Presentation to the **Legislative Health and Human Services Committee**

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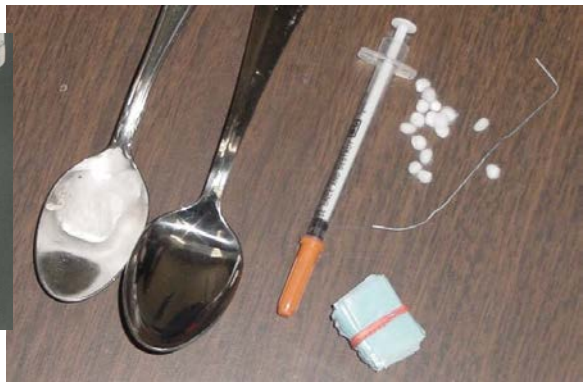
What are opioids?

Opioids are medications that relieve pain. They reduce the intensity of pain signals reaching the brain and affect those brain areas controlling emotion, which diminishes the effects of a painful stimulus.

Medications that fall within this class include hydrocodone (e.g., Vicodin), oxycodone (e.g., OxyContin, Percocet), morphine, as well as illegal drugs such as heroin.



What happens in an opioid overdose?

Breathing slows and can stop completely.

The patient is drowsy or unconscious, blood pressure may be low and pupils may be small.

In a severe overdose which is not treated quickly - breathing stops and the person is unconscious. The oxygen level in the blood will drop, they will turn blue, and eventually because of the low oxygen the heart will stop beating and they will die.

What is the treatment for an acute opioid overdose?

Treatment in the emergency department or in the ambulance includes breathing for the patient with a mask/bag, giving oxygen and then giving the antidote (Naloxone).

Naloxone can be given in an IV or it can be given as a spray into the nose. If given quickly these treatments are very effective.

Patients are then typically watched in the ED for several hours until the opioid has worn off and they are improved.

What is the perspective of the Emergency Department on prescribing opioids?

Emergency medicine physicians and providers are on the front lines of managing this public health crisis.

We see the complications of acute overdose every single day in the ED as well as the vast number of patients with chronic non-cancer pain on long term opioid treatment. This is a growing problem in NM.

The national guidelines for EM (ACEP 2012) include an approach to prescribing in the ED: use the Prescription Monitoring Program to identify patients at high of risk of abuse or harmful behaviors, only prescribe short term (less than 7 days) worth of treatment and do not refill any opioid presciptions for chronic non-cancer pain.

The current Prescription Monitoring Program (PMP) is good but it is very difficult and time consuming to access in the ED. The PMP would be a better tool if the ease of access was improved. Additionally, a more robust electronic medical record which is shared across different health systems would help identify potential problems.

Actions by the State Medical Boards and Boards of Pharmacy:

Federal rules define who can write a prescription, how it must be signed, what informaiton the presciption requires and if it can be a "telephone" prescription or must be a physical copy. Rules are different for the five different "schedules" of controlled substances: Most restrictive for Schedule I, less for Schedule II, etc.

Federal rules also limit who can prescribe opioids for the purpose of treating an addiction.

NMMB orginal rules established in 1996, Rules updated in 2003.

Senate Bill 215 amended Pain Relief Act in 2012 to include:
Ongoing regulations, Required CME on pain management, and defined role of PMP

What can be done to reduce the rate of prescription pain medication related deaths?

(Please see attached, excellent report by the CDC from July of 2014)

1. *Increase use of PMP – easy to access, real time, universal, linked to EMR*
2. *Create additional laws for pain clinics to reduce risky prescribing*
3. *Evaluate data from insurance, Medicaid and other programs to detect concerning patterns of prescribing*
4. *Increase access to substance abuse treatment*
5. *Increase access to harm reduction programs such as providing naloxone to patients or first responders*