Injury Severity Score

Body system
Head and neck
Face
Chest
Abdomen
Extremity, inc pelvis
External

Injury severity	Points
No injury	0
Minor	1
Moderate	2
Serious	3
Severe	4
Critical	5
Unsurvivable	6

http://www.trauma.org/archive/scores/iss.html

- 3 day limit on C-II opioid
- Up to 7 day supply IF…
  - Medically necessary
  - "Acute pain exception" is written on Rx
  - Documents acute condition and lack of alternatives

Note that all 3 criteria must be met

- Emergency opioid antagonist
- "Nonacute pain"

http://www.flsenate.gov/Session/Bill/2018/21/BillText/er/PDF

Pain management clinic: 1/1/2019

- Pain management clinic registration
- Exempt entities
  - Clinic in which the majority of physicians there primarily provide surgical services
  - Clinic held by a publicly traded company whose most recent total quarterly assets exceed $50M
  - Clinic affiliated with a medical school at which training is provided
- Certificate of exemption

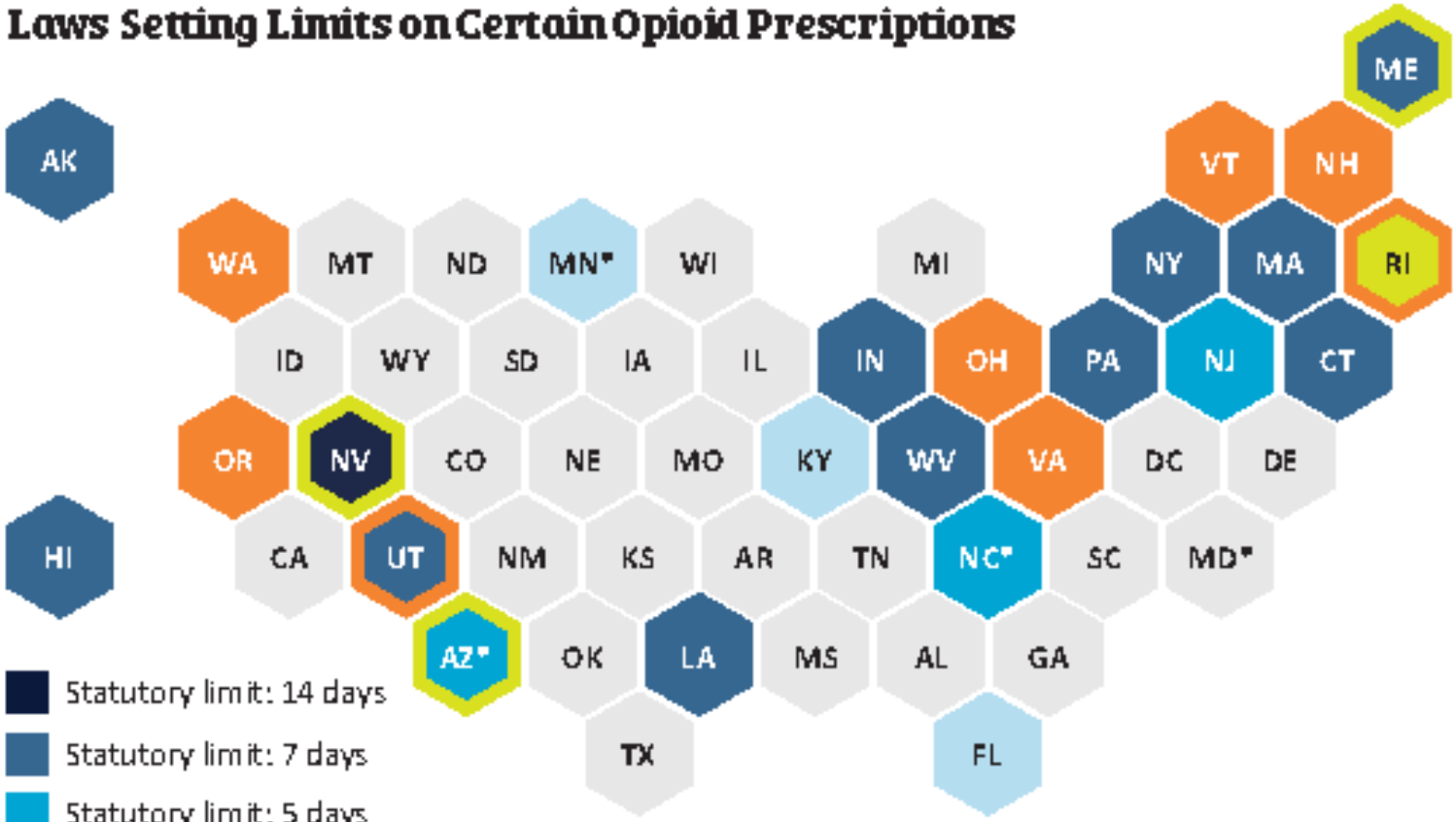
http://www.flsenate.gov/Session/Bill/2018/21/BillText/er/PDF

CME: 1/31/2019

- DEA registrants
- Controlled substance prescribers
- 2 hour, board-approved, CME
- Part of biennial license renewal
- Within the number of CE hours required by law
- Failure to complete course = no license renewal
- By Jan 31, 2019 and each subsequent renewal
- Submit confirmation of course completion

http://www.flsenate.gov/Session/Bill/2018/21/BillText/er/PDF

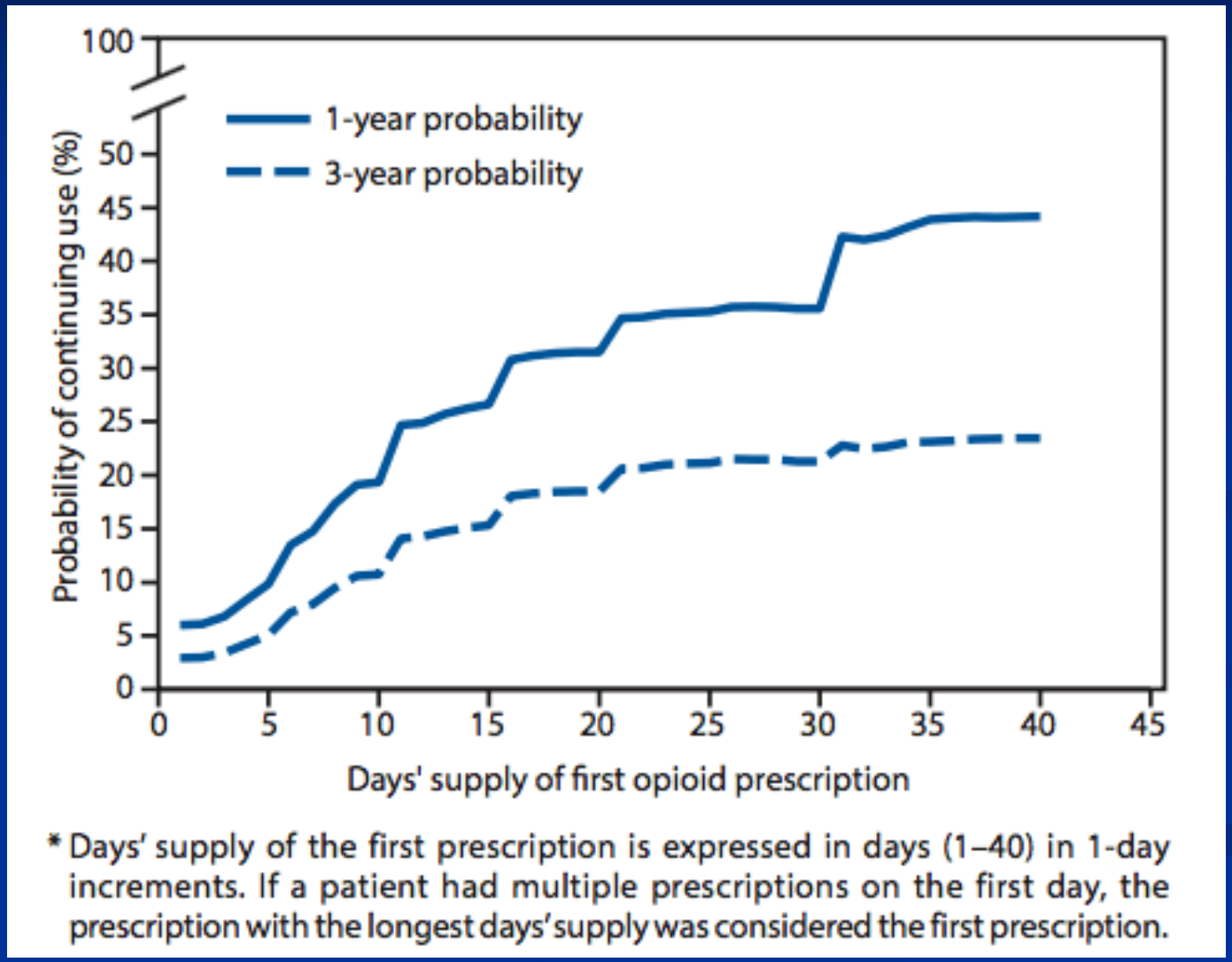
Laws Setting Limits on Certain Opioid Prescriptions



* Note: The map displays the state's primary opioid prescription limit and does include additional limits on certain providers or in certain settings. Arizona allows prescriptions up to 14 days following surgical procedures and North Carolina allows up to 7 days for post-operative relief. Maryland requires the "lowest effective dose." Minnesota's limit is for acute dental or ophthalmic pain. The map also does not reflect limits for minors that exist in at least eight states.

http://www.ncsl.org/research/health/prescribing-policies-states-confront-opioid-overdose-epidemic.aspx

When does dependence begin?

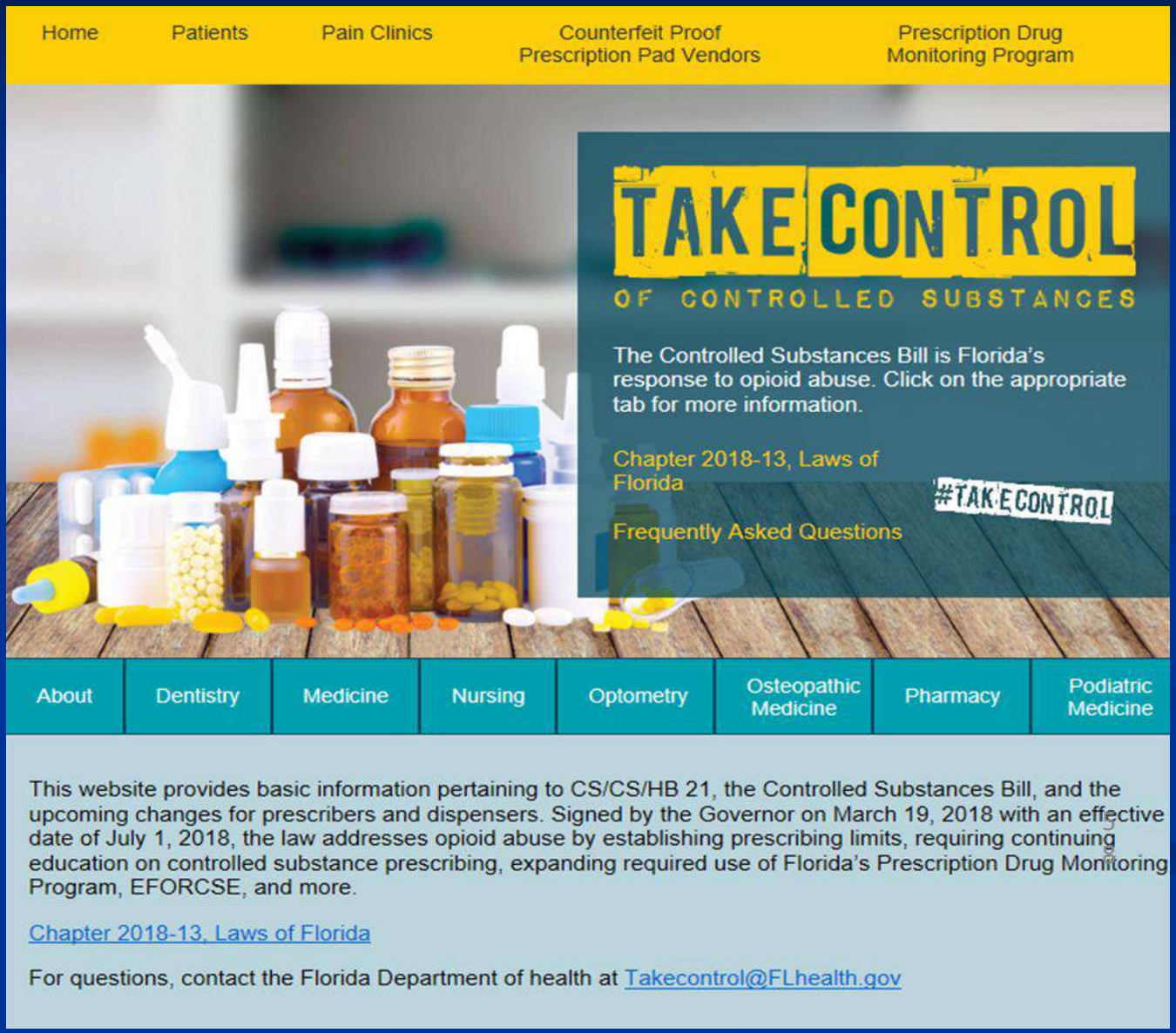


* Days' supply of the first prescription is expressed in days (1–40) in 1-day increments. If a patient had multiple prescriptions on the first day, the prescription with the longest days' supply was considered the first prescription.

http://www.newsweek.com/cdc-opiate-addiction-572498

https://www.cdc.gov/mmwr/volumes/66/wr/mm6610a1.htm

www.flhealthsource.gov/FloridaTakeControl



- Pharmacology of opiates
- Epidemiology of opioid crisis
- Current Florida statistics regarding M&M of controlled substance-related deaths
- Current standards, laws and rules on prescribing controlled substances
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Counterfeit-proof Rx pads

- Controlled substance Rx must be written on a counterfeit-resistant pad produced by an approved vendor, or electronically prescribed
- Otherwise, risk of Rx rejection and confiscation

http://www.floridashealth.com/mqu/counterfeit-proof.html

http://www.deadiversion.usdoj.gov/ecomm/e_rx/faq/faq.html

Components of a legitimate controlled substance Rx

- Legible printed/typed on counterfeit-proof Rx
- Date in textual format
- Patient name & address
- Name and strength of medication
- Dispense amount in both textual and numeric format
- Sig: directions should be legibly written out
- Number of refills, if any
- DEA number legibly written
- Signature – ink or typed (no signature stamps)
- Doctor office name and contact information (eg, address, phone)

Example

Dr. Ali Ababwa
1234 Main Street
Anytown, Florida 33312
555-867-5309

Date: February 16, 2018

Patient Name: Jasmine Akrabah DOB:09/19/1975

Address: 1111 Center Lane, Anytown, Florida 33312

Percocet (5/325)

Disp. # 10 (Ten)

Sig: Take one tab by mouth every 6 hours PRN post-op pain

No Refills

DEA # BA1222103

Signature Santa

WHY GUIDELINES FOR PRIMARY CARE PROVIDERS?

Primary care providers account for approximately **50%** of prescription opioids dispensed

Nearly **2 million** Americans, aged 12 or older, either abused or were dependent on prescription opioids in 2014

- An estimated 11% of adults experience daily pain
- Millions of Americans are treated with prescription opioids for chronic pain
- Primary care providers are concerned about patient addiction and report insufficient training in prescribing opioids

MYTH VS TRUTH

MYTH	TRUTH
1 Opioids are effective long-term treatments for chronic pain	While evidence supports short-term effectiveness of opioids, there is insufficient evidence that opioids control chronic pain effectively over the long term, and there is evidence that other treatments can be effective with less harm.
2 There is no unsafe dose of opioids as long as opioids are titrated slowly	Daily opioid dosages close to or greater than 90 MME/day are associated with significant risks, and lower dosages are safer.
3 The risk of addiction is minimal	Up to one quarter of patients receiving prescription opioids long term in a primary care setting struggles with addiction. Certain risk factors increase susceptibility to opioid-associated harms: history of overdose, history of substance use disorder, higher opioid dosages, or concurrent benzodiazepine use.

WHAT CAN PROVIDERS DO?

First, **do no harm**. Long-term opioid use has uncertain benefits but known, serious risks. CDC's ***Guideline for Prescribing Opioids for Chronic Pain*** will support informed clinical decision making, improved communication between patients and providers, and appropriate prescribing.

PRACTICES AND ACTIONS

USE NONOPIOID TREATMENT

Opioids are not first-line or routine therapy for chronic pain *(Recommendation #1)*

In a systematic review, opioids did not differ from nonopioid medication in pain reduction, and nonopioid medications were better tolerated, with greater improvements in physical function.

START LOW AND GO SLOW

When opioids are started, prescribe them at the lowest effective dose *(Recommendation #5)*

Studies show that high dosages (≥100 MME/day) are associated with 2 to 9 times the risk of overdose compared to <20 MME/day.

REVIEW PDMP

Check prescription drug monitoring program data for high dosages and prescriptions from other providers *(Recommendation #9)*

A study showed patients with one or more risk factors (4 or more prescribers, 4 or more pharmacies, or dosage >100 MME/day) accounted for 55% of all overdose deaths.

AVOID CONCURRENT PRESCRIBING

Avoid prescribing opioids and benzodiazepines concurrently whenever possible *(Recommendation #11)*

One study found concurrent prescribing to be associated with a near quadrupling of risk for overdose deaths compared with opioid prescription alone.

OFFER TREATMENT FOR OPIOID USE DISORDER

Offer or arrange evidence-based treatment (e.g. medication-assisted treatment and behavioral therapies) for patients with opioid use disorder *(Recommendation #12)*

A study showed patients prescribed high dosages of opioids long-term (>90 days) had 122 times the risk of opioid use disorder compared to patients not prescribed opioids.

CDC U.S. Department of Health and Human Services Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

2016 CDC guidelines

- 18yoa+, chronic pain treatment (3mos+)
- Use non-opioid therapies
  - Nonpharmacological therapies
  - Non-opiate treatments
- Start low and go slow
- Follow up

http://www.cdc.gov/drugoverdose/prescribing/guideline.html

Opioid Prescribing Recommendations: Summary of 2016 CDC Guidelines

Determining when to initiate or continue opioids for chronic pain

- Opioids are not first-line or routine therapy
- Establish treatment goals before starting opioid therapy and a plan if therapy is discontinued
- Only continue opioid if there is clinically meaningful improvement in pain and function
- Discuss risks, benefits and responsibilities for managing therapy before starting and during treatment

Opioid selection, dosage, duration, follow-up and discontinuation

- Use immediate-release (IR) opioids when starting therapy
- Prescribe the lowest effective dose
- When using opioids for acute pain, provide no more than needed for the condition
- Follow up and review benefits and risks before starting *and* during therapy
- If benefits do not outweigh harms, consider tapering opioids to lower doses or taper and discontinue

Assessing risk and addressing harms of opioid use

- Offer risk mitigation strategies, including naloxone for patients at risk for overdose
- Review PDMP* data at least every 3 months and perform UDT** at least annually***
- Avoid prescribing opioid and benzodiazepines concurrently when possible
- Clinicians should offer or arrange MAT**** for patients with OUD†

*Prescription drug monitoring program
**Urine drug testing
***Some VA facilities may require more frequent testing
****Medication-assisted treatment
†Opioid use disorder

- Determine when to initiate/continue opioids
  - Non-Rx and non-opioid tx is preferred
  - Establish tx goals; discuss realistic risks and benefits
- Opioid logistics
  - Rx IR instead of ER/LA
  - Begin w/ lowest effective dose; consider quantity and duration
  - Monitor
- Assessing risk & addressing harms
  - Consider risk mitigation
  - Consult PDMP
  - Urine drug screen
  - Avoid opiate/BZD combos
  - Treat opioid use disorder

http://www.cdc.gov/drugoverdose/prescribing/guideline.html

Clinically meaningful improvement

- 30%+ improvement
- Assess and document
- Validated tools

- What is not CMI?

- Rx – CMI = inappropriate care

https://www.medscape.com/viewarticle/813875_2

STEP 2 Develop and Select Policies

PREVENTING OPIOID MISUSE AND OVERDOSE

HEALTH CARE STRATEGIES FOR PREVENTION AND EARLY IDENTIFICATION

- Develop and update guidelines for all opioid prescribers.
- Limit new opioid prescriptions for acute pain, with exceptions for certain patients.
- Adopt a comprehensive opioid management program in Medicaid and other state-run health programs.
- Remove methadone for managing pain from Medicaid preferred drug lists.
- Expand access to non-opioid therapies for pain management.
- Enhance education and training for all opioid prescribers.
- Maximize the use and effectiveness of state prescription drug monitoring programs.
- Use public health and law enforcement data to monitor trends and strengthen prevention efforts.
- Enact legislation that increases oversight of pain management clinics to reduce "pill mills."
- Raise public awareness about the dangers of prescription opioids and heroin.

RESPONDING TO OPIOID MISUSE AND OVERDOSE

HEALTH CARE STRATEGIES FOR TREATMENT AND RECOVERY

- Change payment policies to expand access to evidence-based MAT and recovery services.
- Increase access to naloxone.
- Expand and strengthen the workforce and infrastructure for providing evidence-based MAT and recovery services.
- Create new linkages to evidence-based MAT and recovery services.
- Consider authorizing and providing support to syringe service programs.
- Reduce stigma by changing the public's understanding of substance use disorder.

http://www.nga.org/files/live/sites/NGA/files/pdf/2016/1607NGAOpioidRoadMap.pdf

In The News…

- Aug 2016: influx of fentanyl-laced counterfeit pills and toxic compounds further increases risk of fentanyl-related ODs and fatalities
- Sep 2016: FDA adds boxed warnings to Rx opioids and BZDs
  - DEA issues carfentanil warning

TURN THE TIDE

THE SURGEON GENERAL'S CALL TO END THE OPIOID CRISIS

Open letter to all Medical Providers:

"Years from now, I want us to look back and know that, in the face of a crisis that threatened our nation, it was our profession that stepped up and led the way."

TurnTheTideRx.org website

Launched Aug. 8, 2016

Platform with resources for physicians and their patients

http://turnthetiderx.org/

The White House
Office of the Press Secretary

For Immediate Release September 16, 2016

Presidential Proclamation -- Prescription Opioid and Heroin Epidemic Awareness Week, 2016

NOW, THEREFORE, I, BARACK OBAMA, President of the United States of America, by virtue of the authority vested in me by the Constitution and the laws of the United States, do hereby proclaim September 18 through September 24, 2016, as Prescription Opioid and Heroin Epidemic Awareness Week. I call upon all Americans to observe this week with appropriate programs, ceremonies, and activities that raise awareness about the prescription opioid and heroin epidemic.

IN WITNESS WHEREOF, I have hereunto set my hand this sixteenth day of September, in the year of our Lord two thousand sixteen, and of the Independence of the United States of America the two hundred and forty-first.

BARACK OBAMA

https://www.whitehouse.gov/the-press-office/2016/09/19/fact-sheet-obama-administration-announces-prescription-opioid-and-heroin

In The News…

- Aug 2017: As of Jan 2018, GA docs will be required to take 3hrs of CME on opioid prescribing before license renewal
- Sep 2017: FDA requires 74 opioid manufacturers to develop physician training
- CDC awards $28.6M to help states fight opioid overdose epidemic
- States and cities sue opioid manufacturers and distributors

https://www.cdc.gov/media/releases/2017/p0905-opioid-funding.html?utm_source=PolicyCrush&utm_campaign=e9785151b3-EMAIL_CAMPAIGN_2017_09_06&utm_medium=email&utm_term=0_fe688512b8-e9785151b3-115534997

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Economic burden of opioid abuse

- Nonmedical use of opioid pain relievers cost insurance companies up to $72.5 billion annually in health-care cost

- Social & economical consequences
  - Cost of prevention and treatment
  - Increased incidences of opioid overdose deaths
  - Safety risk to the public due to drug affected driving
  - Environmental contamination due to inappropriate disposal and illicit cultivation
  - Loss of productivity at work
  - Neonatal abstinence syndrome

Volkow, Nora. "Prescription Opioid and Heroin Abuse." *National Institute on Drug Abuse (NIDA)*. N.p., 29 Apr. 2014. Web. 26 Jan. 2017. Available at: https://www.drugabuse.gov/about-nida/legislative-activities/testimony-to-congress/2016/prescription-opioid-heroin-abuse

Consequences

- Opioid use disorder
- Addiction
- Addiction treatment
- Withdrawal
- Toxicity/overdose
- Overdose treatment

Risks of Opioid Therapy

- Mortality (of all-causes)
  - **Hazard ratio (HR) 1.64** for long acting opioids for non-cancer pain
- Overdose deaths (unintentional)
  - **HR 7.18-8.9** for MED > 100 mg/d
- Opioid use disorder

  For patients on long-term opioids (> 90 days)
  - **HR 15** for 1-36 mg/d MED
  - **HR 29** for 36-120 mg/d MED
  - **HR 122** for > 120 mg/d MED

*MED=Morphine Equivalent Daily Dose (in mg/d)