

Dear Medical Professionals,

The Genesee County Medical Society and the Greater Flint Health Coalition's Mental Health & Substance Use Task Force would like to present you with the Genesee County Opioid Prescriber Toolkit. The Toolkit was designed to support a community-wide strategy to address the opioid epidemic in Genesee County.

The healthcare community plays a critical role in addressing the opioid epidemic and has an opportunity to make a difference. Genesee County providers have expressed an interest in additional resources to help navigate substance use treatment options for their patients. This Opioid Prescriber Toolkit is intended to serve as a resource for you to treat and support your Genesee County patients with pain or substance use issues.

Please take a moment to review the Genesee County Opioid Prescriber Toolkit, as well as the expanded online Toolkit with additional resources at www.KnowMoreGenesee.org.

The Toolkit contains:

- Quick Reference Referral Guide for Substance Use Treatment
- Opioid Legislation FAQs
- Prescribing Checklist for Controlled Substances
- Acute Care Prescribing Recommendations
- Chronic Pain Prescribing Recommendations
- Prescription Opioids: What You Need to Know
- Alternative Approaches to Managing Pain

The online Toolkit incorporates additional information to support providers in the treatment and support of their patients. It includes information on how to become a Medication-Assisted Treatment (MAT) provider, as there is a great need for additional MAT providers in Genesee County. Detailed information regarding opioid legislation and the use of the Michigan Automated Prescription System (MAPS) is available, along with specific opioid prescribing guidelines and educational resources for both acute and chronic pain prescribers. At the request of local providers, the online Toolkit also contains information on alternatives to opioid prescribing and proper disposal of opioid prescriptions.

As a medical professional we hope that you find this information useful as you continue to serve your patients with the utmost compassionate care.

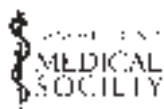
Sincerely



Kirk Smith, MHSA
President & CEO
Greater Flint Health Coalition



Edward A. Christy, MD, FACP
President
Genesee County Medical Society



GREATER FLINT HEALTH COALITION



A p r i l 2 0 1 9

Quick Reference Referral Guide *for Substance Use Treatment*

KnowMoreGenesee.org



ABOUT OPIOID ADDICTION
Genesee County Opioid Prevention Project



As a Genesee County provider encountering changes in legislation regarding utilization of the Michigan Automated Prescription System (MAPS), and navigating the substance use treatment system with your patients, the Greater Flint Health Coalition and its Mental Health & Substance Use Task Force offer this referral guide as an introductory resource.

The First Step: Accessing Substance Use Treatment

1 If an individual has **Medicaid, is uninsured, and/or has general questions**, they may call or visit (during business hours) **the Genesee Health System Access Center** at:

- 810-257-3740 (crisis line available 24/7)
- TTY 810-232-6310
- Toll-Free 877-346-3648
- 420 W. Fifth Avenue, Flint, MI 48503 – Open Monday through Friday, 8 a.m. to 5 p.m.

Please have the following information available when calling to expedite the process:

- Name, date of birth, social security number
- Medical insurance card or numbers, including Medicaid (if applicable)
- Names of current medicines and doctors

- Guardianship or court papers (if applicable)
- Special education or other school records (if applicable)
- Drug (quantity, frequency)
- Services needed (detox, inpatient, outpatient)

Fees for services are based on a person's ability to pay; therefore, staff will need to know the household income and number of dependents of the person seeking help. A coverage determination will be made at the time of the screening. Staff will let you know if you can expect to have any cost for your services. No one will be denied services based on their inability to pay.

2 If an **individual has insurance other than Medicaid**, call the insurance plan directly to determine covered services and providers.

Substance Use Treatment Centers in Genesee County and Surrounding Areas

GENESEE COUNTY RESIDENTIAL CENTERS

Above the Water House

4105 Keyes Street, Flint, MI 48504

(810) 877-2907

Women's recovery housing for females with addiction/alcoholism with mild to moderate psychological impairments.

Flint Odyssey House

529 M.L. King Avenue, Flint, MI 48503

(810) 238-5888

Medication assisted treatment, withdrawal management, long-term residential treatment, outpatient services, recovery housing, women's specialty services, adolescent treatment services.

Kairos Health Care, Holy Cross

8218 N. Jennings Road

Mt. Morris, MI 48458

(844) 452-4767

Corcoran House Residential Treatment for Women

Life Challenge Ministries

Life Challenge of Southeastern Michigan

17667 Pierson Street, Detroit, MI 48219

1230 Dupont St, Flint, MI 48504

(844) 355-LIFE

info@lcministries.org

One-year residential program for men and women with drug, alcohol, and other life-controlling addictions. Affiliated with Teen Challenge USA, International, our goal is more than rehabilitation, Faith based program.

New Paths Inc.

765 E. Hamilton Avenue, Flint, MI 48505

(810) 233-5340

newpaths.org

Short and long-term residential treatment, withdrawal management, outpatient services, recovery housing, 23-hour sobering facility, Court ordered treatment programming.

Salvation Army Adult Rehabilitation (Men Only)

2200 N. Dort Highway, Flint, MI 48506

(810) 234-2678

Long-term residential program, spiritual base, work therapy, group and individual counseling, leisure time activities.



GENESEE COUNTY OUTPATIENT CENTERS & SUPPORT SERVICES

Bio-Med Behavioral Health Care INC. - Flint

1044 Gilbert Road, Flint, MI 48532
(810) 733-7623
Outpatient, integrated treatment,
medication assisted treatment.

Catholic Charities

901 Chippewa Street, Flint, MI 48503
(810) 232-9950
Outpatient SUD treatment, Court
ordered treatment programming.

Families Against Narcotics – Genesee County Chapter

(810) 397-7175
familiesagainstnarcotics.org
Information regarding prescription drug
abuse, local resources, family support
network. Available to answer questions
regarding substance use and steps to
seek treatment.

Genesee Community Health Center

422 W. 4th Avenue, Flint, MI 48503
(810) 496-5777
Integrated health care, treatment
services for co-occurring disorders,
medication assisted treatment
(Suboxone, Vivitrol).

Hamilton Community Health Center

Multiple Locations
(810) 406-HCHN (4246)
Outpatient, substance abuse counseling,
Vivitrol program.

Holy Cross Services

4318 Miller Road, Flint, MI 48507
(810) 249-9924
Outpatient SUD treatment, recovery
housing.



Hope Network

1110 Eldon Baker Drive, Flint, MI 48503
(810) 232-2766
Free family and addiction services.

Insight Wellness Center

4400 S. Saginaw St., Ste. 1370
Flint, MI 48507
(810) 223-0199
Medication assisted treatment, outpatient
SUD treatment, services for co-occurring
disorders, pain management, physical therapy.

Meridian Health Services

1289-D S. Linden Road, Flint, MI 48532
(810) 620-7501
Outpatient care, integrated treatment,
and family therapy.

New Oakland Family Center

2401 South Linden Road
Flint, MI 48507
(810) 957-4310
Intensive outpatient counseling
(dual diagnosis – mental health and
substance use disorder).

Remedy Exchange Programs (outreach services)

8308 Office Park Drive, Suite One
Grand Blanc, MI 48439
(810) 449-0159
remedyexchange@gmail.com
PRIME for Life is a program that helps
youth and adults learn how to reduce
their risk of alcohol and other drug
related problems throughout life.

Sacred Heart - Flint

2091 Professional Drive
Flint, MI 48532
(810) 732-1652
Outpatient, integrated treatment,
medication assisted treatment
(Methadone, Vivitrol), women's
specialty.

The Serenity House of Flint

954 Church Street, Flint, MI 48502
(810) 893-1276
Informational, holistic options for
recovery from addictions.

RESOURCES OUTSIDE OF GENESEE COUNTY

Brighton Center for Recovery

12851 Grand River Road
Brighton, MI 48116
(810) 227-1211
brightonrecovery.org
Inpatient and intensive outpatient.
Provides residential, outpatient, dual diagnosis, and detox services. Will accept private insurance, cash, and Medicare.

Dawn Farms

6633 Stoney Creek Road
Ypsilanti, MI 48197
(734) 485-8725
Adolescent (17+) and adult residential, outpatient. Non-medicated, 12-step based detox is FREE to anyone, even if they do not stay for residential treatment. Transitional housing.

Grace Centers of Hope

35 E. Huron Street, Pontiac, MI 48342
(855) HELP-GCH
Adult residential, family and life-skills programs.

Henry Ford Maplegrove Center

6773 W Maple Road
West Bloomfield, MI 48322
(248) 661-6100
henryford.com
Outpatient and inpatient for adults.
Outpatient only for adolescents.

Kairos Healthcare Adolescents

3400 South Washington Road
Saginaw, MI 48601
(989) 755-1072
Adolescent and adult residential, integrated treatment, informational, prevention and problem assistance, outpatient screening assessment referral and follow-up.

Meridian Health Services

1255 N Oakland Blvd
Waterford, MI 48327
(248) 599-8999
Detox, adult residential, inpatient and outpatient care, integrated treatment, and family therapy.

Sacred Heart – Memphis

400 Stoddard Road
Memphis, MI 48041
(888) 804-7472 Admissions
(888) 802-7472 Admin
Adult residential, detox inpatient, case management, early intervention, integrated treatment, peer recovery and support, screening assessment referral and follow-up, Methadone.
Residential admissions:
(888) 804-7472 or (734) 284-0070
Monday-Friday, 8:30am-5:00pm
Emergency admissions:
(888) 804-7472, ext. 266, weekdays, weekends, and holidays. Sliding fee scale, Medicaid, ABW, and most health insurance.

Salvation Army Harbor Light

42590 Stepnitz Drive
Clinton Township, MI 48036
(586) 954-1838
Adult residential/outpatient, case management, detox, screening assessment referral and follow-up.

Serenity Therapy Center

745 Barclay Circle, #305
Rochester Hills, MI 48307
(586) 219-7010
serenityhelp.com
Outpatient, addiction counseling, family therapy, and interventions.

Teen Challenge of Western Michigan

440 Pontaluna Road
Muskegon, MI 49444
Men's Phone: (231) 798-7927
Women's Phone: (231) 798-2702
Email: info@wm-tc.com
wm-tc.com/contact-us
One year residential program. Faith based.

Vision Quest Recovery

Port Huron, MI
info@visionquestrecovery.com
Program Director: (810) 937-6279
Assistant Program Director:
(248) 421-8143
Transitional housing program, 12-step program, structure, guidelines.

Disclaimer: Resource details provided by Families Against Narcotics. All information was accurate at time of printing. Information is subject to change.

This program is supported by the Michigan Health Endowment Fund.



KNOW

MORE

ABOUT OPIOID ADDICTION



OPIOID LEGISLATION FAQS



GREATER FLINT HEALTH COALITION



KnowMoreGenesee.org

OPIOID *Alert*



MICHIGAN
OSTEOPATHIC
ASSOCIATION



APRIL 5, 2018

NEED TO KNOW

Opioid Legislation FAQs



These FAQs represent a compilation of questions received from MSMS and MAFP members. Please note that this is a “living” document that MSMS intends to continuously update as new information, guidance and questions become available. The Michigan State Medical Society has also prepared an objective analysis of the recently enacted legislation which impacts prescribing practices. Please feel free to contact Stacey Hettiger at shettiger@msms.org if you have questions that have not yet been addressed.

Q: When do these new provisions take effect?

A: The prescribing provisions that impact physicians and other licensed prescribers were part of a larger eleven-bill legislative package. As a result, there are multiple effective dates and some provisions have already taken effect. However, the major issues impacting prescribing are set to become effective later this year. Below are the key effective dates for which prescribers need to be aware:

- **March 27, 2018** – if treating a patient for an opioid-related overdose, provide them with information on “substance use disorder services;” query MAPS if prescribing/dispensing buprenorphine or methadone to a patient in a substance use disorder program; and, if dispensing a controlled substance, a dispensing prescriber shall report such dispensing to MAPS. (Note: Public Act 252 of 2017 rescinded Rule 338.3162e of the Administrative Code, which exempted from mandatory MAPS reporting a controlled substance administered directly to a patient. On April 3, 2018, the Michigan Department of Licensing and Regulatory Affairs, Bureau of Professional Licensing, clarified with MSMS that it is the agency’s position that

the Legislature’s repeal of the exemption does not require reporting to MAPS when a controlled substance is administered directly to a patient.)

- **June 1, 2018** – mandatory Michigan Automated Prescription System (MAPS) check if prescribing controlled substances in a quantity that exceeds a three-day supply; must be registered in MAPS before prescribing controlled substances; and, must comply with specific informed consent provisions when prescribing opioids.
- **July 1, 2018** – cannot prescribe more than a 7-day supply of an opioid within a 7-day period if treating a patient for acute pain.
- **March 31, 2019** or sooner if administrative rules enacted – must have a bona fide prescriber-patient relationship prior to prescribing controlled substances and a mechanism for following-up directly with the patient or by referral. (Note: Pursuant to Public Act 101 of 2018 signed by the Governor on April 2, 2018, the effective date of this provision has been extended to March 31, 2019, or upon the promulgation of administrative rules if before March 31, 2019.)

Opioid Legislation FAQs continue on next page ►

Q: Are all physicians required to register for the Michigan Automated Prescription System (MAPS) by June 1, 2018?

A: No. The law does not require all physicians to register for MAPS. Only those prescribing or dispensing controlled substance on or after June 1, 2018, will have to be registered with MAPS in order to be in compliance with the law. This requirement applies even if the scheduled drug is not an opioid.

MAPS Related

Q: How do I register for MAPS?

A: For registration to PMP AWARe, please visit <https://michigan.pmpaware.net/login> and click on "Create Account." You will need to know your email and what password you want to use, as well as your Controlled Substance ID, DEA Number, Professional Licensee Number, and National Provider Identifier (NPI). The Michigan Department of Licensing and Regulatory Affairs (LARA) also has a MAPS webpage at <http://www.michigan.gov/lara>.

Please note, your Controlled Substance License is issued by the state of Michigan and is not the same as your DEA Number. If you don't number your CS ID, you can find it on the state's "Verify a License" webpage by typing in your name and selecting "Pharmacy" as your occupation. Your name and ID should appear.

View MSMS's registration tip sheet at https://www.msms.org/Portals/0/Documents/MSMS/News/Latest_News/20170331_MAPS_Registration_for_Physicians.pdf.

Additionally, MSMS has a free webinar available by visiting <https://www.MSMS.org/Education/On-Demand-Webinars> (click Pain and Symptom Management for all related courses including MAPS registration) for anyone interested in learning more about the updated MAPS and how to register.

Q: Do I have to register with MAPS even if I'm not writing a prescription for an opioid?

A: Possibly. Effective June 1, 2018, before prescribing or dispensing any controlled substance, the licensed prescriber must be registered with MAPS. This requirement applies even if the scheduled drug is not an opioid. Controlled substances include a wide range of medications, not just opioids.

Q: I prescribe controlled substances, but I do not dispense controlled substances. Do I still need to register with MAPS?

A: Yes. Beginning June 1, 2018, if you prescribe or dispense controlled substances, you must be registered with MAPS. In addition, before prescribing or dispensing controlled substances in excess of a 3-day supply to a patient, you must first obtain and review a MAPS report.

Q: I am a retired physician but still maintain my professional licenses including my controlled substance license. Do I still need to register for MAPS?

A: You only need to register for MAPS if you will be prescribing a controlled substances. There is no cost to register for MAPS so, you may want to consider registering should you find yourself in a position where you need to prescribe such medication (e.g., taking on a locum tenens position).

Q: Can medical residents have their own MAPS account?

A: According to the Michigan Department of Licensing and Regulatory Affairs, medical residents are allowed to have their own MAPS accounts under the role of "medical resident."

Q: How does the state know when MAPS has been queried? (e.g., one physician on a medical staff runs the MAPS for another physician writing a prescription on the same medical staff under their own MAPS login it may appear in the system that the physician writing the prescription did not run a MAPS report before prescribing even though they did review that report.)

A: The legislation doesn't provide specifics as to how it will be enforced. However, should there be a suspected violation of the Public Health Code and an allegation made, the law already provides the Department with the ability to investigate allegations.

Therefore, prescribers will either need software that can provide an audit trail (which the Department is making available via the NarxCare risk tool when facilities and/or practices integrate their electronic health records with MAPS) or they will need to ensure that their MAPS reports are filed in the appropriate patients' medical records. Additionally, MSMS Legal Counsel recommends placing a copy of the MAPS report in the patient's medical record as a recommended best practice should one need to prove this step was taken during litigation. If the prescribing physician did not pull the report from MAPS he/she should indicate on the report that it was reviewed, the date and the notation should be initialed.

Opioid Legislation FAQs continue on next page ►

MAPS Related – *continued*

Q: How close to the time prescription is written does the MAPS check need to occur? For example, if the practice or facility runs a batch MAPS check on Thursday night before a planned Friday appointment, does that count? What if the appointment is rescheduled to a later date?

A: The law does not provide this type of timing requirement. The best practice would be to obtain the MAPS report soon before the prescription is written to make sure the prescriber is aware of all the information (within the previous 24 hours should be reasonable). If an appointment is rescheduled the MAPS report should be obtained a second time.

Q: Can MAPS reports be scanned into our electronic medical record?

A: Yes.

Q: Who must check MAPS? What if the MAPS report is obtained by the prescriber's delegate?

A: Beginning June 1, 2018 the law requires that a prescriber of controlled substances “obtain and review” a MAPS report. The law does not prohibit a prescribing physician’s delegate from pulling a report for him/her. The best practice is for the prescribing physician to indicate on the report (which should be kept in the medical record) the date that it was reviewed and to initial.

Q: Is there a requirement to run a MAPS report at admission or presentation to the emergency department?

A: No. The legislation ties the mandatory MAPs check to the prescribing or dispensing of controlled substances.

Beginning June 1, 2018, a MAPS report must be pulled prior to prescribing or dispensing any Schedule 2-5 controlled substance (regardless of whether it is an opioid) that is written for more than a 3-day supply. The mandatory check does not apply if the drug is dispensed AND administered in a hospital or free-standing surgical outpatient facility.

Physicians and other prescribers prescribing controlled substances must be registered with MAPS to continue that prescribing on and after June 1, 2018. Also, beginning March 31, 2018, there must be a “bona fide prescriber-patient relationship” in order to prescribe a controlled substance.

Q: What if MAPS is down or the internet in the office is interrupted?

A: The law does not address this situation nor does it provide an exception from the requirement that a prescriber obtain and review a MAPS report applicable when MAPS is down or a prescriber does not have access to the internet.

Informed Consent

Q: When is informed consent required?

A: There are two instances in which written informed consent is required effective June 1, 2018. In both instances, the consent forms are required to be included in the patient’s medical record.

“Before issuing for a minor the first prescription in a single course of treatment for a controlled substance containing an opioid, regardless of whether the prescriber modifies the dosage during the course of treatment.” A “Start Talking Consent Form” is required to be signed acknowledging the receipt and discussion of specified information.

Before a controlled substance that is an opioid is prescribed to a patient. Patients need to sign a form that is to be “prescribed” by the Michigan Department of Health and Human Services acknowledging that he/she received information regarding the danger of opioid addiction, how to properly dispose of unused controlled substances, the fact that the delivery of a controlled substance is a felony under MI law, and the short- and long-term effects of exposing a fetus to a controlled substance (if the patient is pregnant or a female of reproductive age).

Opioid Legislation FAQs continue on next page ►

Informed Consent – *continued*

Q: Do I need to obtain informed consent each time I prescribe an opioid? Does this include for refills?

A: Yes, to both questions, based on the current language in the legislation that was passed. If the legislation is changed or contrary guidance is issued MSMS will communicate that information to members.

Q: What about prescriptions for a narcotic that are written following surgery or if the patient has uncontrolled pain when he/she returns home?

A: If the narcotic is dispensed and administered in a hospital or freestanding surgical outpatient facility the requirement that a MAPS report be obtained and reviewed does not apply. Once the patient leaves the hospital or freestanding surgical outpatient facility or if the narcotic is dispensed but not administered prior to the patient leaving then all requirements (pulling a MAPS report, consent etc.) must be complied with by the prescriber.

Q: How often must information regarding the dangers of opioids, etc. be provided? Once? Annually? Every opioid prescription? Even if a refill?

A: Until the law is clarified or authoritative guidance is issued, the best practice would be to do so each time an opioid prescription is given, even a refill.

Q: How exactly do I obtain acknowledgment that patients received the information about the dangers of opioids?

A: The law requires that following your providing the information on the dangers of opioids to a patient you must obtain the patients signature on a form (prescribed by the Michigan Department of Health and Human Services) indication that the patient received the information. This signed form is to be included in the patient's medical record.

Q: What if the patient is unable to consent due to developmental delay, dementia, etc.? If the patient is not able to consent, can prescriptions for injuries like a fracture be provided without a family or guardian present?

A: Only in the case of an emergency or if another exception applies.

Q: Where can I find the required informed consent forms and where should they be stored and for how long?

A: MSMS Legal Counsel has drafted a Start Talking Consent Form that is available at <http://MSMS.org/BeAWARE>. The other form, which the law requires the Michigan Department of Health and Human Services to create, is not yet available. According to the MDHHS, they are considering merging both the minor consent ("start talking consent form") and the patient information consent requirements into a single document. MDHHS is hopeful that the required form or forms will be available electronically on their website by April or May, well before the June 1 effective date.

Q: Can I delegate obtaining informed consent to another health professional?

A: According to the Department of Licensing and Regulatory Affairs Agency's Bureau of Professional Licensing, a prescriber could potentially delegate the responsibility of obtaining informed consent to another health professional in accordance with existing law (MCL 333.16215).

Bona Fide Prescriber-Patient Relationship

Q: What is a bona-fide prescriber-patient relationship?

A: A bona-fide prescriber-patient relationship means a treatment or counseling relationship between a prescriber and a patient in which both of the following are present:

- (1) The prescriber has reviewed the patient's relevant medical or clinical records and completed a full assessment of the patient's medical history and current medical condition, including a relevant medical evaluation of the patient conducted in person or through telehealth.
- (2) The prescriber has created and maintained records of the patient's condition in accordance with medical accepted standards.

Q: Is an in-person patient encounter required to establish a bona-fide prescriber-patient relationship?

A: No. The medical evaluation required to establish a bona-fide prescriber-patient relationship may be conducted either in-person or via telehealth, as defined in the Public Health Code.

Q: Does telehealth include just an audio connection and/or conversation over the telephone? And, how does one satisfy the requirements of a bona fide prescriber-patient relationship in that case?

A: The requirement that a bona fide prescriber-patient relationship exist includes "a patient evaluation in person or by telehealth". Telehealth includes the use of electronic means (telephone, video conferencing, etc.). Whether and under what circumstances a telephone conversation alone will be a sufficient to satisfy the evaluation part of the requirement will be determined on a case by case basis in the first instance by the prescriber and later, when necessary, by those reviewing the prescribing in a licensing action or otherwise.

Q: If the same provider is seeing the same patient do they have to re-establish the bona-fide patient relationship each time they prescribe controlled substances?

A: According LARA, if the same health professional (i.e., doctor) is seeing the same patient, the bona-fide patient-prescriber relationship would have already been established.

Q: Is a covering physician considered a part of the "bona fide" prescriber-patient relationship?

A: A "covering physician" must comply with the statute to be considered to be in a "bona fide" prescriber-patient relationship (i.e. reviewed the patient's records, evaluated, added evidence of this as well as the prescription to the medical record, etc). Pursuant to MCL 333.16204e, the Department of Licensing and Regulatory Affairs (LARA) is permitted to promulgate rules identifying exceptions to the bona fide prescriber-patient relationship and/or alternative requirements when such relationship is not required by the promulgated rules. With the passage of Public Act 101 of 2018, extending the effective date of this requirement to March 31, 2019, or upon the promulgation of rules, LARA is moving forward with the promulgation of rules to address issues of covering physicians, delegation, transitions of care, etc.

Q: My colleagues and I work as a group of pain physicians at a pain center, renewing prescriptions for each other's patients. If I write an opioid prescription for my colleague's patient on a day my colleague is not in the clinic, is that a new opioid prescription for the patient? Will I have a bona-fide physician-patient relationship with that patient if I do not see the patient?

A: Beginning on June 1, 2018 before any prescription of a controlled substance that is an opioid you must both obtain and review a MAPS report and provide the information on the dangers of opioid addiction (and obtain the patients signature on the consent form to be kept in the medical record).

A bona fide prescriber-patient relationship may exist in the absence of an in-person visit. The law provides that the patient's medical evaluation may be done in-person or via telehealth (as described in MCL 333.16283).

Opioid Legislation FAQs continue on next page ►

Bona Fide Prescriber-Patient Relationship – *continued*

Q: Is there a definition of bona fide as it pertains to shared practices? What steps should be taken if a patient of a partner calls in for a prescription refill when another partner in the practice is on call coverage?

A: No. There is only one definition of “bona fide prescriber-patient relationship”. In all cases it requires both: (1) a review of the patient’s relevant medical or clinical records and a full assessment of the patient’s medical history and current medical condition including a medical evaluation of the patient performed in person or via telehealth (as defined in MCL 333.16283) and (2) the creation and maintenance of a medical record.

Q: Can I still prescribe controlled substances through telemedicine?

A: Yes, provided that you establish a prescriber-patient relationship prior to prescribing any controlled substances and comply with all other applicable state and federal laws for prescribing controlled substances.

It is important to keep in mind that notwithstanding Michigan law, which does not require an in-person encounter to prescribe controlled substances, federal law prohibits the prescribing of controlled substances on the basis of a telemedicine encounter unless the prescribing physician has conducted at least one (1) in-person medical evaluation of the patient, subject to limited exceptions that will not be available to most physicians and other prescribers. An “in-person medical evaluation” means a medical evaluation that is conducted with the patient in the physical presence of the practitioner, without regard to whether portions of the evaluation are conducted by other health professionals. Even if the minimum one (1) in-person encounter requirement is satisfied, the prescription must be issued for a legitimate medical purpose in the usual course of the prescriber’s professional practice, which are longstanding legal

requirements applicable to all prescriptions for controlled substances. Federal law provides that nothing is construed to imply or suggest that a one (1) in-person medical evaluation demonstrates compliance with these standards; i.e., all of the facts and circumstances surrounding the issuance of the prescription must be evaluated. Prescribers who fail to comply with the in-person medical evaluation requirement, and any pharmacy that knowingly or intentionally fills such a prescription, violated the Controlled Substances Act.

Prescribing to a Minor

Q. What is the age of majority?

A. In Michigan, the age of majority is 18.

Q. Are there special requirements for obtaining informed consent when prescribing opioids for minors?

A: Yes. “Before issuing for a minor the first prescription in a single course of treatment for a controlled substance containing an opioid, regardless of whether the prescriber modifies the dosage during the course of treatment.” A “Start Talking Consent Form” is required to be signed acknowledging the receipt and discussion of specified information. The start talking consent form must contain all of the following information:

- (1) The name and quantity of the controlled substance being prescribed for the minor and the amount of the initial dose;
- (2) A statement indicating that a controlled substance is a drug or other substance that the United States Drug Enforcement Administration has identified as having a potential for abuse;
- (3) A statement certifying that the prescriber discussed with the minor, and with the minor’s parent or guardian or with another adult authorized to consent to the minor’s medical treatment the required topics of discussion;
- (4) the number of refills, if any, that are authorized by the prescription; and
- (5) A space for the signature of the minor’s parent or guardian, or the signature of another adult authorized to consent to the minor’s medical treatment, and a space to indicate the date that the minor’s parent or guardian, or another adult authorized to consent to the minor’s medical treatment, signed the form.

Opioid Legislation FAQs continue on next page ►

Prescribing to a Minor – *continued*

Q. What is meant by “single course of treatment?”

A. This is not defined in Michigan’s Public Health Code. Presumably this would mean a continual treatment of a single injury or condition. We have requested that LARA clarify their interpretation of “single course of treatment” in their FAQ document that is under development.

Q. What are the exceptions to the new requirements for issuing the first prescription of controlled substances containing an opioid to minors?

A. First, the requirements apply only to prescriptions for controlled substances that contain an opioid. The requirements do not apply to other schedule 2 to 5 controlled substances that do not contain an opioid. Second, the requirements do not apply in any of the following circumstances:

- (1) If the minor’s treatment is associated with or incident to a medical emergency;
- (2) If the minor’s treatment is associated with or incident to a surgery, regardless of whether the surgery is performed on an inpatient or outpatient basis;
- (3) If, in the prescriber’s professional judgment, fulfilling the requirements would be detrimental to the minor’s health or safety;
- (4) If the minor’s treatment is rendered in a hospice or an oncology department of a hospital.
- (5) If the prescriber is issuing the prescription for the minor at the time of discharge from a hospice or oncology department of a hospital; or
- (6) If the consent of the minor’s parent or guardian is not legally required for the minor to obtain treatment.

However, even if the requirements do not apply, and unless the controlled substance is prescribed for in-patient, the prescriber must still provide the minor patient or his or her parent, guardian or representative the following information:

- (i) The danger of opioid addiction
- (ii) How to properly dispose of an expired, unused or unwanted controlled substance
- (iii) That the delivery of a controlled substance is a felony

under Michigan law.

- (iv) If the patient is pregnant or is a female of reproductive age, the short- and long-term effects of exposing a fetus to a controlled substance, including, but not limited to, neonatal abstinence syndrome.

Q. Will the state provide a “Start Talking Consent Form”?

A. Yes, the state is creating this form. We expect that it will be available from the MDHHS website in May 2018. MSMS Legal Counsel has also drafted a form that meets the Act’s requirements. It is available at <http://MSMS.org/BeAWARE>.

Q. My office’s informed consent form for minors already includes the information required in the start talking consent form. Does that satisfy the requirements?

A. No. The start talking consent form must be on a form that is separate from any other document that a prescriber uses to obtain the informed consent for the treatment of a minor.

Prescribing Restrictions

Q: Are there limits on how much pain medication can be prescribed?

A: Beginning July 1, 2018, if prescribing an opioid for “acute pain,” the prescription cannot be written for more than a 7-day supply within a 7-day period. “Acute pain” is defined in the legislation as “pain that is the normal, predicted physiological response to a noxious chemical or a thermal or mechanical stimulus and is typically associated with invasive procedures, trauma, and disease and usually lasts for a limited amount of time.”

Q: If my patients are taking medication for chronic pain do any limits apply?

A: Under the new laws, the supply limits only apply to “acute pain.” See definition above. However, prescribers and patients should check with patients’ insurance plans as payers are implementing their own supply limits.

Opioid Legislation FAQs continue on next page ►

Q: What defines the total number of days for a prescription? For example, what if a prescription is written PRN or with a range of dosing (e.g., 1-2 tablets every 4 hours)?

A: If your prescription will result in the dispensing of more than a 3-day supply you should comply with the requirements of the new law even though it is possible that the patient may not actually take the drug for more than 3 days.

Q: When a physician prescribes a 7-day supply when treating a patient for acute pain, after the 7-day limit expires, does the patient need to return to the physician's office for a visit to obtain another prescription or can a prescription be filled remotely (phone/e-prescribe)?

A: The "bona fide prescriber-patient relationship" must continue to exist. This may require an in person evaluation of the patient.

General Questions

Q: How does the new legislation affect delegated prescribing of controlled substances?

A: Physicians are ultimately responsible for complying with all applicable laws and regulations affecting the prescribing of controlled substances under their delegated authority. Physicians should ensure that their delegates understand and comply with all applicable laws and regulations when prescribing controlled substances under delegated authority. Physicians may wish to review and update their agreements with physician's assistants and/or APRNs as necessary to incorporate the new legislation and any protocols developed by the physician's practice in furtherance of complying with the new legislation.

Q: If a prescriber elects to issue up to a 90-day supply of a controlled substance via three separate prescriptions with written instructions on each prescription (other than the first prescription, if the prescriber intends for that prescription to be filled immediately) indicating the earliest date on which

a pharmacy may fill each prescription, will the MAPS check performed at that appointment be sufficient for all three prescriptions or will they have to check MAPS for the subsequent two prescriptions at the later dates?

A: As we read MCL §333.7303a of the Public Health Code, as amended, if a patient is provided multiple 30-day prescriptions of a controlled substance at a single appointment, the prescriber must obtain and review the MAPS report prior to issuing the prescriptions at that appointment. As we read the statute, the prescriber does not need to review the MAPS report prior to each prescription being filled. The date of the prescription will be key to when the prescriber must obtain and review the MAPS report. Pursuant to MCL §333.7333(7), a prescriber may not postdate a prescription for a controlled substance, but may indicate the earliest date that each prescription may be filled. If the prescriptions each have the same date of issuance and relate to the same appointment,

Opioid Legislation FAQs continue on next page ►

General Questions – continued

only one MAPS report is needed, even if the prescriptions are intended to be filled on different dates. If the prescriber issues one prescription at a time (i.e., different dates of issuance), the prescriber must obtain and review a MAPS report prior to issuing each prescription.

Q: Will prescribers still be allowed to issue multiple prescriptions for Schedule 2 controlled substances in a manner consistent with policy guidance from the U.S. Drug Enforcement Agency?

A: With respect to whether a prescriber may continue to issue multiple prescriptions for schedule II controlled substances consistent with the DEA guidelines, MCL §333.7333 of the Public Health Code continues to permit a practitioner to issue more than one prescription for a schedule II controlled substance. The one caveat is the treatment of a patient for “acute pain” pursuant to MCL §333.7333b. Per this statute, beginning July 1, 2018, a prescriber treating a patient for “acute pain” may not prescribe the patient more than a 7-day supply of an opioid within a 7-day period. “Acute pain” is defined by the statute to mean “pain that is the normal, predicted physiological response to a noxious chemical or a thermal or mechanical stimulus and is typically associated with invasive procedures, trauma, and disease and usually lasts for a limited amount of time.” This requirement will limit a prescriber’s authority to prescribe opioids to the fullest extent permitted by the DEA guidelines.

Q: How does the law apply when cough and cold medicines containing opioid ingredients are prescribed?

A: The law does not carve out situations involving the prescribing of cough and cold medicines containing opioid ingredients. Therefore, they are subject to the same requirements as any Schedule 2-5 controlled substance and any requirement specific to the prescribing of opioids such as informed consent and the 7-day limit for acute pain.

Q: Where do ADHD stimulants fall under this new law?

A: You will have to determine for each drug whether it is listed as a controlled substance on Schedules 2 through 5.

Q: How is an opioid defined?

A: “Opioid drugs” is defined in Michigan Administrative Code Rule 418.10109(i) as “opiate analgesics, narcotic analgesics, or any other Schedule C (II-III) controlled substance as identified in United States Code Controlled Substances Act of 1970, 21. U.S.C. §812. Opioid analgesics are the class of drugs, such as morphine, codeine, and methadone, that have the primary indication for the relief of pain.”

Q: What information exactly is required for me to provide to my patients about the dangers of opioids?

A: The specific information is not included in the new law. It may be included on the consent form to be developed and provided by the Michigan Department of Health and Human Services or in other clarification of the law or guidance to be issued. The Centers for Disease Control and Prevention website, www.cdc.gov, has excellent information and materials on the use and dangers of opioids.

Q: What is considered a “medical emergency” that allows exceptions to the requirement for informed consent? For example, would the treatment of an acute fracture or an acute musculo-skeletal injury be considered a “medical emergency?”

A: Only the new requirements applicable to minors contain an exception for a medical emergency. This law defines “Medical Emergency” as a situation that, in the prescriber’s good-faith medical judgement, creates an immediate threat of serious risk to the life or physical health of the minor.

Q: Would the repair of an acute laceration or removal of a foreign body embedded in soft tissue or cornea be considered “a surgery?”

A: Yes.

Opioid Legislation FAQs continue on next page ►

General Questions – continued

Q: Are there any new documentation needs (e.g., discharge summary, notes, informed consent, etc.)?

A: Consent forms (mandated) and MAPS reports (recommended) will need to be included in patients' medical records. Additionally, in order to meet the definition of a bona fide prescriber-patient relationship, the prescriber must review the patient's relevant records, complete a full assessment of the patient's medical history and current medical condition, and properly document information about the patient's condition.

Q: Any specific plans by MSMS to have a 'toolkit' for physicians to prepare them for the upcoming changes?

A: MSMS staff and Legal Counsel are currently working on resources to assist physicians in successfully complying with the upcoming statutory requirements. Currently, an overview of the bills that impact physician prescribing FAQs, and information on how to register for MAPS and to apply for MAPS-EHR integration are available. Other resources to come include but are not limited to best practices and template forms.

Q: Any new training needs identified? Plans for assessing the training needs?

A: There are always opportunities to enhance one's knowledge on various topics and opioid stewardship is no exception. Training will be needed on the recently passed legislation, MAPS utilization, safe opioid prescribing, recognizing signs of addiction, best practices for treating and when to refer, MAT, etc.

MSMS currently has available the following on-demand webinars: Pain and Opioid Management, The CDC Guidelines, Treatment of Opioid Dependence, The Role of the Laboratory in Toxicology and Drug Testing, and Michigan Automated Prescription System (MAPS) Update. Additionally, there will be several in-person education sessions available in 2018.

Q: Any plans by to require new education and/or practice proof for maintaining licensure?

A: Currently, physicians are required to earn three hours of pain

and symptom management CME during their licensure renewal cycle. This requirement took effect in December 2017 and counts toward the overall 150 hours that are required.

The Michigan Board of Medicine has been discussing the possibility of adding a requirement for opioid specific CME.

Q: Do the new laws apply to nursing home patients or hospice patients?

A: The way the legislation was written, it assigns most of the responsibilities to licensed prescribers and dispensing prescribers. In a few instances, exceptions are provided based on where the prescribing or dispensing is occurring.

For purposes of the mandatory MAPS check for controlled substances in a quantity that exceeds three days, there is an exception if the dispensing occurs in licensed hospital or freestanding surgical center and is administered to the patient on-site. However, the language does not provide for such an exception when the dispensing and administration occurs in a nursing homes or hospice.

In regards to the informed consent that must be obtained when prescribing an opioid to a minor, one of the exceptions provided is "if the minor's treatment is rendered in a hospice or oncology department of a hospital or if the prescription is issued at the time of discharge from one of those facilities."

The informed consent requirements for other patients prescribed opioids applies unless the opioid is prescribed for "inpatient use."

In regards to the MAPS reporting requirement when dispensing a controlled substance to a patient, nursing homes and hospices, as well as other health facilities and agencies licensed under Article 17 of the Public Health Code, will continue to be exempt from that requirement when the "controlled substance is dispensed by a dispensing prescriber in a quantity adequate to treat the patient for not more than 48 hours." The exemption for hospitals will no longer include the quantity restriction of 48 hours.

Opioid Legislation FAQs continue on next page ►

General Questions – continued

Q: Do the new requirements impact surgeries performed at health care facilities including free-standing surgical outpatient facilities when fentanyl is given during anesthesia (via IV at induction or during the procedure for pain management)?

A: No. There are exceptions to the query and consent requirements for when controlled substances are dispensed and administered in a hospital or freestanding surgical outpatient facility, in connection with an inpatient or outpatient surgery of when for inpatient use.

Q: Are there exceptions applicable when the prescribing or dispensing occurs in either a long-term care facility or a short-stay rehabilitation facility?

A: No. With the exception of hospitals and freestanding surgical outpatient facilities, noted above, it does not matter where the prescribing is done. All the requirements apply to prescribing in a long-term care facility or a short-stay rehabilitation facility.

Q: Often times patients on maintenance medications will phone-in for a refill, how does the legislation affect this long-standing practice?

A: There must be a “bona fide prescriber-patient relationship” at the time of each prescription for a controlled substance listed in schedules 2-5. This requires a review of the patient’s medical records, a full assessment of the patient’s medical history and an evaluation of the patient in person or by telehealth. The best practice would be to initial and date a note in the medical record that you reviewed it and the medical history and how you conducted the evaluation of the patient. According to LARA, once the bona-fide patient-prescriber relationship is established, it is ongoing between that specific prescriber and that specific patient (See related FAQ under Bona Fide Prescriber-Patient Relationship).

Because the law makes no distinction between an initial prescription and a refill, each time a refill is requested you will also have to (a) provide the required information (if refilling an opioid), (b) obtain the patient’s signature on the required consent form (if refilling an opioid); (c) if the prescription is an opioid and is for “acute pain” limit the prescription to a 7-day supply in a 7-day period, and (d) query MAPS if prescribing more than a 3- day supply. Until this is clarified in the law or some guidance is issued, you will no longer be able to renew a prescription without meeting these requirements.

Q: What steps must a physician take when prescribing medication upon discharge of a patient to an extended care facility? Is there additional paperwork that needs to be completed to comply with the law?

A: (1) If prescribing a controlled substance in more than a 3 day supply you must query MAPS; (2) if the patient is a minor and the prescription is for a controlled substance containing an opioid and is the first in a single course of treatment you must have the required discussion with the patient, and his/ her guardian or other adult authorized to consent to the minor’s treatment, obtain the required signature on the “Start Talking Consent Form;” (3) if the prescription is for a controlled substance containing an opioid, whether the patient is a minor or not, provide the required information and obtain the required signature on the consent form provided by the MDHHS; (4) if the prescription is for “acute pain” limit the prescription to a 7 day supply within a 7 day period. ♦

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ABOUT OPIOID ADDICTION



PRESCRIBING CHECKLIST FOR CONTROLLED SUBSTANCES



GREATER FLINT HEALTH COALITION



KnowMoreGenesee.org

Prescribing Checklist for Controlled Substances

Updated January 2019

BEFORE PRESCRIBING	WHILE PRESCRIBING	AFTER PRESCRIBING
<ul style="list-style-type: none"> <input type="checkbox"/> Obtain a valid Michigan Controlled Substance License (physicians and physician assistants). <input type="checkbox"/> Obtain a valid DEA Registration (All health professionals). <input type="checkbox"/> If dispensing controlled substance, obtain a valid Michigan Drug Control License (unless exception applies, e.g., dispensing within emergency department, etc.). <input type="checkbox"/> Register with MAPS. <input type="checkbox"/> If delegating prescribing authority to an eligible APRN, execute a collaborative agreement or other written authorization; written practice agreement if a physician's assistant will be prescribing. <input type="checkbox"/> Have a bona fide prescriber-patient relationship (unless an exception applies¹) <input type="checkbox"/> Conduct at least one in-person medical examination if prescribing through the Internet as required by federal law². <input type="checkbox"/> Ask the patient about other controlled substances the patient may be using. Record the patient's response in the patient's medical record. <input type="checkbox"/> If prescribing buprenorphine or a drug containing buprenorphine or methadone to a patient in a substance abuse disorder program, obtain and review the patient's MAPS report. <input type="checkbox"/> Obtain and review patient's MAPS report if prescribing a quantity that exceeds a 3-day supply, unless dispensing and administering to patient within hospital or freestanding surgical outpatient facility. <input type="checkbox"/> If prescribing an opioid, provide the patient with statutorily required information (e.g., dangers of opioid addiction, etc.) and obtain signed acknowledgment on the MDHHS Opioid Start Talking form³ and include the signed form in the patient's medical record. <input type="checkbox"/> If prescribing opioid to a minor, discuss additional statutorily required information (e.g., risks of addiction and overdose associated with a controlled substance, etc.) with the minor and the minor's parent, guardian or another adult authorized to consent to the minor's medical treatment, and obtain the signature of the minor's parent, guardian or authorized adult on a start talking consent form.³ Include the signed form in the minor patient's medical record. 	<p>1</p> <p>If prescribing an opioid to a minor and the start talking consent form is signed by another adult authorized to consent to the minor's medical treatment, must limit prescription to no more than 72-hour supply.</p> <p>2</p> <p>If treating a patient for acute pain, must not prescribe patient more than a 7-day supply of an opioid within a 7-day period.</p> <p>3</p> <p>A physician may not authorize an APRN to issue a prescription for a schedule 2 controlled substance with a quantity greater than a 30 day supply.</p> <p>4</p> <p>Comply with all applicable state and federal laws regarding contents and transmission of prescription.</p>	<p>1</p> <p>If dispensing controlled substances, MAPS reporting is required unless an exception applies (e.g., dispensing to inpatient at hospital, etc.).</p> <p>2</p> <p>If prescribing a controlled substance, provide follow-up care to patient (e.g., schedule a follow-up appointment) or refer patient to his or her primary care provider or another geographically accessible provider if the patient does not have a primary care provider for such follow-up care.</p> <div style="text-align: right;">  </div>

1. Michigan Administrative Code Rule 338-3161a.

2. Federal law requires an in-person medical examination before prescribing a controlled substance by means of the Internet. Notwithstanding, federal guidance suggests that the lack of an in-person medical examination before prescribing a controlled substance (even by written prescription) raises a "red flag" for potential diversion. MSMS recommends that non-covering practitioners perform at least one in-person medical examination on a non-covering practitioner regardless of the means of prescribing (e.g., e-prescribing or written prescription).

3. MDHHS has combined these requirements into one form which is available at msms.org/BeAWARE.

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ABOUT OPIOID ADDICTION



PRESCRIBING GUIDELINES: ACUTE CARE



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Opioid Prescribing Recommendations for Opioid-naïve Patients

Prescribing Recommendations UPDATED 2019

Procedure	Oxycodone* 5mg tablets	Procedure	Oxycodone* 5mg tablets
Laparoscopic Cholecystectomy	10	Hysterectomy – Vaginal, Lap/Robotic, or Abdominal	15
Open Cholecystectomy	15	Cesarean Section	15
Appendectomy – Lap or Open	10	Breast Biopsy or Lumpectomy	5
Hernia Repair – Major or Minor	10	Lumpectomy + Sentinel Lymph Node Biopsy	5
Colectomy – Lap or Open	15	Sentinel Lymph Node Biopsy Only	5
Ileostomy/Colostomy Creation, Re-siting, or Closure	15	Wide Local Excision ± Sentinel Lymph Node Biopsy	20
Open Small Bowel Resection or Enterolysis	20	Simple Mastectomy ± Sentinel Lymph Node Biopsy	20
Thyroidectomy	5	Modified Radical Mastectomy or Axillary Lymph Node Dissection	30
Sleeve Gastrectomy	10	Carotid Endarterectomy	10
Prostatectomy	10	Total Hip Arthroplasty	30
Laparoscopic Anti-reflux (Nissen)	10	Total Knee Arthroplasty	50
Laparoscopic Donor Nephrectomy	10	Dental	0
Cardiac Surgery via Median Sternotomy	15		

*The recommendations remain the same if prescribing hydrocodone 5mg.

Recommendations were based on patient-reported data from MSQC and published studies. Recommended amounts meet or exceed self-reported use of 75% of patients. Previous studies have shown that when patients are prescribed fewer pills, they consume fewer pills with no changes in pain or satisfaction scores. Many patients use 0-5 pills. Recommendations are for patients with no preoperative opioid use. For patients taking opioids preoperatively, prescribers are encouraged to use their best judgment.

These recommendations will be updated frequently with new data.

Find up-to-date recommendations, and patient education materials at: opioidprescribing.info

Recommendations were last updated on 1/14/2019. See opioidprescribing.info for more info.

Acute Care Opioid Treatment and Prescribing Recommendations:

Summary of Selected Best Practices

These recommendations are to be used as a clinical tool, but they do not replace clinician judgment.

Surgical Department

Preoperative Counseling:
For patients not using
opioids before surgery

- Discuss the expectations regarding recovery and pain management goals with the patient.
- Educate the patient regarding safe opioid use, storage, and disposal.
- Determine the patient's current medications (e.g., sleep aids, benzodiazepines), and any high-risk behaviors or diagnosis (e.g., substance use disorder, depression, or anxiety).
- Do NOT provide opioid prescription, for postoperative use, prior to surgery date.

Intraoperative

- Consider nerve block, local anesthetic catheter or an epidural when appropriate.
- Consider non-opioid medications when appropriate (e.g., ketorolac).

Postoperative

- Meperidine (Demerol) should NOT be used for outpatient surgeries.
- If opioids are deemed appropriate therapy, oral is preferred over IV route.
- Ensure all nursing, ancillary staff and written discharge instructions communicate consistent messaging regarding functional pain management goals.

For patients discharged
from surgical department
with an opioid prescription

- The prescription drug monitoring program (PDMP) must be accessed prior to prescribing controlled substances schedules 2-5, in compliance with Michigan law.
- Non-opioid therapies should be encouraged as a primary treatment for pain management (e.g., acetaminophen, ibuprofen).
- Non-pharmacologic therapies should be encouraged (e.g., ice, elevation, physical therapy).
- Do NOT prescribe opioids with other sedative medications (e.g., benzodiazepines).
- Short-acting opioids should be prescribed for no more than 3-5 day courses (e.g., hydrocodone, oxycodone).
- Fentanyl or Long-acting opioids such as methadone, OxyContin and should NOT be prescribed to opioid naïve patients.
- Consider offering a naloxone co-prescription to patients who may be at increased risk for overdose, including those with a history of overdose, a substance use disorder, those already prescribed benzodiazepines, and patients who are receiving higher doses of opioids (e.g., >50 MME/Day).
- Educate patient and parent/guardian (for minors) regarding safe use of opioids, potential side effects, overdose risks, and developing dependence or addiction.
- Educate patient on tapering of opioids as surgical pain resolves.
- Refer to opioidprescribing.info for free prescribing recommendations for many types of surgeries.
- Refer and provide resources for patients who have or are suspected to have a substance use disorder.

Acute Care Opioid Treatment and Prescribing Recommendations:

Summary of Selected Best Practices

These recommendations are to be used as a clinical tool, but they do not replace clinician judgment.

Emergency Department (ED)

For patients presenting with acute exacerbation of chronic non-cancer pain

- Non-opioid therapies should be used as first line therapy.
- Lost or stolen prescriptions should not be replaced.
- The prescription drug monitoring program (PDMP) must be accessed prior to prescribing controlled substances schedules 2-5, in compliance with Michigan law.
- Consider care coordination and/or effective ED-based Screening, Brief Intervention, and Referral to Treatment (SBIRT) with patients that have suspected risky opioid use or frequent ED visits.

For patients in methadone maintenance programs

- Replacement methadone should NOT be provided in the Emergency Department (ED).

For patients presenting with acute painful conditions

- Non-opioid therapies (e.g., acetaminophen, ketorolac) are encouraged as primary or adjunctive treatments.
- Non-pharmacologic therapies (e.g., ice, splinting) should be utilized.
- The prescription drug monitoring program (PDMP) must be accessed prior to prescribing opioids, in compliance with Michigan law.
- Meperidine (Demerol) should not be used.

For patients discharged from the ED with an opioid prescription for acute pain

- Long-acting opioids (e.g., fentanyl, methadone, OxyContin) should NOT be prescribed.
- Short-acting opioids (e.g., hydrocodone, oxycodone) should be prescribed for no more than three-day courses.
- Do not prescribe opioids with benzodiazepines and other sedatives.
- Information should be provided about opioid side effects, overdose risks, potential for developing dependence or addiction, avoiding sharing and non-medical use, and safe storage and disposal.
- Consider offering a naloxone co-prescriptions to patients who may be at an increased risk for overdose, including those with a history of overdose, a substance use disorder, those already prescribed benzodiazepines, and patients who are receiving a higher doses of opioids (e.g., >50 MME/day).
- Refer and provide resources for patients who have or are suspected to have a substance use disorder.

Acute Care Opioid Treatment and Prescribing Recommendations:

Summary of Selected Best Practices

These recommendations are to be used as a clinical tool, but they do not replace clinician judgment.

Dental

Pre-Procedure

- Opioid prescriptions should not be written prior to completing a dental procedure.
- Communicate a conservative philosophy by emphasizing the efficacy and appropriateness of over the counter medications' analgesic properties.
- Address dental pain through clinical intervention rather than opioid pain relief.
- Refer patients to a free or low-cost dental program in the absence of insurance or financial constraints.

Prescribing

- The prescription drug monitoring program (PDMP) must be accessed prior to prescribing controlled substances schedules 2-5, in compliance with Michigan law.
- Conduct full dental and medical history of the patient and include analysis of current medications.
- Identify any high-risk behaviors or diagnoses (previous substance use disorders, alcohol or tobacco use, psychiatric comorbidities including depression or anxiety).
- Non-opioid therapies (e.g., acetaminophen, ibuprofen) should be encouraged as the primary treatment.
- Non-pharmacologic therapies (e.g., acupuncture, mindful practice) should be encouraged when the patient is open to these alternative solutions to pain control.
- For breakthrough or severe pain, short-acting opioids (e.g., hydrocodone, oxycodone) should be prescribed at the lowest effective dose for no more than 3-5 day courses.
- Do not co-prescribe opioids with other sedatives or CNS depressant medications (e.g., benzodiazepines).
- Consider offering a naloxone co-prescription to patients who may be at increased risk for overdose, including those with a history of overdose, a substance use disorder, those already prescribed benzodiazepines, and patients who are receiving higher doses of opioids (e.g., >50 MME/Day).

For patients discharged with an opioid prescription

- Discuss the expectations regarding recovery and pain management goals with the patient.
- Educate patient and parent/guardian (for minors) regarding safe use of opioids, potential side effects, overdose risks, and developing dependence or addiction as required by Michigan law.
- Emphasize not using opioids concomitantly with alcohol or other sedative medications (e.g., benzodiazepines).
- Educate patient on tapering of opioids as dental/oral pain resolves.
- Refer to Michigan-Open.org for additional patient resources.
- Refer and provide resources for patients who have or are suspected to have a substance use disorder.

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ABOUT OPIOID ADDICTION



PRESCRIBING GUIDELINES: CHRONIC PAIN



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GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

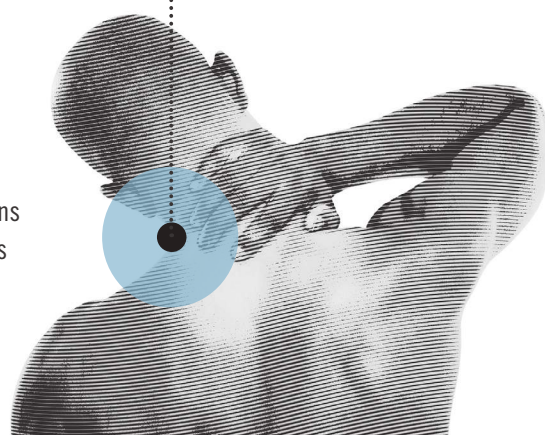
1 Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

2 Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3 Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CLINICAL REMINDERS

- Opioids are not first-line or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss benefits and risks and availability of nonopioid therapies with patient



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

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

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

CLINICAL REMINDERS

- **Use immediate-release opioids when starting**
- **Start low and go slow**
- **When opioids are needed for acute pain, prescribe no more than needed**
- **Do not prescribe ER/LA opioids for acute pain**
- **Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed**

4

When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

5

When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥ 50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥ 90 MME/day or carefully justify a decision to titrate dosage to ≥ 90 MME/day.

6

Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

7

Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.



ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

8

Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥ 50 MME/day), or concurrent benzodiazepine use, are present.

9

Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10

When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11

Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

12

Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

CLINICAL REMINDERS

- **Evaluate risk factors for opioid-related harms**
- **Check PDMP for high dosages and prescriptions from other providers**
- **Use urine drug testing to identify prescribed substances and undisclosed use**
- **Avoid concurrent benzodiazepine and opioid prescribing**
- **Arrange treatment for opioid use disorder if needed**

Checklist for prescribing opioids for chronic pain

For primary care providers treating adults (18+) with chronic pain ≥ 3 months, excluding cancer, palliative, and end-of-life care

CHECKLIST

When **CONSIDERING** long-term opioid therapy

- ☐ Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- ☐ Check that non-opioid therapies tried and optimized.
- ☐ Discuss benefits and risks (eg, addiction, overdose) with patient.
- ☐ Evaluate risk of harm or misuse.
 - Discuss risk factors with patient.
 - Check prescription drug monitoring program (PDMP) data.
 - Check urine drug screen.
- ☐ Set criteria for stopping or continuing opioids.
- ☐ Assess baseline pain and function (eg, PEG scale).
- ☐ Schedule initial reassessment within 1–4 weeks.
- ☐ Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

If **RENEWING** without patient visit

- ☐ Check that return visit is scheduled ≤ 3 months from last visit.

When **REASSESSING** at return visit

Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.

- ☐ Assess pain and function (eg, PEG); compare results to baseline.
- ☐ Evaluate risk of harm or misuse:
 - Observe patient for signs of over-sedation or overdose risk.
 - If yes: Taper dose.
 - Check PDMP.
 - Check for opioid use disorder if indicated (eg, difficulty controlling use).
 - If yes: Refer for treatment.
- ☐ Check that non-opioid therapies optimized.
- ☐ Determine whether to continue, adjust, taper, or stop opioids.
- ☐ Calculate opioid dosage morphine milligram equivalent (MME).
 - If ≥ 50 MME/day total (≥ 50 mg hydrocodone; ≥ 33 mg oxycodone), increase frequency of follow-up; consider offering naloxone.
 - Avoid ≥ 90 MME/day total (≥ 90 mg hydrocodone; ≥ 60 mg oxycodone), or carefully justify; consider specialist referral.
- ☐ Schedule reassessment at regular intervals (≤ 3 months).

REFERENCE

EVIDENCE ABOUT OPIOID THERAPY

- *Benefits of long-term opioid therapy for chronic pain not well supported by evidence.*
- *Short-term benefits small to moderate for pain; inconsistent for function.*
- *Insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.*

NON-OPIOID THERAPIES

Use alone or combined with opioids, as indicated:

- Non-opioid medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants).
- Physical treatments (eg, exercise therapy, weight loss).
- Behavioral treatment (eg, CBT).
- Procedures (eg, intra-articular corticosteroids).

EVALUATING RISK OF HARM OR MISUSE

Known risk factors include:

- Illegal drug use; prescription drug use for nonmedical reasons.
- History of substance use disorder or overdose.
- Mental health conditions (eg, depression, anxiety).
- Sleep-disordered breathing.
- Concurrent benzodiazepine use.

Urine drug testing: Check to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.

Prescription drug monitoring program (PDMP):

Check for opioids or benzodiazepines from other sources.

ASSESSING PAIN & FUNCTION USING PEG SCALE

PEG score = average 3 individual question scores (30% improvement from baseline is clinically meaningful)

Q1: What number from 0–10 best describes your **pain** in the past week?

0 = “no pain”, 10 = “worst you can imagine”

Q2: What number from 0–10 describes how, during the past week, pain has interfered with your **enjoyment of life**?

0 = “not at all”, 10 = “complete interference”

Q3: What number from 0–10 describes how, during the past week, pain has interfered with your **general activity**?

0 = “not at all”, 10 = “complete interference”



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

CS273808A

KNOW

MORE

ABOUT OPIOID ADDICTION



PRESCRIBING OPIOIDS: WHAT YOU NEED TO KNOW



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PRESCRIPTION OPIOIDS: WHAT YOU NEED TO KNOW

Prescription opioids can be used to help relieve moderate-to-severe pain and are often prescribed following a surgery or injury, or for certain health conditions. These medications can be an important part of treatment but also come with serious risks. It is important to work with your health care provider to make sure you are getting the safest, most effective care.

WHAT ARE THE RISKS AND SIDE EFFECTS OF OPIOID USE?

Prescription opioids carry serious risks of addiction and overdose, especially with prolonged use. An opioid overdose, often marked by slowed breathing, can cause sudden death. The use of prescription opioids can have a number of side effects as well, even when taken as directed:

- Tolerance—meaning you might need to take more of a medication for the same pain relief
- Physical dependence—meaning you have symptoms of withdrawal when a medication is stopped
- Increased sensitivity to pain
- Constipation
- Nausea, vomiting, and dry mouth
- Sleepiness and dizziness
- Confusion
- Depression
- Low levels of testosterone that can result in lower sex drive, energy, and strength
- Itching and sweating

As many as
1 in 4
PEOPLE*



receiving prescription opioids long term in a primary care setting struggles with addiction.

* Findings from one study

RISKS ARE GREATER WITH:

- History of drug misuse, substance use disorder, or overdose
- Mental health conditions (such as depression or anxiety)
- Sleep apnea
- Older age (65 years or older)
- Pregnancy

Avoid alcohol while taking prescription opioids. Also, unless specifically advised by your health care provider, medications to avoid include:

- Benzodiazepines (such as Xanax or Valium)
- Muscle relaxants (such as Soma or Flexeril)
- Hypnotics (such as Ambien or Lunesta)
- Other prescription opioids



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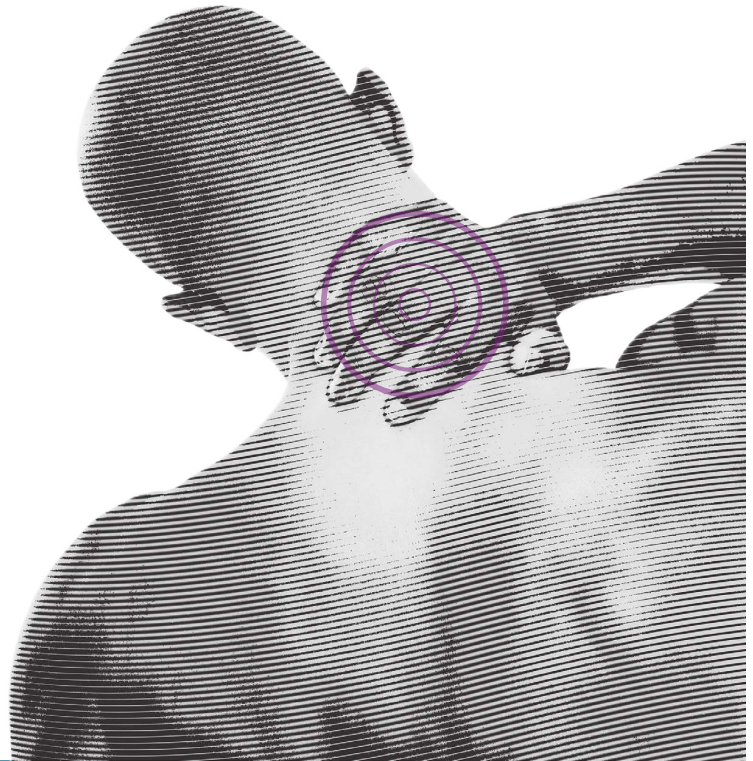
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May 9, 2016

KNOW YOUR OPTIONS

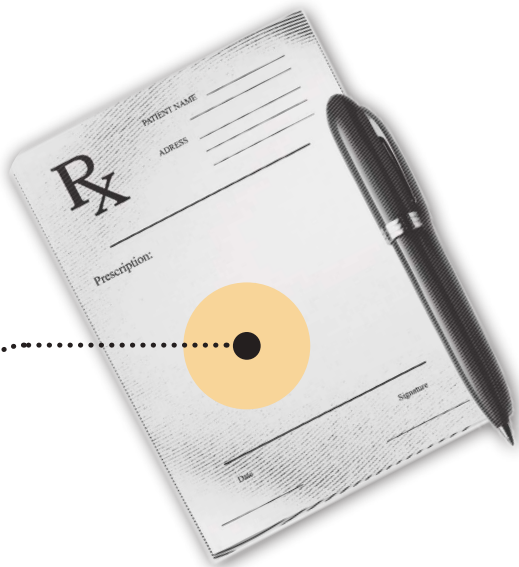
Talk to your health care provider about ways to manage your pain that don't involve prescription opioids. Some of these options **may actually work better** and have fewer risks and side effects. Options may include:

- ❑ Pain relievers such as acetaminophen, ibuprofen, and naproxen
- ❑ Some medications that are also used for depression or seizures
- ❑ Physical therapy and exercise
- ❑ Cognitive behavioral therapy, a psychological, goal-directed approach, in which patients learn how to modify physical, behavioral, and emotional triggers of pain and stress.



IF YOU ARE PRESCRIBED OPIOIDS FOR PAIN:

- ❑ Never take opioids in greater amounts or more often than prescribed.
- ❑ Follow up with your primary health care provider within ____ days.
 - Work together to create a plan on how to manage your pain.
 - Talk about ways to help manage your pain that don't involve prescription opioids.
 - Talk about any and all concerns and side effects.
- ❑ Help prevent misuse and abuse.
 - Never sell or share prescription opioids.
 - Never use another person's prescription opioids.
- ❑ Store prescription opioids in a secure place and out of reach of others (this may include visitors, children, friends, and family).
- ❑ Safely dispose of unused prescription opioids: Find your community drug take-back program or your pharmacy mail-back program, or flush them down the toilet, following guidance from the Food and Drug Administration (www.fda.gov/Drugs/ResourcesForYou).
- ❑ Visit www.cdc.gov/drugoverdose to learn about the risks of opioid abuse and overdose.
- ❑ If you believe you may be struggling with addiction, tell your health care provider and ask for guidance or call SAMHSA's National Helpline at 1-800-662-HELP.



Be Informed! ←

Make sure you know the name of your medication, how much and how often to take it, and its potential risks & side effects.

KNOW

MORE

ABOUT OPIOID ADDICTION



MANAGING YOUR PAIN: WHICH APPROACH IS RIGHT FOR YOU?



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Rx Pain Medications

KNOW THE OPTIONS • GET THE FACTS

Managing Your Pain: Which Approach Is Right for You?

Although prescription pain medications can be effective at treating certain types of pain, there are different treatment options and therapies available. Whether one approach is safer and more effective than another will depend on your unique situation.

Do not use this information to diagnose or treat any medical condition. Use this information to help you discuss your pain management options with your provider so that together you can identify the most effective approach to your care. This list is not exhaustive.

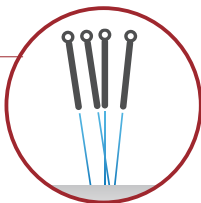
To minimize the risk of negative effects and ensure the best possible treatment of your pain:

- Learn as much as possible about the therapy you are considering.
- Discuss all treatments, including complementary and nonpharmacologic practices, with your doctor before beginning or changing a treatment approach.

Acupuncture

Acupuncture is a practice that involves the stimulation of specific points on the body, usually through the insertion of thin needles into the skin.¹

<https://nccih.nih.gov/health/acupuncture/introduction>



Chiropractic

Chiropractic care typically involves manipulation or adjustment of the spine and other parts of the body by a chiropractor or osteopath.^{2,3} Chiropractors are health care professionals who are licensed by the state in which they practice.⁶

<https://nccih.nih.gov/health/spinalmanipulation>

<https://nccih.nih.gov/health/chiropractic/introduction.htm>



Cognitive behavioral therapy

Cognitive behavioral therapy is a form of psychotherapy that focuses on helping patients change their thinking patterns in order to change unhealthy behavior or moods.⁴ Sessions involve structured meetings with a trained mental health counselor or psychologist for a limited amount of time.⁴ Cognitive behavioral therapy often involves relaxation exercises, journal writing, and certain stress and pain relief methods.

<http://www.nimh.nih.gov/health/topics/psychotherapies/index.shtml>



Massage therapy

Massage therapy may have many different forms, but typically massage therapy involves the manipulation of soft tissue for health-related issues.³

<https://nccih.nih.gov/health/massage/massageintroduction.htm>



continued... >>>

Meditation and relaxation

Relaxation techniques are practices used to provoke the natural relaxation response of the body—slowing breathing, reducing heart rate and blood pressure, and producing a feeling of calm.³ Some common forms of relaxation practices include guided imagery, deep breathing, biofeedback, self-hypnosis, and progressive relaxation.⁶

<https://nccih.nih.gov/health/meditation/overview.htm>

<https://nccih.nih.gov/health/stress/relaxation.htm>



Physical therapy

Physical therapy is a rehabilitative process that may include a number of different physical techniques, including heat and cold, exercise, massage, and electrical stimulation to improve functioning and manage pain.^{5,6} Practitioners of physical therapy are health care professionals who are licensed by the state in which they practice.⁶

<http://www.moveforwardpt.com/Default.aspx>



Yoga

Yoga is a mind and body practice that combines breathing techniques, physical postures, and meditation or relaxation.³ Many different styles of yoga exist, varying in focus and intensity of physical movement.

<https://nccih.nih.gov/health/yoga/introduction.htm>



ADDITIONAL INFORMATION

Find more information on safer, more effective pain management in the CDC Guideline for Prescribing Opioids for Chronic Pain.

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

Find more information on complementary and nonpharmacologic approaches to pain management.

<https://nccih.nih.gov/health/pain/ebook>

Find more information on helpful tips on how to locate and evaluate online resources for complementary and nonpharmacologic approaches.

<https://nccih.nih.gov/health/webresources>

Find more information on licensing and credentialing of complementary health practitioners.

<https://nccih.nih.gov/health/decisions/credentialing.htm>

NEED HELP?

Call 1-800-662-HELP (4357) for 24-hour free and confidential treatment referral and information about mental and/or substance use disorders, prevention, and recovery in English and Spanish.

www.samhsa.gov/find-help

- ¹ National Center for Complementary and Integrative Health. (2016). Pain: Considering complementary approaches. Retrieved from <https://nccih.nih.gov/health/pain/ebook>
- ² National Center for Complementary and Integrative Health. (2016). Chiropractic: An introduction. Retrieved from https://nccih.nih.gov/sites/nccam.nih.gov/files/D403_06-07-2012.pdf
- ³ National Center for Complementary and Integrative Health. (2016). Get the facts: Yoga for health. Retrieved from [https://nccih.nih.gov/sites/nccam.nih.gov/files/Get_The_Facts_Yoga_for_Health_06-04-2013_\(2\).pdf](https://nccih.nih.gov/sites/nccam.nih.gov/files/Get_The_Facts_Yoga_for_Health_06-04-2013_(2).pdf)
- ⁴ National Institute of Mental Health. (2016). Psychotherapies. Retrieved from <http://www.nimh.nih.gov/health/topics/psychotherapies/index.shtml>
- ⁵ National Institute of Neurological Disorders and Stroke. (2014). Pain: Hope through research. Retrieved from <https://www.ninds.nih.gov/Disorders/Patient-Caregiver-Education/Hope-Through-Research/Pain-Hope-Through-Research>
- ⁶ American Physical Therapy Association. (2017). Choosing your physical therapist: How to choose a physical therapist. Retrieved from http://www.moveforwardpt.com/Resources/Choose.aspx#VPSfD_nF-3c

