Taking Data to Care – Part II

Developing a Systematic Strategic Approach to Limiting Prescription Opioid Overutilization & Illicit Use – A Bedside Perspective

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Making A Person Centered Community-based Action Plan Requires All Stakeholders

- MDHHS
- Payers

Person Suffering Addiction

- Schools
- Neighbhorhd. Orgs.
- Civic Groups
- Non-Profit Organizations
- Nursing Homes
- Community Centers
- Hospitals
- Doctors
- CHCs
- EMS
- Drug Treatment
- Law Enforcement
- Tribal Health
- Laboratories
- Faith Instit.
- Mental Health
- Home Health
- Community Centers
- Community Centers
- Employers Corrections
- Elected Officials
- Fire
- Transit
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

ASSESSING RISK AND ADDRESSING HARMs OF OPIOID USE

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 ≥150 MME/day or carefully justify a decision to titrate dosage to ≥300 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.

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 (PDPMP) 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 PDPMP 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.

Access the full CDC guideline for prescribing opioids for chronic pain at:

https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm
NONOPIOID TREATMENTS FOR CHRONIC PAIN

PRINCIPLES OF CHRONIC PAIN TREATMENT

- Patients with pain should receive treatment that provides the greatest benefit. Opioids are not the first-line therapy for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. Evidence suggests that non-opioid treatments, including non-opioid medications and nonpharmacological therapies, can provide relief to those suffering from chronic pain, and are safer. Effective approaches to chronic pain should:
  - Use non-opioid therapy to the extent possible
  - Identify and address co-existing mental health conditions (e.g., depression, anxiety, PTSD)
  - Focus on functional goals and improvement, engaging patients actively in their pain management
  - Use disease-specific treatments when available (e.g., brighteners for migraines, gabapentin/pregabalin for neuropathic pain)

Use first-line medication options prudently
Consider interventional therapies (e.g., corticosteroid injections) to patients who fail standard non-opioid therapies
Use multidisciplinary approaches, including interdisciplinary rehabilitation for patients who have failed standard treatments, have severe functional deficits, or psychosocial risk factors

NONOPIOID MEDICATIONS

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>MAGNITUDE OF BENEFITS</th>
<th>HARMs</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetaminophen</td>
<td>Small</td>
<td>Hypersensitivity, particularly at higher doses</td>
<td>First-line analgesic, probably less effective than NSAI ds</td>
</tr>
<tr>
<td>NSAIDs</td>
<td>Small-to-moderate</td>
<td>Gastrointestinal, renal</td>
<td>First-line analgesics, COX-2 selective NSAIDs less Gastrointestinal</td>
</tr>
<tr>
<td>Gabapentin/pregabalin</td>
<td>Small-to-moderate</td>
<td>Sedation, dizziness, ataxia</td>
<td>First-line agent for neuropathic pain, pregabalin approved for fibromyalgia</td>
</tr>
<tr>
<td>Triptans, serotonergic antidepressants, sodium channel blockers</td>
<td>Small-to-moderate</td>
<td>Headache, nausea, dizziness, fatigue</td>
<td>First-line for acute migraine, TCAs and SNRIs for fibromyalgia, GABA A reuptake inhibitors for neuropathic pain</td>
</tr>
<tr>
<td>Topical agents (lidocaine, capsaicin, NSAIDs)</td>
<td>Small-to-moderate</td>
<td>Capsaicin-induced burning, irritation, or mucous membranes</td>
<td>Consider an alternative if side effects from systemic medications, lidocaine for neuropathic pain, non-opioid NSAIDs for osteoarthritis, topical capsaicin for musculoskeletal and neuropathic pain</td>
</tr>
</tbody>
</table>

RECOMMENDED TREATMENTS FOR COMMON CHRONIC PAIN CONDITIONS

**Low back pain**

**Self-care and education** in all patients; advise patients to remain active and limit bedrest

**Nonpharmacological treatments** Exercise, cognitive behavioral therapy, interdisciplinary rehabilitation

**Medications**
- First-line acetaminophen, non-steroidal anti-inflammatory drugs (NSAIDs)
- Second-line: Serotonin and noradrenaline reuptake inhibitors (SNRIs)/tricyclic antidepressants (TCAs)

**Migraine**

**Preventive treatments**
- Beta-blockers
- TCAs
- Anticonvulsant medications
- Calcium channel blockers
- Non-pharmacological treatments (Cognitive behavioral therapy, relaxation, biofeedback, exercise therapy)
- Avoid migraine triggers

**Acute treatments**
- Aspirin, acetaminophen, NSAIDs (may be combined with caffeine)
- Antiviral medications
- Topiramate/mexiletine-specific

**Osteoarthritis**

**Nonpharmacological treatments** Exercise, weight loss, patient education

**Medications**
- First-line: Acetaminophen, oral NSAIDs, topical NSAIDs
- Second-line: intra-articular hyaluronic acid, capsaicin (limited number of intra-articular glucocorticoid injections if acetaminophen and NSAIDs is insufficient)

**Fibromyalgia**

**Patient evaluation** Address diagnosis, treatment, and the patient's role in treatment

**Nonpharmacological treatments** Low-intensity aerobic exercise (e.g., brisk walking, swimming, water aerobics, or bicycling), cognitive behavioral therapy, biofeedback, interdisciplinary rehabilitation

**Medications**
- FDA-approved, Pregabalin, duloxetine, milnacipran
- Other options: TCAs, gabapentin

**Neuropathic pain**

**Medications** TCAs, SNRIs, gabapentin/pregabalin, topical lidocaine
ASSESSING BENEFITS AND HARMs OF OPIOID THERAPY

THE EPIDEMIC

The United States is in the midst of an epidemic of prescription opioid overdose deaths, which killed more than 14,000 people in 2014 alone.

Since 1999, sales of prescription opioids—and related overdose deaths—have quadrupled.

Since 1999, there have been more than

165,000 deaths from overdose related to prescription opioids.

GUIDANCE FOR OPIOID PRESCRIBING

The CDC Guideline for Prescribing Opioids for Chronic Pain provides up-to-date guidance on prescribing and weighing the risks and benefits of opioids.

1. Before starting and periodically during opioid therapy, discuss the known risks and realistic benefits of opioids.
2. Also discuss provider and patient responsibilities for managing therapy.
3. Within 1-4 weeks of starting opioid therapy, and at least every 3 months, evaluate benefits and harms with the patient.

ASSESS BENEFITS OF OPIOID THERAPY

Assess your patient’s pain and function regularly. A 30% improvement in pain and function is considered clinically meaningful. Discuss patient-centered goals and improvements in function (such as returning to work and recreational activities) and assess pain using validated instruments such as the 3-item (PEG) Assessment Scale:

1. What number best describes your pain on average in the past week? (from 0-no pain to 10-pain as bad as you can imagine)
2. What number best describes how, during the past week, pain has interfered with your enjoyment of life? (from 0-does not interfere to 10-complete interference)
3. What number best describes how, during the past week, pain has interfered with your general activity? (from 0-does not interfere to 10-complete interference)

If your patient does not have a 30% improvement in pain and function, consider reducing dose or tapering and discontinuing opioids.

TAPERING AND DISCONTINUING OPIOID THERAPY

Symptoms of opioid withdrawal may include drug craving, anxiety, insomnia, abdominal pain, vomiting, diarrhea, and tremors. Tapering plans should be individualized. However, in general:

1. Go Slow
2. Consult
3. Support

To minimize symptoms of opioid withdrawal, decrease 10% of the original dose per week. Some patients who have taken opioids for a long time might find slower tapering safer (e.g., 10% of the original dosage per month).

Work with appropriate specialists as needed—especially for those at risk of harm from withdrawal such as pregnant patients and those with opioid use disorder.

Support patients who require psychological support for anxiety if warranted, work with mental health providers and other or arrange for treatment of opioid use disorder.

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html
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 (e.g., walk around the block).
- Check that non-opioid therapies tried and optimized.
- Discuss benefits and risks (e.g., 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 (e.g., PEG scale).
- Schedule initial reassessment within 1–4 weeks.
- Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

**H 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 (e.g., PEG); compare results to baseline.
- Evaluate risk of harm or misuse:
  - Observe patient for signs of over-sedation or overdose risk.
  - If you: Taper dose.
  - Check PDMP.
  - Check for opioid use disorder if indicated (e.g., difficulty controlling use).
  - If you: 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 oxycodeone), increase frequency of follow-up; consider offering naloxone.
  - Avoid ≥90 MME/day total (≥90 mg hydrocodone, ≥60 mg oxycodeone), 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 (e.g., NSAIDs, TCAs, SNRIs, anti-consultants).
- Physical treatments (e.g., exercise therapy, weight loss).
- Psychological treatment (e.g., CBT).
- Procedures (e.g., intra-articular corticosteroids).

**EVALUATING RISK OF HARM OR MISUSE**
Known risk factors include:
- Illegitimate use; prescription drug use for non-medical reasons.
- History of substance use disorder or overdose.
- Mental health conditions (e.g., depression, anxiety).
- Sleep-disordered breathing.
- Concomitant benzodiazepine use.

Use the drug testing: Check to confirm presence of prescribed substances and for undiagnosed 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 0–100% 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”
CALCULATING TOTAL DAILY DOSE OF OPIOIDS FOR SAFER DOSAGE

Higher Dosage, Higher Risk.

Higher dosages of opioids are associated with higher risk of overdose and death—even relatively low dosages (20-50 morphine milligram equivalents (MME) per day) increase risk. Higher dosages haven’t been shown to reduce pain over the long term. One randomized trial found no difference in pain or function between a more liberal opioid dose escalation strategy (average final dosage 52 MME) and maintenance of current dosage (average final dosage 40 MME).

Doses at or above 50 MME/day increase risks for overdose by at least 2x the risk at <20 MME/day.

WHY IS IT IMPORTANT TO CALCULATE THE TOTAL DAILY DOSAGE OF OPIOIDS?

Patients prescribed higher opioid dosages are at higher risk of overdose death.

In a national sample of Veterans Health Administration (VHA) patients with chronic pain receiving opioids from 2004-2009, patients who died of opioid overdose were prescribed an average of 98 MME/day, while other patients were prescribed an average of 48 MME/day.

Calculating the total daily dose of opioids helps identify patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose.

HOW MUCH IS 50 OR 90 MME/DAY FOR COMMONLY PRESCRIBED OPIOIDS?

50 MME/day:
- 50 mg of hydrocodone (10 tablets of hydrocodone-acetaminophen 5/300)
- 33 mg of oxycodone (2 tablets of oxycodone sustained-release 16 mg)
- 12 mg of methadone (<3 tablets of methadone 5 mg)

90 MME/day:
- 50 mg of hydrocodone (9 tablets of hydrocodone-acetaminophen 10/325)
- 60 mg of oxycodone (<2 tablets of oxycodone sustained-release 30 mg)
- ~20 mg of methadone (4 tablets of methadone 5 mg)

HOW SHOULD THE TOTAL DAILY DOSE OF OPIOIDS BE CALCULATED?

1. DETERMINE the total daily amount of each opioid the patient takes.
2. CONVERT each to MMEs—multiply the dose for each opioid by the conversion factor. (See table)
3. ADD them together.

Calculating morphine milligram equivalents (MME)

<table>
<thead>
<tr>
<th>OPIOID (dose in mg/day except naloxone)</th>
<th>CONVERSION FACTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine</td>
<td>0.15</td>
</tr>
<tr>
<td>Fentanyl transdermal (in mg/hr)</td>
<td>2.4</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>1</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>4</td>
</tr>
<tr>
<td>Methadone</td>
<td>1</td>
</tr>
<tr>
<td>1-20 mg/day</td>
<td>4</td>
</tr>
<tr>
<td>21-40 mg/day</td>
<td>8</td>
</tr>
<tr>
<td>41-60 mg/day</td>
<td>10</td>
</tr>
<tr>
<td>≥ 61-80 mg/day</td>
<td>12</td>
</tr>
<tr>
<td>Morphine</td>
<td>1.5</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>1</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>3</td>
</tr>
</tbody>
</table>

These dose conversions are estimated and cannot account for all individual differences in genetics and pharmacokinetics.

USE EXTRA CAUTION:
- Methadone; the conversion factor increases at higher doses
- Fentanyl: dosing in mg/hr instead of mg/day and absorption is affected by sweat and other factors

HOW SHOULD PROVIDERS USE THE TOTAL DAILY OPIOID DOSE IN CLINICAL PRACTICE?

- Use caution when prescribing opioids at any dosage and prescribe the lowest effective dose.
- Use extra precautions when increasing to ≥50 MME per day* such as:
  - Monitor and assess pain and function more frequently
  - Discuss reducing dose or tapering and discontinuing opioids if benefits do not outweigh harms.
  - Consider offering naloxone.
- Avoid or carefully weigh increasing dosage to ≥90 MME/day.*

* These dosage thresholds are based on overdose risk when opioids are prescribed for pain and should not guide dosing of medication-assisted treatment for opioid use disorder.
**WHEN TO TAPER**

Consider tapering to a reduced opioid dosage or tapering and discontinuing opioid therapy when your patient:

- Requests dosage reduction
- Does not have clinically meaningful improvement in pain and function (e.g., at least 30% improvement on the 3-item PEG scale)
- Is on dosages ≥ 50 MME/day without benefit or opioids are combined with benzodiazepines
- Shows signs of substance use disorder (e.g., work or family problems related to opioid use, difficulty controlling use)
- Experiences overdose or other serious adverse event
- Shows early warning signs for overdose risk such as confusion, sedation, or slurred speech

*Morphine milligram equivalents*

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**HOW TO TAPER**

Tapering plans should be individualized and should minimize symptoms of opioid withdrawal while maximizing pain treatment with nonpharmacologic therapies and nonopioid medications. In general:

- **Decide**
  - A decrease of 10% of the original dose per week is a reasonable starting point. Some patients who have taken opioids for a long time might find even slower tapers (e.g., 10% per month) easier.
  - Discuss the increased risk of overdose if patients quickly revert to a previously prescribed higher dose.

- **Consult**
  - Coordinate with specialists and treatment experts as needed—especially for patients at high risk of harm such as pregnant women or patients with an opioid use disorder.
  - Use extra caution during pregnancy due to possible risk to the pregnant patient and to the fetus if the patient goes into withdrawal.

- **Support**
  - Make sure patients receive appropriate psychosocial support. If needed, work with mental health providers, arrange for treatment of opioid use disorder, and offer naloxone for overdose prevention.
  - Watch for signs of anxiety, depression, and opioid use disorder during the taper and offer support or referral as needed.

- **Encourage**
  - Let patients know that most people have improved function without worse pain after tapering opioids. Some patients even have improved pain after a taper, even though pain might briefly get worse at first.
  - Tell patients “I know you can do this” or “I’ll stick by you through this.”

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**CONSIDERATIONS**

1. Adjust the rate and duration of the taper according to the patient’s response.
2. Don’t reverse the taper; however, the rate may be slowed or paused while monitoring and managing withdrawal symptoms.
3. Once the smallest available dose is reached, the interval between doses can be extended and opioids may be stopped when taken less than once a day.

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**RESOURCES:**

- CDC Guideline for Prescribing Opioids for Chronic Pain
  [www.cdc.gov/drugoverdose/prescribing/guideline.html](http://www.cdc.gov/drugoverdose/prescribing/guideline.html)
- Washington State Opioid Taper Plan Calculator
- Tapering Long-Term Opioid Therapy in Chronic Noncancer Pain
Medications Approved in the Treatment of Opioid Use Disorder*

**Pharmacologic Category**

<table>
<thead>
<tr>
<th>Extended Release Injectable Naltrexone</th>
<th>Methadone</th>
<th>Buprenorphine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioid antagonist</td>
<td>Opioid agonist</td>
<td>Opioid partial agonist</td>
</tr>
<tr>
<td>Naltrexone displaces opioids from receptors to which they have bound. This can precipitate severe, acute withdrawal symptoms if administered in persons who have not completely cleared opioid from their system. Patients who have been treated with extended-release injectable naltrexone will have reduced tolerance to opioids. Subsequent exposure to previously tolerated or even smaller amounts of opioids may result in overdose.</td>
<td>Patients starting methadone should be educated about the risk of overdose during induction on methadone, if relapse occurs, or substances such as benzodiazepines or alcohol are consumed. During induction, a dose that seems initially inadequate can be toxic a few days later because of accumulation in body tissues. For guidance on methadone dosing for all phases of MAT consult TIP 43 (<a href="http://store.samhsa.gov/product/TIP43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214">http://store.samhsa.gov/product/TIP43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214</a>)</td>
<td>Buprenorphine’s partial agonist effect relieves withdrawal symptoms resulting from cessation of opioids. This same property will induce a syndrome of acute withdrawal in the presence of long-acting opioids or sufficient amounts of receptor-bound full agonists. Naloxone, an opioid antagonist, is sometimes added to buprenorphine to make the product less likely to be abused by injection.</td>
</tr>
</tbody>
</table>

**Who May Prescribe or Dispense**

<table>
<thead>
<tr>
<th>Extended Release Injectable Naltrexone</th>
<th>Methadone</th>
<th>Buprenorphine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any individual who is licensed to prescribe medicines (e.g., physician, physician assistant, nurse practitioner) may prescribe and/or order administration by qualified staff.</td>
<td>SAMHSA-certified Opioid Treatment Programs dispense methadone for daily administration either on site or, for stable patients, at home.</td>
<td>Physicians must have board certification in addiction medicine or addiction psychiatry and/or complete special training to qualify for the federal waiver to prescribe buprenorphine, but any pharmacy can fill the prescription. There are no special requirements for staff members who dispense buprenorphine under the supervision of a waived physician.</td>
</tr>
</tbody>
</table>
Changing the Conversation About Opioid Tapering

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Tamara M. Haegerich, PhD
Centers for Disease Control and Prevention
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Changing the Conversation...

• The CDC guideline does not support involuntary or precipitous tapering
• Such practice could be associated with withdrawal symptoms, damage to the clinician–patient relationship, and patients obtaining opioids from other sources
• Clinicians have a responsibility to carefully manage opioid therapy and not abandon patients in chronic pain
• Obtaining patient buy-in before tapering is a critical and not insurmountable task
• Motivational interviewing techniques can help patients who are not obtaining expected benefits or are experiencing harms from opioids to articulate and act on discrepancies between how they are approaching pain and how they would like to live
• Optimal dose reduction may be challenging in primary care, but many of the approaches could translate effectively, especially in team-based practices
• Most of the higher-quality studies evaluated interdisciplinary pain programs using a biopsychosocial model of chronic pain emphasizing nonpharmacologic and self-management approaches, a framework that has been successfully adopted by primary care – based interdisciplinary teams in the Veterans Health Administration
• Others evaluated behavioral interventions, including those supported by technology (an interactive voice response intervention) or by different members of the health care team (such as a physician assistant delivering motivational interviewing and pain self-management education)
• Slow and steady changes in primary care practice can better align opioid use with circumstances in which benefits outweigh harms
A practical strategy for managing a panel of patients with chronic pain in primary care could include starting long-term opioid therapy in fewer patients initially.

Avoid dose escalation in those using opioids in the long term;

Working with a few interested and motivated patients to slowly taper opioid dosages:
  - closely monitor and mitigate overdose risk for patients who continue use of long-term, high-dose opioids, using periodic and strategic motivational questions and statements to encourage movement toward therapeutic changes.

For example, nonjudgmentally asking what the patient likes and dislikes about opioid therapy can facilitate exploration of ambivalence, and asking patients how they would like things to be different can empower them to imagine change.

Over time, this strategy should decrease the number of patients who require intensive monitoring while focusing on tapering in a few motivated patients at a time.

All patients could receive nonopioid pain management and support through some combination of clinician follow-up, team-based support, and referral.

Clinicians can also offer or arrange medication-assisted treatment for patients found to be struggling with opioid use disorder.

To support management of patients with chronic pain and tapering of opioid therapy, the CDC offers a tapering pocket guide, a mobile app and online training with motivational interviewing components, and information about nonopioid treatments for pain.
Prescriber Documentation Guidance: Developing a Pain and Opioid Management System
Key Practice Management Principles

• Utilize a team-based approach to manage pain minimally using opioids balanced with managing opioid tolerance, dependence, addiction and overdose risk as complexity of case management dictates
• Minimize the unnecessary use of opioid from first day to last of prescribing
• At the same time, do not abandon the chronic pain patient and continue to manage the suffering caused by chronic pain
• Avoid abrupt cessation of long-term opioid use and minimize complications of acute withdrawal
• Prioritize using non-opioid chronic pain control strategies over opioids
• Utilize opioids only at the lowest necessary dose and for the shortest duration
• Minimize polypharmacy, including benzodiazepines and other sedating medications to avoid cardiopulmonary depression
• Identify and reduce the risks of abuse, addiction, overdose, non-lethal complications, death and diversion of prescription opioids in addition to illicitly non-prescribed addictive substances
• For acute pain under most circumstances, prescribe opioids for less than 1 week.
Key Practice Management Principles (Continued)

• For more severe pain under prolonged extenuating circumstances greater than 1 week and again at 4 weeks
  • assess pain frequently
  • adjust pain medications downward
• Make every effort to avoid prescribing opioids over 4 weeks and/or greater than 90 MMED
  • Document and justify need to continue and/or use higher doses
• Do not escalate opioid dose once steady state to control pain has been achieved or when tapering is in progress, whenever possible
• Depending on dose and duration of exposure, taper slowly enough to reduce withdrawal and untoward complications
• Use adjuvant medications such as alpha agonists to alleviate withdrawal symptoms when tapering
• Consider switching to MAT if unable to control craving and other signs of chronic or acute withdrawal
• Overall, optimize the health and wellbeing of Michigan citizens and avoid overdose risk
Highlight Medical Necessity, Risk Assessment, Weighing of Benefit vs. Risk, Management Plan and Monitoring Process
History & Physical (H&P) with Supporting Progress Notes

- describing the course of the condition causing pain
- medical necessity to use opioids
- an overdose risk assessment
- the decision that benefit exceeds risk and a pain management plan
- consistent with the CDC Chronic Pain Guidelines and ASAM Addiction Guidelines
Pain Assessment

• History of the source of pain including it’s
• Onset, location, distribution, quality, severity, duration and associated factors with coexisting diagnoses
• A pain assessment description technique such as SOCRATES or OPQRST and/or a vetted pain assessment score such a Numeric Rating Scale 0-10 (NRS-11) or Brief Pain Inventory (BPI)
• Physical examination highlighting objective signs that accurately describe the pain condition
Risk Assessment for potential addiction or overdose

• Detailed narrative description in the history
• Validated risk scores
  • MAPS/NarxCare Overdose Prediction Score
  • Addiction/Overdose - DIRE, DAST-10, and/or SBIRT
  • Withdrawal - COWS, SOWS, OOWS
Latest Improvement for MAPS Starting 11/1/17 - Sample Risk Score for the Electronic Health Record

https://michigan.pmpaware.net
Diagnostic Studies

- Laboratory reports
- Imaging studies
- EMG and other neurodiagnostic studies
- Toxicology Screen Report(s) – urine, saliva, blood for controlled substances and illicit drugs from a commercial lab (less than 30 days old)
- Other studies that evaluate the region or location of pain
Additional Consultation and Treatment Reports highlighting previous evaluation and treatment

- PMR/Physical therapy/Manual Medicine
- Counselling sessions
- Surgery
- Pain Management
- Addiction
- Behavior Health
- 2\textsuperscript{nd} Opinion Consults
A Succinct Summary Assessment Weighing Benefit Versus Risk of Utilizing Opioids

• Medical necessity
• Potential for abuse, addiction, overdose injury or death and/or diversion
• Affirmation that benefit outweighs risk
Comprehensive Treatment and Monitoring Plan

• Surgery
• Pain Management – including non-opioid and opioid options
• PMR/Physical therapy/Manual Medicine
• Counselling sessions
• Addiction
• Behavior Health
• 2nd Opinion Consults (within one’s own specialty)
Management Agreements with Informed Consent and signed by the patient

- Pain Management Agreement
  - Start Talking Tool for initiating opioids
- Controlled Substance Use Agreement
- Taper Agreement
- MAT Agreement (if withdrawal symptoms cannot be controlled with tapering)
Chronic Pain Management Plan

Patient Name: __________________ Date: ______
DOB: ________________

Diagnosis/Condition(s) causing pain:
1. ________________________________ (ICD-10 Code(s))
2. ________________________________ (ICD-10 Code(s))
3. ________________________________ (ICD-10 Code(s))
4. ________________________________ (ICD-10 Code(s))
5. ________________________________ (ICD-10 Code(s))

Pain Management Goals:
What are your goals as the result of treatment? What activities do you hope to do because of pain? As a result of pain management, I want to be able to:
1. ________________________________
2. ________________________________
3. ________________________________
4. ________________________________
5. ________________________________
My current pain levels (1-10): ______
My goal for pain management is to reduce my pain to (1-10): ______

Which of these treatments or strategies might help you meet your goals?

- Specialty consultation:
  - Orthopedic/Surgery
  - Neurology
  - PAIN
  - Physical therapy
  - Occupational therapy
  - Osteopathic manipulative therapy
  - Chiropractic

- Pain specialty clinic
- Pulmonary sleep study
- Addiction
- Depression
- Cognitive behavioral therapy focused on pain management
- Training in meditation and relaxation
- Therapy or counseling to treat depression, anxiety, or other mental health condition(s)
- Attend support group or pain classes:
  - ________________
  - ________________
  - ________________
  - ________________
  - ________________
  - ________________
  - ________________
  - ________________
  - ________________
  - ________________

Medications:
- Non-opioid pain medication (such as anti-inflammatory medications or acetaminophen):
- Opioid pain medication:
  - Adjusted:
  - Other:

- Sleep:

Integrative medicine:
- Acupuncture
- Hypnosis
- Biofeedback
- Other:

- Self-care (home therapies):
  - Ice/heat therapies
  - Exercise
    - Aquatic
    - Aerobic
    - Strength building
    - Stretching
- Quit tobacco use
- Quit alcohol use
- Quit caffeine use
- Quit cannabidiol use
- Manage weight
- Practice meditation, yoga or relaxation
- Improve sleep habits
- Other:

Signatures:
Patient or Patient/Guardian: __________________ Date: ______

Mature Minor Patient: __________________ Date: ______

Provider: __________________ Date: ______
Controlled Medication Management Agreement

1. I understand that my physician may discontinue opioid therapy and other controlled substances if the risks of use outweigh the benefits or if I fail to meet my obligations under this agreement.

2. I understand that controlled substance usage may be a temporary part of my pain management program and dose reduction/tapering is an essential part of my treatment and care.

3. I understand that reducing/tapering my controlled substance usage may take weeks or even months of cooperation and coordination with my physician.

4. I will actively participate in complimentary therapies to help manage and treat my pain as selected by my physician.

5. I will participate in psychiatric/psychologic evaluation and diagnosis for the treatment of mental illnesses or conditions such as depression, post-traumatic stress disorder, anxiety, psychosis, opioid use disorder and all forms of addiction to help me improve my pain management.

6. I acknowledge that I might develop tolerance, dependence, an opioid use disorder, opioid addiction or other serious and potentially life-threatening conditions and risks from even the short-term use of prescribed controlled substances.

7. I will cooperate with urine/blood drug testing and pill counts whenever requested.

8. I understand my opioid usage goal should be less than 90 morphine equivalents per day.

9. I will comply with my physician’s recommendation to enter drug rehabilitation treatment if determined to be medically necessary.

10. I will take prescribed medication only as directed and will not use alcohol, illegal drugs, or prescription drugs that have not been prescribed for me.

11. I will refrain from taking actions that could endanger myself or the public while under the influence of controlled substances that may reduce my coordination or judgment, including driving and using heavy machinery.

12. I will securely lock and store my controlled substance prescriptions. I will return all unused opioids and controlled substances to an approved collection site as soon as they are no longer needed for the condition being treated.

13. I will not share, trade or sell my opioid medication or other controlled substances.

14. I acknowledge that I am responsible for any lost, stolen or diverted controlled substances.

15. I understand that the confirmed use of heroin, cocaine and nonprescribed morphine, fentanyl, and/or amphetamines will result in my immediate referral and transfer of care to a drug rehabilitation facility or Addiction Specialist.

16. I will be immediately discharged from my physician’s care and reported to law enforcement if I threaten or attempt to intimidate my healthcare provider or their staff in an attempt to obtain controlled substances.

17. I understand that the Michigan Department of Licensing and Regulatory Affairs maintains and makes available a database of my controlled drug prescriptions to medical providers.

18. I understand that my medical records shall be reviewed by an independent review team to evaluate my ongoing opioid and controlled substance usage.

My signature confirms that I have had an opportunity to ask about this agreement, and that I understand and agree to all the statements above. I have been given a copy of this Agreement and agree to keep the copy for my future reference.

Sign and Date below:

Patient or Patient’s Representative (required): ____________________________ Date: __________

Mature Minor Patient: ____________________________ Date: __________

Provider: ____________________________ Date: __________
Opioid and/or Benzodiazepine Tapering Plan Agreement

The purpose of this document is to develop a specific tapering plan with a timeline for discontinuation or reaching a taper “target dose”.

We will work with you to develop a plan that is safe, effective and will minimize any symptoms that may be associated with tapering. Enclosed is a sample of a tapering schedule that can be used to help keep everyone apprised.

Taper Schedule

<table>
<thead>
<tr>
<th>Visit</th>
<th>Date</th>
<th>Medication</th>
<th>Taper Frequency (# weeks)</th>
<th>Single Dose</th>
<th>Dose Frequency</th>
<th>Total Daily Dose</th>
<th>Total Dose/Day</th>
<th>Quantities Needed</th>
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</table>

We will allow for gradual dose reductions and will reassess regularly and adjust accordingly.

Sign and Date below:

Patient or Patient’s Representative (required):

_________________________ Date: _____________

Mature Minor Patient:

_________________________ Date: _____________

Physician Signature or Provider:

_________________________ Date: _____________
Identifying Illicit Opioid Use Beyond the Prescription and What to Do About It
Understand and Respond to the Clues of Addictive Behavior

1. Sudden change in baseline behavior
2. Loss of Personal Hygiene
3. Loss of interest in school or work
4. Inability to constrain personal spending within available financial resources
5. Sudden changes in typical relationship networks
6. Sudden defiant behavior and unwillingness to discuss changes in behavior
7. Drugs or drug paraphernalia immediately in sight
8. Classically suspicious smells or odors
Know the Signs of Opioid Withdrawal

- Early symptoms typically begin in the first 24 hours after discontinuation
- They include:
  - muscle aches
  - restlessness
  - anxiety
  - lacrimation (eyes tearing up)
  - runny nose
  - excessive sweating
  - inability to sleep
  - yawning very often

- Later symptoms during days 2-4, which can be more intense
- They include:
  - diarrhea
  - abdominal cramping
  - goose bumps on the skin
  - nausea and vomiting
  - dilated pupils and possibly blurry vision
  - rapid heartbeat
  - high blood pressure

- Although very unpleasant and painful, symptoms usually begin to improve within 72 hours, and within a week there is a significant decrease in the acute symptoms of opiate withdrawal.
Evaluate Risk and Either Treat or Refer Early

• **Assesses for Risk of Misuse and Overdose Potential**
  - *Diagnosis, Intractability, Risk & Efficacy (DIRES)* - evaluates suitability for long term opioid management and risk for misuse
  - *Opioid Risk Tool (ORT)* – assesses risk for opioid misuse for primary care patients with pain
  - *Drug Abuse Screening Test 10 (DAST 10)* – Assesses for degree of problems related to drug misuse

• **Assesses for Withdrawal Symptoms**
  - *Subjective Opioid Withdrawal Scale (SOWS)* – subjectively assesses for active withdrawal
  - *Objective Opioid Withdrawal Scale (OOWS)* – objectively assesses for signs of active withdrawal
  - *Clinical Opioid Withdrawal Scale (COWS)* - used in both inpatient and outpatient settings to reproducibly rate common signs and symptoms of opiate withdrawal and monitor these symptoms over time

• **Aids in How to Assess, Treat and/or Refer**
  - Screening, Brief Intervention and Referral to Treatment (SBIRT)
SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT (SBIRT) SERVICES

WHAT IS SBIRT?

SBIRT is an early intervention approach for individuals with nondependent substance use to effectively help them before they need more extensive or specialized treatment. This approach differs from the primary focus of specialized treatment of individuals with more severe substance use or those who meet the criteria for diagnosis of a substance use disorder.

SBIRT consists of three major components:

1. Screening:
   Screening/Assessing a patient for risky substance use behaviors using standardized assessment tools (in Medicare, referred to as Medicare Structured Assessment; in Medicaid, referred to as Medicaid Screening).

2. Brief Intervention:
   Engaging a patient showing risky substance use behaviors in a short conversation, providing feedback, motivation, and advice. This consists of up to five counseling sessions.

3. Referral to Treatment:
   Providing a referral to brief therapy or additional treatment to patients whose assessment or screening shows a need for additional services.
Take 10 Steps To Improve Clinical Practice and Community Engagement

1. First – Do NO Harm
2. Find ways to increase individual and community resilience to all pressures related to opioid and polysubstance misuse
3. Remember Opioid Tolerance Starts Somewhere Between 3-7 days
4. User Fewer Opioids and Use Non-opioid Pain Management Techniques
5. Start Talking with Patients and Families About Risk and Benefits of Using Opioids
6. Utilize Patient Agreements w/Informed Consent
7. Teach Patients How to Securely Store and Properly Dispose Their Medications
8. Use PDMP & Urine Drug Screening Routinely to Assess & Reduce Risk
9. Identify Risk Early and Refer to Addiction Specialists – Naloxone 1st, MAT and Cognitive Therapies, Syringe Service Programs and Needle Exchange Programs
10. Lead in Community Engagement Initiatives - Take a Team Based Approach and Talk with the Patients, Families, Neighbors, Schools, Churches, Additional Social Connections and the Entire Community
Summary

1. The root causes for the opioid epidemic are complex and multifactorial.
2. It is imperative to shrink supply and demand for both prescription opioids and heroin/fentanyl analogues.
3. A well organized state-wide and nation-wide plan is necessary to avoid abandoning patients with “true” pain and also not send people to the street for heroin and synthetic opioids.
4. Focusing only on prescription opioids without simultaneously addressing “heroin and fentanyl trafficking” will dramatically shrink probability of success.
5. Most of all it will “take a village” – “every village”.
6. Health professionals are well positioned to help lead the way.
THANK YOU!

For more information contact:

David Neff, DO
neff@msu.edu
drneffdo@hotmail.com
Cell Phone: 517-290-1079
Additional Resources
TOGETHER WE CAN STOP THIS DEADLY EPIDEMIC.

Prescription drug misuse is a serious problem in Michigan. Drug overdose deaths are on the rise across the state. Two types of prescription drugs are the leading cause of misuse - painkillers (opioids) and tranquilizers (benzodiazepines). Opioids include both illegal drugs, such as heroin, and prescription pain medicine. Common opioids used to treat pain include oxycodone, hydrocodone, morphine, methadone, and codeine. Synthetic opioids are contributing to the crisis, too. Synthetic opioids that are appearing across Michigan include fentanyl and carfentanil. These drugs are far more powerful and deadly than other opioids and are frequently mixed with heroin, often times without the user knowing.

OPIOID EPIDEMIC BY THE NUMBERS

2,729 Deaths from Drug Overdoses
17x Increase in Overdose Deaths
11.4M Prescriptions for Painkillers
WHAT ARE OPIOIDS?
Opioids are commonly prescribed drugs that affect the nervous system to relieve pain. Both illegal opioids and prescription opioids can result in an overdose if too much is consumed.

COMMON OPIOIDS

RISK FACTORS FOR OVERDOSE
Some predictors make it more likely for certain people to overdose than for others.
- Mixing opioids with alcohol or other “downer” drugs like sleep aids or benzodiazepines (such as Xanex or Valium).
- Combining drugs may slow heart rate and breathing more than taking opioids only.
- High opioid dose
- Previous history of overdose(s)
- Taking opioids by injection
- Taking opioids after a long period of not using, such as prison or a detox program.
- Opioid tolerance decreases while not using, so people cannot take as high of a dose as they could before taking a break.
- Using opioids alone
- Having kidney, liver, or respiratory (breathing) issues
- Engaged in use (taking more than prescribed)

MORE TIPS & FACTS
Opioid users should designate a friend or family member to be their rescue person (one they live with or see often).
- Good Samaritan laws in most states protect people who ask for help from 911/EMS in an overdose emergency.
- Naloxone only works for opioid overdoses. It will not influence the effects of any other types of drugs.
- When calling 911, tell the operator that someone is unconscious and not breathing. Try to reduce background noise and be prepared with location and contact information if possible.
- Learn how to use your Naloxone kit before you need to use it. After reading this pamphlet, store it with your Naloxone kit so you have it as a reference.
- For more information about substance abuse and mental health please visit: Findtreatment.samhsa.gov
  Helpline: 1-800-662-4357

OPSI OD OVERDOSE PREVENTION:
NALOXONE
Naloxone is a medication intended for reversal of opioid overdose.
Learn how to spot an overdose and respond in an emergency before you ever need to.

DO YOU KNOW...
- What puts someone at risk for an overdose?
- How can I recognize an overdose if I see one?
- How do I know if I should give Naloxone?
- What should I do in an overdose situation?
Answers, instructions, and more information provided inside.

http://michigan-open.org/
Michigan Opioid Collaborative (MOC)

In partnership with Michigan Department of Health and Human Services (MDHHS), the Department of Psychiatry and the Injury Center of the University of Michigan is working to build a statewide network to help Michigan prescribers (“providers”) to use Medication Assisted Treatment (MAT) for patients with an Opioid Use Disorder (OUD). The resulting project, called the Michigan Opioid Collaborative (MOC), provides same day consultation from physicians with specialty addiction training to support enrolled providers.

Three Easy Steps:
1. Contact us to enroll to as a Provider
2. Contact our local Behavioral Health Consultant (BHC) when you have a patient you are concerned may have an OUD
3. Receive patient support and referrals from our BHC and same day consultation from our physician team

How to Enroll

Enrollment is easy.
1. Contact us using the contact us page or email us at: moc-administration@umich.edu
2. We will contact you to complete the process which includes having the prescriber sign an MOC Prescriber Agreement.
3. You begin calling for consultations as needed.

Contact Us

If you are a provider treating patients with Opioid Use Disorders (OUDs) and interested in learning more about Medication Assisted Treatment, please contact Suzanne Kapica, MOC Project Manager, via email at: suszanna@med.umich.edu
Household Medication Disposal Event

Clean out your medicine cabinets and bring your unused, unwanted or expired medications to the Michigan State Capitol in Lansing for safe disposal on Tuesday, September 12, 2017, from 10:30 a.m. to 1:30 p.m.

The Michigan Department of Environmental Quality (DEQ) is once again partnering with the Michigan Pharmacists Association (MPA) to increase public awareness about the importance of proper medication disposal. Pharmacists, student pharmacists and police officers will be on the south Capitol lawn collecting unused, unwanted or expired medications, including controlled substances, for incineration. People with disabilities or those who are short of time can utilize the drop-off tent at the intersection of Capitol Avenue and Michigan Avenue.

Visit www.MichiganPharmacists.org/medicationdisposal for more details about the event, including what is and is not being accepted, or see the DEQ Drug Disposal Web page at www.michigan.gov/deqdrugdisposal to locate other medication take-back options near you.

Not sure if you have time? Take two minutes to hear why proper disposal of unused medications in both a human health and environmental concern.
Kick start lifesaving conversations about DRUG-FREE living

There is an epidemic of prescription opioid misuse and heroin use nationwide. To combat this, Discovery Education and the Drug Enforcement Administration (DEA) have joined forces to bring you Operation Prevention, an education program for elementary, middle and high school classrooms which aims to educate students, using science, about the impacts of these drugs.

Check out these resources and more at OperationPrevention.com
Operation Prevention offers an expanding collection of resources for students, teachers, and parents:

**Digital Classroom Lessons**
Elementary, middle, and high school classroom-ready lessons and companion guides provide educators with standards-aligned tools to integrate seamlessly into classroom instruction.

**Video Challenge**
This scholarship contest encourages students to send a message to their peers about the dangers of prescription opioid misuse by creating a 30-60 second original Public Service Announcement to win up to $10,000. The 2018 Video Challenge will launch November 2017.

**Parent Toolkit**
Parents can join the conversation with a family discussion guide which provides information on the warning signs of opioid misuse and a guide to prevention and intervention to empower families to take action. Now includes talking points for parents of elementary students. Available in English and Spanish.

**On Demand Virtual Field Trip**
Take students on a virtual journey, where leading experts provide the unfiltered facts on drugs and addiction. A companion activity helps start discussions in the classroom.

**Spanish Resources**
Operation Prevention offers expanding Spanish resources, including a Spanish website, student learning module and translated parent toolkit to aid families with their discussions about opioid misuse and prevention.

**Student Learning Module**

Check out these resources and more at [OperationPrevention.com](http://OperationPrevention.com)
ASK THE DOCS: ABOUT HEROIN

What exactly is heroin? And how is it different from legal drugs? Students asked, and doctors answered these questions and more during NIDA's "Chat Day."

Read Full Story

https://www.justthinktwice.gov/
Additional resources that are available for providers and patients:

- Posters
- Fact Sheets
- Checklists
- Education on Epidemic

https://www.cdc.gov/drugoverdose/index.html

For additional training:

https://www.cdc.gov/drugoverdose/training/overview/training.html