MSHRM MICHIGAN SOCIETY OF HEALTHCARE RISK MANAGEMENT

OPIOID AND CONTROLLED SUBSTANCE PRESCRIBING IN MICHIGAN

Dealing with the Challenge of New Laws, New Prescribing Requirements, & New Sanctions for Non-Compliant Prescribers

Presenters:

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Disclosure Statement

Greg Drutchas and Elise Arsenault are attorneys at Kitch Drutchas Wagner Valitutti & Sherbrook. They do not have any relevant financial relationships with any commercial interests producing health care goods or services.

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Opioid Crisis (1)

- Michigan had:
  - 13 fold increase in opioid overdose deaths between 1999 and 2015 – MI Office of Recovery Oriented Systems
  - 8th most opioid-related deaths in US (2016) – 2,347 deaths
  - 14th highest death rate (24.4 deaths per 100,000 people)
- National Institute on Drug Abuse estimate:
  - 21 to 29% of patients misuse opioids prescribed for chronic pain
- Opioid-related deaths outpace car accident and breast cancer deaths in Michigan and nationally
- Babies treated for drug dependence statewide has risen from 4.1 per 1,000 births in 2010, to 7.6 in 2016
  - U.P.: 29 per 1,000 births in 2016 (down from 37 in 2015)

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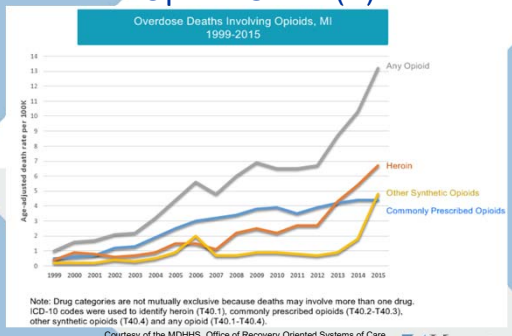
Opioid Crisis (2)



Courtesy of the MDHHS, Office of Recovery Oriented Systems of Care

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Objectives

- After this presentation, participants will be able to:
  - Define the new legal requirements in Michigan for prescribing opioids and controlled substances
  - Identify and analyze the remaining areas of uncertainty or ambiguity in the law
  - Assess and discuss practical, best practice suggestions to comply with law despite ambiguity
  - Formulate an internal (mental) compliance checklist for dealing appropriately with opioids and other controlled substances

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Outline

- Presentation will discuss new opioid/controlled substance requirements for:
  - MAPS registration, consultation and reporting
  - Educational Information and consent forms for patients
  - Limitations on the amount/duration of prescriptions
  - Bona Fide Prescriber-Patient Relationship
  - License discipline and liabilities for all of the above
  - Pharmacist dispensation (time permitting)
  - Risk management tips (time permitting)

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What is an Opioid? (1)

Michigan Law

- The Public Health Code defines "Opiate" (not Opioid)
  - "A substance having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having addiction-forming or addiction-sustaining liability. It does not include, unless specifically designated as controlled under section 7212, the dextrorotatory isomer of 3-methoxy-n-methyl-morphinan and its salts (dextromethorphan). It does include its racemic and levorotatory forms." MCL 333.7108
- Mich. Admin. Code R 338.3101 et seq. schedules categories of "opiates" and "opium derivatives"
- Michigan Worker's Compensation regulations do define "Opioid drugs"
  - "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." Mich. Admin. Code R 418.10109(i).

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Opioid Definition (2)

Federal Law

- Centers for Disease Control provide federal definition
  - "Natural or synthetic chemicals that interact with opioid receptors on nerve cells in the body and brain, and reduce the intensity of pain signals and feelings of pain. This class of drugs that include the illegal drug heroin, synthetic opioids such as fentanyl, and pain medications available legally by prescription, such as oxycodone, hydrocodone, codeine, morphine, and many others."

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Inpatient Definition (1)

- Generally: term of art referring to patients formally admitted to hospital
- LARA interprets "inpatient" to mean administration inside a licensed health facility
  - Includes:
    - Observation and ER patients in hospital
    - Nursing homes, homes for the aged, inpatient hospice, freestanding surgical outpatient facility
    - Outpatients (in a licensed facility)
  - Does NOT include outpatient hospice
  - Affects several exceptions to new requirements

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Inpatient Definition (2)

- LARA was asked if "inpatients" include administration to patients in hospital on outpatient basis (e.g., patient at hospital for 20 minutes to receive injection)
- LARA's response:
  - With the pieces of legislation that allow exemptions for inpatient administration, we rely on that differentiation between **administering/ordering** and prescribing/ dispensing. If the prescriber is ordering/administering the drug (a schedule 2-5 controlled substance), *where the patient does not have possession of, nor will they leave a facility or dispenser with possession of the drug*, the checking of MAPS and the completion of education and the Opioid Start Talking form do not have to be done. (Emphasis in original).

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Ordering vs Prescribing (1)

- LARA making distinction between ordering and prescribing
  - Affects several new requirements
  - Restrictions apply when provider is prescribing and dispensing for use outside of health facility
    - Patient takes possession of the drug or leaves facility with drug
  - Restrictions do NOT apply when ordering or administering for inpatient use
    - See slide 11 for "inpatient" definition

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Ordering vs Prescribing (2)

- Distinction is not clear from statute
  - No separate definition of "ordering"
  - "Prescription" is defined as an order:
    - "an order by a prescriber to fill, compound, or dispense a drug or device . . . In a health facility or agency licensed under article 17 or other medical institution, an order for a drug or device in the patient's chart is considered for the purposes of this definition the original prescription. MCL 333.17708(3) (emphasis added).
  - Distinction would make some statutory exceptions redundant

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Ordering vs Prescribing (3)

- Reliability of distinction between ordering and prescribing
  - Likely high
  - Possibility that a court could hold LARA's interpretation is not consistent with statutes
  - Risk management suggestions:
    - Create facility-wide policy tailored to facility's needs
    - Keep up to date with guidance from LARA

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Ordering vs Prescribing (4)

- Response from MAPS representative to question:
  - The key to all of these laws is for the prescriber to know the difference between *prescribing and dispensing* versus *administering or ordering* an opioid or controlled substance. So if the prescriber is "ordering" a schedule 2-5 controlled substance for inpatient stay then the checking of MAPS and signing of the [Start Talking] form would not apply. Regardless of the clinical setting or facility type, if the prescriber is not "ordering" or "administering" the drug for inpatient use, but is prescribing or dispensing to the patient where the patient takes **possession of** the drug, then MAPS needs to be checked before prescribing or dispensing to the patient and an [Start Talking] form needs to be completed, in the instance the medication is one containing an opioid. (emphasis in original).

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MAPS CHANGES (1)

- April, 2017
  - New software technically PMP AWARxE
  - MAPS name still used (although not the current name)
- March 27, 2018 (MCL 333.7333a)
  - Narrowed exception for post-prescription MAPS reporting
    - Prior exemption: no report for administration directly to patient
    - New exception: no report for administration at the hospital
  - Before dispensing/prescribing drug with buprenorphine or methadone to patient in substance abuse treatment program, prescriber must:
    - Obtain and review MAPS report, regardless of duration
    - Report dispensation to MAPS, if permitted by federal law

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MAPS Changes (2)

- Began June 1, 2018 – MAPS Registration Required
  - Prescribers must register with MAPS before dispensing or prescribing controlled substances (not just opioids). (MCL 333.7303a(5))
    - Delegates must register
    - Limited waiver for prescribers without software
  - LARA created prescriber registration verification tool
  - Failure to comply is ground for license discipline
    - Probation, reprimand, limitation, denial, fine, suspension, revocation
    - LARA not required to investigate; can instead send non-disciplinary warning letter

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MAPS Changes (3)

3 Day Rule

- Began June 1, 2018 – MCL 333.7303a(4)
- If prescribing more than 3 day supply of controlled substance (not just opioids), provider must first obtain and review MAPS report on the patient
  - **Exception**:
    - Statute: No report required where the dispensing AND administration occurs in a hospital or freestanding surgical outpatient facility
    - LARA's interpretation is that no report required for drug ordered for inpatient administration
      - Would include additional facilities (SNF)
- MAPS review can be delegated

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MAPS Changes (4)

3 Day Rule

- Lack of Clarity:
  - How far back does the MAPS report need to go?
    - Unclear from statute, but 6 month lookback period is good practice
    - Lookback period should be suited to patient's needs
  - How closely in time to the prescription does MAPS need to be checked? How often must MAPS be checked?
    - No precise requirements
    - LARA says best practice = as close to prescribing as possible
- One MAPS check for serial prescriptions

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MAPS Changes (5)

3 Day Rule

- Failure to check MAPS grounds for disciplinary action
  - Probation, reprimand, limitation, denial, fine suspension, revocation, or permanent revocation
  - LARA not required to investigate, can send non-disciplinary warning letter
- Record of compliance
  - MAPS retains user activity information
  - For data access outages, make note of issue, complete MAPS requirements once restored

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MAPS Changes (6)

3 Day Rule

- Confidentiality/Access
  - Patients not entitled to MAPS report. MCL 333.7333a(9)
    - LARA says provider should not provide hard copy of report to patient or allow patient access in EMR
  - Prescribers may document finding in notes
  - Prescribers should not provide MAPS report directly to law enforcement
    - LARA leaves open possibility to cautiously report suspicious behavior to law enforcement.
    - Prescribers cannot pull MAPS reports on individuals without patient relationship

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Patient Information Requirements

- March 27, 2018 (MCL 333.16282)
  - Licensees treating patient for an opioid-related overdose must give patient information on substance use disorder services.
    - "Opioid-related overdose" is "a condition, including, but not limited to, extreme physical illness, decreased level of consciousness, respiratory depression, coma, or death, that results from the consumption or use of an opioid or another substance with which an opioid was combined or that a layperson would reasonably believe to be an opioid-related overdose that requires medical assistance."
- March 31, 2018 (MCL 333.7303a(3))
  - Before prescribing any controlled substance (not just an opioid), prescriber must ask about other controlled substances the patient is using
    - Response must be recorded in medical record

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Start Talking Consent Form (1)

- Began June 1st, new requirements (for opioids only) to:
  - Provide "Start Talking" information to patients prior to opioid prescription
  - Obtain patient (or representative) signature on consent form
- Minors and patients generally have different requirements
  - Some requirements similar enough to be combined
  - But there are differences prescribers must heed

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Start Talking Consent Form (2)
Minors

- MCL 333.7303b
- Before issuing first prescription in a single course of treatment for opioid controlled substance, must discuss:
  - Risks of addiction/overdose with the controlled substance
  - Increased risk of addiction to a controlled substance to an individual who is suffering from both mental and substance abuse disorders
  - Danger of taking opioid controlled substance w/ benzodiazepine, alcohol, or another central nervous system depressant
  - Any other information in the patient counseling information section of the drug label required under federal law
- Minor's parent, guardian or another adult authorized to consent to the minor's medical treatment must receive information and sign consent form

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Start Talking Consent Form (3)
Minors

- Specific Start Talking form must:
  - Be separate from any other consent document (kind of!)
  - Have name/quantity of controlled substances
  - Have amount of initial dose
  - Have statement that a controlled substance is a drug DEA identified as having potential for abuse
  - Certify that prescriber discussed the required topics
  - Have number of refills, if any
  - Have signature and date by appropriate individual

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Start Talking Consent For (4)
Minors

- **Exceptions** to information and signature requirements:
  - Treatment is associated with or incident to an emergency
  - Treatment is associated with or incident to inpatient or outpatient surgery.
  - Prescriber determines filling the requirements would be detrimental to minor's health or safety.
  - Treatment is rendered in a hospice or oncology department of a hospital
  - Prescription issued at the time of discharge from a hospice or oncology department of a hospital
  - When consent of the minor's parent/guardian not legally required.

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Start Talking Consent For (5)
Minors

- No statutory exception for inpatient use for minors
  - Recent indications from LARA indicate LARA will interpret minor statute to include exception for inpatient use
- FAQ: Does the Start Talking Form have to be completed for inpatient administration of an opioid drug?
  - No, for inpatient as well as outpatient surgical procedures, the form does not have to be completed given that the opioid is being administered while the patient is at the facility. For example, administration of the opioid for inpatient stay within, but not limited to, a hospital, freestanding surgical outpatient facility, skilled nursing facility, hospice, homes for aged, etc.

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Start Talking Consent For (6)
Minors

- LARA was asked: If a provider is ordering an opioid for inpatient use with a minor patient, but the minor does not meet the listed exceptions in MCL 333.7303b, is a Start Talking form needed?
  - LARA Response: . . . [W]hen the drug is being administered/ordered, and the patient is not taking possession of the drug via prescribing/dispensing, the form does not need to be completed

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Start Talking Consent Form (7)
General

MCL 333.7303c

- Prior to prescribing or dispensing opioid controlled substances, must provide the information below to the patient (or patient representative):
  - Dangers of opioid addiction
  - Proper disposal of controlled substances
  - Delivery of a controlled substance is a felony in Michigan
  - For pregnant/female patients of reproductive age, short & long-term effects of exposing fetus to a controlled substance, including neonatal abstinence syndrome

Exception: Opioids ordered for <u>inpatient use</u> do not require information or Start Talking form

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Start Talking Consent Form (8)
General

- Patient (or patient's representative) must sign a consent form confirming receipt of information
- Remaining Issues / Areas Lacking Clarity
  - Narrow definition of "patient representative"
    - Means a "guardian of a patient, if appointed, or a parent, guardian, or person acting in loco parentis, if the patient is a minor, unless the minor lawfully obtained health care without the consent or notification of a parent, guardian, or other person acting in loco parentis"
    - Patient advocate not listed
      - LARA advises that is likely just an oversight
      - Facilities should create standard policy

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Start Talking Consent Form (9)
Areas of Uncertainty/LARA Deviation from Statute

1. Combination of General/Minor forms?
   - LARA has one form for both general and minor requirements
     - Directly contradicts statute
     - LARA indicated combination is permissible
   - LARA developed a model consent form
     - English, Spanish, Arabic versions available
   - Use of LARA's form is not required
     - Unique forms must comply with legal requirements
     - Can adapt form for use with more than one drug

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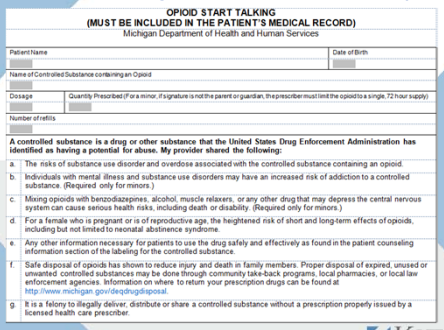
Start Talking Consent Form (10)



OPIOID START TALKING
(MUST BE INCLUDED IN THE PATIENT'S MEDICAL RECORD)
Michigan Department of Health and Human Services

Patient Name	Date of Birth

Name of Controlled Substance containing an Opioid

Dosage	Quantity Prescribed (For a minor, if signature is not the parent or guardian, the prescriber must limit the opioid to a single, 72 hour supply)

Number of refills

A controlled substance is a drug or other substance that the United States Drug Enforcement Administration has identified as having a potential for abuse. My provider shared the following:

a. The risks of substance use disorder and overdose associated with the controlled substance containing an opioid.
b. Individuals with mental illness and substance use disorders may have an increased risk of addiction to a controlled substance. (Required only for minors.)
c. Mixing opioids with benzodiazepines, alcohol, muscle relaxers, or any other drug that may depress the central nervous system can cause serious health risks, including death or disability. (Required only for minors.)
d. For a female who is pregnant or is of reproductive age, the heightened risk of short and long-term effects of opioids, including but not limited to neonatal abstinence syndrome.
e. Any other information necessary for patients to use the drug safely and effectively as found in the patient counseling information section of the labeling for the controlled substance.
f. Safe disposal of opioids has shown to reduce injury and death in family members. Proper disposal of expired, unused or unwanted controlled substances may be done through community take-back programs, local pharmacies, or local law enforcement agencies. Information on where to return your prescription drugs can be found at http://www.michigan.gov/deqdrugdisposal.
g. It is a felony to illegally deliver, distribute or share a controlled substance without a prescription properly issued by a licensed health care prescriber.

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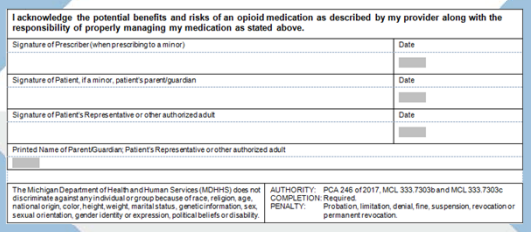
Start Talking Consent Form (11)



I acknowledge the potential benefits and risks of an opioid medication as described by my provider along with the responsibility of properly managing my medication as stated above.

Signature of Prescriber (when prescribing to a minor)	Date
Signature of Patient, if a minor, patient's parent/guardian	Date
Signature of Patient's Representative or other authorized adult	Date
Printed Name of Parent/Guardian; Patient's Representative or other authorized adult	

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

AUTHORITY: PCA 246 of 2017, MCL 333.7303b and MCL 333.7303c
COMPLETION: Required.
PENALTY: Probation, limitation, denial, fine, suspension, revocation or permanent revocation.

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Start Talking Consent Form (12)

Areas of Uncertainty/LARA Deviation from Statute

2. Application of the General Requirements to Minors
   - General statute applies to all patients, including minors
   - Not completely clear how to address differences
     - Different requirements
       - e.g., discussion topics, required elements for minor form
     - Different exceptions
       - e.g., hospice use, outpatient surgery

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Start Talking Consent Form (13)

Areas of Uncertainty/LARA Deviation from Statute

General Exceptions	Minor Exceptions
Inpatient Use [use at facility]	Emergency
	Surgery
	Detrimental to Health/Safety
	Hospice/Hospital Oncology Department Use
	Discharge from Hospice/Hospital Oncology Department
	Where Parent/Guardian consent not required
	Inpatient Use [LARA interpretation]

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Start Talking Consent Form (14)

Areas of Uncertainty/LARA Deviation from Statute

- No published guidance from LARA on what happens when patient is exempted under one, not both, statutes
- Informally, LARA has only provided narrow answers
  - Suggests a form is required unless there is an exception to both requirements
- Best practice
  - Minors: discuss all required topics in general & minor statutes
  - All patients: include elements required for minor form (e.g., dosage, refills) to reduce opportunity for errors
  - Must complete Start Talking form unless general AND minor exceptions are met

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Start Talking Consent Form (15)

Areas of Uncertainty/LARA Deviation from Statute

- Retroactivity
  - LARA indicated Start Talking requirement not retroactive
    - If same drug was prescribed prior to 6/1/18, Start Talking consent form is not required for:
      - That prescription
      - Refills on that prescription, even if after 6/1/18
      - Changes in dosage to that prescription after 6/1/18
- Timing of When to "Start Talking"
  - Before prescribing, but no specific time frame
  - LARA indicated may be circumstances where there is time gap between Start Talking form and prescribing (e.g., surgery)

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Start Talking Consent Form (16)

Areas of Uncertainty/LARA Deviation from Statute

- Frequency of consent requirements
  - Technical differences in legal language for minors and general could suggest different requirements
  - LARA acknowledges language differences suggests that standards are effectively the same
    - Minors: Start Talking form required before issuing the first prescription in a single course of treatment
      - Refills/modification in dosage does not constitute new course of treatment
    - Adults: Start Talking form required before issuing prescription for new opioid drug
      - Refills/modification in dosage does not require new form

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Start Talking Consent Form (17)

- Consent forms must be incorporated into the medical record
- Prescribers can delegate providing information
  - Normal delegation principles apply (e.g., PAs, as subfield, cannot delegate)
- Failure to comply is grounds for disciplinary action including probation, limitation, denial, fine suspension, revocation, or permanent revocation
  - Unlike MAPS registration/3 Day Rule, no investigatory discretion

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Prescription Limitations (1)

- 72 Hour Limit in Limited Circumstances (MCL 333.7303b(3))
  - Effective June 1, 2018
  - If the signer of minor's "Start Talking" consent form was "another adult authorized to consent to the minor's medical treatment", cannot prescribe more than 72 hour supply of that opioid controlled substances

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Prescription Limitations (2)

7 Day Opioid Limit for Acute Pain

- 7 Day Opioid Limit for Acute Pain (MCL 333.7333b)
  - Began July 1, 2018
  - If treating patients for acute pain, cannot prescribe more than a 7 day supply of opioids within 7 day period
    - "Acute pain" means "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".
  - Currently no exceptions to this limit
    - Common exceptions in other states not present

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Prescription Limitations (3)

7 Day Opioid Limit for Acute Pain

- LARA indicated restriction not applicable to opioids ordered for inpatient administration
  - Question: Does the 7 day supply limitation for acute pain apply where the prescriber is ordering and administering the controlled substance to an inpatient?
    - LARA Response: Keywords in this statute are "shall not prescribe". In the instance where the drug is not being prescribed or dispensed and/or where the patient does not take possession of them, it does not apply
  - Note: not included in published guidance

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Prescription Limitations (4)

7 Day Opioid Limit for Acute Pain

- Challenges with 7 day rule
  - Difficulty differentiating between acute and chronic pain
    - LARA emphasizes good documentation to show medical necessity and clinical judgment
  - Pain can change characterization over time
    - LARA advised prescribers can re-characterize pain classification as needed, with documentation in medical record
  - Burden on underserved and rural areas
  - Providers "dropping out" of opioid prescribing

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Bona Fide Prescriber-Patient Relationship (1)

- MCL 333.7303a
- Prescriber pre-condition that applies to all controlled substances
- Implementation was delayed until March 31, 2019 or until LARA publishes regulations, whichever is earlier
  - LARA released initial draft of the regulations in May
  - Regulations in rule-making process

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Bona Fide Prescriber-Patient Relationship (2)

- Before prescribing a controlled substance, prescriber must have a "bona fide prescriber-patient relationship"
  - A Bona Fide Relationship exists when both elements are met:
    - 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 via telehealth.
    - The prescriber creates and maintains a record of the patient's treatment in accordance with medically accepted standards

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Bona Fide Prescriber-Patient Relationship (3)

- Unanswered Issues:
  - Alternate/covering physicians (including groups)
    - Delegation does not fit physicians; Subfield licensees (PAs) cannot delegate
  - Frequency of review and evaluation/retroactivity
  - Could cause delays in care upon movement to different facilities (e.g., Hospital to SNF)
- Failure to comply is grounds for licensure violation
  - Disciplinary action may include probation, limitation, denial, fine suspension, revocation or permanent revocation

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Bona Fide Prescriber-Patient Relationship (4)

- Proposed Mich. Admin Code R 338.3161a
  - In progress
  - Regulation expressly permits delegation of Bona Fide Relationship elements (full assessment & creation and maintenance of records)
  - Objections raised by stakeholders at 1st hearing
    - Delegation does not fit many common scenarios
    - Does not include any exceptions (e.g., emergency, transition to other care setting, on-call)
    - No clarification on frequency, timing or retroactivity

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Follow-Up Care

- Delayed until March, 2019, or publication of regulations (MCL 333.7303a(2))
  - When controlled substance (not just an opioid) prescribed, must provide follow up care to monitor effectiveness
    - Where prescriber follow up, must refer patient to patient's primary care physician for follow up
    - If no primary care physician, refer to another licensed provider geographically accessible to patient
  - Issues/Concerns
    - Reimbursement
    - Underserved/rural areas
    - What constitutes follow up care?

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Proposed/Potential Changes

- Proposed Regulations
  - Training Requirements (Proposed Mich. Admin Code R 338.3135)
    - Individuals licensed to prescribe/dispense opioids or controlled substances must complete training course
    - Course also required for any other individuals who prescribe, dispense, administer under delegation
- Potential Changes
  - LARA working with hospice stakeholders to address unique situation hospice patients face
    - Less concern over addiction and abuse
    - Quick changes in condition and intense pain levels

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Changes for Pharmacist Dispensing (1)
(Already in Place)

- January 23, 2018 – new rules regarding opioid antagonist
  - MCL 333.17744e, Mich. Admin. Code R 339.201 et seq.
  - Permits pharmacies to establish a standing order for opioid antagonists
    - Reverse effects of opioid overdoses (Naloxone, Evzio)
  - Pharmacies that establish standing order must register with LARA prior to dispensing under the order
    - Link to registration page of LARA's website

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Changes for Pharmacist Dispensing (2)
(Already in Place)

- Opioid antagonist rules, cont.
  - Pharmacists who dispense under standing order must:
    - Be trained in antagonist use and overdose response
    - Provide individual educational materials and referral for treatment services after dispensation
  - Pharmacies must submit information each quarter with:
    - # of opioid antagonist doses dispensed under standing order
    - # of total opioid antagonist doses dispensed under any order/prescription
    - # of each type of formulation dispensed
    - Other relevant information required by LARA

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Changes for Pharmacist Dispensing (3)
(Already in Place)

- As of 2/11/18 (MCL 333.17751)
  - Pharmacists cannot dispense additional controlled substances except schedule 5 non-opioid controlled substances without new prescription
- As of 3/27/18 (MCL 333.7333(3); See 21 CFR 1306.13)
  - Revision to MI law defers to federal law, which allows partial filling of schedule 2 CS prescriptions for:
    - Terminally ill subjects [no change]
    - Patients in long term care facilities
    - Cases where the pharmacist does not have enough supply to fill the entire prescription (for initial amount; for remaining amount, if within 72 hours)

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Risk Management Tips (1)

- Prepare administration and providers to address:
  - Increase in costs/patient visits due to new laws
  - Patient concerns regarding opioids
- Maintain complete and accurate lists of "opioids" and "controlled substances" easily accessible to all health professionals
- Communicate with EMR provider to "build-in" reminders and cues for providers
- Begin planning/coordinating required training sessions for all clinical staff members

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Risk Management Tips (2)

- Consider adding opioid prescriptions as distinct element of quality review/peer review
- Oversight needed for all controlled substances prescribers
- Be aware of private payor/pharmacy restrictions on opioid/CS prescribing
- Follow new accreditation requirements (e.g., The Joint Commission, Acute Care, LD.04.03.13, MS.05.01.01)
- Consider creating uniform reference materials for patient information requirements

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References (1)

- American College of Physicians course, SAFE Opioid Prescribing: Strategies. Assessment. Fundamentals. Education – Link
- Centers for Disease Control, Guidelines for Prescribing Opioids for Chronic Pain – Link
- Centers for Disease Control, Checklist for Prescribing Opioids for Chronic Pain – Link
- Michigan prescription Drug & Opioid Abuse Commission Acute Care Opioid Treatment and Prescribing Recommendations
  - Emergency Department – Link
  - Surgery Department – Link
  - Dental – Link
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- US Department of Health and Human Services, Best Practices for Addressing Prescription Opioid Overdoses, Misuses and Addiction – Link

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