The University of Vermont
LARNER COLLEGE OF MEDICINE

Vermont Dentists' Opinions and Attitudes Regarding the 2017 Opioid Prescribing Rules

Vermont Strategic Prevent Framework—Prescription Drugs (SPF-Rx)
VDH Grant 03420-A18131S (UVM A.33338, P.034909)

REPORT

February 15, 2019

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Acknowledgements

Thank you to the Vermont dentists who participated in our survey and informed this report and its recommendations.

Project Funding

This project was funded by the Vermont Department of Health's Strategic Prevention Framework (SPF-Rx) grant (VDH 03420-A181315, UVM A.33338, P.034909) from the federal Substance Abuse & Mental Health Services Administration (SAMHSA) (CFDA # 93.243).

Note

In this report, reference to the Vermont's Opioid Prescribing Rule or its plural "Rules" is discussing the same guidance.

Objective:

The purpose of this project was to engage dentists and oral surgeons in Vermont to learn their opinions and attitudes about the 2017 Rule Governing the Prescribing of Opioids for Pain and summarize that information to inform potential next steps that best support these health professionals in their care of patients experiencing pain.

Background: The Opioids Crisis

The United States is in the midst of an unprecedented opioid epidemic. In 2017, approximately 11.4 million people misused prescription opioids, prompting the Department of Health and Human Services to declare a nationwide public health emergency. (1) That year, 17,087 deaths were attributed to overdosing on commonly prescribed opioids. (1) From 2010 to 2015, opioid prescribing rates among dental patients with private insurance increased from 130.58 to 147.44 per 1,000 patients. (2) The use of opioid painkillers for teenagers and young adults who have their wisdom teeth extracted may put them at risk of addiction, according to a study published in the *Journal of the American Medical Association*. The study points out that in 2015, nearly 15,000 adolescents and young adults received opioid prescriptions from dentists, of which 6.9% received at least one more prescription three months to one year later, a potential red flag for persistent opioid use. Also, 5.8% were diagnosed with opioid abuse within a year of the first prescription. Researcher Alan Schroeder, a pediatrician and professor at the Stanford University School of Medicine said, "Our findings should trigger heightened scrutiny over the frequency of prescribing dental opioids." (3)

A potential substitute to opioid prescriptions may be a combination of non-opioid analgesics. A recent examination of treatments for managing acute dental pain showed that 400 milligrams of Ibuprofen and 1000 milligrams of Acetaminophen taken in conjunction provided greater treatment of pain benefit to dental patients than opiates alone, such as codeine (3). Thus,

it is important for dental providers to individualize pain management and recognize that alternative medications in combination may have a synergistic effect.

Background: Response to the Opioid Crisis, a Sample of Available Resources

Vermont policy makers have responded to the opioid crisis in many ways including the implementation of opioid prescribing rules that went into effect July 1, 2017. These rules provide guidance to prescribers and set limits on the dosage and number of opioid painkillers that may be prescribed. In drafting the rule, the Vermont Department of Health hosted more than 20 separate meetings and conference calls with a range of providers and stakeholders, including physicians, pharmacists, and dentists from around the state. Prescribers, including dentists, have been impacted by the requirements and limitations placed by these rules. Continuing education credit hours focused on opioid prescribing are required for each two-year professional license period.(4) During 2018, a review of the 2017 Rules occurred with stakeholder input. An update to the rules was anticipated for January 1, 2019 but has been delayed to March 1, 2019. The publically available final draft shows technical corrections and clarifications but not a significant re-write. Additionally, most states, including Vermont, have instituted statewide electronic databases that collect designated data on controlled substances dispensed in that state, known as prescription drug monitoring programs (PDMP). (5) Vermont's PDMP is called the Vermont Prescription Monitoring System (VPMS). Prescribers are required to query the VPMS under specific circumstances such as new prescriptions for 10 or more pills, and periodically for patients on chronic opioid therapy. The VPMS produces alerts to prescribers when specific thresholds are met, such as concomitant use of an opioid and a benzodiazepine, or when there may be a signal to indicate doctor-shopping. Prescriber-specific reports are also available that include a peer comparison for prescribers in the same field or specialty. These VPMS reports are available to dentists who prescribe opioids via the VPMS Menu – Rx Search – Prescriber Report section. Further information and technical support are available from VPMS staff. A study investigating

the effect of mandatory PDMP on opioid drug prescriptions by dentists demonstrated that PDMP was effective in reducing prescriptions for opioid analgesics, such as hydrocodone and oxycodone, while prescription rates for non-opioid analgesics increased. (6)

To educate dental providers regarding opioid prescribing best practices, the American Dental Association (ADA) has hosted webinars and published a toolkit. *The ADA Practical Guide to Substance Use Disorders and Safe Prescribing* is available for a fee and can be ordered at www.ada.org. These resources discuss ways dentists can work to reduce opioid abuse, educate patients about the addictive qualities of painkillers, and prevent prescription opioid diversion. (7) The Centers for Disease Control and Prevention (CDC) web site, www.cdc.gov, includes opioid prescribing guidelines and reports. The Vermont Department of Health's Division of Alcohol and Drug Abuse Programs (ADAP) has many resources for health professionals. A health professional's page "Help Me Stay Informed" is located at www.healthvermont.gov/alcohol-drugs/professionals/help-me-stay-informed. On February 4, 2019, the Vermont State Dental Society (VSDS) offered a "Spotlight on Opioid Addiction: The Worst Public Health Crisis Our Nation Has Ever Seen" continuing education opportunity with nationally recognized speaker Austin Eubanks. A presentation prepared by the Boston University School of Medicine on safe opioid prescribing for acute dental pain is available online. Among its main points are suggestions for general dentists and dental specialists to individualize pain management, to recognize that opioids alone have limited efficacy, and to use a risk-benefit framework to guide clinical judgement. (8) Providers Clinical Support System (PCSS) is a coalition of 20 national organizations, including the American Dental Association (ADA), and funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). The program was created in response to the opioid overdose epidemic to train providers in the evidence-based prevention and treatment of opioid use disorders (OUD) and treatment of chronic pain. The project is geared

toward primary care providers, with online modules (https://pcssnow.org/) beneficial to all prescribers including dentists.

There have been numerous initiatives and a variety of resources publically available to health professionals, both medical and dental, and the general public to combat the opioid crisis, but the crisis continues. This project aims to inform potential next steps specifically for Vermont's oral health and dental prescribers.

Methods

A REDCap (9) electronic survey was developed, with input from dentists, and deployed to compile Vermont dentists' opinions and attitudes about the 2017 Opioid Prescribing Rules and to identify potential next steps. The survey included multiple choice and qualitative (open-ended) questions. See Appendix G for the survey instrument. Responses to qualitative questions were reviewed and categorized. Multiple choice items were analyzed using SPSS Statistics software.

Survey Implementation

In 2018, the University of Vermont (UVM) Larner College of Medicine's (LCOM) Office of Primary Care (OPC) and Area Health Education Centers (AHEC) Program collected information about the Vermont dentists' workforce including practice sites, specialty, and contact email addresses. UVM OPC/AHEC compiled basic information for 391 active Vermont dentists. Of the 391 active dentists, UVM OPC/AHEC had practice site mailing addresses for each, and email addresses for 270 (69%). Of these, 16 are identified as oral surgeons (9 email addresses available/56%). In general, workforce information is dynamic and difficult to maintain; UVM OPC/AHEC used publically available information from numerous sources (e.g., VT Office of Professional Regulations (OPR) public roster, Department of Vermont Health Access (DVHA) Find a Provider Portal, National Provider Index, ADA/VSDS Find-a-Dentists, and Internet searches), as well as information stemming from dentists' direct contact with OPC/AHEC.

UVM OPC/AHEC participated in the VSDS Annual Meeting on 1/20/18 in Burlington. A UVM OPC/AHEC representative provided information about the project and engaged with dentists. A VDH ADAP representative also participated in this event and reinforced messaging; a shared script was used about the project and upcoming release of the survey.

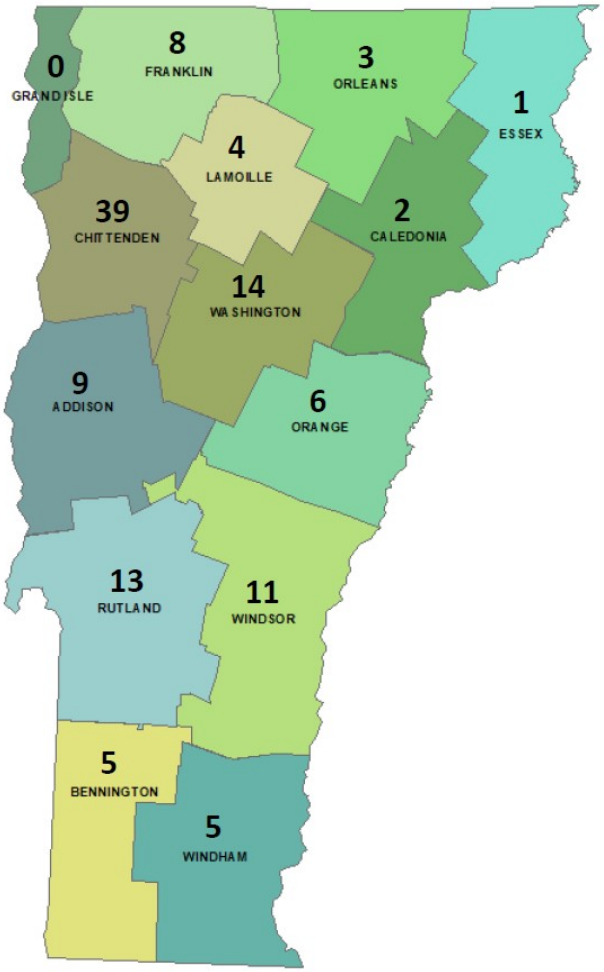
The survey invitation was sent three times from REDCap: 12/11/18, 12/18/18, and 01/08/19 (final reminder). A paper mailing with the link to the REDCap survey was sent on 12/26/18. The survey closed on 1/13/19 (midnight).

Results

Respondents:

A total of 130 surveys were returned. Seven responses are excluded from this summary due to incomplete required information, or because respondents did not provide dental care in Vermont. The remaining 123 survey responses are summarized in this report. All respondents were licensed to practice dentistry in Vermont. Detailed demographic data are available in Appendix B.

Practice Location



n=120; 3 of the 123 survey respondents selected "prefer not to answer"

Of the 123 surveys:

- 85% identified specialty as general dentistry; 5% identified oral surgery; 10% other specialties
- 13 of 14 Vermont Counties were represented (based on practice site location); exception is Grand Isle (See map)
- 62% of providers (n=77) had prescribed an opioid in the past year. Among these prescribers, frequently cited categories for prescribing opioids included infection, extractions and post-operative pain

Note: In the following data, Figures 1-8, and Appendix B, small discrepancies in total percentages listed are due to rounding.

Respondents' prescribing practices:

- 19% did not prescribe prior to the July 1, 2017 Opioid Prescribing Rule (Figure 1).
- 8% stopped prescribing after the July 1, 2017 Opioid Prescribing Rule. This group's overall patterns of responses to survey questions did not differ substantially from other respondents described in Figure 1.

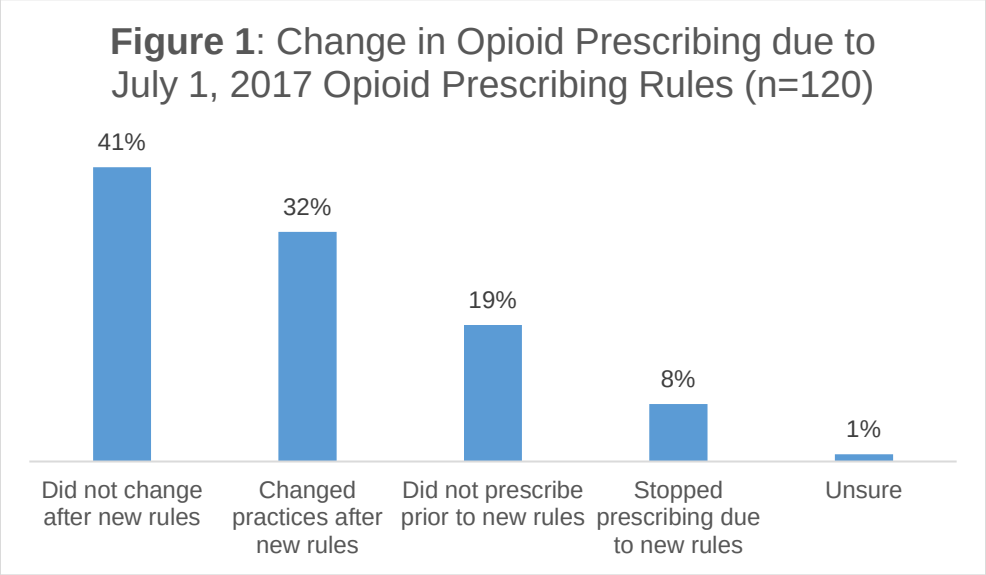
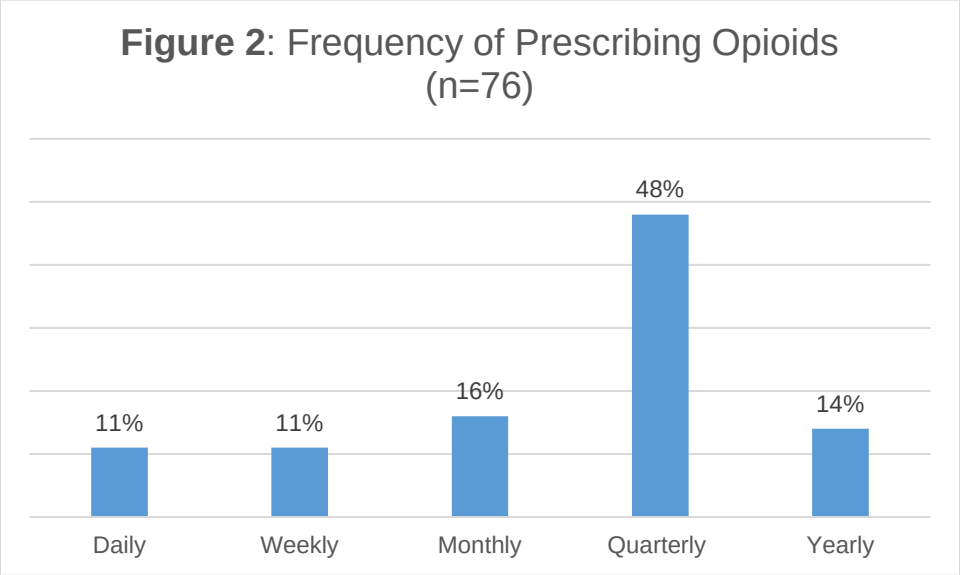
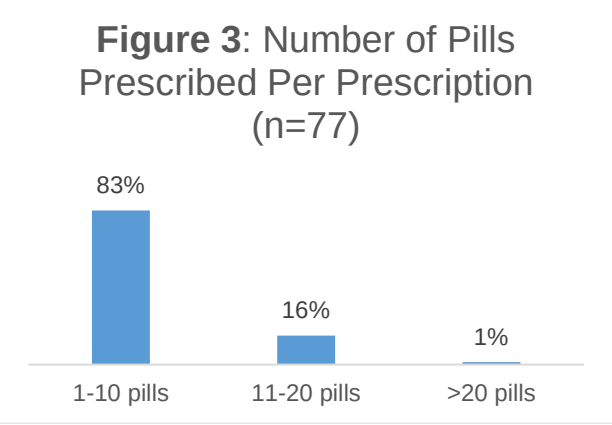


Figure 1: Change in Opioid Prescribing due to July 1, 2017 Opioid Prescribing Rules (n=120)

- Results also showed almost two-thirds of the dentists only prescribe opioids on a quarterly or less frequent basis. (Figure 2)

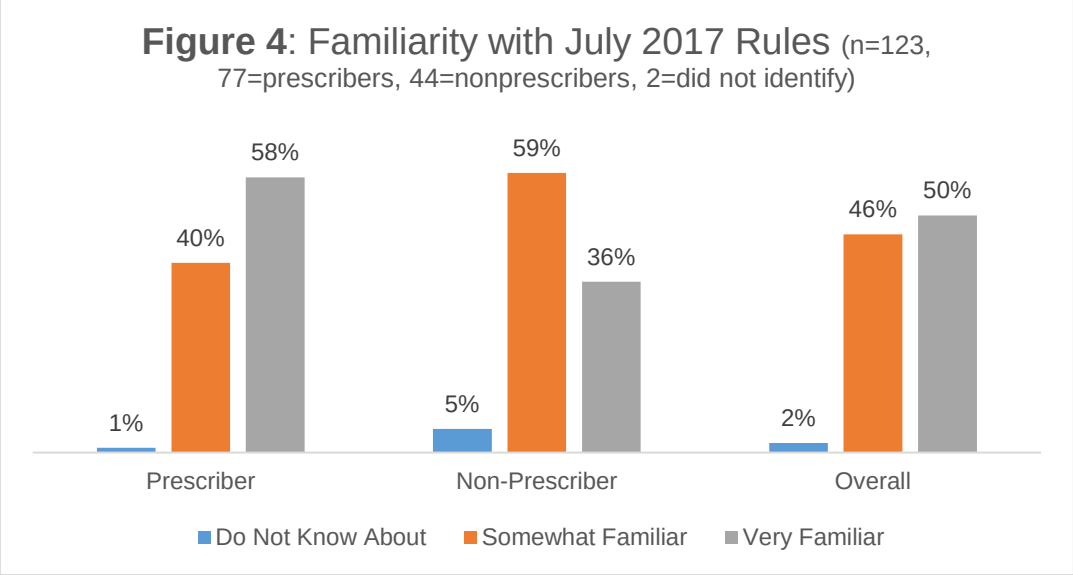


- Of those prescribers, 83% typically prescribed 10 or fewer pills per prescription. (Figure 3)



Respondents' responses to questions concerning 2017 opioid prescribing rules:

- Of the respondents, 41% said dentists did not need opioid prescribing rules and 39% said "yes" they did. The remaining 18% responded "not sure."
- 58% of the dentists who prescribed opioids in the past year were "very familiar" with the prescribing rules. However, 40% were only "somewhat familiar" with the rules, indicating that additional education and outreach is needed. (Figure 4)



- Respondents' perceptions on how successful they have been at complying with the rules varied based on requirement. Eighty-four percent felt they were "very successful" at complying with prescribing limits, and 81% were "very successful" at non-opioid prescribing for pain management. However, only 48% were "very successful" at querying VPMS. (Figure 5)

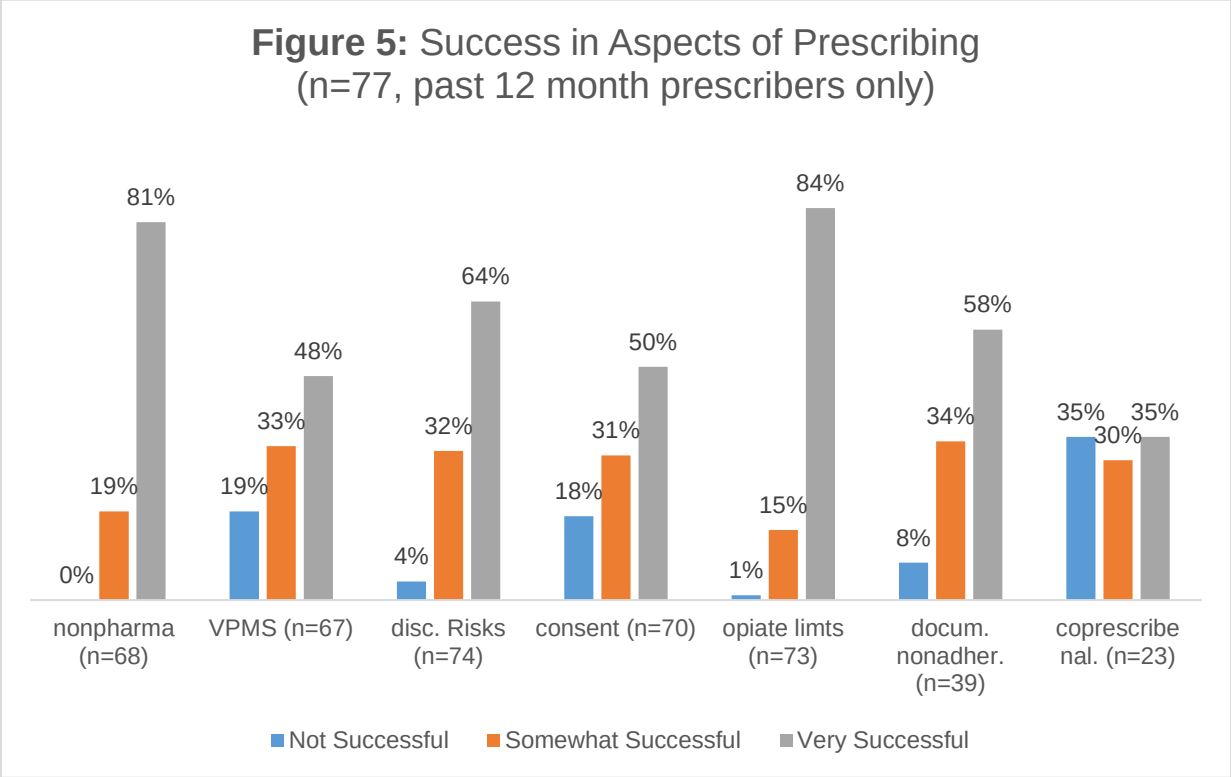


Figure 5: Definitions
nonpharma: Consider non-opioid and non-pharmacological treatment
VPMS: Querying VPMS
disc. Risks: Discussing risks, benefits, and patient education
consent: Obtaining informed consent
opiate limts: Adhering to specified opioid prescription limits
docum. nonadher: Justifying and documenting in the patent dental record when not adhering to prescribing rules
coprescribe: Co-prescribing Naloxone when MME>90 or concurrent prescription of Benzodiazepines

- Views concerning the consequences of non-compliance with the Opioid Prescribing Rules were varied; approximately half believed they would lose opioid prescribing authority, but almost 10% thought they could be incarcerated. (Figure 6)
- There was little difference about perceived consequences between prescribers and non-prescribers.

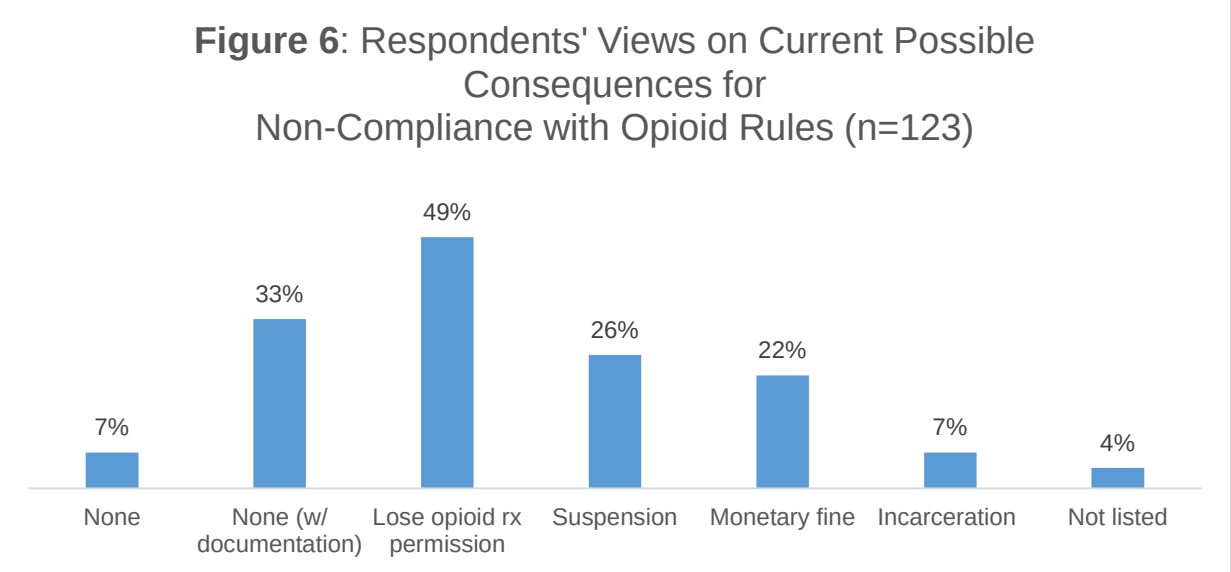
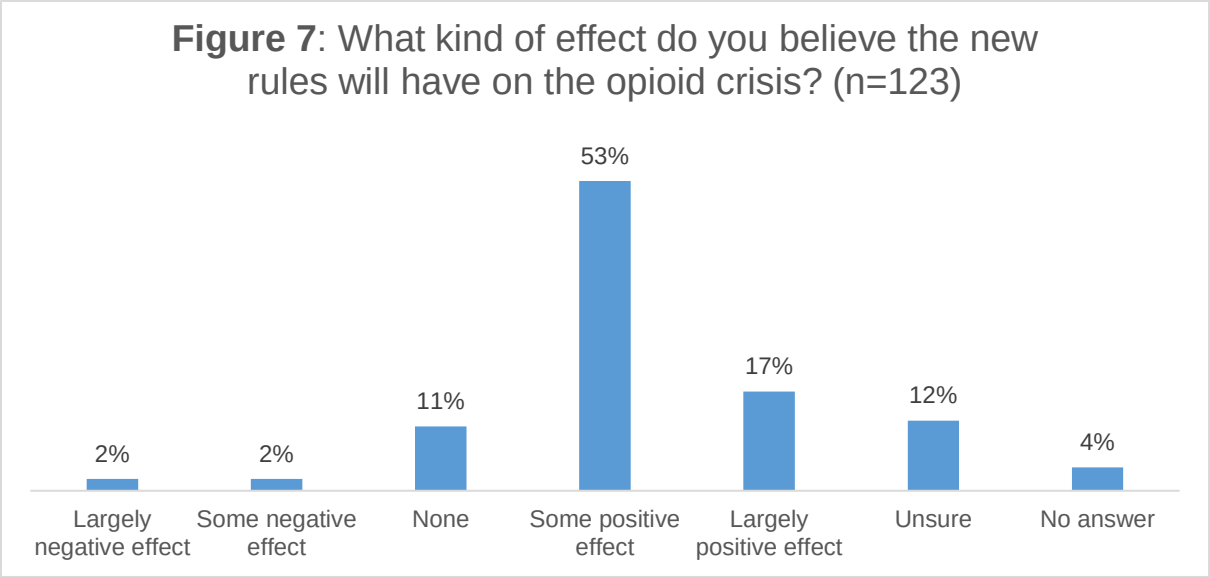


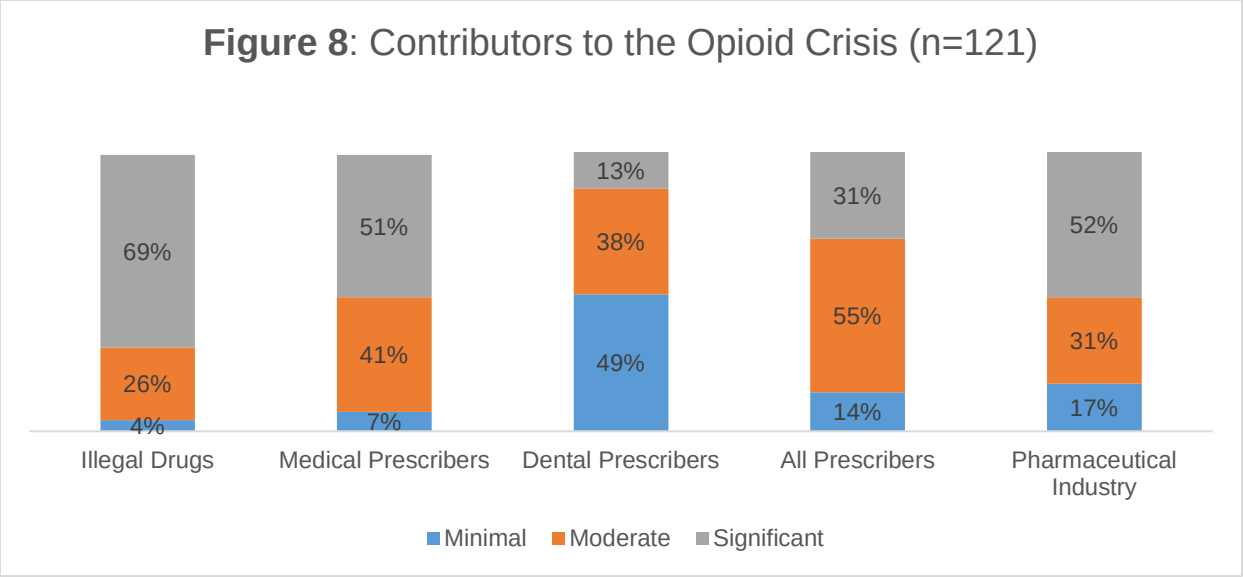
Figure 6: Definitions
None: No consequences
None (w/ documentation): No consequences with proper documentation
Lose opioid rx permission: Suspension of opioid prescribing authority
Suspension: Dental license suspension
Monetary fine
Incarceration
Not listed (specify): See Appendix D

Respondents' responses to questions concerning opioid crisis:

- 70% of the dentists who replied to the survey believe the new prescribing rules will have a positive effect on the opioid crisis. (Figure 7)



- Dentists' opinions, when asked to rate contribution to the opioid crisis as "minimal," "moderate," and "significant" showed that only 13% believe that their profession was a significant contributor to the crisis whereas 50% felt medical providers were significant contributors. 68% felt illegal drugs were significantly contributing and 51% felt the pharmaceutical industry was a significant contributor. (Figure 8)



- Fifty-one responded to open-ended questions identifying their top three continuing education priorities. Fifty-nine percent identified topics related to opioid prescribing. In comparison, 29% prioritized business practice topics, 16% identified emergencies, 20% identified public health and wellness topics, 16% identified restorative dentistry, 12% identified endodontics, and 37% included other clinical topics such as implants, and cosmetic dentistry.
- To gauge direct engagement, the survey asked if they are engaged in the rulemaking process, underway in 2018, to update the July 1, 2017 prescribing rules or if they had provided feedback. Eighty-six percent reported "no" and 2% said "yes" engaged or provided feedback. The remaining respondents did not answer the questions. The 2% who responded "yes" were current opioid prescribers.
- As another gauge of direct engagement, the survey asked dentists if they had participated in a recent survey from the VT Department of Health regarding the VPMS and the usefulness of the clinical alerts and prescriber insight report enhancements: 24% said "yes," they had participated in the VPMS survey, 63% said "no" they had not participated, and 13% did not respond to the question.

Discussion:

Direct feedback from the dental community provides an opportunity to better understand perspectives as public and private organizations work together to improve patient care, help solve a public health problem, and increase provider satisfaction. Overall, the survey indicates that dentists are prescribing opioids infrequently and, when they do prescribe, are writing for few pills. Many felt that the new laws were an improvement by decreasing drug seeking behavior and creating more awareness about the health risks of opioids. One respondent writes, *"I feel our patient population has been well educated on the risks of opioid use and would prefer to omit opioids for post-operative pain."* The survey data suggest that dentists have been successful in managing pain without opioids and complying with opioid prescribing limits. Informed consent, discussing risks with patients, and checking the VPMS were reported as less successful. Co-prescribing naloxone was reported as least successful. The open-ended comments in this survey capture possible reasons that dental providers are not more familiar with the rules, and not more confident in implementing them. The data and comments do not suggest full support for the July 1, 2017 Opioid Prescribing Rules. The dental profession has a long history of advocacy that values autonomy in the delivery of patient care. Resentment at being required to comply with regulations was a strong sentiment in many of the comments. For instance, *"This is government regulation gone amok. The guidelines for prescribing are reasonable, but the redundant education, informed consent, and record keeping demands are just plain overkill. I write 3-4 narcotic RXs per year, and they are for ten pills or less. Please tell me how I am causing an epidemic. This is overkill, plain and simple, so the powers that be can say they are doing something*." **Appendices C-E** include all general comments (unedited content), including both positive and negative impacts.

The survey responses also indicate that the dental community do not believe their profession has been a significant contributor to the crisis. This belief may lead to frustration of being required to comply with administrative burden of the new rules. *"I believe a better system would be for the state to make recommendations, rather than rules, regarding opioid prescribing practices, and that the state should monitor, as it currently seems to be, prescribing practices for opioids,"* wrote a respondent. Multiple providers asked for a simple chart that clarifies how many pills they can prescribe by medication class. A request for VPMS enhancements was expressed in comments. One comment about VPMS recommends, *"Better, easier to use website with less password changes, and easier for staff to use."* The dissatisfaction with the opioid prescribing rules may also be reflected in the broad beliefs about the consequences of noncompliance.

Recommendation:

While opioid prescriptions by dental providers may in part be contributing to the opioid crisis in the U.S., resources and guidelines are currently available that minimize unnecessary opioid exposure for patients. Through initiatives from federal, state, and private agencies, dentists have been encouraged to familiarize themselves with the current literature on best practices and Vermont's prescribing rules. While sounding no alarms, the survey data do indicate that a deeper understanding of Vermont's Opioid Prescribing Rules would eliminate misconceptions, and potentially reduce provider frustration. A recommendation of this report is additional engagement of Vermont's dentists regarding opioid prescribing and public health policy. A VPMS study and data analysis of dental prescribing would inform stakeholders about actual prescribing trends rather than relying on national trends, media headlines, or self-report information. Recommended next steps are:

- Increase outreach and continuing education offerings to clarify misconceptions and better communicate available resources.

- Increase access to technical assistance, process/quality improvement (QI), change implementation facilitation for dental practices.
- Develop comprehensive reports of opioid prescribing by Vermont dentists and oral surgeons to understand variability across the dental specialties, and the prescribing volume relative to medical specialties. VPMS would be a useful data resource for this purpose.
- Leverage opportunities for public and private partners to better engage the dental community in policy making such as the July 1, 2017 Opioid Prescribing Rules and the updated rules, anticipated implementation date March 1, 2019.
- Ensure a comprehensive dissemination and communication plan for the updated Rule Governing the Prescribing of Opioids for Pain effective March 1, 2019. (See Appendix F)
- Develop and disseminate a "one-pager" summary of the March 1, 2019 Rules.
- Provide a diversity of continuing education opportunities, such as conference-based, in practice-based, online, and telephone support.
- Explore enhanced electronic prescribing for dentists, without increasing cost, may also improve compliance.
- Re-survey one year after March 1, 2019 rules are implement to gauge degree of change in awareness levels, and compare opinions, and perspectives with the 2018 survey data.

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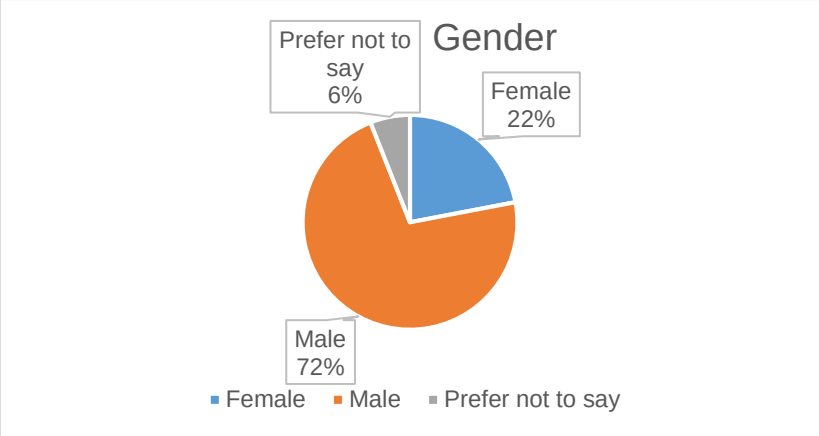
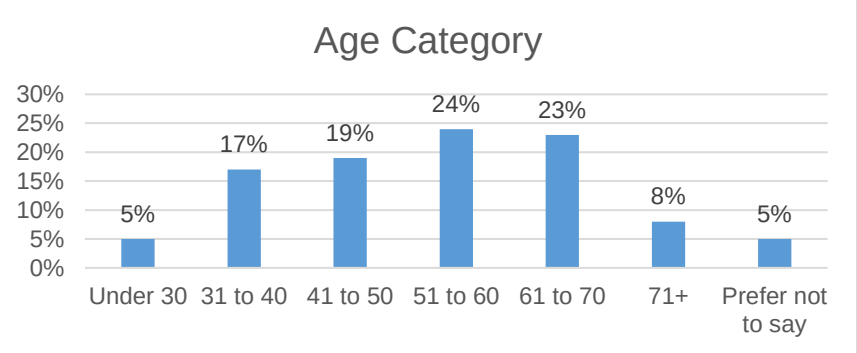
Appendix A: Notice of Required Continuing Education (CE) Regarding Controlled Substances

Web resource: Vermont Office of the Secretary of State, Office of Professional Regulation, CE Requirement for License Renewal

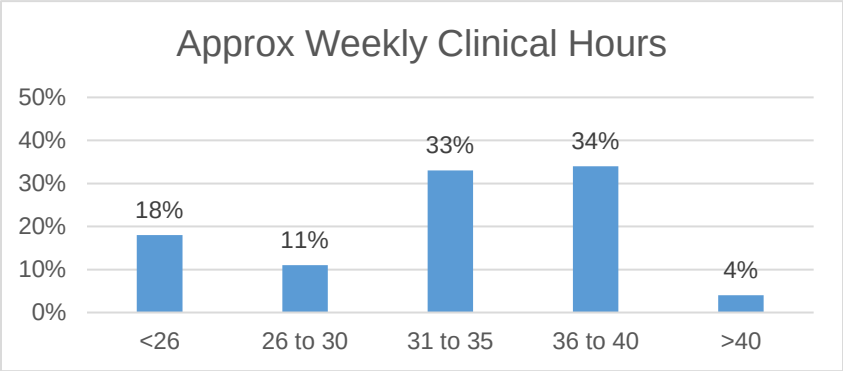
https://www.sec.state.vt.us/media/913567/notice-of-required-ce-regarding-controlled-substances.pdf

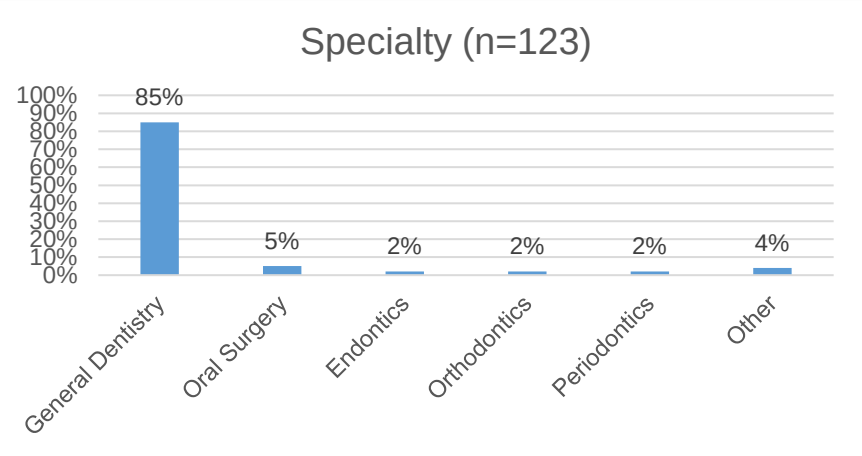
Appendix B: Participants' Demographic Data





Appendix B: Participants' Demographic Data (continued)





"Other" includes: orofacial pain, and pediatric dentistry.

Appendix C: Impact on patients

Do you have any non-identifying examples of particularly positive effects of the rules with regard to patients? (Open-ended Question)

Since the new rules and all the national attention about the opioid crisis, patients are much less likely to expect or request opioids.
I think we see less drug seeking behavior as patients know these rules are in place.
drug seeking patients have all but disappeared
Many parents do not want or want a limited supply of narcotics if required. They have become better educated.
The law helps explain to Patients why I do not want to prescribe a large quantity of opiates.
In general, patients have an awareness of the risks associated with opioid prescriptions and no longer request them.
Significantly reduced the number of prescriptions written and the number of dosages per prescription. Began more questioning of and counseling to patients before considering pain medication alternatives. I wish these guidelines had been in place thirty years ago.
When patients (there are very few) ask for an opioid I tell them the rules have changed and I can't prescribe them.
No. But I have been prescribing less numbers of pills and lower strength of pills for fear of retaliation from the State. So if you consider just the lower number of drugs prescribed to be a good thing, I guess you can call this positive. I do not think denying people medication that they need a positive.
It makes the patient more aware of the problem, and that they should expect some discomfort - the VAS and pharmaceutical companies were responsible for the "I should feel no pain after surgery request."

Nope. I think what IS having effect is educating us all on how to reduce the amount of narcotics in circulation while offering alternative pain control methods.
The rules make it easier to not be pressured by a patient to prescribe a narcotic.
The limit to the recommended number of pills to prescribe. 3 days is sufficient in most cases. also, the prescription monitoring system is beneficial for both providers and patients
patients are more aware that pain killer meds can be addictive and they should try to avoid getting a script
I have found that a written post-operative pain management protocol that explains the safe use of acetaminophen and ibuprofen in combination after surgery has resulted in a successful treatment of post op pain with low to no complaints from the patient.
The consent process does frighten patients and parents resulting in decreased interest in using opioids for pain.
They don't even ask for any opioids anymore.
I have always prescribed Tylenol #3 or Percodan/Percocet in rather small amounts for more extensive oral surgery i.e.: sub antral augmentation bone grafting, selective dental implant surgeries. I have found that a short course of corticosteroids and NSAIDs have minimized my use of opioids years before today's regulations.
Yes patients do not call seeking pain medication
more accountability for both the prescriber and patient
Seen greater results of pain management with ibuprofen/Tylenol regimen
Limited number of medication

I think it makes the conversations I have with patients around opioid prescriptions easier and standardized. It makes the decision to not prescribe significantly less burdensome. I work with a public health population, and often get asked for opioids. It helps me not to hesitate in saying no.
As the rules become more widely known, I have noticed that there are no longer patients with pain seeking behaviors. They KNOW that we are going to check the Vermont Rx site. In particular, our patients are likely to give a good trial of Ibuprofen/Tylenol combination therapy.
Rules have decreased drug seeking behaviors of at risk patients. Rules have decreased the amount of opioids that I would have prescribed to surgical patients.
None
My patients are aware that I use multimodal analgesia for dental pain, they do not ask nor expect opioid prescriptions.
Now that patients are aware of the issue, they are less likely to assume I will give them narcotic drugs after every extraction. It is easier for me to explain to patients that they are only appropriate in very specific situations.
None
Overall less opioid prescriptions are going out.
no
I feel less pressure to prescribe as I tell my patients that I have to work within the government guidelines.

Do you have any non-identifying examples of particularly negative effects of the rules with regard to patients? (Open-ended Question)

I had an emergency patient that had logistic problems that would have benefited by a simple call in of 6 pills on a Sunday afternoon
I have had a lot of patients get mad at me for not Prescribing them a narcotic
Dictating how I am to take care of my patients. Removing professional discretion.
Most all of my patients who are in pain are in more pain now. And I tell them they will just have to deal with the pain. It is ridiculous to deny medicine to people because drug addicts are taking advantage of the system. People that are going to abuse drugs are going to abuse them one way or another. We should not be denying normal patient's medicine due to poor behavior from addicts. As far as I am concerned, opioids should be legal if for no other reason than to limit the effect on normal patients. If addicts can go to the store and get heroine, they aren't going to pester providers for cheap drugs and doctors can more effectively prescribe things for pain. Also since these new rules have gone into place, I do not hear about a noticeable decrease in the drug epidemic. There has just been a larger burden on law abiding providers.
It was an issue when I couldn't get pain meds for a patient after hours on a Sunday for an endodontic infection. The patient was due to see the specialist in the morning. The hospital wouldn't allow for narcotic prescription over the phone and no long
I truly don't think I should have to run a pmpaware check on someone just to issue an Rx for 2 mg. Diazepam in the treatment of muscle pain. I also think the rules about signed consents is ridiculous. Seriously ridiculous. Nobody in severe pain is going to turn down a short-term Vicodin Rx because of this dumb rule.
The pharmacy did not have the drug in the strength written, but did have it in a lesser strength. I could not direct the pharmacist by telephone to change the prescription. The patient had to return to the office for another written script in the strength the pharmacy had in stock.
Not at this time

Not specifically the rules but the VPMS has been onerous to work with frequent password changes, confusing reports, I work in a multi dentist practice and narcotic prescriptions written by my colleagues have been attributed to me on VPMS due to Pharmacists picking the first name on the provider list off the rx not who writes it
Instead of focusing on what I can do to get my patient out of pain, my first thought is to how I can avoid giving an opioid Rx because the additional hoops and scrutiny.
N/A
None yet, most of our patients are adverse to opioids which I attribute to the increased knowledge and public awareness associated with the risks is opioid use for post-operative pain management.
Many patients who need opioids for pain have inadequate supply and cannot obtain additional meds outside of office hours.
None
None. I do want to say something about 'recreational' marijuana. The current permissiveness regarding this substance is policy NOT going in the right direction. If the goal of human endeavor is to encourage clear, unimpaired productive and joy filled contributing members of society, I fail to see laws that ENCOURAGE impairment of brain function having benefit. Why don't you do something about the US Border Security and prevent the flow of drugs into the country from entering. Extreme penalty for anyone attempting to traffic drugs including marijuana into our country. Current border policy is entirely obtuse to the goals of personal and collective health of our citizens and society. Try prevention for a change rather than the cure after damage has been done. Many of our public officials lack common sense, have a lack of will power and waste resources by not preventing problems in the first place. The question below asks about my 'belief' of effect? What kind of question is that? Why don't you demonstrate some positive results as to the effect of your legislation? Then ask us if the results are acceptable!
The rare times that it happens when the patient may require pain meds such as an acute abscess over the weekend I can no longer call anything in for them for pain relief. I have to tell them to go to the ER.

None of this has looked at the metal health aspect of pain which is what I believe drives all of this seeking to escape reality. And I further believe we will continue to see and uptick in abuse as cannabis is forced into the market place.
Patients on lithium which is toxic with NSAIDS , chronic disease, and other medical conditions that effect the acetaminophen/ibuprofen combination I have found have become more cautious about taking narcotics Public attention including to health care professionals will benefit the patient.
None noted
Excessive government intrusion into the private practice without supportive data for a generalized problem caused by practitioners. Of course you will be able to point out isolated cases, but to turn the whole industry upside down because of a few bad actors is government at its worse.
no
Opioid consent rule shifts blame of opioid abuse to the provider. Opioid rules intrude upon the doctor/patient relationship. Rules have decreased my ability to provide adequate pain relief to patients with low pain tolerance. Opioid consent process stigmatizes patient and makes them feel 'weak' if they need to rely on an opioid to get through the healing process. Opioid rules have decreased the number of patients I can easily see due to the amount of time it takes to provide opioid consent and check the VTPMS for every patient prescribed an opioid.
None
Pain management services for true chronic pain sufferers are minimal and hard to access.
More emergency calls from patients with inadequate pain management.
no
It can be difficult to check the prescription monitoring site for each patient when you are managing a busy schedule.

Appendix D: Barriers and possible resources needed

Thinking about your practice in the past 12 months, what are some barriers to implementing [identified] best practices? (Open-ended Question)

Write so few opioid prescriptions that it is easy to forget the informed consent after years of not having the need to do it.
none
Increased bureaucracy. Unable to adequately treat some patients pain after major reconstructive surgery
'Best practices' indicated above has been developed by lawmakers while ignoring the treating professionals discretion.
Time constraints for counselling with patient education and checking the data system.
I have not prescribed any opioids in the last 12 months mostly because of the hassle of going to the website to check.
Time consuming and unnecessary for the types of drugs that I prescribe
Time
Trouble negotiating the website.
You call them best practices. I call them a pain in the tush. There are no barriers, there is just more wasted time.
The VPMS often does not work well (won't let me reset password in a timely manner, won't let me sign in etc.).
none
Just the time needed to check the prescription monitoring system prior to prescribing.
I can't remember the last time I prescribed a pain medication.

Just confusion about what can be prescribed and how many pills. Calculating is a pain. Would be nice to have a chart of the most commonly prescribed meds and how many can be given prescribed before activating the entire new system. IE Tylenol #3 10 tabs or less Vicodin, ...
None, again I feel our patient population has been well educated on the risks of opioid use and would prefer to omit opioids for post-operative pain.
RX monitoring system is unrealistic time suck for providers. Especially since the rare time we need to use it is for pre op RX of sedative meds and not opioids.
N/A
None
Convincing patients the OTC pain meds will help
I have always been extremely conservative in my opioids prescribing practices. I never wanted to get reputation of being easy to con. People engaged in drug seeking behavior always end up being very disruptive to an office. So I haven't had to make any changes.
I don't really Rx them much. When needed, but still rarely.
It takes time to recondition and modify behavior
It's difficult to find time to query the VPMS.
None.
Can't think of what you are asking is unreasonable so I can't think of any
None- I never believed my patients need opioids. I have a relatively healthy patient population and over the counter pain relievers have always been my go to for my patients in pain.
It does take a good degree of foresight to use an opioid. Between consent, the Rx monitoring system etc., it is not something that you can just prescribe 'on the fly' anymore. However, I cannot even recall the last time I have given opioids for pain management.

none
Our extremely low volume.
none
Patient's refusal to fill Narcan/naloxone Rx when rules indicate due to stigma. Makes them feel like a 'drug abuser'. Patients are shocked by this rule. Opioid 'consent' is time consuming and ridiculous and opens providers up to potential lawsuits if prescribed patient develops an addiction at any time in the future.
None
No barriers.
The electronic dental record was not designed with this in mind, so there are more steps.
the time to implement with how little I prescribe
PMS Website doesn't work very well. Patients call when we don't have access to all our resources (weekend, holidays, etc.)
none
No unmanageable barriers

What specific resources or materials would help your practice comply with the state's opioid prescribing rules? (Open-ended Question)

I don't prescribe opiates.
None
Handout or wall chart
Public PSA on TV and/or Social Media to further educate the public
Trivializing the potential pain associated with molar removal. It is not always a simple procedure and is not always treated the same way.
Example written informed consent or prescription contract for patients to sign.
The only way to make it easier to comply with all the rules is to simply make less rules.
Better website
No opinion.
unknown
I believe I have all of the resources I need. this isn't a difficult process to comply with
I can't remember the last time I prescribed a pain medication.
Being able to talk to someone who can clarify some simple questions
I feel all practices will benefit from local CE designed specifically to address best practices for dentists and opioid use to control post op pain.
none I can think of
N/A
Summarized information in graphical form for easy reference.
None. Anything that you feel is generally helpful, we are happy to post or put up on our web site.
None
Perhaps having available a pamphlet explaining how a conservative prescribing practice is best for everyone. If greater pain management is required then it should only be done following consultation with other professionals.

Internet, brochures, patient education and updates. Simplified resources
More opportunity for the new CE requirements to be fulfilled/met
Online print brochures that educate patients who the majority qualify in my practice to the effectiveness of alternative medicine like acetaminophen/ibuprofen combined
I would love to our dental society (VSDS) to host an opioid CE event for us.
None come to mind.
none
We are getting on board
None
if they eliminated them
Better, easier to use website with less password changes, and easier for staff to use. Only have requirements for prescriptions over a certain amount or for chronic pain. Most of our scripts are infrequent and <10 pills.
none
Not needed

Please select what you believe are the current possible consequences for prescribers who do not follow the best practices prescribing rules. Consequences not listed [in the survey] (specify):

Education
Public shaming
Mandatory continuing education course.
Required education about implementing new rules.
Living with the knowledge of contributing to or starting a patient's addiction or death from opioids.
As with any change in behaviors it may make sense to have a tiered consequence. First offense is required education on best prescribing practices with monitoring. Second offense is suspension from prescribing opioids. Third offense, however I'm not sure how you could offend if you cannot prescribe, but if for some reason you were still handing out opioids with a suspension to prescribe than I feel it is absolutely fair to suspend the license.
Apply the current laws. Doesn't this make sense? I do not know what the legal consequences are specifically. Stop being hesitant about applying the law. Shorten the time in the courts. It's a waste of valuable tax dollars.
Consequences should only apply in truly egregious cases. I think most practitioners are conscientious and if they violate the rules they are attempting to solve a patient problem, not for lack of caring or financial gain.
If there are no consequences for drug abusers there should be no consequences for the prescribers.
Formal warnings first

I understand that the state had passed rules regarding opioid prescribing, and as a busy practitioner I strive to adhere to these rules, though I believe that ultimately the final decision as to what is prescribed should be made by properly licensed and practicing medical and dental doctors. I believe a better system would be for the state to make recommendations, rather than rules, regarding opioid prescribing practices, and that the state should monitor, as it currently seems to be, prescribing practices for opioids, and that when opioid prescribing practices occur outside of the recommended practices, that the state investigate this, and then work with the practicing doctor to modify the opioid prescribing practice, if it is found that it needs to be modified. I don't believe that doctors should have their 'hands shackled' by making un-necessary rules or laws for opioid prescribing practices, and I don't believe that doctors should be required to increase the amount of time and effort that they put into their daily documentation, as the extensive documentation necessary for doctors is already cumbersome, and by further utilization of the doctors time with documentation, the time available for patient care is continually decreased. Any consequences, as suggested above, should only be considered after multiple, documented educational sessions and efforts and training have been undertaken. Opioids are good and useful medications. They should be available when necessary for patients, they should be used responsibly and appropriately by patients, and they should be considered and prescribed responsibly and appropriately by doctors.

Appendix E: Further comments

Do you have any final suggestions, thoughts, or concerns regarding the opioid prescribing rules that we have not covered? (Open-ended Question)

Dentists are not the problem.
Consider personal responsibility to the opioid user.
Keep up the vigilance: dentists, physicians, pharmacists, drug companies, academics and state and federal health authorities! Consider use of cannabis- related therapies
Stop trying to micro manage prescribers. I saw a commercial the other day where a drug addict blamed his drug addiction on getting a prescription for post-operative pain from a doctor. It is not a doctor's fault when an addict uses them to feed their habit. The sooner people start taking responsibility for their own actions, the sooner we will be able to combat the opioid problem and many other problems that face our country.
I do think the informed consent requirement seems excessive for the type of practice I have, endodontics. I see a patient for one procedure, usually two visits. Often they are in significant pain when they present. They usually are told to take non opioid drugs, occasionally given one small Rx for opioids if needed.
This is government regulation gone amok. The guidelines for prescribing are reasonable, but the redundant education, informed consent, and record keeping demands are just plain overkill. I write 3-4 narcotic Rx's per year, and they are for ten pills or less. Please tell me how I am causing an epidemic. This is overkill, plain and simple, so the powers that be can say they are doing something.
no, I think it was long overdue
I don't prescribe them.
Not specifically regarding the rules. However, it's important to look at the bigger picture and work on social/community network and support systems on the macro level: education, after school activities, physical, emotional, nutritional wellness, especially in the support of developing children, so as to try to divert substance abuse in the first place.
1. A phone # to ask questions 2. A chart with how much of the main opioids we can prescribe

Many of us dentists do not prescribe opioids for tooth pain. The literature shows that a combination of ibuprofen/Tylenol at fairly high doses is every bit as effective as an opioid. In regards to the implementation of new rules, please make sure we do not burden a non-prescriber of opioids with additional paperwork. As for myself, I have not prescribed a single opioid dose in 18 years, and never will again. I don't even have the necessary DEA licensure to do so.
Prevention is a wise use of public resources. Deal with the CAUSES effectively. Shut the illegal flow of drugs down and prosecute the dealers with extreme prejudice! Clear out the rats. Don't allow illegals into our country. If you do then YOU are part of our drug problem. The more you permit the worse the problem gets. 'You can't stop bleeding by releasing the tourniquet! Tighten it up.' We don't need to expand the care for this problem by building a bunch of new treatment clinics. It's about prevention. For once talk about HEALTH CARE promoting 'health sustaining behaviors' rather than SICK CARE (rehabilitation after the fact).
For a general dentist, I do a significant amount of extractions and root canals. I stopped prescribing anything stronger than codeine over ten years ago. Over the past five years, I have prescribed codeine with Tylenol less than ten times and only to patients I know well and who I know are in significant pain that I cannot alleviate through a dental procedure. From my personal perspective, I did not need any more government hoops to jump through to help my patients.
None
It would be advantageous to have a dental drug reference handbook supplement with a list of alternative drugs that could be prescribed in place of opioids as well as holistic measures (i.e. food, OTC's, vitamin suggestions).
Make more CE classes available with some notice for us dentists who do not live near Burlington or the capital.
Support for a referral resource for potential at risk patients.
There are legitimate chronic pain patients who have carefully and responsibly used opioids for years to improve quality of life. There are also responsible medical practitioners who have helped these patients. The rules, as they are, are onerous for providers and potentially harmful to the quality of life for these chronic pain patients.

I assume the data bank on opioid rx in VT is searchable for providers who routinely over prescribe....are those providers targeted for reform.
For a competent professional, more restrictive rules tend to inhibit appropriate practice

Appendix F: Updates to Opioid Prescribing Rule Effective March 1, 2019

The Vermont Department of Health recently finalized updates to the Rule Governing the Prescribing of Opioids for Pain. The changes go into effect March 1 2019 and are largely technical or clarifying in nature. In summary, the changes:

- Permanently exempt patients who are terminally ill, receiving hospice services or who are hospice eligible from all aspects of the rule except for providing the patient with an education sheet and informing the patient regarding safe storage and disposal (previously the rule required informed consent in such instances);
- Adds patients in skilled and intermediate care nursing facilities to those that must follow acute pain prescribing limits;
- Clarify that co-prescribing of naloxone is not required if the patient already has a prescription or states they are in possession of naloxone;
- Clarify that the rule does not apply to orders of medication for immediate administration to a patient;
- Updates the definition of patients in nursing home care for the purposes of an exemption from the chronic pain aspects of the rule.
- For the full text of the rule visit: http://www.healthvermont.gov/sites/default/files/documents/pdf/Opioid%20Prescribing%20Rule%202.1.19.pdf

Appendix G: Survey instrument

Study data were collected and managed using REDCap1 electronic data capture tools hosted at University of Vermont. REDCap (Research Electronic Data Capture) is a secure, web-based application designed to support data capture for research studies, providing: 1) an intuitive interface for validated data entry; 2) audit trails for tracking data manipulation and export procedures; 3) automated export procedures for seamless data downloads to common statistical packages; and 4) procedures for importing data from external sources.

Dear Vermont Dentist:

Please complete this brief survey regarding the Vermont opioid prescribing rules—this is a topic of interest to all of us and of great importance to the public health of the state.

The University of Vermont Larner College of Medicine's Office of Primary Care and Area Health Education Centers (AHEC) Program is gathering healthcare perspectives on the rules for opioid prescribing that took effect July 1, 2017 in Vermont. As part of this project, we are asking Vermont dentists to participate in a brief survey.

By completing this survey, you ensure that your voice and the voices of Vermont dentists are part of this important policy discussion. All data will be de-identified and shared only in aggregate. A summary of the data collected regarding the strengths and challenges of the current rules will be reported in February 2019 and made available to policymakers, dental care, health care, and public health professionals to inform next steps.

This survey takes **about 5 minutes.** Please complete the survey as soon as possible.

Your participation is completely voluntary and anonymous. Neither your name nor other identifying information will be collected. You may receive duplicate requests to participate in this survey; we are working hard to have a strong response. Thank you for your understanding. Please respond to the survey only once.

We greatly appreciate your time and input.

Sincerely,

David E. McLean, DDS
McLean Dental Group
AHEC Advisor

Charlie D. MacLean, MD
Larner College of Medicine
Associate Dean for Primary Care

Katherine Mariani, MD
Larner College of Medicine
Family Medicine Faculty

Liz Cote
Larner College of Medicine
Director of the Office of Primary Care and AHEC Program

This public health project is in collaboration with the *Vermont Department of Health, Division of Alcohol and Drug Abuse Programs, with funding from federal Substance Abuse & Mental Health Services Administration (SAMHSA).*

VT Opioid Prescribing Rules Survey

Are you currently licensed by the state to practice dentistry in Vermont?

◯ Yes
◯ No

Do you currently work in Vermont as a dentist?

◯ Yes
◯ No

What is your degree?

◯ DDS
◯ DMD
◯ Not listed (specify)

Degree not listed (specify)

_____

What is your primary dental specialty?

◯ General dentistry
◯ Oral surgery
◯ Not listed (specify)

Dental specialty not listed (specify)

_____

What is your age?

◯ 30 or under
◯ 31 to 40
◯ 41 to 50
◯ 51 to 60
◯ 61 to 70
◯ 71+
◯ Prefer not to answer

What is your gender?

◯ Female
◯ Male
◯ Prefer not to answer
◯ Not listed (specify)

Gender not listed (specify)

_____

What County in Vermont do you practice dentistry? (If multiple locations, please choose the County of your primary work site)

◯ Addison County
◯ Bennington County
◯ Caledonia County
◯ Chittenden County
◯ Essex County
◯ Franklin County
◯ Grand Isle County
◯ Lamoille County
◯ Orange County
◯ Orleans County
◯ Rutland County
◯ Washington County
◯ Windham County
◯ Windsor County
◯ Prefer not to answer

In a typical week, approximately how many clinical hours do you work? (2 digits)

_____

In the past 12 months, have you prescribed opioids for any of your patients (including Tramadol)?

◯ Yes
◯ No

What are the common categories for which you would prescribe opioids? (Check all that apply)

☐ Infection
☐ Extraction
☐ Post-operative
☐ Not Listed (specify)

Category not listed (specify)

_____

In the past 12 months, approximately how often have you prescribed opioids?

◯ Daily
◯ Weekly
◯ Monthly
◯ Quarterly
◯ Yearly

In the past 12 months, what is your estimated number of chronic pain patients that you treat with opioids?

◯ 0
◯ 1 to 10
◯ 11 to 20
◯ 21 to 50
◯ 51+

In the past 12 months, when prescribing opioids to a typical patient, how many pills do you prescribe?

◯ 1-5
◯ 6-10
◯ 11-20
◯ 21-30
◯ 31+

Many factors have impacted the current opioid crisis in Vermont and the U.S. For each of the following factors, please indicate your opinion about how strongly each has contributed to the opioid crisis.

	Minimal contribution	Moderate contribution	Significant contribution
Illegal Drug Trade	◯	◯	◯
Patients Receiving Prescriptions from Medical Providers	◯	◯	◯
Patients Receiving Prescriptions from Dental Providers	◯	◯	◯
Prescribers Overall	◯	◯	◯
Pharmaceutical Companies	◯	◯	◯

How familiar are you with the rules for opioid prescribing that took effect July 1, 2017 in Vermont?

◯ I do not know about the rules
◯ I am somewhat familiar with the rules
◯ I am very familiar with the rules

Do you believe more restrictive opioid prescribing rules were necessary for dental prescribers?

◯ Yes
◯ No
◯ Unsure

Do you believe more restrictive opioid prescribing rules were necessary for medical prescribers?

◯ Yes
◯ No
◯ Unsure

Have the July 1, 2017 rules influenced your prescribing?

◯ No, I did not prescribe opioids before or after the July 1, 2017 rules
◯ No, the rules have not changed how I prescribe
◯ Yes, the rules have changed how I prescribe
◯ Yes, I no longer prescribe opioids because of the rules
◯ Unsure

Do you have any non-identifying examples of particularly positive effects of the rules with regard to patients?

Do you have any non-identifying examples of particularly negative effects of the rules with regard to patients?

What kind of effect do you believe the new rules will have on the opioid crisis?

◯ Largely negative effect
◯ Some negative effect
◯ No effect
◯ Some positive effect
◯ Largely positive effect
◯ Unsure

How successfully are you implementing these best practices in opioid prescribing?				
	Not successfully	Somewhat successfully	Very successfully	Not applicable
Considering non-opioid and non-pharmacological treatment	◯	◯	◯	◯
Querying Vermont Prescription Monitoring System (VPMS)	◯	◯	◯	◯
Discussing risks, benefits, and patient education	◯	◯	◯	◯
Obtaining informed consent	◯	◯	◯	◯
Adhering to specified opioid prescription limits	◯	◯	◯	◯
Justifying and documenting in the patient dental record when not adhering to prescribing rules	◯	◯	◯	◯
Co-prescribing Naloxone when MME>90 or concurrent prescription of Benzodiazepines	◯	◯	◯	◯

Thinking about your practice in the past 12 months, what are some barriers to implementing the best practices indicated above?

What specific resources or materials would help your practice comply with the state's opioid prescribing rules?

Please select what you believe are the current possible consequences for prescribers who do not follow the best practices prescribing rules. (Check all that apply)

- ☐ No consequences
- ☐ No consequences with proper documentation
- ☐ Suspension of opioid prescribing authority
- ☐ Dental license suspension
- ☐ Monetary fine
- ☐ Incarceration
- ☐ Not listed (specify)

Consequences not listed (specify)

A rulemaking process is underway to update the July 1, 2017 prescribing rules. Are you currently engaged in that process, or have you provided feedback to the state?

- ◯ Yes
- ◯ No

Did you recently participate in a survey from the VT Department of Health regarding the VT Prescription Monitoring System (VPMS) and the usefulness of the Clinical Alerts and the Prescriber Insight Report enhancements?

- ◯ Yes
- ◯ No

Thinking about different possible continuing education (CE) topics, please indicate your top 3 priorities (any topic) for your own continuing education:

Highest Priority

_____

Medium Priority

_____

Lowest Priority

_____

Thinking about different possible continuing education (CE) topics, please indicate your top 3 priorities (any topic) for your practice team's continuing education:

Highest Priority

_____

Medium Priority

_____

Lowest Priority

_____

Do you have any final suggestions, thoughts, or concerns regarding the opioid prescribing rules that we have not covered?

An overview of the July 1, 2017 prescribing rules are available at the following link (please copy and paste the URL into your browser).

http://www.healthvermont.gov/sites/default/files/documents/pdf/REG_opioids-prescribing-for-pain.pdf

Proposed updates to the July 1, 2017 Rule Governing the Prescribing of Opioids for Pain are available at the following link (please copy and paste the URL into your browser).

http://www.healthvermont.gov/sites/default/files/documents/pdf/Opioid%20Prescribing%20Rule%20Annotated.pdf

Thank you for taking time to complete this survey.