research subject at the direction and in the presence of the practitioner.

"Bureau" means the Virginia Department of State Police, Bureau of Criminal Investigation, Drug Diversion Unit.

"Controlled substance" means a drug, substance or immediate precursor in Schedules I through VI of the Drug Control Act, Chapter 34 (§ 54.1-3400 et seq.) of this title.

"Covered substance" means all controlled substances included in Schedules II, III, and IV; controlled substances included in Schedule V for which a prescription is required; naloxone; and all drugs of concern that are required to be reported to the Prescription Monitoring Program, pursuant to this chapter. "Covered substance" also includes cannabidiol oil or THC-A oil dispensed by a pharmaceutical processor in Virginia.

"Department" means the Virginia Department of Health Professions.

"Director" means the Director of the Virginia Department of Health Professions.

"Dispense" means to deliver a controlled substance to an ultimate user, research subject, or owner of an animal patient by or pursuant to the lawful order of a practitioner, including the prescribing and administering, packaging, labeling or compounding necessary to prepare the substance for that delivery.

"Dispenser" means a person or entity that (i) is authorized by law to dispense a covered substance or to maintain a stock of covered substances for the purpose of dispensing, and (ii) dispenses the covered substance to a citizen of the Commonwealth regardless of the location of the dispenser, or who dispenses such covered substance from a location in Virginia regardless of the location of the recipient.

"Drug of concern" means any drug or substance, including any controlled substance or other drug or substance, where there has been or there is the potential for abuse and that has been identified by the Board of Pharmacy pursuant to § 54.1-3456.1.

"Prescriber" means a practitioner licensed in the Commonwealth who is authorized pursuant to §§ 54.1-3303 and 54.1-3408 to issue a prescription for a covered substance or a practitioner licensed in another state to so issue a prescription for a covered substance.

"Recipient" means a person who receives a covered substance from a dispenser and includes the owner of an animal patient.

"Relevant health regulatory board" means any such board that licenses persons or entities with the authority to prescribe or dispense covered substances, including the Board of Dentistry, the Board of Medicine, the Board of Veterinary Medicine, and the Board of Pharmacy.

2002, c. 481; 2005, cc. 637, 678; 2014, c. 664; 2018, cc. 185, 379, 567, 772.

The chapters of the acts of assembly referenced in the historical citation at the end of this section may not constitute a comprehensive list of such chapters and may exclude chapters whose provisions have expired.

11/20/2018

Code of Virginia
Title 54.1. Professions and Occupations
Chapter 29. Medicine and Other Healing Arts

This section has more than one version with varying effective dates. Scroll down to see all versions.

# § 54.1-2912.1. (Effective until July 1, 2022) Continued competency and office-based anesthesia requirements.

A. The Board shall prescribe by regulation such requirements as may be necessary to ensure continued practitioner competence, which may include continuing education, testing, or any other requirement.

B. In promulgating such regulations, the Board shall consider (i) the need to promote ethical practice, (ii) an appropriate standard of care, (iii) patient safety, (iv) application of new medical technology, (v) appropriate communication with patients, and (vi) knowledge of the changing health care system.

C. The Board shall require prescribers identified by the Director of the Department of Health Professions pursuant to subdivision C 10 of § 54.1-2523 to complete two hours of continuing education in each biennium on topics related to pain management, the responsible prescribing of covered substances as defined in § 54.1-2519, and the diagnosis and management of addiction. Prescribers required to complete continuing education pursuant to this subsection shall be notified of such requirement no later than January 1 of each odd-numbered year.

D. The Board may approve persons who provide or accredit such programs in order to accomplish the purposes of this section.

E. Pursuant to § 54.1-2400 and its authority to establish the qualifications for registration, certification, or licensure that are necessary to ensure competence and integrity to engage in the regulated practice, the Board shall promulgate regulations governing the practice of medicine related to the administration of anesthesia in physicians' offices.

1997, c. 227; 2002, c. 324; 2016, c. 447.

# § 54.1-2912.1. (Effective July 1, 2022) Continued competency and office-based anesthesia requirements.

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1997, c. 227; 2002, c. 324.

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11/20/2018

*Commonwealth of Virginia*

# REGULATIONS

## GOVERNING PRESCRIBING OF OPIOIDS AND BUPRENORPHINE

## VIRGINIA BOARD OF MEDICINE

**Title of Regulations: 18 VAC 85-21-10 et seq.**

**Statutory Authority: § 54.1-2400 and Chapter 29 of Title 54.1 of the *Code of Virginia***

**Revised Date: August 8, 2018**

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# Part I
# General Provisions

**18VAC85-21-10. Applicability.**

A. This chapter shall apply to doctors of medicine, osteopathic medicine, and podiatry and to physician assistants.

B. This chapter shall not apply to:

1. The treatment of acute or chronic pain related to (i) cancer, (ii) sickle cell, (iii) a patient in hospice care, or (iii) a patient in palliative care;

2. The treatment of acute or chronic pain during an inpatient hospital admission or in a nursing home or an assisted living facility that uses a sole source pharmacy; or

3. A patient enrolled in a clinical trial as authorized by state or federal law.

**18VAC85-21-20. Definitions.**

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Acute pain" means pain that occurs within the normal course of a disease or condition or as the result of surgery for which controlled substances may be prescribed for no more than three months.

"Board" means the Virginia Board of Medicine.

"Chronic pain" means nonmalignant pain that goes beyond the normal course of a disease or condition for which controlled substances may be prescribed for a period greater than three months.

"Controlled substance" means drugs listed in The Drug Control Act (§ 54.1-3400 et seq. of the Code of Virginia) in Schedules II through IV.

"FDA" means the U.S. Food and Drug Administration.

"MME" means morphine milligram equivalent.

"Prescription Monitoring Program" means the electronic system within the Department of Health Professions that monitors the dispensing of certain controlled substances.

"SAMHSA" means the federal Substance Abuse and Mental Health Services Administration.

# Part II
# Management of Acute Pain

**18VAC85-21-30. Evaluation of the acute pain patient.**

A. Nonpharmacologic and non-opioid treatment for pain shall be given consideration prior to treatment with opioids. If an opioid is considered necessary for the treatment of acute pain, the practitioner shall give a short-acting opioid in the lowest effective dose for the fewest possible days.

B. Prior to initiating treatment with a controlled substance containing an opioid for a complaint of acute pain, the prescriber shall perform a history and physical examination appropriate to the complaint, query the Prescription Monitoring Program as set forth in § 54.1-2522.1 of the Code of Virginia, and conduct an assessment of the patient's history and risk of substance misuse.

**18VAC85-21-40. Treatment of acute pain with opioids.**

A. Initiation of opioid treatment for patients with acute pain shall be with short-acting opioids.

1. A prescriber providing treatment for acute pain shall not prescribe a controlled substance containing an opioid in a quantity that exceeds a seven-day supply as determined by the manufacturer's directions for use, unless extenuating circumstances are clearly documented in the medical record. This shall also apply to prescriptions of a controlled substance containing an opioid upon discharge from an emergency department.

2. An opioid prescribed as part of treatment for a surgical procedure shall be for no more than 14 consecutive days in accordance with manufacturer's direction and within the immediate perioperative period, unless extenuating circumstances are clearly documented in the medical record.

B. Initiation of opioid treatment for all patients shall include the following:

1. The practitioner shall carefully consider and document in the medical record the reasons to exceed 50 MME/day.

2. Prior to exceeding 120 MME/day, the practitioner shall document in the medical record the reasonable justification for such doses or refer to or consult with a pain management specialist.

3. Naloxone shall be prescribed for any patient when risk factors of prior overdose, substance misuse, doses in excess of 120 MME/day, or concomitant benzodiazepine is present.

C. Due to a higher risk of fatal overdose when opioids are prescribed with benzodiazepines, sedative hypnotics, carisoprodol, and tramadol (an atypical opioid), the prescriber shall only co-prescribe these substances when there are extenuating circumstances and shall document in the medical record a tapering plan to achieve the lowest possible effective doses if these medications are prescribed.

D. Buprenorphine is not indicated for acute pain in the outpatient setting, except when a prescriber who has obtained a SAMHSA waiver is treating pain in a patient whose primary diagnosis is the disease of addiction.

**18VAC85-21-50. Medical records for acute pain.**

The medical record shall include a description of the pain, a presumptive diagnosis for the origin of the pain, an examination appropriate to the complaint, a treatment plan, and the medication prescribed or administered to include the date, type, dosage, and quantity prescribed or administered.

## Part III
## Management of Chronic Pain

### 18VAC85-21-60. Evaluation of the chronic pain patient.

A. Prior to initiating management of chronic pain with a controlled substance containing an opioid, a medical history and physical examination, to include a mental status examination, shall be performed and documented in the medical record, including:

1. The nature and intensity of the pain;

2. Current and past treatments for pain;

3. Underlying or coexisting diseases or conditions;

4. The effect of the pain on physical and psychological function, quality of life, and activities of daily living;

5. Psychiatric, addiction, and substance misuse history of the patient and any family history of addiction or substance misuse;

6. A urine drug screen or serum medication level;

7. A query of the Prescription Monitoring Program as set forth in § 54.1-2522.1 of the Code of Virginia;

8. An assessment of the patient's history and risk of substance misuse; and

9. A request for prior applicable records.

B. Prior to initiating opioid treatment for chronic pain, the practitioner shall discuss with the patient the known risks and benefits of opioid therapy and the responsibilities of the patient during treatment to include securely storing the drug and properly disposing of any unwanted or unused drugs. The practitioner shall also discuss with the patient an exit strategy for the discontinuation of opioids in the event they are not effective.

### 18VAC85-21-70. Treatment of chronic pain with opioids.

A. Nonpharmacologic and non-opioid treatment for pain shall be given consideration prior to treatment with opioids.

B. In initiating and treating with an opioid, the practitioner shall:

1. Carefully consider and document in the medical record the reasons to exceed 50 MME/day;

2. Prior to exceeding 120 MME/day, the practitioner shall document in the medical record the reasonable justification for such doses or refer to or consult with a pain management specialist.

3. Prescribe naloxone for any patient when risk factors of prior overdose, substance misuse, doses in excess of 120 MME/day, or concomitant benzodiazepine is present; and

4. Document the rationale to continue opioid therapy every three months.

C. Buprenorphine mono-product in tablet form shall not be prescribed for chronic pain.

D. Due to a higher risk of fatal overdose when opioids, including buprenorphine, are given with other opioids, benzodiazepines, sedative hypnotics, carisoprodol, and tramadol (an atypical opioid), the prescriber shall only co-prescribe these substances when there are extenuating circumstances and shall document in the medical record a tapering plan to achieve the lowest possible effective doses of these medications if prescribed.

E. The practitioner shall regularly evaluate for opioid use disorder and shall initiate specific treatment for opioid use disorder, consult with an appropriate health care provider, or refer the patient for evaluation and treatment if indicated.

**18VAC85-21-80. Treatment plan for chronic pain.**

A. The medical record shall include a treatment plan that states measures to be used to determine progress in treatment, including pain relief and improved physical and psychosocial function, quality of life, and daily activities.

B. The treatment plan shall include further diagnostic evaluations and other treatment modalities or rehabilitation that may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

C. The prescriber shall document in the medical record the presence or absence of any indicators for medication misuse or diversion and shall take appropriate action.

**18VAC85-21-90. Informed consent and agreement for treatment for chronic pain.**

A. The practitioner shall document in the medical record informed consent, to include risks, benefits, and alternative approaches, prior to the initiation of opioids for chronic pain.

B. There shall be a written treatment agreement signed by the patient in the medical record that addresses the parameters of treatment, including those behaviors that will result in referral to a higher level of care, cessation of treatment, or dismissal from care.

C. The treatment agreement shall include notice that the practitioner will query and receive reports from the Prescription Monitoring Program and permission for the practitioner to:

1. Obtain urine drug screens or serum medication levels when requested; and

2. Consult with other prescribers or dispensing pharmacists for the patient.

D. Expected outcomes shall be documented in the medical record including improvement in pain relief and function or simply in pain relief. Limitations and side effects of chronic opioid therapy shall be documented in the medical record.

**18VAC85-21-100. Opioid therapy for chronic pain.**

A. The practitioner shall review the course of pain treatment and any new information about the etiology of the pain and the patient's state of health at least every three months.

B. Continuation of treatment with opioids shall be supported by documentation of continued benefit from such prescribing. If the patient's progress is unsatisfactory, the practitioner shall assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities.

C. The practitioner shall check the Prescription Monitoring Program at least every three months after the initiation of treatment.

D. The practitioner shall order and review a urine drug screen or serum medication levels at the initiation of chronic pain management and thereafter randomly at the discretion of the practitioner, but at least once a year.

E. The practitioner (i) shall regularly evaluate the patient for opioid use disorder and (ii) shall initiate specific treatment for opioid use disorder, consult with an appropriate health care provider, or refer the patient for evaluation for treatment if indicated.

**18VAC85-21-110. Additional consultations.**

A. When necessary to achieve treatment goals, the prescriber shall refer the patient for additional evaluation and treatment.

B. When a prescriber makes the diagnosis of opioid use disorder, treatment for opioid use disorder shall be initiated or the patient shall be referred for evaluation and treatment.

**18VAC85-21-120. Medical records for chronic pain.**

The prescriber shall keep current, accurate, and complete records in an accessible manner readily available for review to include:

1. The medical history and physical examination;

2. Past medical history;

3. Applicable records from prior treatment providers or any documentation of attempts to obtain those records;

4. Diagnostic, therapeutic, and laboratory results;

5. Evaluations and consultations;

6. Treatment goals;

7. Discussion of risks and benefits;

8. Informed consent and agreement for treatment;

9. Treatments;

10. Medications (including date, type, dosage, and quantity prescribed and refills);

11. Patient instructions; and

12. Periodic reviews.

## Part IV
## Prescribing of Buprenorphine for Addiction Treatment

**18VAC85-21-130. General provisions pertaining to prescribing of buprenorphine for addiction treatment.**

A. Practitioners engaged in office-based opioid addiction treatment with buprenorphine shall have obtained a SAMHSA waiver and the appropriate U.S. Drug Enforcement Administration registration.

B. Practitioners shall abide by all federal and state laws and regulations governing the prescribing of buprenorphine for the treatment of opioid use disorder.

C. Physician assistants and nurse practitioners who have obtained a SAMHSA waiver shall only prescribe buprenorphine for opioid addiction pursuant to a practice agreement with a waivered doctor of medicine or doctor of osteopathic medicine.

D. Practitioners engaged in medication-assisted treatment shall either provide counseling in their practice or refer the patient to a mental health service provider, as defined in § 54.1-2400.1 of the Code of Virginia, who has the education and experience to provide substance misuse counseling. The practitioner shall document provision of counseling or referral in the medical record.

**18VAC85-21-140. Patient assessment and treatment planning for addiction treatment.**

A. A practitioner shall perform and document an assessment that includes a comprehensive medical and psychiatric history, substance misuse history, family history and psychosocial supports, appropriate physical examination, urine drug screen, pregnancy test for women of childbearing age and ability, a check of the Prescription Monitoring Program, and, when clinically indicated, infectious disease testing for human immunodeficiency virus, hepatitis B, hepatitis C, and tuberculosis.

B. The treatment plan shall include the practitioner's rationale for selecting medication-assisted treatment, patient education, written informed consent, how counseling will be accomplished, and a signed treatment agreement that outlines the responsibilities of the patient and the prescriber.

**18VAC85-21-150. Treatment with buprenorphine for addiction.**

A. Buprenorphine without naloxone (buprenorphine mono-product) shall not be prescribed except:

1. When a patient is pregnant;

2. When converting a patient from methadone or buprenorphine mono-product to buprenorphine containing naloxone for a period not to exceed seven days;

3. In formulations other than tablet form for indications approved by the FDA; or

4. For patients who have a demonstrated intolerance to naloxone, such prescriptions for the mono-product shall not exceed 3.0% of the total prescriptions for buprenorphine written by the prescriber, and the exception shall be clearly documented in the patient's medical record.

B. Buprenorphine mono-product tablets may be administered directly to patients in federally licensed opioid treatment programs. With the exception of those conditions listed in subsection A of this section, only the buprenorphine product containing naloxone shall be prescribed or dispensed for use off site from the program.

C. The evidence for the decision to use buprenorphine mono-product shall be fully documented in the medical record.

D. Due to a higher risk of fatal overdose when buprenorphine is prescribed with other opioids, benzodiazepines, sedative hypnotics, carisoprodol, and tramadol (an atypical opioid), the prescriber shall only co-prescribe these substances when there are extenuating circumstances and shall document in the medical record a tapering plan to achieve the lowest possible effective doses if these medications are prescribed.

E. Prior to starting medication-assisted treatment, the practitioner shall perform a check of the Prescription Monitoring Program.

F. During the induction phase, except for medically indicated circumstances as documented in the medical record, patients should be started on no more than eight milligrams of buprenorphine per day. The patient shall be seen by the prescriber at least once a week.

G. During the stabilization phase, the prescriber shall increase the daily dosage of buprenorphine in safe and effective increments to achieve the lowest dose that avoids intoxication, withdrawal, or significant drug craving.

H. Practitioners shall take steps to reduce the chances of buprenorphine diversion by using the lowest effective dose, appropriate frequency of office visits, pill counts, and checks of the Prescription Monitoring Program. The practitioner shall also require urine drug screens or serum

medication levels at least every three months for the first year of treatment and at least every six months thereafter.

I. Documentation of the rationale for prescribed doses exceeding 16 milligrams of buprenorphine per day shall be placed in the medical record. Dosages exceeding 24 milligrams of buprenorphine per day shall not be prescribed.

J. The practitioner shall incorporate relapse prevention strategies into counseling or assure that they are addressed by a mental health service provider, as defined in § 54.1-2400.1 of the Code of Virginia, who has the education and experience to provide substance misuse counseling.

**18VAC85-21-160. Special populations in addiction treatment.**

A. Pregnant women may be treated with the buprenorphine mono-product, usually 16 milligrams per day or less.

B. Patients younger than the age of 16 years shall not be prescribed buprenorphine for addiction treatment unless such treatment is approved by the FDA.

C. The progress of patients with chronic pain shall be assessed by reduction of pain and functional objectives that can be identified, quantified, and independently verified.

D. Practitioners shall (i) evaluate patients with medical comorbidities by history, physical exam, appropriate laboratory studies and (ii) be aware of interactions of buprenorphine with other prescribed medications.

E. Practitioners shall not undertake buprenorphine treatment with a patient who has psychiatric comorbidities and is not stable. A patient who is determined by the prescriber to be psychiatrically unstable shall be referred for psychiatric evaluation and treatment prior to initiating medication-assisted treatment.

**18VAC85-21-170. Medical records for opioid addiction treatment.**

A. Records shall be timely, accurate, legible, complete, and readily accessible for review.

B. The treatment agreement and informed consent shall be maintained in the medical record.

C. Confidentiality requirements of 42 CFR Part 2 shall be followed.

D. Compliance with 18VAC85-20-27, which prohibits willful or negligent breach of confidentiality or unauthorized disclosure of confidential Prescription Monitoring Program information, shall be maintained.

# Virginia Board of Medicine

## Frequently Asked Questions about the Prescribing of Opioids for Pain

1. **Do I need to refer a patient being treated for chronic pain to a pain management specialist before exceeding 120 MME/day?**

The regulations require the prescriber to document the reasonable justification for the increase OR refer to or consult with a pain management specialist.

2. **If a patient being treated for chronic pain admits to occasional marijuana use or has a positive screen, what should I do?**

This issue is not addressed in the regulations. The Board of Medicine expects physicians to use good judgement in their care of patients and fully document what you do and why in the chart.

3. **If a patient I am treating for chronic pain is on a benzodiazepine from another provider, must I prescribe naloxone?**

YES. The regulations are meant to save lives. There would need to be coordination with the other practitioner so that you are on the same page. Controlled substances from more than one prescriber could lead to an inadvertent overdose. There is a provision for "extenuating circumstances" in the regulations, in case the benzo is absolutely essential to the patient's well-being.

4. **What if the benzodiazepine is only PRN?**

The Board of Medicine cannot recommend deviation from the regulations.

5. **What formulation of naloxone do I prescribe?**

The prescribing of naloxone required by these regulations is intended to rescue those who are in the midst of an overdose or anticipated to be in overdose. The regulations do not require a specific formulation. Here are the options in the Pharmacy guidance document. http://www.dhp.virginia.gov/Pharmacy/guidelines/110-44.docx

6. **Do I have to ensure that a patient fills the prescription for naloxone?**

NO, the prescriber's responsibility is to prescribe the naloxone, but the regulations do not require that the prescriber ensures that the patient gets it filled. However, a prescriber may wish to revisit the dose of opioid prescribed, if warranted.

7. **Can a pharmacist fill an opioid prescription exceeding 120 MME/day, or with concomitant benzodiazepine, if a patient does not present a naloxone prescription?**

The answer is YES, but it would be within your discretion to call the prescriber to ask if that is what he/she intended.

**8. Must naloxone be prescribed for lower doses of opioids in the presence of benzodiazepines?**

YES, the regulations state that is the case.

**9. Must I drug screen all patients that I will be putting on opioids for chronic pain?**

YES, a drug screen is required initially upon beginning chronic pain management, and at least once a year thereafter.

**10. What is the Board's policy on PRN pain medications?**

The regulations require drug screens for patients on chronic opioid medications. The Board cannot recommend deviation from the regulations. The Board would make the determination about the standard of care in such a case, based upon the documentation of the treatment.

**11. Is it true that I can only prescribe 1 week of opioid for acute pain?**

Prescribing is limited to a 7-day supply unless "extenuating circumstances are clearly documented in the medical record."

**12. Can I write for more than 14 days for post-operative pain?**
Prescribing is limited to a 14-day supply unless "extenuating circumstances are clearly documented in the medical record."

**13. Is tramadol an opioid?**

YES. It is an opioid and a Schedule IV drug.

**14. Is tramadol subject to these regulations?**

YES.

**15. How can a pharmacist determine that a physician is prescribing for acute pain, post-op pain, or chronic pain?**

It has been suggested that prescribers put a notation on the prescription as to whether the drug is for acute pain, post-op pain, or chronic pain. The Board sees this as an excellent communication between professionals involved in the patient's care.

**16. Does the Board of Medicine have a list of "sedative hypnotics"?**

NO

**17. Must patients that have been stable on their current dose of opioid analgesic for a long time be drug tested?**

YES, the regulations require testing at least once a year.

**18. Can I use Subutex and Suboxone off-label for the treatment of pain?**

The amended emergency regulations that became effective August 24, 2017 allow Suboxone, or any naloxone-containing tablet, to be used to treat chronic pain. Subutex cannot be used for chronic pain. Buprenorphine products are not indicated for acute pain.

**19. Does the physician have to see pain patients every 3 months or can a nurse practitioner or a physician assistant see a patient, assess the opioid therapy, evaluate for opioid use disorder and document findings in the medical record?**

The regulations use the term "practitioner" and state these issues need to be addressed every 3 months. Nurse practitioners and physician assistants can perform acts of medicine through a practice agreement with a physician. As long as the NP and PA are trained and competent to accomplish the assessments required, and the physician maintains responsibility for patient care, it would appear that the requirements of the law would be met.

**20. If a patient is held in the ED or other part of the hospital for 24-48 hours, do the regulations apply?**

The regulations do not apply to pain treated during an inpatient hospital admission. Observation is an administrative status for a patient that is under clinical watch and care within the hospital, therefore the regulations would not apply. However, when the patient is discharged, the regulations would apply in regards to the 7-day limit of opioid or more if extenuating circumstances are documented.

**21. Are there any exemptions to the requirements of these regulations?**

Yes, patients with cancer, sickle cell, and those in hospice and palliative care are exempt from these regulations.

# Virginia Board of Medicine

## Frequently Asked Questions about the Prescribing of Buprenorphine for Addiction

1. **Can I continue to prescribe mono-product for my patients that have a demonstrated intolerance to naloxone –containing products?**

The amended emergency regulations that became effective August 24, 2017 read as follows: *For patients who have a demonstrated intolerance to naloxone; such prescriptions for the mono-product shall not exceed 3% of the total prescriptions for buprenorphine written by the prescriber, and the exception shall be clearly documented in the patient's medical record.* So 3% of buprenorphine prescriptions that will be administered off-site can be for mono-product, and the rest must be for naloxone-containing products. The 3% restriction does not apply to injectable formulations of buprenorphine mono-product administered directly to patients in a waivered physician's office, a clinic staffed by a waivered provider, or in a federally licensed opioid treatment program or to mono-product tablets administered directly to patients in federally licensed opioid treatment programs.

2. **What alternatives to buprenorphine mono-product are there that contain no or low-dose naloxone?**

This is not an endorsement for a particular medication, and there may be other alternatives unknown to the Board at this time. The only other mono-products currently FDA-approved for the treatment of addiction are the Probuphine implant and Sublocade extended-release injection. Formulations with low-dose naloxone include Zubsolv sublingual tablets and Bunavail buccal film. Methadone and Vivitrol are also options.

3. **Is there a grace period for switching patients to a naloxone-containing product?**

It is lawful to prescribe up to 7 days of mono-product in the switching of a patient from methadone to a naloxone-containing product or for 7 days in switching a patient from the mono-product to a naloxone-containing product.

4. **Is there a grace period for tapering patients off the mono-product if they choose not to take a naloxone-containing product?**

There is no grace period in the regulations, other than what is stated above. The Board does expect that sound medical judgement and safety of the patient will be paramount in the tapering process.

5. **Are buprenorphine and naloxone safe for mothers and their breastfeeding infants?**

The American Society of Addiction Medicine National Practice Guideline adopted June 2015 stated, "It was shown that the amount of buprenorphine metabolites secreted in breastmilk are so low that they pose little risk to breastfeeding infants." In the May 11, 2016 issue of the ASAM Magazine, a question about breastfeeding was

addressed by a Providers' Clinical Support System expert, "While buprenorphine levels transfer to breastmilk in very low levels, naloxone is even much less detectable, if at all." An August 2016 article from the Journal of Human Lactation confirmed that infant plasma levels were low or undetectable. A consultant to the Board, an OB-GYN who provides MAT, opines that naloxone-containing products prescribed to the mother can be considered safe for breastfeeding infants.

**6. Is the prescribing of tramadol subject to these regulations?**

YES, tramadol is an opioid and is therefore subject to these regulations.

**7. Can I use the mono-product for induction and then switch to the naloxone-containing product?**

The regulations do not speak to induction with the mono-product and then switching to a naloxone-containing product. The regulations state that 7 days of mono-product can be written in the switching from mono-product to a naloxone containing product.

**8. Can a pharmacist dispense a prescription of the mono-product for a non-pregnant individual after March 15, 2017?**

A pharmacist should dispense mono-product in keeping with the 3% rule for prescribers described in #1.

**9. Can my staff see the patient during the induction phase?**

The regulations require that the patient be seen "by the prescriber" at least once a week during induction.

**10. Does the Board have a list of "sedative hypnotics"?**

No.

**11. Can I continue to prescribe benzodiazepines with buprenorphine?**

The regulations allow for benzodiazepines in the lowest effective dose required for the treatment of co-morbid conditions. Extenuating circumstances must be documented in the medical record to support the prescriber's rationale.

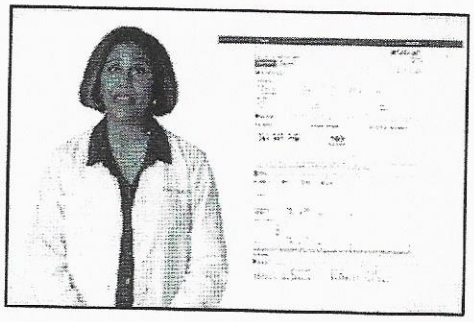
**12. Is there an exception for financial hardship that allows a patient to take Subutex instead of Suboxone?**

NO. There is no such exception in the regulations. However, the Medical Society of Virginia has developed the following list of resources for patients that may need help with the expenses of treatment with naloxone-containing products. https://www.msv.org/sites/default/files/patient_assistance_resources.pdf

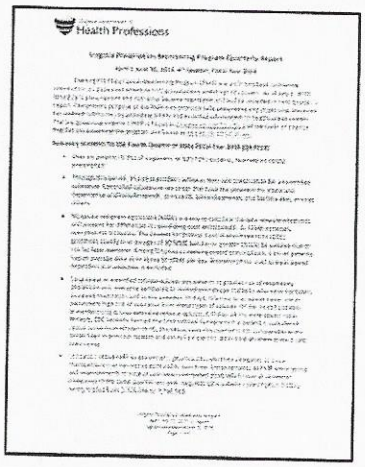
Virginia Department of Health Professions

## Program updates

- NarxCare video (5 min)



- Most recent quarterly report



Virginia Department of Health Professions

## Statutory authority and DHP's mission

- Code of Virginia § 54.1-2523.1, effective July 1, 2017
  - Develop "criteria for indicators of unusual patterns of prescribing or dispensing of covered substances… and a method for analysis of data collected by the PMP"
  - Authority to disclose information about unusual prescribing and dispensing to the Enforcement Division of DHP
- DHP mission: Keep People Safe
  - "Our mission is to ensure safe and competent patient care by licensing health professionals, enforcing standards of practice, and providing information to health care practitioners and the public."

Virginia Department of Health Professions

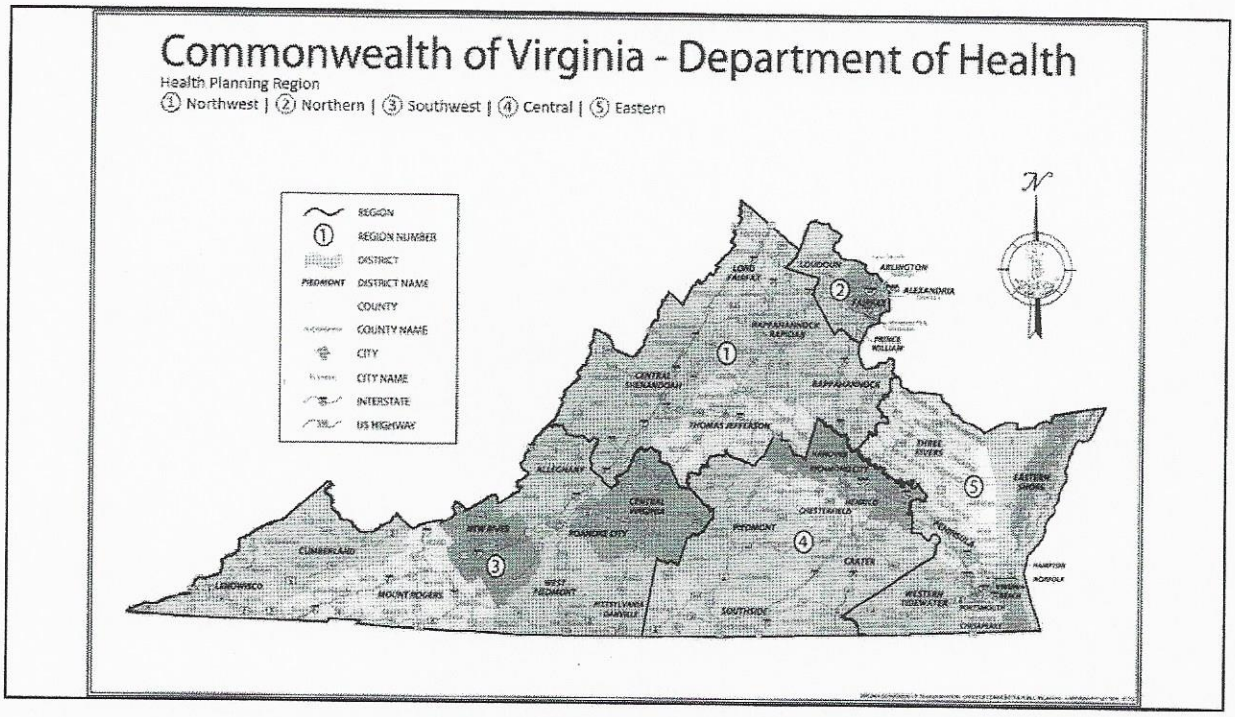
## Collaborations between PMP and the Enforcement Division

- Data provided by PMP to Enforcement Division on quarterly basis to initiate proactive investigations
  - Proactive vs. reactive investigations
    - Proactive: PMP-initiated, unsolicited reports
    - Reactive: complaint-driven
- Indicators investigated on priority basis
  - By varying indicators, reveal different types of misconduct
- Refine indicators based on experience/knowledge gained
  - Maximize resources and impact
- PMP will continue to notify Enforcement Division about any unusual findings as encountered

Virginia Department of Health Professions

## Indicators of unusual patterns used in previous investigations: prescribers and dispensers

- Top 10 prescribers/dispensers by prescription count reported to PMP (n=20)
  - All covered substances
- Morphine milligram equivalents (MMEs)
  - 2,000/day x 1 patient (n=22)
  - 1,000/day x 10 patients (n=10)
  - 750/day x 5 patients (n=4)
  - 500/day x 25 patients (n=6)
- Total: 62 prescribers/dispensers sent to Enforcement Division for review




Virginia Department of Health Professions

## Proposed indicators of unusual prescribing/dispensing

| | |
|---|---|
| **Prescriber** | |
| A. | Top 10 prescribers of opioids per quarter by dose quantity |
| B. | Top 10 prescribers of opioids with minimal PMP use |
| C. | Prescribers of patients with a daily MME ≥ 1,500 [with overlapping benzodiazepine] |
| D. | Top 10 prescribers of ER/LA opioids to opioid naïve patients |
| E. | Top 10 prescribers of buprenorphine for MAT dosing > 24mg/day |
| **Dispenser** | |
| F. | Top 10 dispensers of opioids from out of state [out of health region] prescribers |
| G. | Top 10 dispensers based on ratio of CS II to all CS II-V prescriptions, minimum of 1,000 CS II prescriptions |

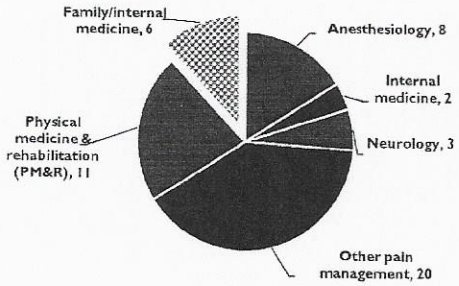
Data presented based on April 1-June 30, 2018 (Quarter 2) unless otherwise specified

Virginia Department of Health Professions

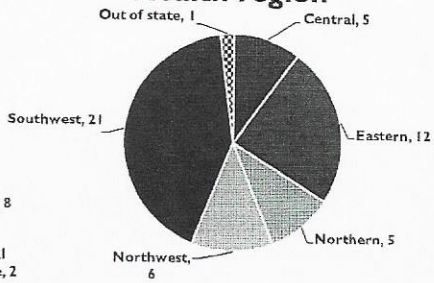
## Characteristics of top 50 opioid prescribers by dose quantity

### License type


### Specialty or practice type




### Health region

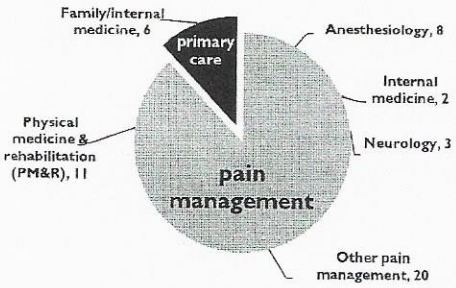



Virginia Department of Health Professions

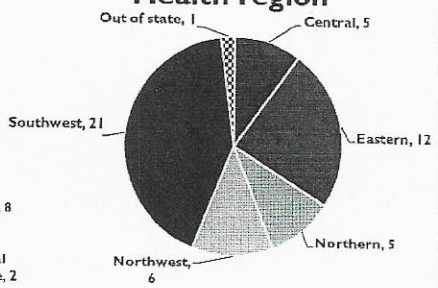
## Characteristics of top 50 opioid prescribers by dose quantity

### License type


### Specialty or practice type

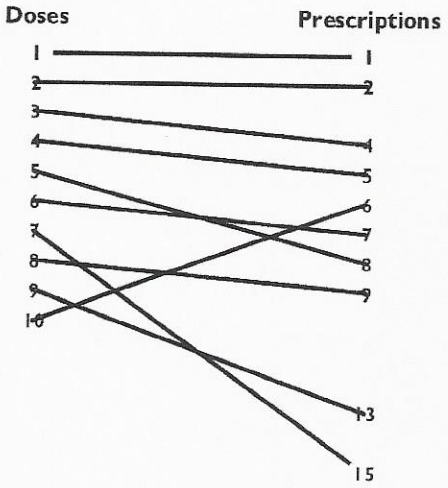



### Health region



Virginia Department of Health Professions

# A. Top 10 prescribers of opioids by dose quantity

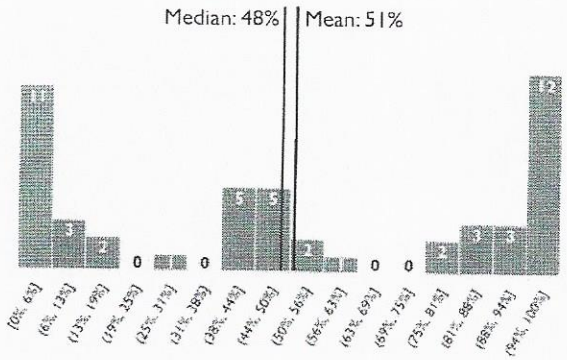



- Ranking of prescribers varies by measure used (dose quantity or prescription count)
- Dose quantity is a better representation of trends over time
- Differentiates between acute, time-limited uses (e.g., oral surgery) and high quantity, ongoing prescribing and the associated sequelae
- Progress towards safer prescribing may result in increasing prescriptions but decreasing dose quantities

Virginia Department of Health Professions

# B. Top 10 prescribers of opioids with minimal PMP use

- Reviewed PMP usage for top 50 opioid prescribers to calculate ratios and identify the first 10
  - 7 prescribers did not conduct any patient searches during the quarter
- Ratio of PMP requests to opioid prescriptions
  - Example 1
    - PMP requests: 2,921
    - Prescriptions for opioids: 4,805
    - Ratio: 61%
  - Example 2
    - PMP requests: 64
    - Prescriptions for opioids: 2,751
    - Ratio: 2%



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## C. Daily MME ≥ 1,500 [with overlapping benzodiazepine]

- Data based on July-August 2018
- Patients exceeding 2,000 MME/ day: 10
  - 7 exempted condition/specialty
    - 6 sickle cell
    - 1 oncology
    - 0 hospice
- Patients exceeding 1,500 MME/ day: 20
  - 10 exempted condition/specialty
    - 6 sickle cell
    - 2 oncology
    - 2 hospice
  - Prescriber specialty for remaining 10 patients
    - 3 pain management
    - 7 family/internal medicine
  - 7 overlapping opioid-benzodiazepine

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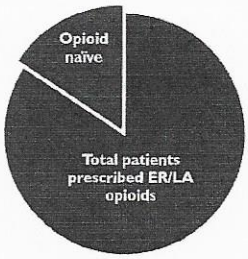
## D. Top 10 prescribers of ER/LA opioids prescribed to opioid naïve patients

- Extended-release or long acting (ER/LA) opioids put patients at greater risk of respiratory depression and overdose compared to immediate-release (IR)
  - Opioid naïve patients are at particularly high risk of overdose from ER/LA opioids
- Opioid naïve refers to patients who have not taken an opioid medication within the previous 45 days
  - Inconsistent definition of opioid naïve in the literature: CDC lowered threshold from 60 to 45 days in March 2018
- Of the 34,653 patients prescribed ER/LA opioids, 6,478 or 19% were opioid naïve
  - 92% of opioid doses are IR
- Further analyses needed to identify opioid naïve patients by prescriber



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## E. Top 10 prescribers of buprenorphine for MAT dosing >24mg/day

- 18VAC85-21-150. Treatment with Buprenorphine for Addiction
  - "Documentation of the rationale for prescribed doses exceeding 16 milligrams of buprenorphine per day shall be placed in the medical record. *Dosages exceeding 24 milligrams of buprenorphine per day shall not be prescribed.*"
- Inclusion criteria: buprenorphine products FDA-approved for Medication-Assisted Treatment (MAT)
- Patients receiving prescriptions for daily dosage >24mg (July-August 2018): 392
  - Top 10 prescribers, by patient count, represent 31% (n=120) of total

18VAC85-21 Regulations Governing Prescribing of Opioids and Buprenorphine https://law.lis.virginia.gov/admincode/title18/agency85/chapter21/

Virginia Department of Health Professions

## Proposed indicators of unusual prescribing/dispensing

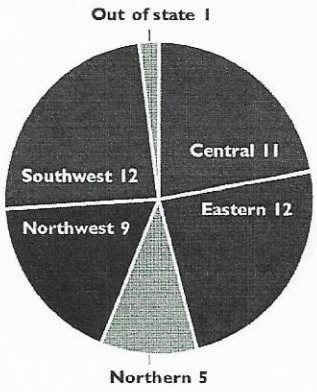
| Prescriber | |
|---|---|
| A. | Top 10 prescribers of opioids per quarter by dose quantity |
| B. | Top 10 prescribers of opioids with minimal PMP use |
| C. | Prescribers of patients with a daily MME ≥ 1,500 [with overlapping benzodiazepine] |
| D. | Top 10 prescribers of ER/LA opioids to opioid naïve patients |
| E. | Top 10 prescribers of buprenorphine for MAT dosing > 24mg/day |

| Dispenser | |
|---|---|
| F. | Top 10 dispensers of opioids from out of state [out of health region] prescribers |
| G. | Top 10 dispensers based on ratio of CS II to all CS II-V prescriptions, minimum of 1,000 CS II prescriptions |

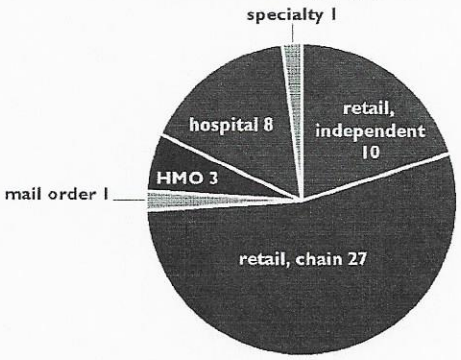
Virginia Department of Health Professions

## Characteristics of top 50 opioid dispensers by prescription count

### Pharmacy region




### Pharmacy type

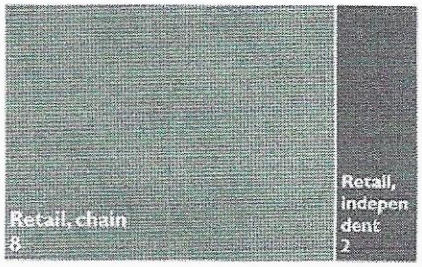



Virginia Department of Health Professions

## F. Top 10 dispensers of opioids from *out of state* prescribers

| Rank | Pharmacy type | Region |
|---|---|---|
| 1. | Retail, chain | Southwest |
| 2. | Retail, independent | Southwest |
| 3. | Retail, chain | Southwest |
| 4. | Retail, chain | Southwest |
| 5. | Retail, chain | Southwest |
| 6. | Retail, independent | Southwest |
| 7. | Retail, chain | Southwest |
| 8. | Retail, chain | Southwest |
| 9. | Retail, chain | Southwest |
| 10. | Retail, chain | Southwest |

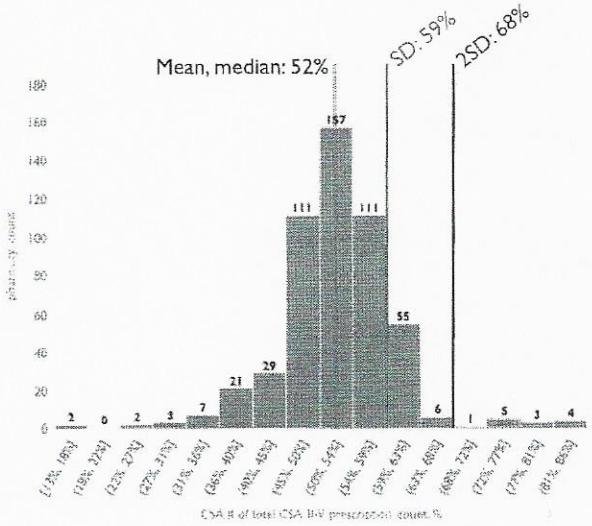

Region




Pharmacy type

Virginia Department of Health Professions

## G. Ratio of schedule II to all controlled substance prescriptions

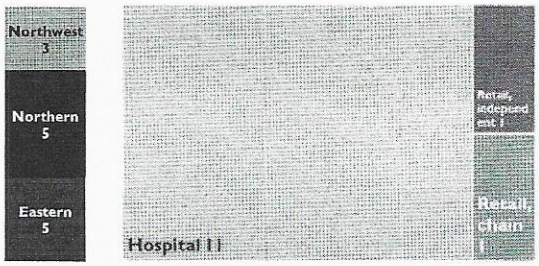



- Inclusion criteria: minimum of 1,000 CS II prescriptions in Q2 2018 (n=517)
  - 4/517 out of state
- 13 outpatient pharmacies are greater than 2 standard deviations (2SD) from the mean

Virginia Department of Health Professions

## G. Ratio of schedule II to all controlled substance prescriptions

- Characteristics of pharmacies >2 standard deviations from the mean (n=13)
  - Region: 77% Northern/Eastern
  - Pharmacy type: 85% hospital outpatient
- Discuss addition of inclusion criteria



REGISTER

Sign in

Opioid Therapy

ENROLL IN 045

# How to Taper Patients Off Of Chronic Opioid Therapy

| | |
|---|---|
| Course Number | **045** |
| Classes Start | **Aug 2, 2018** |
| Classes End | **Aug 31, 2021** |
| Estimated Effort | **1.25 hours** |
| Price | **Free** |

**Internet Enduring Material Sponsored by:**

Stanford University School of Medicine

Stanford MEDICINE

**Presented by:**

The Department of Psychiatry and Behavioral Sciences at Stanford University School of Medicine

**Course Description**

This CME activity will enable doctors to recognize when risks of chronic opioid therapy outweigh benefits, and how to safely and compassionately taper patients off of chronic opioid therapy (including the use of buprenorphine to make this transition). A real life patient case scenario will be used to illustrate these principles in practice, including what to say to patients to communicate risks and provide support through the difficult period of withdrawal. When to refer for addiction treatment will also be discussed.

**Intended Audience**

This course is designed to meet the educational needs of physicians and nurses in primary care, family practice, internal medicine, neurology, oncology, psychiatry, addiction medicine, and interested Allied Health Professionals.

**Dates, Duration & Fee**

- Release Date: August 2, 2018
- Expiration Date: August 2, 2021
- Estimated Time to Complete: 1.25 hours
- CME Credits Offered: 1.25
- Registration Fee: FREE

**To Obtain CME Credits**

- Review the information below and complete the entire activity.
- Complete the CME Post-test, CME Evaluation Survey, and CME Activity Completion Statement at the end of the activity.
- You must receive a score of 75% or higher on the post-test in order to receive a certificate. You will have two attempts to answer each multiple-choice question (or one attempt for questions with only two options) to pass the post-test.
- Once you attest to completing the entire online activity and have scored 75% or higher on the post-test, your certificate will be generated automatically and will be available on your Dashboard page.
- Physicians will be awarded *AMA PRA Category 1 Credit™*. All other participants will receive a Certificate of Participation.

**Learning Objectives**

At the conclusion of this activity, participants should be able to:

- Recognize when risks of chronic opioid therapy outweigh benefits and effectively communicate this information to patients.
- Employ language to prepare patients in advance for the opioid taper, and to provide emotional support in the midst of withdrawal.
- Integrate the key features of a successful outpatient taper off of chronic opioid therapy: go slowly, take breaks, never go backwards.
- Distinguish the signs and symptoms of opioid use disorder (addiction), and intervene with compassion

when, in the process of a taper, an opioid use disorder comes to light.
- Counsel patients on non-opioid alternatives to chronic pain.

**Table of Contents**



**Disclosures**

The following planner, speaker and author has indicated that she has no relationships with industry to disclose relative to the content of this activity:

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Associate Professor of Psychiatry and Behavioral Sciences
Program Director for the Stanford University Addiction Medicine Fellowship
Chief of the Stanford Addiction Medicine Dual Diagnosis Clinic
Stanford University School of Medicine
**Course Director**
**Speaker/Author**

**Laura**
**Speaker**
The patient in the course, using the pseudonym Laura, has indicated that she has no relationships with industry to disclose relative to the content of this activity.

**Technical Design and Development**

Stanford IRT EdTech

Stanford Online

**Hardware/Software Requirements**

- Computer with Internet connection
- Current version of Chrome, Firefox or Safari browser. You must have javascript enabled.

**Accreditation and Designation of Credits**

The Stanford University School of Medicine is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The Stanford University School of Medicine designates this enduring material for a maximum of 1.25 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

The American Nurses Credentialing Center (ANCC) accepts *AMA PRA Category 1 Credits™* from organizations accredited by the ACCME. Please check with your state's credentialing board for their requirements.

**Commercial Support Acknowledgement**

The Stanford University School of Medicine has received and has used undesignated program funding from Pfizer, Inc. to facilitate the development of innovative CME activities designed to enhance physician competence and performance and to implement advanced technology. **A portion of this funding supports this activity.**

**Cultural and Linguistic Competency**

California Assembly Bill 1195 requires continuing medical education activities with patient care components to include curriculum in the subjects of cultural and linguistic competency. It is the intent of the bill, which went into effect July 1, 2006, to encourage physicians and surgeons, CME providers in the State of California and the Accreditation Council for Continuing Medical Education to meet the cultural and linguistic concerns of a diverse patient population through appropriate professional development. The planners and speakers of this CME activity have been encouraged to address cultural issues relevant to their topic area. The Stanford University School of Medicine Multicultural Health Portal also contains many useful cultural and linguistic competency tools including culture guides, language access information and pertinent state and federal laws. You are encouraged to visit the portal:

http://lane.stanford.edu/portals/cultural.html

**CME Privacy Policy**

Click here to review the Stanford Center for CME Privacy Policy.

**Contact Information**

If you are having technical problems or have questions related to CME credit, requirements or course content, contact the CME Online support team at cmeonline@stanford.edu

**Bibliography**

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Sullivan MD, Howe CQ. Opioid therapy for chronic pain in the United States: promises and perils. Pain. 2013;154 Suppl :S94-S100.

For a complete list, please view the References/Bibliography Module in the Course.

Commonwealth of Virginia

Harp, William <william.harp@dhp.virginia.gov>

# RE: How to Taper Patients Off of Chronic Opioid Therapy

1 message

**Anna Lembke** <alembke@stanford.edu> Mon, Nov 19, 2018 at 6:44 PM
To: Mark Rosenberg <rosenb10@stanford.edu>, "william.harp@dhp.virginia.gov" <william.harp@dhp.virginia.gov>
Cc: Laura Elizabeth Corbett <laura17@stanford.edu>

Dear Dr. Harp,

I want to second what Mark says below. We're thrilled that you want to adopt the course for your prescribers in Virginia. That is really awesome! Let me know if there is anything I personally can do to help.

Fond regards,

Anna

Anna Lembke, MD

Medical Director, Addiction Medicine

Program Director, Addiction Medicine Fellowship

Chief, Addiction Medicine Dual Diagnosis Clinic

Associate Professor, Department of Psychiatry and Behavioral Sciences

Courtesy Faculty Appointment, Department of Pain and Anesthesia

Stanford University School of Medicine

401 Quarry Road

Stanford, CA

94305

**From:** Mark Rosenberg <rosenb10@stanford.edu>
**Sent:** Monday, November 19, 2018 3:42 PM
**To:** william.harp@dhp.virginia.gov
**Cc:** Laura Elizabeth Corbett <laura17@stanford.edu>; Anna Lembke <alembke@stanford.edu>
**Subject:** RE: How to Taper Patients Off of Chronic Opioid Therapy

Hello Dr. Harp,



Thanks for reaching out and proposing Dr. Lembke's course as a requirement for your next biennium. We've had a lot positive feedback about the course, and we appreciate YOUR help in getting the word out about this timely and important topic. If you have any questions or concerns I can address as you're drafting your proposal, please feel free to reach out.

Best,

Mark

Mark Rosenberg
CME Online Programs Manager
Stanford Center for Continuing Medical Education

650.725.5077 | mark.rosenberg@stanford.edu | appear.in/markimark

1520 Page Mill Road Palo Alto, CA 94304

**From:** Harp, William <william.harp@dhp.virginia.gov>
**Sent:** Monday, November 19, 2018 1:30 PM
**To:** stanfordcme <stanfordcme@stanford.edu>
**Subject:** How to Taper Patients Off of Chronic Opioid Therapy

Dear CME Staff:

I serve as the Executive Director for the Virginia Board of Medicine, and I have just completed Dr. Lembke's 1.25 hour course on "How to Taper Patients Off of Chronic Opioid Therapy."

Each year, the Board of Medicine requires 2 hours of opioid CME for its licensees with prescriptive authority. This year I would like to propose to the Board that it designate Dr. Lembke's course as a a requirement for the next biennium.

I appreciate you getting the word out about this topic. Since our opioid regulations became effective, tapering has been the #1 issue the Board has heard about from patients.

We have more than 50,000 prescribers that would be taking the course in 2019-2020.

Is this acceptable to you and Dr. Lembke?

Thanks for your consideration,

William L. Harp, MD

Executive Director



Virginia Board of Medicine

American College of Surgeons
Improving Quality: Higher Standards, Better Outcomes

American College of Surgeons Education MyCME CME State Requirements

# CME State Requirements

Revised April 24, 2018

Some state licensing boards or health agencies established specific content requirements for Continuing Medical Education (CME) Credit. In an effort to help individuals meet these requirements, the American College of Surgeons (ACS) offers sessions that include content areas, and are identified and designated as **Credit to Address Regulatory Mandates**. For example, state requirements might include:

Cultural Competence (CC)

End-of-Life Care (EoL)

Ethics (E)

Opioid/Pain Management (OPM)

Palliative Care (PA)

Patient Safety (PtS)

Risk Management (RM)

When claiming CME Credit for these sessions, individuals can elect to include the **Credit to Address Regulatory Mandates** and this will be documented as part of their CME Certificate. Individuals MUST check with their state or local medical board, hospital, or organization to verify that the content does meet the specific requirements.

This information is updated four times a year. These state requirements are subject to change, so please contact mduckworth@facs.org if you have any questions or concerns about the content of this website.

## Alabama

**CME Hours/Year:** 25/1

State-Mandated Content
**Opioid/Pain Management:** Two hours of controlled substance prescribing education every two years as part of the licensee's yearly CME requirement. The controlled substance prescribing education shall include instruction on controlled substance prescribing practices, recognizing signs of the abuse or misuse of controlled substances, or controlled substance prescribing for chronic pain management. January 2017 (January 2018)

## Alaska

**CME Hours/Year:** 50/2

State-Mandated Content
**Opioid/Pain Management:** At least two hours of continuing education in pain management and opioid analgesic use and addiction in the two years preceding application for renewal of a license. (July 2017)

## Arizona

**CME Hours/Year:** 40/2

State-Mandated Content
**Opioid/Pain Management:** The 7-day opioid limit for an initial prescription Governor's Emergency declaration in 2017. The prescriber must check before prescribing a Schedule II–IV opioid or benzodiazepine for a new course of treatment. Subsequent check at least quarterly while the substance(s) remains part of the treatment. Minimum of 1 credit hour of the mandatory 40 credit hours shall be in the area of opioid prescribing. (2016)

Arizona-DO

**CME Hours/Year:** 40/2

State-Mandated Content
**Opioid/Pain Management**

Arkansas

**CME Hours/Year:** 20/1

State-Mandated Content
**Opioid/Pain Management:** Prescribers are required to obtain at least 2 hours of CME on prescribing (emphasis on schedule II and regulations) within the first 2 years of obtaining a license in the state.

California

**CME Hours/Year:** 50/2

State-Mandated Content
**Pain Management:** A one-time requirement that physicians complete 12 hours of continuing medical education in pain management and/or the treatment of terminally ill and dying patients.

**End-of-Life Care:** 12 units may be divided in any way that is relevant to the physician's specialty and practice setting.

**Geriatric Medicine**: Physicians who have patient population of which 25 percent are 65 years of age or older

California-DO

**CME Hours/Year:** 100/2

State-Mandated Content
Minimum of 40 hours of the 100 hours must be American Osteopathic Association (AOA) Category 1A or 1B.

**Pain Management:** A one-time requirement that physicians complete 12 hours of continuing medical education in pain management and/or the treatment of terminally ill and dying patients.

**End-of-Life Care:** 12 units may be divided in any way that is relevant to the physician's specialty and practice setting.

**Geriatric Medicine:** Physicians who have patient population of which 25 percent are 65 years of age or older

Colorado

**CME Hours/Year:** N/A

Connecticut

**CME Hours/Year:** 50/2

State-Mandated Content
**Infectious Diseases**: One (1) hour every six years after first renewal; including, but not limited to, acquired immune deficiency syndrome and human immunodeficiency virus.

**Risk Management:** One (1) hour every six years after first renewal, including, but not limited to, prescribing controlled substances and pain management)

One (1) hour for the following:

Sexual Assault

Domestic Violence

Cultural Competency

Behavioral Health

**Opioid/Pain Management**

Delaware

**CME Hours/Year:** 40/2

State-Mandated Content
**Identify and Report Child Abuse:** 1 hour

**Domestic Violence:** 1 hour

District of Columbia

**CME Hours/Year:** 50/2

State-Mandated Content
**Cultural Competency:** 2 hours/2 years

**HIV/AIDS:** 3 hours

**Opioid/Pain Management:** The DC Center for Rational Prescribing (DCRx) provides information about medications and other therapeutic options to physicians and healthcare professionals.

The DC Department of Health is providing non-commercial, independent continuing education, along with access to other educational resources.

Florida

**CME Hours/Year:** 40/2

State-Mandated Content
**Medical Errors:** 2 hours (Course MUST include information regarding the 5 most misdiagnosed conditions, in accordance with Rule 64B8-13.005, F.A.C.)

**Domestic Violence:** 2 hours required every third biennium included in the 40 general

**Ethics and Risk Management:** 5 hours for attending one full day or 8 hours, whichever is more.

**Opioid/Pain Management**

Florida-DO

**CME Hours/Year:** 40/2

State-Mandated Content
**Ethics** (professional and medical—must be live): 1 hour

**Florida Laws and** Rules (must be live): 1 hour

**Federal and State Laws Related to the Prescribing of Controlled Substances** (must be live): 1 hour

**Domestic Violence** (required every third renewal period): 2 hours

**HIV/AIDS** (for first renewal): 1 hour

**Medical Errors Prevention** (must be live): 2 hours

**Prescribing Controlled Substances:** 1 hour of physician's prescribing controlled substances

Georgia

**CME Hours/Year:** 40/2

State-Mandated Content
**Opioid/Pain Management:** Effective January 1, 2018, every physician not subject to Rule 360-15-.01(3) who maintains an active DEA certificate and prescribes controlled substances, except those holding a residency training permit, shall complete at least one time three or more hours of AMA/AOA PRA Category 1 CME that is designed specifically to address controlled substance prescribing practices. The controlled substance prescribing CME shall include instruction on controlled substance prescribing guidelines, recognizing signs of the abuse or misuse of controlled substances, and controlled substance prescribing for chronic pain management. The certification of such completion must occur at the first renewal following January 1, 2018, or the first renewal following licensure. Completion of this requirement may count as three hours toward the CME requirement for license renewal.

## Guam

**CME Hours/Year:** 100/2

## Hawaii

**CME Hours/Year:** 40/2

State-Mandated Content
40 category 1 or 1A CME hours if you initially received your license in Hawaii prior to 2/1/16; or 20 categories 1 or 1A CME hours if you initially received your license in Hawaii between 2/1/16 and 1/31/17. Only 20 hours are required for the initial renewal. Beginning with the 2020 renewal and thereafter, 40 hours will be required. The hours may be obtained at any time during the years 2016 or 2017. As such, obtaining all CME hours in a single month (for instance, 40 hours in February of 2016) would be acceptable.

**Opioid/Pain Management**

## Hawaii-DO

**CME Hours/Year:** 40/2

State-Mandated Content
40 category 1 or 1A CME hours if you initially received your license in Hawaii prior to 2/1/16; or 20 categories 1 or 1A CME hours if you initially received your license in Hawaii between 2/1/16 and 1/31/17. Only 20 hours are required for the initial renewal. Beginning with the 2020 renewal and thereafter, 40 hours will be required. The hours may be obtained at any time during the years 2016 or 2017. As such, obtaining all CME hours in a single month (for instance, 40 hours in February of 2016) would be acceptable.

## Idaho

**CME Hours/Year:** 40/2

State-Mandated Content
**Opioid/Pain Management**

## Illinois

**CME Hours/Year:** 150/3

## Indiana

**CME Hours/Year:** N/A

State-Mandated Content
**Opioid/Pain Management:** Effective July 1, 2017, pursuant to Senate Enrolled Act 226, new laws concerning the prescribing and dispensing of opioids will go into effect. Please be advised, these changes affect any practitioner who maintains an Indiana controlled substance registration and a federal Drug Enforcement Administration registration

## Iowa

**CME Hours/Year:** 40/2

State-Mandated Content
**Chronic Pain Management:** 2 hours

**End-of-Life Care:** 2 hours/5 years

**Child Abuse and Reporting:** (A licensee who regularly provides primary health care to children) needs to have been within 5 years

***Please note.*** The board has not established a set of guidelines or objectives for course content. The course content and objectives should meet the needs of the local physician community. There is a general need for a greater understanding amongst most physicians for alternatives to narcotic drug use for pain management, appropriate selection, dosage and duration of therapy when narcotics are selected, and the growing problem with abuse, addiction, and diversion of physician-prescribed narcotics. Additional needs might include understanding relative equivalencies between various narcotics and how to switch from one to another, various kinds of physical pain and their most effective management, working with a team of health care providers in addressing chronic pain (mental health specialists, physical therapists, pain management specialists, neurologists), how to assess patient seeking treatment for chronic pain for potential drug misuse, and finally the use of pain management agreements.

Physicians are also encouraged to check with their medical associations to access additional applicable CMEs on chronic pain management and end-of-life care.

## Kansas

**CME Hours/Year:** 50/1

State-Mandated Content
One-year update: 50 hours with a minimum of 20 hours of Category I and a maximum of 30 hours of Category II, Two-year update: 100 hours with minimum of 40 hours Category I and a maximum of 60 hours of Category II, Three-year update: 150 hours with a minimum of 60 hours Category I and a maximum of 90 hours of Category II.

## Kentucky

**CME Hours/Year:** 60/3

State-Mandated Content
HB 1 (passed in 2012) requires a minimum of 4.5 hours required for physicians who are authorized to prescribe or dispense controlled substances in Kentucky. This CME is required every three (3) years CME cycle period.

HB 157 (passed on 2014) requires pediatricians, radiologists, family practitioners, and emergency medicine and urgent care physicians to complete 1 hour of training on this subject that is approved by the Board prior to December 31, 2017. Information can be found on this page under the Approved Pediatric Abusive Head Trauma CME above.

Primary care physicians, who are granted licensure after July 1, 1996, are required to successfully complete a 3-hour domestic violence training course within 3 years of the date of initial licensure. Click here for more information.

As of June 24, 2015, the HIV/AIDS education CME is no longer required.

Be sponsored by an organization accredited for continuing medical education by one of the state medical associations or by the Accreditation Council for Continuing Medical Education (ACCME) or the AOA Council on Continuing Medical Education.

Be designated as AMA or AOA Category 1 education by that organization

**Opioid Management**

## Louisiana

**CME Hours/Year:** 20/1

State-Mandated Content
One-time board orientation course

**Opioid/Pain Management:** The new law requires all prescribers of controlled dangerous substances (CDS) in Louisiana to obtain three continuing education credit hours as a prerequisite of license renewal in the first annual renewal cycle after January 1, 2018. CME course completion is a one-time requirement for all CDS permits holders in the state. The course content shall encompass drug diversion training, best practices for the prescribing of controlled substances, and appropriate treatment for addiction.

## Maine

**CME Hours/Year:** 100/2

State-Mandated Content
**Opioid/Pain Management:** Currently, by law, only clinicians who prescribe opioids (this includes buprenorphine) need to do 3 hours of CME on opioid prescribing every 2 years.

Three hours of any *Category 1 AMA* approved program on the prescribing of opioids will suffice

## Maryland

**CME Hours/Year:** 50/2

## Massachusetts

**CME Hours/Year:** 100/2

State-Mandated Content
Effective February 1, 2012, physicians applying to renew their license or obtain a new license must complete at least three (3) credits of education and training in pain management and opioid education.

**MA Board of Registration in Medicine's Regulations:** 2 hours

**Pain Management:** 3 hours (opioid education)

**End-of-Life Care:** 2 hours

**Risk Management:** 10 hours

**Electronic Health Records** (for renewals after 1/1/15): 3 hours

**Recognize and Report Child Abuse or Neglect:** One-time requirement (not CME/CPD requirement)

**Opioid/Pain Management**

**Offered through Massachusetts Medical Society**

## Michigan

**CME Hours/Year:** 150/3

State-Mandated Content
**Medical Ethics:** 1 hour

**Pain Management:** Effective December 6, 2017, a minimum of 3 hours of continuing education must be earned in the area of pain and symptom management.

One-time for **Training Standards for Identifying Victims of Human Trafficking** with the tile of the state mandate to include a hyperlink directing the user to the state's rules.

## Minnesota

**CME Hours/Year:** 75/3

## Mississippi

**CME Hours/Year:** 40/2

Missouri

**CME Hours/Year:** 50/2

Montana

**CME Hours/Year:** N/A

Nebraska

**CME Hours/Year:** 50/2

Nevada

**CME Hours/Year:** 40/2

State-Mandated Content
**Ethics, Pain Management, or Addiction Care:** 2 hours must complete biennially

**Misuse and Abuse of Controlled Substances, Prescribing of Opioids, or Addiction:** 2 hours

**Within Scope of Practice or Specialty:** 20 hours

Nevada-DO

**CME Hours/Year:** 35/1

State-Mandated Content
**Ethics, Pain Management, or Addiction Care:** 2 hours

**Opioid/Pain Management:** Misuse and abuse of controlled substances, the prescribing of opioids or addiction-2hours

**Evidence-Based Suicide Prevention and Awareness:** 1/year and 4 years thereafter

2 hours of continuing education credits in the detection of suicidal thoughts and ideations, and the intervention and prevention of suicide for the purposes of satisfying an equivalent requirement for continuing education in ethics.

New Hampshire

**CME Hours/Year:** 100/2

State-Mandated Content
**Opioid/Pain Management**: 3 hours/2 years

3 hours of NH Board of Medicine approved CME are required every two years (beginning with the 2016-2017CME reporting cycle) relating to opioid prescribing, including medicated assisted treatment (MAT).

New Jersey

**CME Hours/Year:** 100/2

State-Mandated Content
**Cultural Competency:** 6 hours

**End-of-Life Care:** 2 hours

**Opioid/Pain Management**: One credit of educational programs or topics concerning prescription opioid drugs, including responsible prescribing practices, alternatives to opioids for managing and treating pain, and the risks and signs of opioid abuse, addiction, and diversion.

New Mexico

**CME Hours/Year:** 75/3

State-Mandated Content
**Review of NM Medical Practice Act:** 1 hour

**Prescribing Controlled Substances:** 5 hours

**Pain Management:** 5 hours—The 5 hours of CME in pain management continuing education set forth in Subsections A and B of 16.10.14.11 NMAC may apply toward the 75 hours required in Subsection A of this section and may be included as part of the required CME hours in pain management in either the triennial cycle in which these hours are completed, or the triennial cycle immediately thereafter. Each subsequent triennial renewal cycle shall include five hours of CME hours in pain management.

New York

**CME Hours/Year:** N/A

State-Mandated Content
Identify and Report Child Abuse: 2 hours

Infection Control: 4 hours

All prescribers who hold a DEA license must take a 3-hour course on pain management, palliative care, and addiction.

MSSNY OFFERS 3 Hour CME Program on Pain Management, Palliative Care, and Addiction; NYS Requires Every Prescriber to Take 3 Hour Course By July 1, 2017

North Carolina

**CME Hours/Year:** 60/3

State-Mandated Content
**Opioid/Pain Management:** 3 hours/3 years

Licensees, who prescribe, order, supply, administer, or otherwise provide controlled substances to patients under their care must complete the mandated CME.

Licensees may select any course that is ACCME Category 1 or similar that covers "controlled substances prescribing practices, recognizing signs of the abuse or misuse of controlled substances, and controlled substance prescribing for chronic pain management,"

North Dakota

**CME Hours/Year:** 60/3

Ohio

**CME Hours/Year:** 100/2

Oklahoma

**CME Hours/Year:** 60/3

State-Mandated Content
Additional information on continuing professional development

Oklahoma-DO

**CME Hours/Year:** 16/1

State-Mandated Content

1 hour every other year on prescribing, dispensing, and administering of controlled substances

## Oregon

**CME Hours/Year:** 60/2

State-Mandated Content
**Pain Management:** One-time requirement

**End-of-Life Care:** One-time requirement

A one-hour course provided by the Oregon Pain Management Commission is required plus at least six more hours in the subjects of pain management or the treatment of terminally ill and dying patients.

## Pennsylvania

**CME Hours/Year:** 100/2

State-Mandated Content
**Patient Safety or Risk Management:** 12 hours

**Identify and Report Child Abuse:** 2 hours

**Opioid/Pain Management:** There is a CME requirement that went into effect January 1, 2017, for both initial licenses and renewal licenses. For initial applicants, no later than 12 months after obtaining an initial license or certification, at least two hours of education in pain management or identification of addiction and at least two hours of education in the practices of prescribing of opioids. For physicians seeking relicensure, at least two hours of continuing education in pain management, identification of addiction or the practices of prescribing of opioids, with some exceptions.

## Puerto Rico

**CME Hours/Year:** 60/3

## Rhode Island

**CME Hours/Year:** 40/2

State-Mandated Content
At least 4 hours of continuing medical education shall be earned on **topics of current concern** as determined by the director of the Rhode Island Department of Health:

- Ethics
- Risk management
- End-of-life/palliative care
- Antimicrobial stewardship
- Opioid pain management/chronic pain management

The Department of Health and the Warren Alpert Medical School, can help you meet your continuing education requirements.

## South Carolina

**CME Hours/Year:** 40/2

State-Mandated Content
Two (2) hours of which may be related to approved procedures of prescribing and monitoring controlled substances. Must be received from a statewide organization recognized by the Accreditation Council for Continuing Medical Education.

## South Dakota

**CME Hours/Year:** N/A

Tennessee

**CME Hours/Year:** 40/2

State-Mandated Content
**Opioid/Pain Management:** At least two (2) of the forty (40) required hours must relate to controlled substance prescribing, which must include instruction in the Department's treatment guidelines on opioids, benzodiazepines, barbiturates and carisoprodol and may include instruction on topics such as medicine addiction, risk management tools and other topics approved by the Board.

Tennessee-DO

**CME Hours/Year:** 40/2

State-Mandated Content
**Opioid/Pain Management:** At least two (2) of the forty (40) required hours must relate to controlled substance prescribing, which must include instruction in the Department's treatment guidelines on opioids, benzodiazepines, barbiturates and carisoprodol and may include instruction on topics such as medicine addiction, risk management tools and other topics approved by the Board.

Texas

**CME Hours/Year:** 48/2

State-Mandated Content
**Ethics/Professional Responsibility:** 2 hours

**Pain Management** (for those that practice in a pain clinic): 10 hours

**Opioid/Pain Management:** Per Board rule 195.4(e), the medical director of a pain management clinic must, on an annual basis, ensure that all personnel (including the medical director) are properly licensed, and if applicable, trained to include 10 hours of continuing medical education (CME) related to pain management.

Utah

**CME Hours/Year:** 40/2

Vermont

**CME Hours/Year:** 30/2

State-Mandated Content
Licensees must certify that at least 1 hour of qualifying CME credit was on **hospice, palliative care, or pain management services**.

**Opioid/Pain Management:** If licensee prescribes controlled substances, at least 1 of the required hours must be on the subject of safe and effective prescribing of controlled substances. If you have a DEA number, or have a pending application, you are presumed to prescribe controlled substances and must meet this requirement.

Vermont-DO

**CME Hours/Year:** 30/2

State-Mandated Content
For physicians licensed in Vermont for the first time during the most recent two-year licensing period, if licensed in Vermont for less than one year, there is no requirement for CME at the time of the first renewal. If licensed for one year or more during that initial period of Vermont licensure, the licensee shall complete at least 15 hours of approved CME activity and those 15 hours shall include any subject-specific CME required by these rules.

Virginia

**CME Hours/Year:** 60/2

State-Mandated Content
**Opioid/Pain Management:** 2 hours in the 24 months prior to next biennial renew

Pain management, proper prescribing of controlled substance, diagnosis and management of addiction—2 hours in the 24 months prior to next biennial renewal

Virgin Islands

**CME Hours/Year:** 25/1

Washington

**CME Hours/Year:** 200/4

State-Mandated Content
**Suicide Assessment:** The training must be taken by the end of the first full CME reporting period after January 1, 2016 or during the first full CME reporting period after initial licensure, whichever is later.

**HIV/AIDS:** 4 hours

**Opioid/Pain Management**

Washington-DO

**CME Hours/Year:** 150/3

State-Mandated Content
**Suicide Assessment:** The training must be taken by the end of the first full CME reporting period after January 1, 2016 or during the first full CME reporting period after initial licensure, whichever is later.

West Virginia

**CME Hours/Year:** 50/2

State-Mandated Content
30 hours of the hours must be related to the physician's area or areas of specialty.

West Virginia-DO

**CME Hours/Year:** 32/1

State-Mandated Content
16 hours must be AOA Category 1A or 1B Osteopathic credit

Wisconsin

**CME Hours/Year:** 30/2

State-Mandated Content
**Opioid/Pain Management:** Opioid prescribing 2 hours

Wyoming

**CME Hours/Year:** 60/3

# Opioid / Pain Management (PM) / Controlled Substances CME Requirements by State (June 2017)

| State | Law or regulation addressing general CME requirements | Opioids / PM CME law or regulation requirements for DPMs | Opioids / PM specific? | Notes |
|---|---|---|---|---|
| Alabama | Ala. Admin. Code r. 730-X-3-.06 (2017) | None | n/a | AL Board of Medical Examiners (separate from Board of Podiatry) provides a set of guidelines (applicable to MDs/DOs) at Ala. Admin. Code r. 540-X-19 (2017). |
| Alaska | 12 AAC 40.200 (2017) | None | n/a | There is currently a bill (HB 159) in progress in AK Legislature that would require DPMs to receive education in PM and opioid use and addiction as part of continuing education requirements. It would require 2 CME hours in PM and opioid use and addiction per renewal cycle. |
| Arizona | A.A.C. § R4-25-501 (2017) | None | n/a | AZ Dept. of Health Services created the AZ Opioid Prescribing Guidelines for AZ clinicians.<br><br>Current AZ Governor Ducey sent a letter to MD/DO societies (but not DPMs) urging required opioid abuse education as part of an AZ medical license and CMEs. |
| California | Cal Bus & Prof Code § 2496 (2017) | None | n/a | Only MDs/DOs are currently required to complete, as a one-time requirement, 12 CME hours on PM and the appropriate care and treatment of the terminally ill.<br><br>CA provides clinicians with Guidelines for Prescribing Controlled Substances for Pain. |
| Colorado | 3 CCR 712-2 (2017) | None | n/a | CO provides CO health-care providers with a wealth of references on its Pain Management Resources and Opioid Use. |
| Connecticut | None | None | n/a | CT created the Connecticut Opioid REsponse Initiative to address opioid issues, lay out a strategic planning process, and discuss possible changes to prescribing practitioners' education requirements in the future. |

# Opioid / Pain Management (PM) / Controlled Substances CME Requirements by State (June 2017)

| State | Law or regulation addressing general CME requirements | Opioids / PM CME law or regulation requirements for DPMs | Opioids / PM specific? | Notes |
|---|---|---|---|---|
| Delaware | CDR 24-500-6.1 (2017) | CDR 24-0001-3.1.3 (2017) | Yes and no—mostly refers to "controlled substances," but mentions chronic pain treatment once as a possible focus. | DE has set of prescription opioid guidelines for health-care providers. It also provides a resource website with information on screening tools, identifying addiction, etc.<br><br>**During the first year of registration, DPMs must complete 1 CME hour on DE law, regulation, and programs pertaining to the prescribing and distribution of controlled substances. For subsequent license renewals, DPMs must complete 2 CME hours in the areas of controlled substances prescribing practices, treatment of chronic pain, or other topics related to prescribing of controlled substances.** |
| D.C. | CDCR 17-6806 (2017) | None | n/a | DC's District of Columbia Hospital Association (DCHA) Opioid Taskforce is currently working to determine the safest and best path for addressing opioid abuse and addiction in DC. Currently the DHCA ED Opioid Prescribing Guidelines are available to health-care practitioners. |
| Florida | 64B18-17.001, F.A.C. | None | n/a | There are policies for prescribing and distributing opioids and other pain medications, as applicable to MDs, but none currently for DPMs. |
| Georgia | Ga. Comp. R. & Regs. r. 500-5-.01 (2017) | None | n/a | Currently no opioid education requirements are on file for DPMs—only MDs/DOs (Ga. Comp. R. & Regs. r. 360-15-.01) |
| Hawaii | HAR 16-85-74 (2017) | None | n/a | HI's Board of Medical Examiners provides a set of guidelines for PM. |

# Opioid / Pain Management (PM) / Controlled Substances CME Requirements by State (June 2017)

| State | Law or regulation addressing general CME requirements | Opioids / PM CME law or regulation requirements for DPMs | Opioids / PM specific? | Notes |
|---|---|---|---|---|
| Idaho | IDAPA 24.11.01.700 (2016) | None | n/a | ID has adopted and posted the CDC's guidelines for prescribing opioids for chronic pain. |
| Illinois | 68 Ill. Adm. Code 1360.70 (2017) | None | n/a | IL Dept. of Healthcare and Family Services, in partnership with the UIC College of Pharmacy, provides guidelines on opioid prescribing. |
| Indiana | 845 IAC 1-5-1 (2017) | None | n/a | IN does not have CME requirements; however, it has codified a very specific set of rules addressing podiatrists who prescribe opioids (845 IAC 2-1 (2017)). |
| Iowa | 645 IAC 222.2 (2017) | None | n/a | IA currently has in place the Strategic Prevention Framework for Prescription Drugs (SPF Rx), which works to address IA's substance abuse problem. |
| Kansas | K.A.R. § 100-49-8 (2017) | None | n/a | KS recently received a grant from HHS to address opioid abuse in Kansas. |
| Kentucky | 201 KAR 25:031 (2017) | 201 KAR 25:031 (2017) | Yes and no—requirement includes "pain management" as an option of CME focus, in addition to KASPER and addiction disorders generally. | **DPMs are required to complete 1.5 CME hours, annually, related to the use of the KY Prescription Reporting System (KASPER), PM, or addiction disorders.**<br><br>KY has codified a very specific set of rules for podiatrists prescribing and dispensing controlled substances (201 KAR 25:090 (2017)).<br><br>KY Board of Medical Licensure has also issued Guidelines on the Use of Controlled Substances in Pain Treatment (directed at MDs/DOs). |

# Opioid / Pain Management (PM) / Controlled Substances CME Requirements by State (June 2017)

| State | Law or regulation addressing general CME requirements | Opioids / PM CME law or regulation requirements for DPMs | Opioids / PM specific? | Notes |
|---|---|---|---|---|
| Louisiana | LAC 46:XLV.1377 (2017) | None | n/a | LA Dept. of Health issued Informational Bulletin 17-2, addressing the opioid epidemic and providing a number of resources and references. |
| Maine | CMR 02-396-003 (2017) | 32 M.R.S. § 3657 (2017) | Yes | **ME podiatrists are required to complete 3 CME hours initially by 12/31/17, and then every two years thereafter.**<br><br>ME has also codified guidelines for use of controlled substances to treat pain at CMR 02-313-021 (2017). |
| Maryland | COMAR 10.40.02.03 (2017) | None | n/a | Previously there was a MD DHMH mandate requiring that physicians complete 1 CME hour of opioid education that the MD Board of Podiatric Medical Examiners had adopted, but the mandate was abandoned in 2016, and the BPME is no longer requiring either. |
| Massachusetts | 249 CMR 3.05 (2017) | ALM GL ch. 94C, § 18(e) (2017)<br><br>249 CMR 3.05 (2017) | Yes | **MA DPMs are required to complete at least 1 CME hour annually that pertains to opioid education and PM training, annually.** |
| Michigan | MICH. ADMIN. CODE R 338.8130 (2017) | MICH. ADMIN. CODE R 338.8127 (2017) | Yes | **MI DPMs are required to complete at least 5 CME hours every three years in pain and symptom management.** Topics covered may include, but are not limited to, courses in behavior management, pharmacology, behavior modification, stress management, clinical applications, and drug interventions as they relate to professional practice. |
| Minnesota | Minn. R. 6900.0300 (2017) | None | n/a | MN Boards of Medical Practice, Nursing, and Pharmacy released a joint statement on PM (Dec. 2015). |

# Opioid / Pain Management (PM) / Controlled Substances CME Requirements by State (June 2017)

| State | Law or regulation addressing general CME requirements | Opioids / PM CME law or regulation requirements for DPMs | Opioids / PM specific? | Notes |
|---|---|---|---|---|
| Mississippi | CMSR 30-026-2610 (2017) | None | n/a | MS has adopted the CDC guidelines on opioid prescribing for chronic pain. |
| Missouri | 20 CSR 2150-2.125 (2017) | None | n/a | MO has adopted practitioners' guidelines for prescribing, administering, and dispensing controlled substances. |
| Montana | None | None | n/a | MT endorsed the CDC guidelines for opioid prescribing. |
| Nebraska | Nebraska Admin. Code Title 172, Ch. 143 | None | n/a | NE does not require DPMs complete any CME hours on opioid education but it does provide Guideline for the Use of Controlled Substances for the Treatment of Pain (June 2016). |
| Nevada | Nev. Rev. Stat. Ann. § 635.115 (2017) | None | n/a | NV has an action plan currently to reduce general prescription drug abuse and opioid abuse specifically. |
| New Hampshire | N.H. Admin. Rules, Pod 402.01 (2017) | RSA 318-B:40 (2017) | Yes | Recently adopted rules on Opioid Prescribing (Mar. 8, 2017)<br><br>**All prescribers who possess a US DEA license number must complete 3 CME hours of free appropriate prescriber's regulatory board-approved online continuing education or pass an online examination, in the area of PM and addiction disorder or a combination, as a condition for initial licensure and license renewal.** |

# Opioid / Pain Management (PM) / Controlled Substances CME Requirements by State (June 2017)

| State | Law or regulation addressing general CME requirements | Opioids / PM CME law or regulation requirements for DPMs | Opioids / PM specific? | Notes |
|---|---|---|---|---|
| New Jersey | N.J. Stat. § 45:9-7.1 (2017)<br><br>N.J.A.C. 13:35-6.15 (2017) | None | n/a | NJ recently enacted a law that requires continuing education for other health-care providers (not physicians or DPMs).<br><br>Additionally, NJ Board of Medicine recently adopted new rules on prescribing opioids and PM medications |
| New Mexico | 16.21.8.8 NMAC (2017) | 16.21.8.8 NMAC (2017)<br><br>16.21.9.11 NMAC (2017) | Yes | **NM requires DPMs to complete at least 2 CME hours on PM education every year or 4 hours every two years.** |
| New York | 8 NYCRR § 65.5 (2017) | NY CLS Pub Health § 3309-a (2017) | Yes | **NY requires any DPM who has a DEA registration number to prescribe controlled substances, as well as medical residents who prescribe controlled substances under a facility DEA registration number, to complete at least 3 CME hours in PM, palliative care, and addiction, every three years.** |
| North Carolina | 21 N.C.A.C. 52.0208 (2017) | 21 N.C.A.C. 52.0208 (2017) | Yes and no—both controlled substances generally and chronic PM specifically are mentioned. | **NC requires DPMs to complete 1 CME hour annually on controlled substances prescribing practices and controlled substance prescribing for chronic PM.** |
| North Dakota | N.D. Admin. Code 63-03-02-01 (2017) | None | n/a | ND Dept. of Human Services has a task force ("Reducing Pharmaceutical Narcotics in Our Communities") whose goal includes a timeline to implement policies in the future to address provider education. |

# Opioid / Pain Management (PM) / Controlled Substances CME Requirements by State (June 2017)

| State | Law or regulation addressing general CME requirements | Opioids / PM CME law or regulation requirements for DPMs | Opioids / PM specific? | Notes |
|---|---|---|---|---|
| Ohio | OAC Ann. 4731-10-02 (2017) | OAC Ann. 4731-11-12 (2017) | Yes | **OH requires any physician providing "office-based opioid treatment" (OBOT) to complete at least 8 CME hours of "Category I" relating to substance abuse and addiction every two years**<br><br>Also, OH Dept. of MHAS provides guidelines on management of acute pain outside of ERs, and for prescribing opioids for treatment of chronic pain. |
| Oklahoma | O.A.C. § 545:20-3-1 (2017) | None | n/a | OK has opioid prescribing guidelines for providers in office-based settings. |
| Oregon | OAR 847-008-0070 (2017) | OAR 847-008-0075 (2017) | Yes | **OR requires that all licensees of the OR Medical Board complete 1 CME hour of PM education specific to OR provided by Pain Management Commission of DHS and at least 6 CME hours in subject of PM and/or treatment of terminally ill/dying patients.** |
| Pennsylvania | 49 Pa. Code § 29.61 (2017) | 35 P.S. § 872.9a (2017) | Yes | **PA will require DPMs complete at least 2 CME hours in PM or identification of addiction and at least 2 CME hours of education in the practices of prescribing or dispensing of opioids.** The PA Licensing Board has not approved or finalized training yet, but expects it to be done by 2018.<br><br>PA provides guidelines to health-care providers for the use of opioids to treat chronic non-cancer pain. |

# Opioid / Pain Management (PM) / Controlled Substances CME Requirements by State (June 2017)

| State | Law or regulation addressing general CME requirements | Opioids / PM CME law or regulation requirements for DPMs | Opioids / PM specific? | Notes |
|---|---|---|---|---|
| Rhode Island | 14 RICR 140-035 | 14 RICR 060-009 | Yes | **RI requires that all practitioners prescribing long-acting opioids shall have completed an educational program compliant with the ER/LA Opioid Analgesic REMS Educational requirements issued by the FDA.** This training may be from a continuing education program or from an accredited professional preparation education program including approved residency training programs. |
| South Carolina | S.C. Code Ann. § 40-51-140 (2017) | None | n/a | SC does not have requirements for podiatrists, but there are requirements for MD/DOs do (S.C. Code Ann. § 40-47-40 (2017)). |
| South Dakota | ARSD 20:55:01:08 (2017) | None | n/a | Currently there is a SD Prescription Opioid Abuse Prevention Initiative, funded through a CDC grant. |
| Tennessee | Tenn. Code Ann. § 63-3-116 (2017) | None | n/a | There are no general opioid or PM CME requirements for DPMs in TN, however, certain MDs/DOs who are classified as pain medicine specialists (PMS) do have requirements. DPMs are ineligible to be PMSs.<br><br>TN has clinical practice guidelines for managing chronic pain. |
| Texas | 22 TAC § 378.1 (2017) | None | n/a | Currently only MDs/DOs are "encouraged" to include CMEs specifically on pain treatment in their general CME (Tex. Occ. Code § 156.055 (2017)). |

# Opioid / Pain Management (PM) / Controlled Substances CME Requirements by State (June 2017)

| State | Law or regulation addressing general CME requirements | Opioids / PM CME law or regulation requirements for DPMs | Opioids / PM specific? | Notes |
|---|---|---|---|---|
| Utah | U.A.C. R156-5a-304 (2017) | Utah Code Ann. § 58-37-6.5 (2017) | Yes and no—controlled substances generally and opioids are both specifically mentioned | **UT DPMs are required to complete 4 CME hours, per licensing period, that satisfy the statute's conditions (.5 CME hours can be the online tutorial and passing test, with the remaining 3.5 hours in one or more controlled substance prescribing classes).**<br><br>The 3.5 hours of the controlled substance prescribing classes under Subsection (4) shall include educational content covering the following:<br>a) the scope of the controlled substance abuse problem in Utah and the nation;<br>b) all elements of the FDA Blueprint for Prescriber Education under the FDA's Extended-Release and Long-Acting Opioid Analgesics Risk Evaluation and Mitigation Strategy, as published July 9, 2012, or as it may be subsequently revised;<br>c) the national and Utah-specific resources available to prescribers to assist in appropriate controlled substance and opioid prescribing;<br>d) patient record documentation for controlled substance and opioid prescribing; and<br>e) office policies, procedures, and implementation.<br><br>After January 1, 2024, as a condition precedent for license renewal, each controlled substance prescriber shall complete at least 3.5 continuing education hours in an SBIRT-training class that satisfies the requirements of Subsection (5). |
| Vermont | 26 V.S.A. § 1400 (2017) | None | n/a | VT provides a very specific set of regulations for prescribing opioids for pain that all prescribers (including DPMs) must follow (CVR 13-140-076 (2017)). |

# Opioid / Pain Management (PM) / Controlled Substances CME Requirements by State (June 2017)

| State | Law or regulation addressing general CME requirements | Opioids / PM CME law or regulation requirements for DPMs | Opioids / PM specific? | Notes |
|---|---|---|---|---|
| Virginia | 18 VAC 85-20-235 (2017) | None | n/a | VA added a new statute (Va. Code Ann. § 54.1-2928.2 (2017)), requiring the VA Board of Medicine to institute new guidelines that address prescribing opioids and buprenorphine. This statute may result in new provider education requirements in the future. |
| Washington | WAC § 246-922-300 (2017) | WAC § 246-922-668 (2017) | Yes | **WA State requires DPMs to have completed at least 4 CME hours related to prescription of opioids (lifetime requirement, not annually or every license cycle).**<br><br>WA State also recently adopted interagency guidelines on PM treatment. |
| West Virginia | W. Va. Code § 30-3-12 (2017)<br><br>W. Va. CSR § 11-6-3 (2017) | W. Va. CSR § 11-6-3 (2017) | No, controlled substances generally | **WV DPMs must complete 3 CME hours of drug diversion training, and best-practice prescribing of controlled substances training, unless a podiatrist has completed and timely provided to the Board a Board-developed certification waiver form attesting that he or she has not prescribed, administered, or dispensed a controlled substance during the entire previous reporting period. Required for renewals of license.**<br><br>WV also has disseminated best practices for prescribing opioids. |
| Wisconsin | Wis. Adm. Code Pod 3.01 (2017) | None | n/a | WI has a set of guidelines addressing all prescribers of opioids. |
| Wyoming | WCWR 028-0001-2 | None | n/a | WY has a set of guidelines for treating chronic pain with opioids. |