Cleveland Clinic

Kristen Morris
Chief Government and Community Relations Officer

February 16, 2018

The Honorable Orrin G Hatch
Chairman
Senate Committee on Finance
104 Hart Office Building
Washington DC 20510

The Honorable Ron Wyden
Ranking Member
Senate Committee on Finance
221 Dirksen Office Building
Washington DC 20510

Submitted via email: opioids@finance.senate.gov

Dear Chairman Hatch and Ranking Member Wyden:

Cleveland Clinic (CC) is a not-for-profit, integrated healthcare system dedicated to patient care, teaching, and research. Our health system is comprised of a main campus, 10 community hospitals, and 21 family health centers with over 4,100 salaried physicians and scientists. Last year, our system had more than seven million patient visits and over 220,000 hospital admissions.

We applaud the Committee for taking leadership on this important issue and wish to respond to the questions the Committee has posed in its Request for Information.

Background

As you are no doubt aware, the opioid epidemic has taken a profound toll on Cleveland and Northeast Ohio. The latest figures from the Centers for Disease Control and Prevention (CDC) show an intensification of annual drug overdose deaths in Ohio amounting to almost triple the national average, which is likely related to the state's ongoing opioid crisis. According to the National Vital Statistics System's recently released Provisional Drug Overdose Death Counts report, 5,232 drug overdose deaths were reported between July, 2016 and July 2017, up significantly from the 3,763 overdose deaths reported for the same period the previous year. The additional 1,469 reported deaths constitute a 39 percent increase in annual overdose deaths from the previous year, giving Ohio the third-largest increase in the nation, eclipsed only by Pennsylvania, with a 43.4 percent increase, and Florida, with a 39.4 percent increase. The nation as a whole experienced a 14.4 percent increase in overdose deaths. The state's 5,232 overdose deaths comprised 4.3 percent of all deaths in the state within the study's year-long period.

The root cause of this crisis is a "perfect storm" of perverse pharmaceutical industry incentives, well-intentioned, but damaging, government initiatives and messaging, changes in patient

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perceptions of wellness and pain control and reimbursement policies that have caused opioid medications as the "path of least resistance" for pain control. For example, when the cost of IV Tylenol is $23 a dose, and the cost of an oxycodone tablet is pennies, the wrong behavior is reinforced at all levels. In order to "turn the tide", our national healthcare and insurance systems will need to address all of these root causes.

Addiction is a chronic disease, and treatment encompasses both acute and chronic needs. The acute treatment course can include Medication Assisted Treatment (MAT) and stays in inpatient, Partial Hospitalization (PHP), or residential rehabilitation facilities. Chronic/maintenance treatment can require weeks to months in a residential support setting ('sober living'), and the need for ongoing therapy and MAT can be life-long. Current challenges to treatment include a lack of sufficient sober living facilities and treatment beds, poor access to MAT and other treatment options, and poor educational resources for those fighting addiction.

In addition to a focus on providing better treatment options, more can be done to prevent abuse of and dependence on opioid medications. As awareness of the dangers of using opioids to treat chronic pain has increased over the last several years, greater emphasis has been placed on alternatives to medical management, especially for indications such as chronic lower back pain. These programs are rooted in behavior management, including physical therapy and cognitive behavioral therapy. While opioid-free efficacy of these programs has been demonstrated in a variety of patient cohorts and settings, these largely are reimbursed inadequately if at all. This pushes patients to have care outside of these programs, where medical providers are inadequately equipped to have critical conversations with patients about pain management and rehabilitation. While patients often want a "passive" solution to chronic pain (i.e. a pill) the reality is that in order to achieve the goals of rehabilitation and full-time-employment patients need to be actively involved in their care.

Cleveland Clinic's Approach

As healthcare providers, Cleveland Clinic is acutely aware of its role in helping to create this crisis and in addressing it. We would like to share a couple of Cleveland Clinic programs that we believe have the potential to help reduce future OUD and SUDs.

Back on TREK

About 80 percent of adults experience low back pain at some point in their lifetimes. It is the most common cause of job-related disability and a leading contributor to missed work days. Chronic back pain is defined as pain that persists for 12 weeks or longer, even after an initial injury or underlying cause of acute low back pain has been treated. About 20 percent of people affected by acute low back pain develop chronic low back pain with persistent symptoms at one year. We understand back pain can be difficult to treat and confusing for patients to know what course of care is best to treat their pain. Patients often confuse hurt with harm and choose to stay inactive. Unfortunately inactivity can feed into the vicious cycle of pain and pain pills compound the problem. With more than 7 million total patient visits in our health system,

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Cleveland Clinic confronts thousands of back pain cases each day. The burden on the system is immense, as is the cost. New guidelines for the treatment of back pain released by the American College of Physicians call for the use of drug therapies only as a last resort, as in most cases they are ineffective. This is corroborated by a detailed report from the Institute of Medicine of the National Academy of Sciences. While we agree with these recommendations, there are no wide-scale systems for non-pharmacological management of chronic pain patients, including those with back pain. The Cleveland Clinic has been in the forefront of developing innovative new treatment strategies. One of the new programs is showing great results and rehabilitation, with lower long-term costs. Known as *Back on TREK* (**T**ransform **R**estore **E**mpower **K**nowledge), the program is profiled below.

The Back on TREK low back pain program at the Cleveland Clinic is a 12-week interdisciplinary program in which spine specialists have partnered with physical therapists and behavioral medicine specialists to improve outcomes of chronic back pain. Interdisciplinary pain rehabilitation approaches such as that utilized in Back on TREK are supported, but substantial evidence also exists supporting their benefits in terms of improving pain, mood and function for up to 10 years post-treatment[1,2,3]. Such approaches are aimed at minimizing future unnecessary utilization of health care and distancing patients from the role of "patient", driving them back towards self-care and full-time employment.

The Back on TREK program is uniquely structured with the overarching goal of empowering patients to manage their pain through physical and behavioral approaches. Behavioral medicine specialists, physical therapists, and spine physicians work collaboratively to develop individualized treatment plans and continually evaluate patients' progress as they advance through the program. Treatment plans include individual and group physical therapy and behavioral medicine sessions. Consultation with spine physicians and/or pain psychiatry inputs is initiated as needed. Family education sessions are offered to support the family members who are caregivers of those with pain.

Patients begin with an initial evaluation by behavioral medicine specialists and physical therapists. Those individuals who can benefit from the program then enter an intensive 12-week program combining physical and behavioral therapy. This program is designed to improve functionality and quality of life without the use of opioids.

<u>Weeks 1-4</u>

• 1 individual physical therapy session per week

[1] Schatman ME. Interdisciplinary chronic pain management: international perspectives. Pain Clinical Updates 2012; 20(7):1-5. Accessed 2/1/14 at http://www.iasp-pain.org/AM/AMTemplate.cfm?Section=Pain_Clinical_Updates1&CONTENTID=16590&SECTION=Pain_Clinical_Updates1&TEMPLATE=/CM/ContentDisplay.cfm

[2]Gatchel RJ, McGeary DD, Peterson A, Moore M, LeRoy K, Isler WC, Hryshko-Mullen AS, Edell T. Preliminary findings of a randomized controlled trial of an interdisciplinary military pain program. Mil Med. 2009;174(3):270-7.

[3] Patrick LE, Altamaier EM, Found EM. Long-term outcomes in multidisciplinary treatment of chronic low back pain: results of a 13-year follow-up. Spine. 2004;8:850–855.

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• 2 group physical therapy sessions per week
• 1 group behavioral medicine session per week

Weeks 5-8
• 1 individual physical therapy session every other week
• 1 group physical therapy session per week
• 1 group behavioral medicine session per week

Weeks 8-12
• 1 individual physical therapy session every other week
• 1 group physical therapy session per week
• 1 group behavioral medicine session every other week

Because of the connection between chronic pain, opioid prescriptions and, ultimately, heroin abuse, the Back on TREK program is designed to attack the Opioid Crisis by 'nipping it in the bud'. People who are at risk for the opiate addiction often begin their horrifying journey with a chronic pain problem. The Back on TREK program specifically addresses this subset of the at risk patient population. The program is the nidus for Cleveland Clinic's plan to offer large-scale non-pharmacological care for patients with chronic back pain.

R.E.D.E to Communicate:

We recognize that there are (extremely limited) instances of providers who prescribe opioids without due diligence and thorough review of patient needs. It is much more commonly the case that providers are pressured to prescribe opioids to patients for whom the benefit may be considered marginal. These patients can present impassioned arguments for their need, and in many cases the provider may lack the training and skills to say "no" in a firm but compassionate way. Further, until recently, the CMS patient satisfaction scores (which in turn had an effect on provider reimbursement) included questions that some providers interpreted as linked to patient-directed prescribing of pain relief medications, including opioids.

As a result, there is a need for providers to have access to training and resources to enable "Crucial Conversations" around opioid prescribing and patient access. At Cleveland Clinic, we have initiated a course, in conjunction with our Foundations of Healthcare Communications training, on Communicating with Patients about Pain.

The complexity of pain treatment is often exacerbated by disparate goals and attitudes between patient and provider concerning the condition and treatment. This experiential, skills-based course focuses on enhancing patient-provider communication using the R.E.D.E. (Relationship: Establishment, Development and Engagement) model of relationship-centered communication to align agendas and expectations, and engage in collaborative decision

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making. Relationship-centered communication has the ability to reduce fear and increase adherence associated with various treatment methods as well as increasing readiness to accept pain as a disease and adopt more effective self-management strategies. Participants will be engaged in interactive dialogue and skills practice with standardized patients trained to present with various communication challenges often found within this patient population. All Cleveland Clinic providers are being trained on this important skill, and we believe that the program can serve as a national model for prescriber training.

Using Electronic Medical Records to change prescriber behaviors:

Over the last 12 months, Cleveland Clinic's Opiate Task Force, led by Dr. Lisa Yerian, has undertaken to transform prescriber behaviors using tools and dashboards developed for our EMR. A comprehensive Opiate Toolkit (see appendix materials) alerts providers about state regulations, disseminates best practices for prescribing, and leads providers through consent processes with patients to help them make the best decisions about their own pain control. Enterprise dashboards help leadership and individual providers track Cleveland Clinic's progress toward doing everything we can to help minimize patient risk of developing OUD while continuing to use appropriate pain control wisely.

Potential Federal Policy Solutions:

The federal government can play a role in addressing some of these challenges. We offer the following models and recommendations for the consideration of the Committee and in answer to its request for information:

1. **How can Medicare and Medicaid payment incentives be used to promote evidence-based care for beneficiaries with chronic pain that minimizes risk of developing OUD or other SUDs?**

   Patients are increasingly passive regarding pain management, while most health care professionals know that recovery from both acute and chronic pain conditions requires a combination of physical therapy, behavioral therapy and lifestyle modifications. Reimbursement misalignment (discussed in more detail below) can further disincentivize patient engagement. In some cases, the beneficiary co-pays alone represent barriers to completing a program like Back on TREK. In addition, there are perverse reimbursement and pharmaceutical pricing incentives that make opioid medications more cost effective for providers and patients alike, driving them to make choices for pain relief that not only put patients at risk for dependency but are potentially ineffective for pain management.

   Recommendation: We believe it is essential to re-structure reimbursement for behavioral health and physical therapy to adequately reimburse providers who engage patients in these long-term, non-medical pain management programs. Further, we believe there is an opportunity to use the Innovation Center to create more targeted incentive payment programs

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that help patients choose active (non-medical) pain management in place of opioid or even non-opioid medical management**. For example, removing co-pays for Behavioral Health and Physical Therapy while retaining (or even increasing) co-pays for medical treatment of chronic pain such as low back pain**. **As a further step, we believe that specific financial incentives (such as lowered premiums) for choosing evidence-based non-medical pain management could align incentives with goals for choosing more active patient engagement.**

Recommendation: Align cost and reimbursement for pain medications with treatment objectives. When effective non-narcotic pain medications (like IV Tylenol or ketoprofen) are hundreds to thousands of times the cost of opioid tablets, the wrong prescribing and utilization behaviors are reinforced. Incentives can and should be in place to either fully reimburse opioid alternatives or to impose negative financial incentives for using opioid-based medications when a non-opioid alternative (including NSAIDs, gabapentin, or temporary antidepressants) might be more suitable. This is particularly the case when treating chronic and neuropathic pain, which do not respond to opioids.

2. **What barriers to non-pharmaceutical therapies for chronic pain currently exist in Medicare and Medicaid? How can those barriers be addressed to increase utilization of those non-pharmaceutical therapies when clinically appropriate**?

Currently, both commercial and public health plans, such as Medicare and Medicaid, impose limits and co-pays on behavioral health and physical therapy, that can interfere with participation in a program like Back on TREK. For example, Cleveland Clinic estimates that, while the program has demonstrated efficacy in avoiding both costly surgery and use of opioid pain relievers, reimbursement under State and Federal programs falls short of costs to provide care at a rate of $1.3 million per 500-1000 patients (range due to fixed overhead and administrative costs). As a result, only health systems that are large enough to absorb these losses are even willing to pilot these important and potentially life-saving programs.

Recommendation: Expand Reimbursement for Non-medical Pain Management – Programs that help patients manage chronic pain without opioids can save the health of the patient and can be very cost-effective in the long term through avoidance of addiction and even surgical interventions. However, they can require intensive, multi-modal intervention for weeks to months. Federal programs such as Medicare and Medicaid need to prioritize reimbursement for these programs as part of their overall population health and opioid management strategies. **We recommend removing yearly and lifetime caps on behavioral health and physical therapy payments for patients having documented acute or chronic pain.**

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3. **How can Medicare and Medicaid payment incentives be used to remove barriers or to ensure beneficiaries receive evidence-based prevention, screening, assessment, and treatment for OUD and SUDs to improve patient outcomes?**

   While most insurers, including Medicaid, cover MAT, many have instituted rigorous prior authorization requirements that create burdensome hurdles for overworked healthcare providers. Opioid addicts are often victims of these hurdles, as delays in starting treatment, or interruptions in established treatment regimens, can lead to relapse or even accidental death from overdose. In the end, these hurdles increase health care costs for the entire system.

   Recommendation: Require all Public and Private Insurers to Cover Treatment – No American with insurance should have to worry that addiction treatment they need won't be covered. At present, many commercial insurance plans will cover only acute detox treatment and hospitalization. However, long-term recovery requires ongoing behavioral and medical therapy lasting weeks to months or longer, which, even if covered, is often subject to caps. It is not unusual for patients (especially young adults under 26) to be forced to drop off commercial insurance and seek Medicaid coverage, just to ensure they can get the long term treatment they need.

   Recommendation: Eliminate Prior Authorization and Other Hurdles to obtaining MAT – Providers treating people with opioid addiction should be focusing their time on patient care, not on battling insurers to ensure needed treatment can be dispensed. When possible, the federal government should eliminate prior authorization when MAT is prescribed as part of an approved treatment program for individuals covered by Medicare and Medicaid. Furthermore, states should consider removing prior authorization hurdles for necessary MAT. **Lawmakers should consider prohibiting discrimination against coverage of MAT and the individuals who receive it, along with elimination of the prohibition of state Medicaid funds to treat incarcerated adults.**

4. **Are there changes in Medicare or Medicaid prescription drug program rules that can minimize the risk of developing OUD or SUDs while promoting efficient access to appropriate medications?**

   Recent new regulations in the state of Ohio require limiting home-going opioid prescriptions for patients having outpatient surgery or recovering from acute injury to 3-7 days, with a requirement to see a provider for a follow up visit prior to refilling those prescriptions. While the results of these new policies have not yet been evaluated, we expect to see a measureable decrease in both prescribing and dispensing of refills and overall utilization. In addition, however, new technologies are emerging that allow providers to conduct genomic screening on patient before an elective procedure, to identify patients who are "high metabolizers" of opioid medications and are at higher risk for escalating dosing and dependence. These technologies are potentially revolutionary, but in the absence of effective, alternative non-opioid medications to offer these patients, providers are faced with two bad choices: under-

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management of legitimate acute pain or use of opioid pain medications with the potential risk of dependency.

Recommendation: Allocate dedicated NIH or Department of Defense research funding for the development of non-opioid pain medications that show improved efficacy over current NSAID and other non-narcotic pain medications for acute pain.

5. **How can Medicare or Medicaid better prevent, identify and educate health professionals who have high opioid prescribing patterns?**

   As stated above, providers are chronically pressured to write opioid prescriptions for chronic pain, neuropathic pain or for other indications for which opioids may not be appropriate. These prescriptions may be abused, diverted or simply employed without efficacy. Training like the *R.E.D.E to Communicate: How to Talk to Patients about Pain* course can equip providers to have critical conversations that engage patients in making healthier choices. These trainings are not without cost, however, and comprehensive education support could make a measurable difference in prescribing patterns.

   Recommendation: Make Federal funds available for training of ALL providers in crucial conversations around pain and treatment, using evidence-based methods that increase provider understanding and adherence with best practices in opioid prescribing. These can either be administered through national grants for training and dissemination, or through incentives for participants in MIPS or APMs through the Quality Payment Program for clinical integration and population health activities.

6. **What can be done to improve data sharing and coordination between Medicare, Medicaid and state initiatives, such as Prescription Drug Monitoring programs?**

   Ohio has a successful PDM program that has significantly reduced opiate prescriptions and dispensing. Established in 2006, the Ohio Automated RX Reporting System (OARRS) is Ohio's state wide prescription drug monitoring program. OARRS collects information on all controlled substance prescriptions written by Ohio licensed prescribers and dispensed by pharmacies across the state.

   The OARRS data base can be accessed by pharmacists, prescribers and law enforcement. Pharmacists use the database to review all controlled substance prescriptions being taken by a patient. OARRS allows the pharmacist to see the details of those prescriptions for an individual patient.

   Prescribers access the database to ensure the appropriate treatment for patients and to assess compliance with prescribed medication regimens. Law enforcement officials can review OARRS reports when legal issues emerge surrounding controlled substance use.

   The OARRS database promotes the use of best practices when prescribing opioids, benzodiazepines and other medications that can have dangerous side effects if used inappropriately.

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A recent report published by the Ohio Board of Pharmacy on opioid prescribing between 2012 and 2016 shows encouraging outcomes including:

- 4% (162 million dose) decrease in the total number of opioids doses dispensed
- 20% (2.5 million) decrease in number of opioid prescriptions
- 5% (43 million) decrease in the total number of benzodiazepine doses dispensed
- 2% decrease in the number of individuals who see multiple prescribers to obtain controlled substances illicitly ("doctor shopping")
- 11 million requests for OARRS reports in 2016

Recommendation: Require all states to share PDM data, both with in-state prescribers and across state lines.

7. **What human services efforts (including specific programs or funding design models) appear to be effective in preventing or mitigating adverse impacts from OUD or SUD in children or families?**

We believe that mitigating the effects of OUD and SUD requires a focus both on adequate treatment and on increased focus on prevention. Both death from overdose and inability to access adequate treatment have devastating effects on both those struggling with OUD and their families. To that end, we make the following recommendations

Recommendation: Increase Federal Funding for Naloxone – in many communities, the incidence of overdose (especially due to fentanyl contamination) has risen at an overwhelming rate -- so much so that the cost of life-saving interventions, such as Naloxone, is bankrupting municipalities and forcing first responders to ration life-saving treatments or to stand by helplessly as victims die. While CARA has provided some funding opportunities to municipal and FQHC programs for Naloxone, these funds (up to $200,000 per year) have fallen far short of need for some of the hardest hit communities. Federal funding to state and municipal emergency response is needed to ease this impact and save lives.

Recommendation: Eliminate the IMD exclusion – Under current rules, facilities that accept Medicaid cannot dedicate more than 16 beds to psychiatric/substance abuse treatment without applying for and receiving a waiver. Congress should either repeal this exclusion entirely or expand the allowable waivers to this rule to accommodate a growing need among this population.

Recommendation: Focus on Prevention – Education of prescribers and patients alike on safe guidelines for opiate use is critical to eliminating the most common cause of addiction and abuse – the over prescribing and overuse of prescription opiates after traumatic injury, surgery or in response to pain from chronic illness. Federal prescribing guidelines, national education programs, and funding for research into alternative pain management strategies all can meaningfully reduce the emergence of future addiction.

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We thank the Committee for its commitment to doing all it can to help the healthcare community and the American people tackle this critical health crisis. If you have any questions about the programs or recommendations made here, please do not hesitate to contact Carlos Jackson, Executive Director, Government Relations (jacksoc7@ccf.org) or myself. We are committed to being of service to the Committee and to our patients in any way we can.

Respectfully submitted,

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Cleveland Clinic

Back on **TREK**

Low Back Pain Pilot

Transform **R**estore **E**mpower **K**nowledge

The Back on TREK Low Back Pain program at Cleveland Clinic Lutheran Hospital is a 12-week multidisciplinary program for patients who are experiencing chronic back pain, with or without associated leg pain.

With a unique team approach to care, the program is designed to promote recovery of function and to empower patients to manage their pain. Behavioral medicine specialists, physical therapists, physicians and nurses work collaboratively to develop individualized treatment plans. Plans include physical therapy and behavioral medicine sessions. Family education and individual sessions may also be included.

Patients begin with an initial evaluation by our behavioral medicine specialist and physical therapist. Patients who are eligible for the program will follow the program schedule:

Weeks 1-4

- 1 individual physical therapy session per week
- 2 group physical therapy sessions per week
- 1 group behavioral medicine session per week

Weeks 5-8

- 1 individual physical therapy session every other week
- 1 group physical therapy session per week
- 1 group behavioral medicine session per week

Weeks 8-12

- 1 individual physical therapy session every other week
- 1 group physical therapy session per week
- 1 group behavioral medicine session every other week

The eligibility criteria for participation in this pilot includes:

- Patients who are able to receive their care at Lutheran Hospital
- Are between 18-65 years old
- Have experienced back pain for a minimum of three months
- Have not had back surgery

Contact Us

If you would like to learn more about the program and to determine your eligibility, please call 216.636.5860 to schedule a phone call with the Back on TREK nurse or email BackonTREK@ccf.org.

Cleveland Clinic

MyPractice

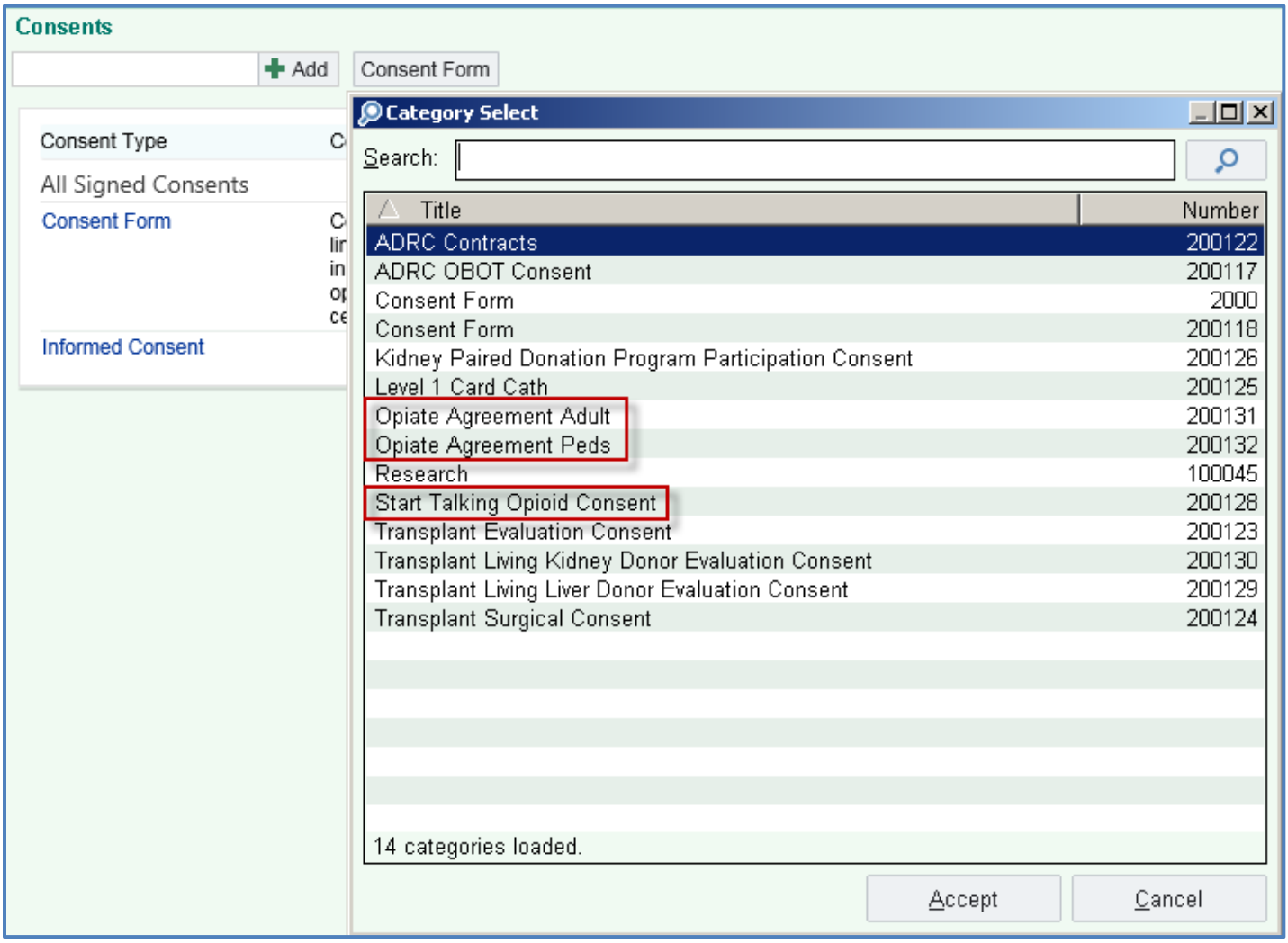
Effective July 11, 2017 **Enterprise (Excluding Florida & ACMC)**

Electronic Opiate Consents Available in MyPractice

Beginning Tuesday, July 11, three existing opiate consents/patient agreements will be available electronically in MyPractice (Epic). These include:

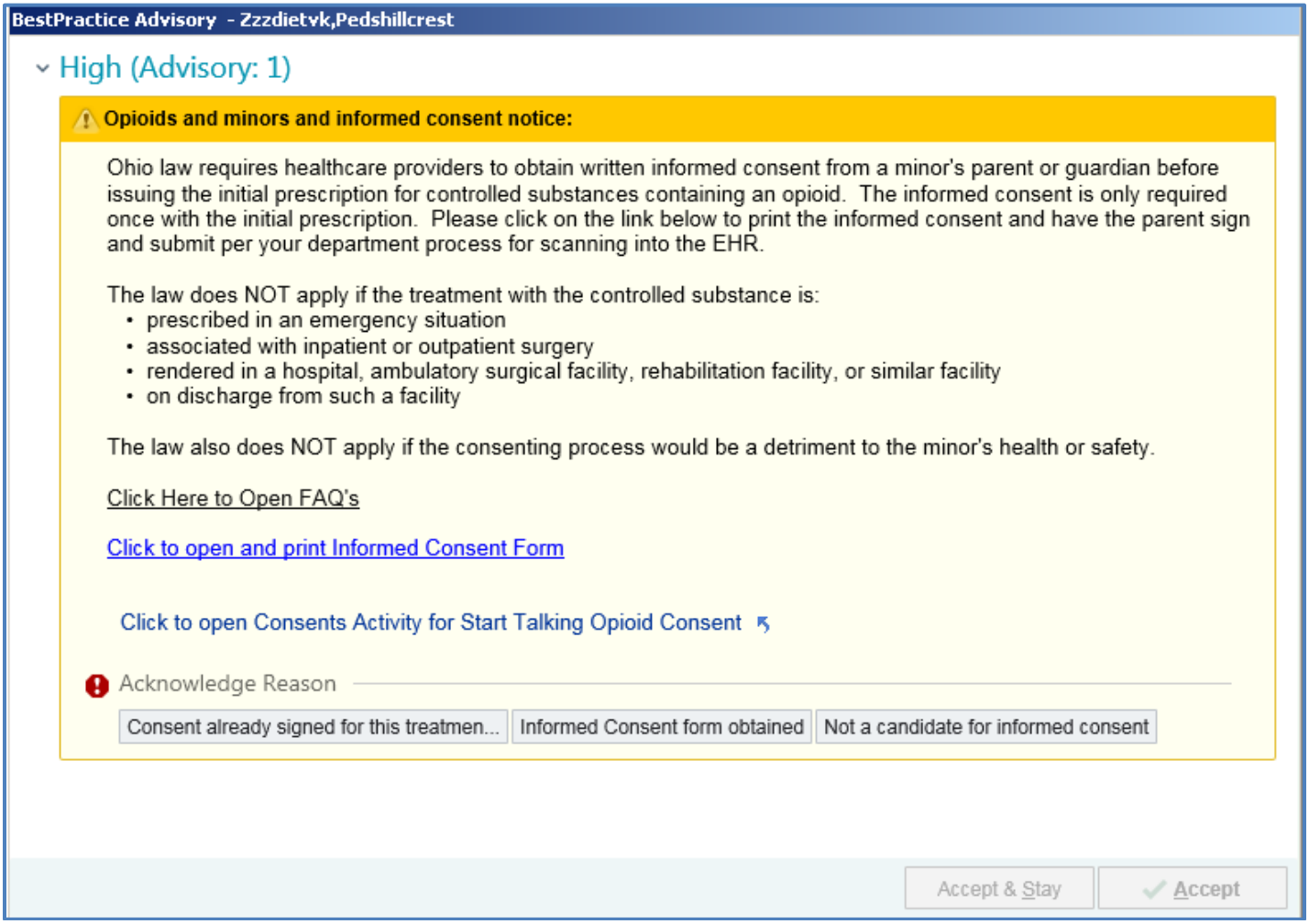
- Start Talking Opioid Consent for minors
- Opiate Agreement Adult
- Opiate Agreement Peds

These will be available through the **Consents Activity** > **Add button**, as shown below.



The existing BPAs that display for opioids and minors will be updated to include:

- A link to jump to the Consents Activity
- Updated Acknowledge Reason buttons



Questions?

If you have questions or need assistance, please contact the Physician Specialist / COA for your area, or call the Help Desk at 216.444.HELP (4357). Florida caregivers, please call 5-5555, option 1.

December 19, 2017 Ambulatory Enterprise (including Florida)

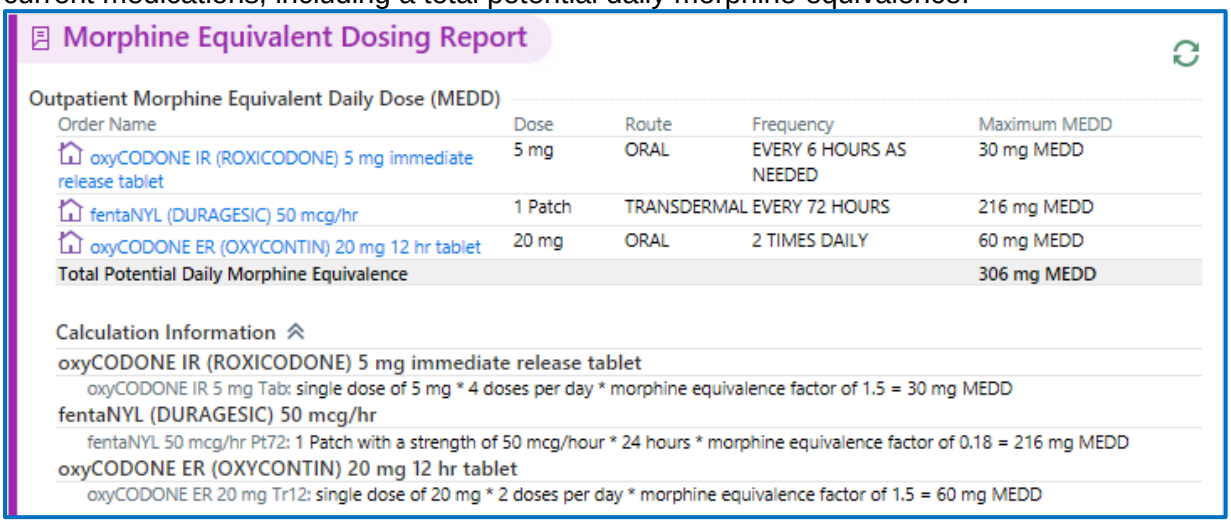
New toolkit assists with safe and compliant prescribing of maintenance opioids

Available on Tuesday, December 19, the new Opioid Toolkit will centralize the reports and documentation used to assist providers when prescribing opioids for long-term use (e.g. chronic pain, cancer, hospice, addiction treatment). This activity will eliminate the need to navigate to other areas of the chart to access this crucial information and place orders.

The Opioid Toolkit includes:

- E-signature Consents
- Appointments
- OARRS Report (Ohio only)
- Morphine Equivalent Dosing Report (new)
- Urine Toxicity and Pain Panel Results
- Meds and Orders

The new Morphine Equivalent Dosing Report will calculate the maximum MEDD for each of the patient's current medications, including a total potential daily morphine equivalence.

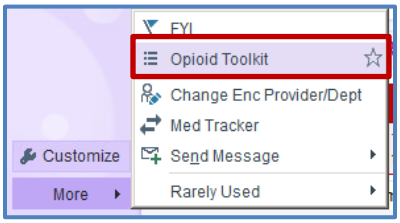


The Opioid Tool kit is accessible in the following locations:

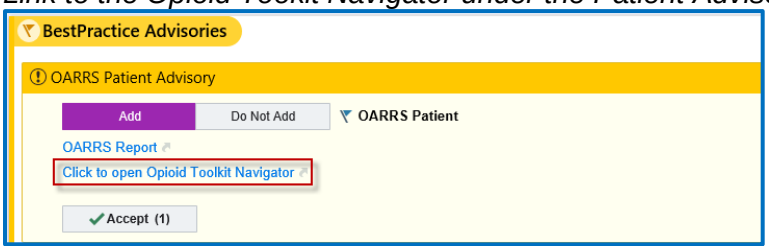
- a button on the toolbar
- an activity in the More menu on the navigator
- a link in the OARRS Patient Advisory BPA banner (Ohio only)
- a link within the OARRS Report (Ohio only)

Opioid Toolkit toolbar button

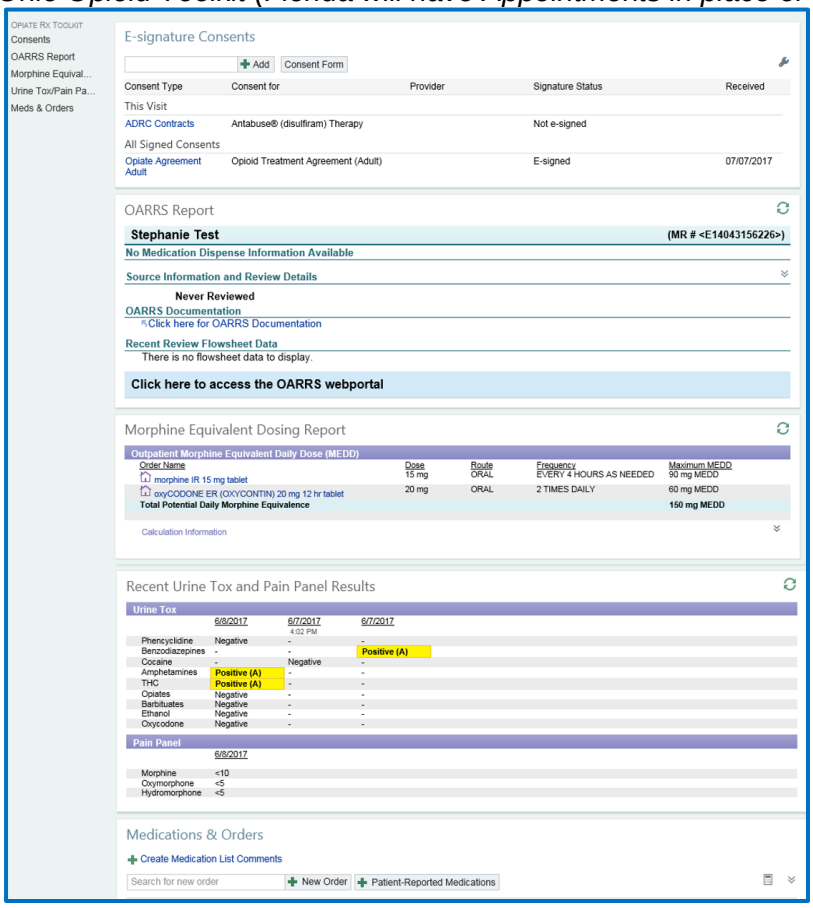
The Opioid Toolkit activity available under the "More" button



Link to the Opioid Tookit Navigator under the Patient Advisory BPA (Ohio only)



Ohio Opioid Toolkit (Florida will have Appointments in place of the OARRS report)



Questions?

If you have additional questions or need assistance, please contact the physician specialist / COA for your area or call the Help Desk at 216.444.HELP.

Cleveland Clinic MyPractice

December 19, 2017 Enterprise (excluding FL)

Notifications assist providers in complying with acute pain opioid prescription regulations

Beginning Tuesday, December 19, new alerts will notify providers when they are attempting to order opioids for acute pain that exceed the recent restrictions enacted by the Ohio State Board of Pharmacy.

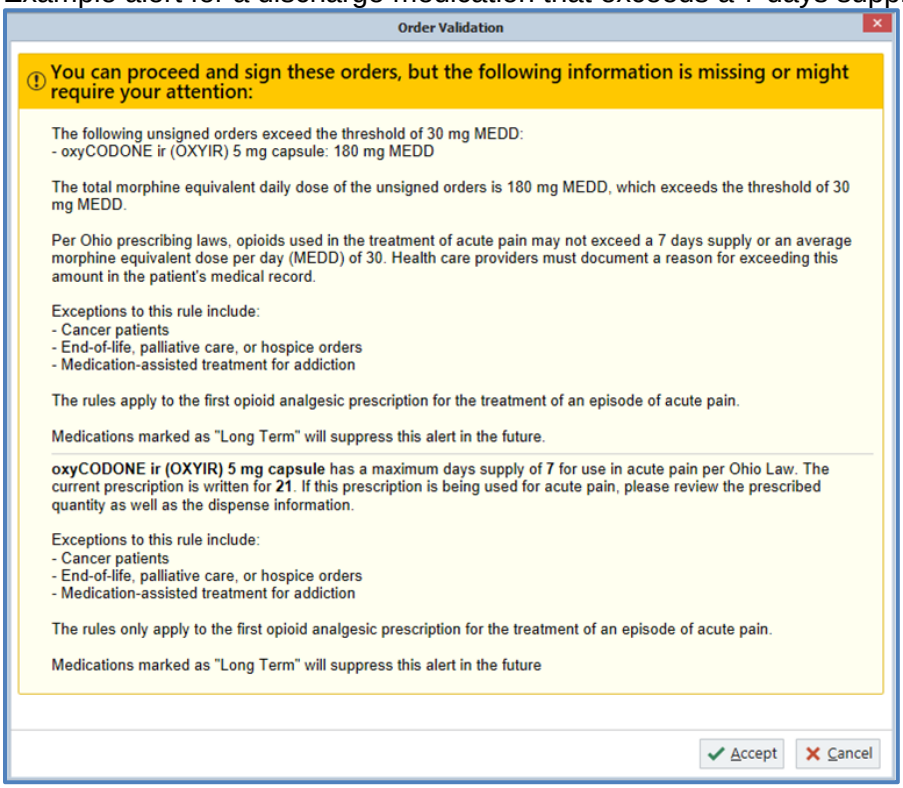
The alert will not prevent the provider from placing the order; however, per the legislation, providers are required to document a reason for exceeding the restrictions for acute pain outpatient medications (including those marked PRN):

- Daily Morphine Equivalency must be less than 30 MEDD
- Days supply must be less than 7 days for adults
- Days supply must be less than 5 days for pediatrics
- Days supply must be less than 3 days for ED patients (per internal Cleveland Clinic guidelines)

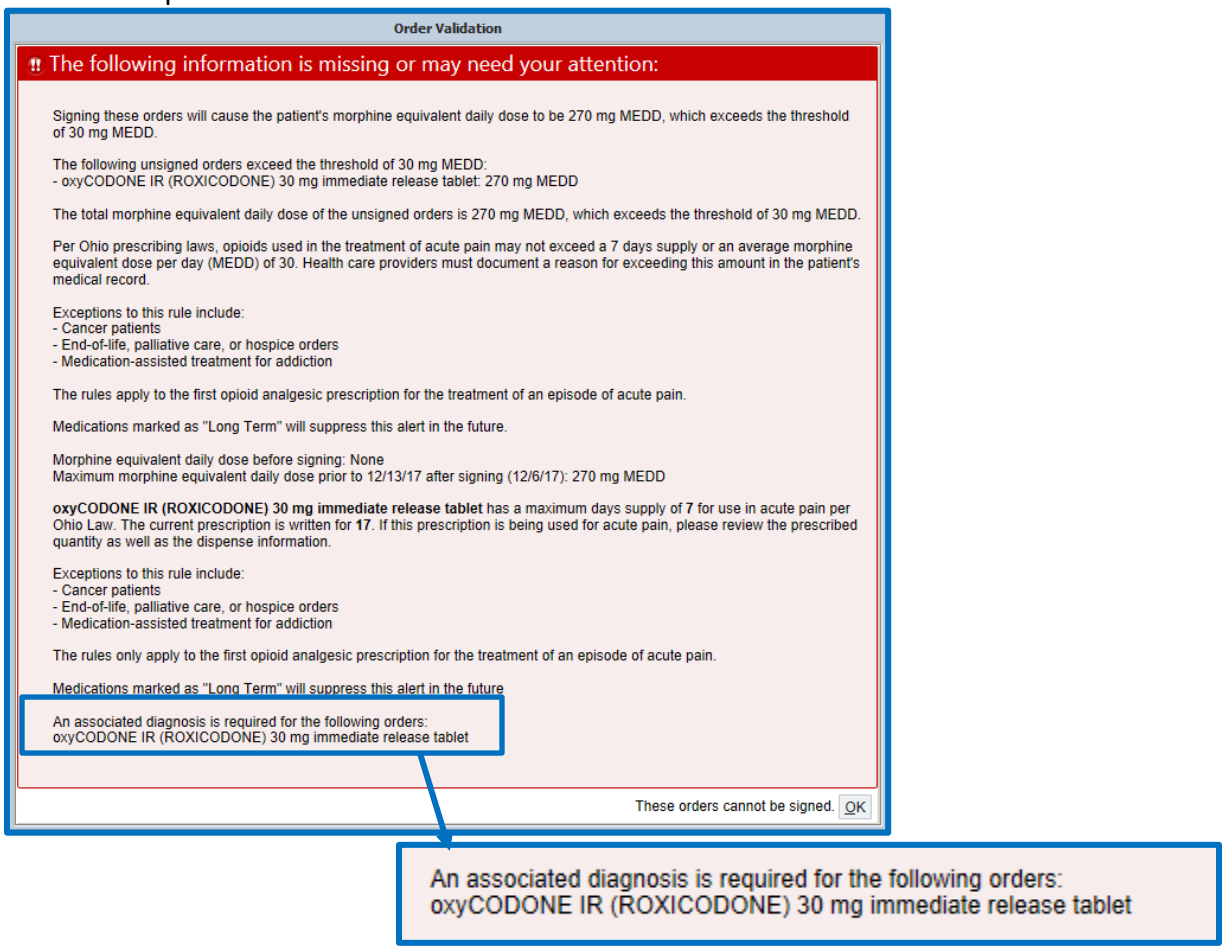
In keeping with the current regulations, these alerts will not display for medications ordered during an admission, but will apply to discharge medications.

The alert will not display for opioids marked as a “Long Term Medication.” Click here to learn more about marking opioids as long term when it is appropriate (e.g. chronic pain, cancer, hospice, addiction treatment).

Example alert for a discharge medication that exceeds a 7 days supply:



Please note that if the prescription is missing a diagnosis, because the diagnosis requirement is a hard stop, the alert will present as follows:



Associating a diagnosis will allow the end user to “Accept” the prescription if deemed appropriate. See (QRG for Requirement to Associate Diagnosis) for more information.

Questions?

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Cleveland Clinic MyPractice

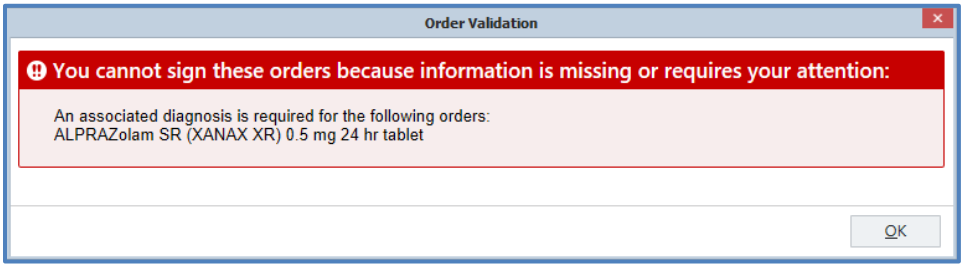
December 19, 2017 Enterprise (including Florida)

Updates ensure providers add an associated diagnosis and duration on controlled substances

Beginning Tuesday, December 19, updates will ensure providers comply with upcoming regulation changes for the prescription of controlled substances. These changes will be enabled in Florida as similar updates to Florida Board of Pharmacy regulations are anticipated.

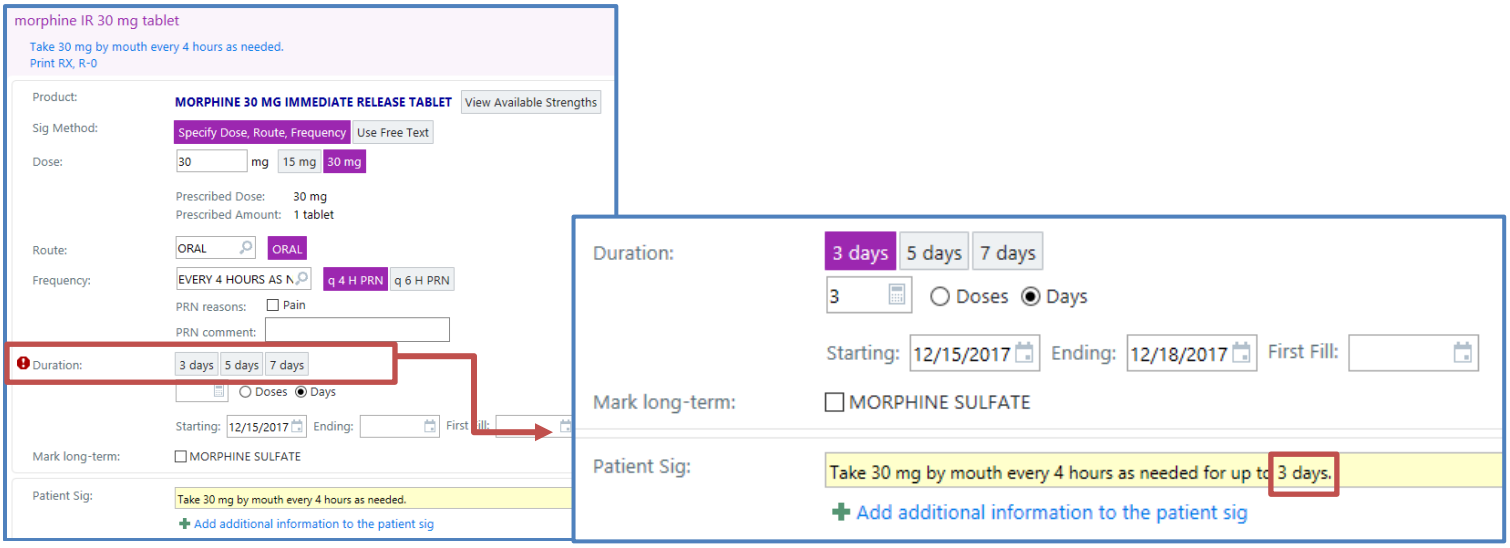
A new alert will prevent providers from placing an order for a controlled substance without an associated diagnosis, as all opioid prescriptions will require an ICD-10 diagnosis code or procedure code beginning December 29. This rule will expand to include all controlled substances on June 1, 2018 in Ohio.

Click here for details on adding associated diagnoses to a prescription.



Duration will now be a required field within orders for controlled substances and gabapentin, as this will also be required for prescriptions beginning December 29. Note that that this duration field is intended to indicate the duration of the script, and not of the specific fill.

Utilize the duration speed buttons for acute pain indications, or type a duration in the window (e.g. 30, 90 days) for long-term medications.



Questions?

If you have additional questions or need assistance, please contact the physician specialist / COA for your area or call the Help Desk at 216.444.HELP.