The Evolving Landscape of the Opioid Epidemic in 2018 – What the Provider Can Do

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Disclosures – David Neff, DO

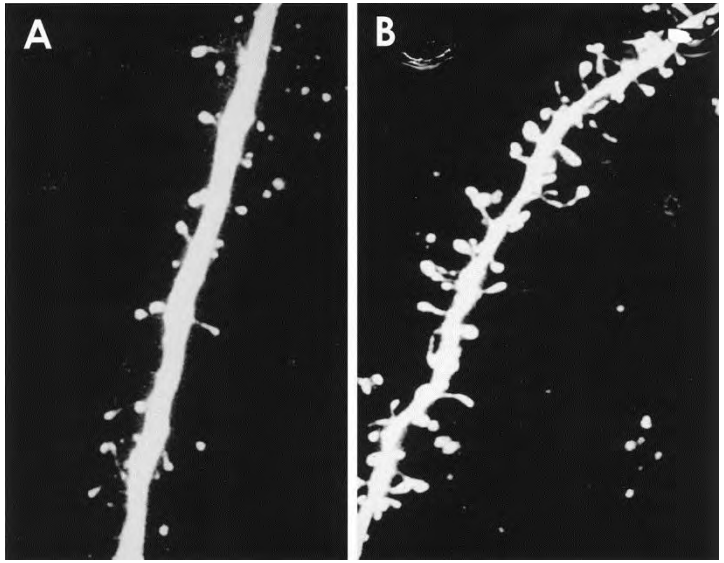
- Full time employee – MDHHS
- Conflicts – None

Overview

1. The Neurobiological and Sociological Consequences of Addiction
2. The Expanding Magnitude of the Epidemic
    - When the Prescription Is The Problem
    - When Prescription Opioid Diversion Is The Problem
    - When Heroin Is the Problem
    - When Fentanyl and Fentanyl Analogues Are the Problem
3. What Can Be Done to Address the Dual Epidemic Within
4. What Can The Provider Do to Prevent Addiction, Overdose and Death – Starting On Monday?

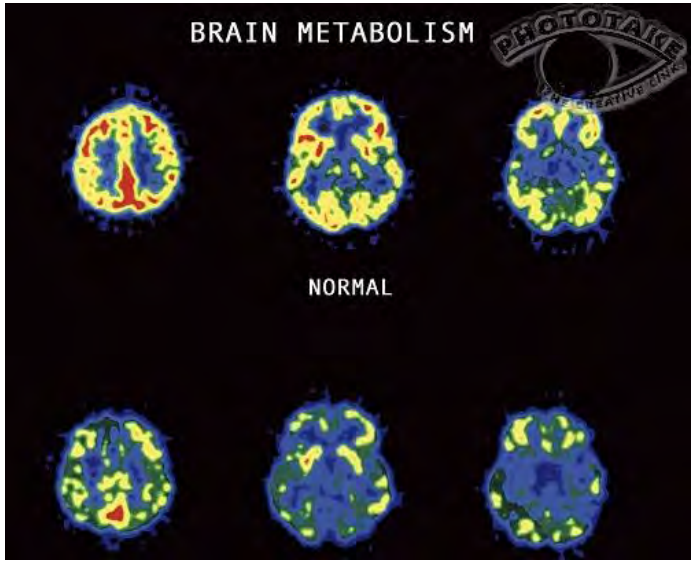
The Neurobiological and Sociological Consequences of Addiction

Addiction Is A Neurodegenerative and Neurocognitive Disorder From Prolonged Exposure of External Chemicals on the Brain



Loss of Neural Dendrites (Prolonged Drug Exposure)

Normal Dendrites



Loss of Brain Function Including the Frontal Lobe

Biological and Social Consequences of Ongoing Addiction

- Prolonged exposure leading to downregulated structure and function (decreased neurotransmitters, receptors and structural proteins)
- Loss of self control and executive function, ie, judgement
- Inability to calculate risk versus benefit
- Severe uncontrollable drug seeking to satisfy craving and avert withdrawal symptoms
- Loss of Family, Job and Shelter
- Petty Theft Leading to Larger Crimes, Arrest and Incarceration
- Accidental overdose, cardiorespiratory arrest, brain injury and death

The Problem Grows Exponentially with the Cyclical Nature of Aberrant Behaviors and Adverse Childhood Events (ACE's)

Landmark study of 17,000 participants from 1995-1997 by the Centers for Disease Control in partnership with Kaiser Permanente

Aberrant Behaviors Increase Risk for ACE's

- Physical abuse
- Sexual abuse
- Emotional abuse
- Physical neglect
- Emotional neglect
- Intimate partner violence
- Mother treated violently
- **Substance misuse within household**
- Household mental illness
- Parental separation or divorce
- Incarcerated household member

Findings: A person's ACEs score has a strong relationship to numerous health, social and behavioral problems across a lifespan, including substance use disorders

ACE's Increase Risk for Aberrant Behaviors

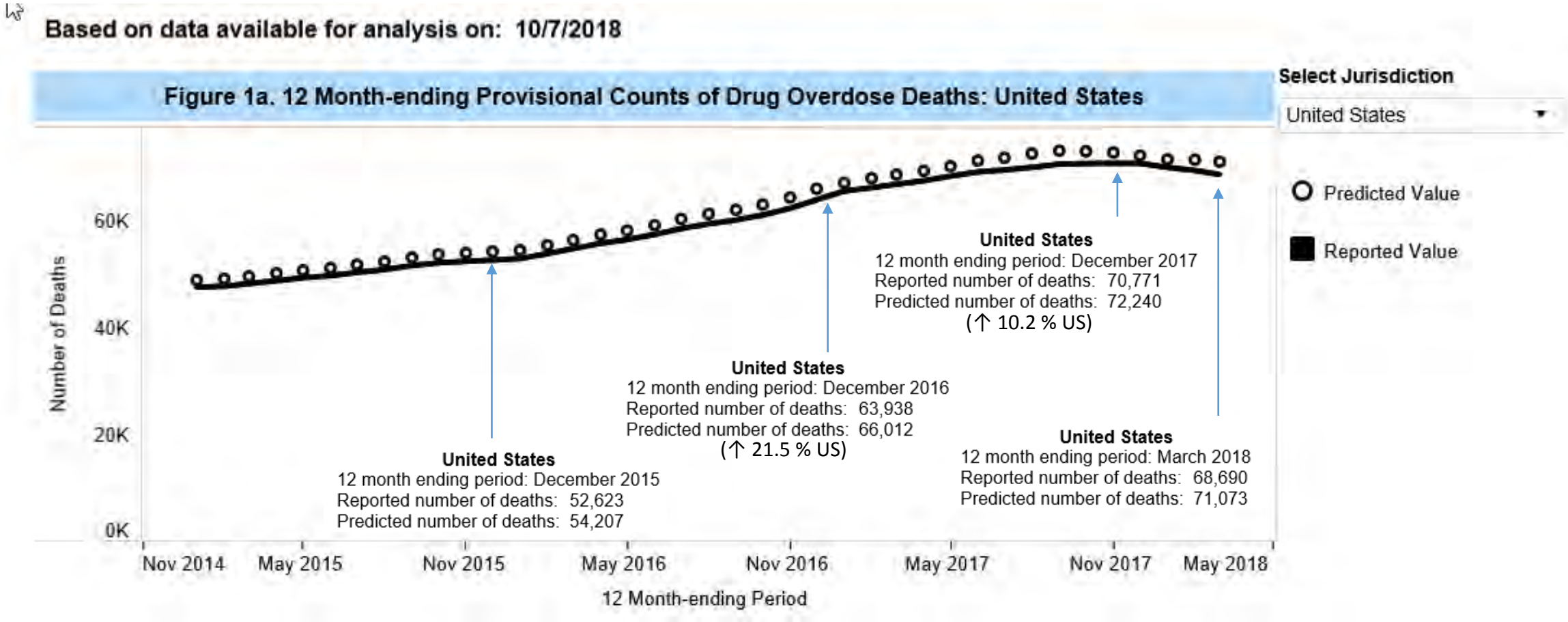
- Alcoholism and alcohol abuse
- Chronic obstructive pulmonary disease (COPD)
- Depression
- Fetal death
- Health-related quality of life
- **Illicit drug use**
- Ischemic heart disease (IHD)
- Liver disease
- Risk for intimate partner violence
- Multiple sexual partners
- Sexually transmitted diseases (STDs)
- Smoking
- Suicide attempts
- Unintended pregnancies
- **Neonatal Abstinence Syndrome**
- Early initiation of smoking
- Early initiation of sexual activity
- Adolescent pregnancy
- Diabetes
- Lung cancer

https://www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/adverse-childhood-experiences

The Opioid Epidemic in 2018

National Center for Health Statistics
NVSS Vital Statistics Rapid Release
Provisional Drug Overdose Death Counts

12 Month-ending Provisional Counts and Percent Change of Drug Overdose Deaths

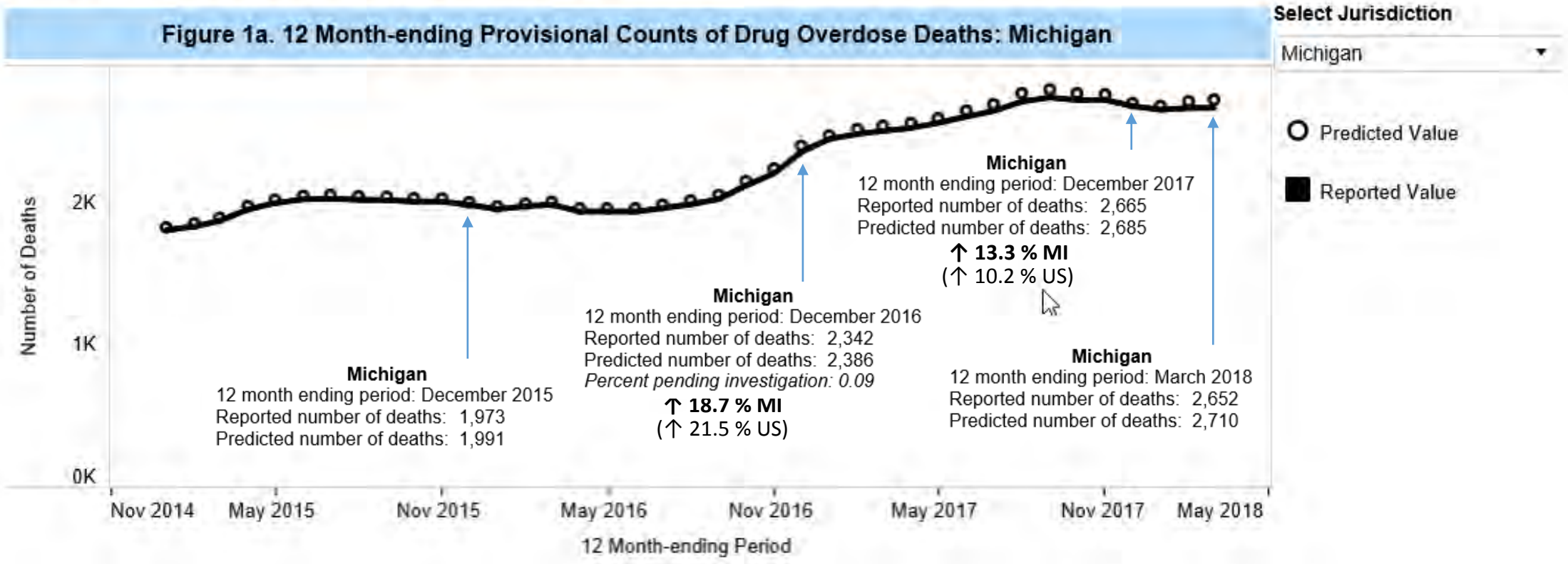


https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm Accessed 10/18/18

National Center for Health Statistics
NVSS Vital Statistics Rapid Release
Provisional Drug Overdose Death Counts

12 Month-ending Provisional Counts and Percent Change of Drug Overdose Deaths

Based on data available for analysis on: 10/7/2018

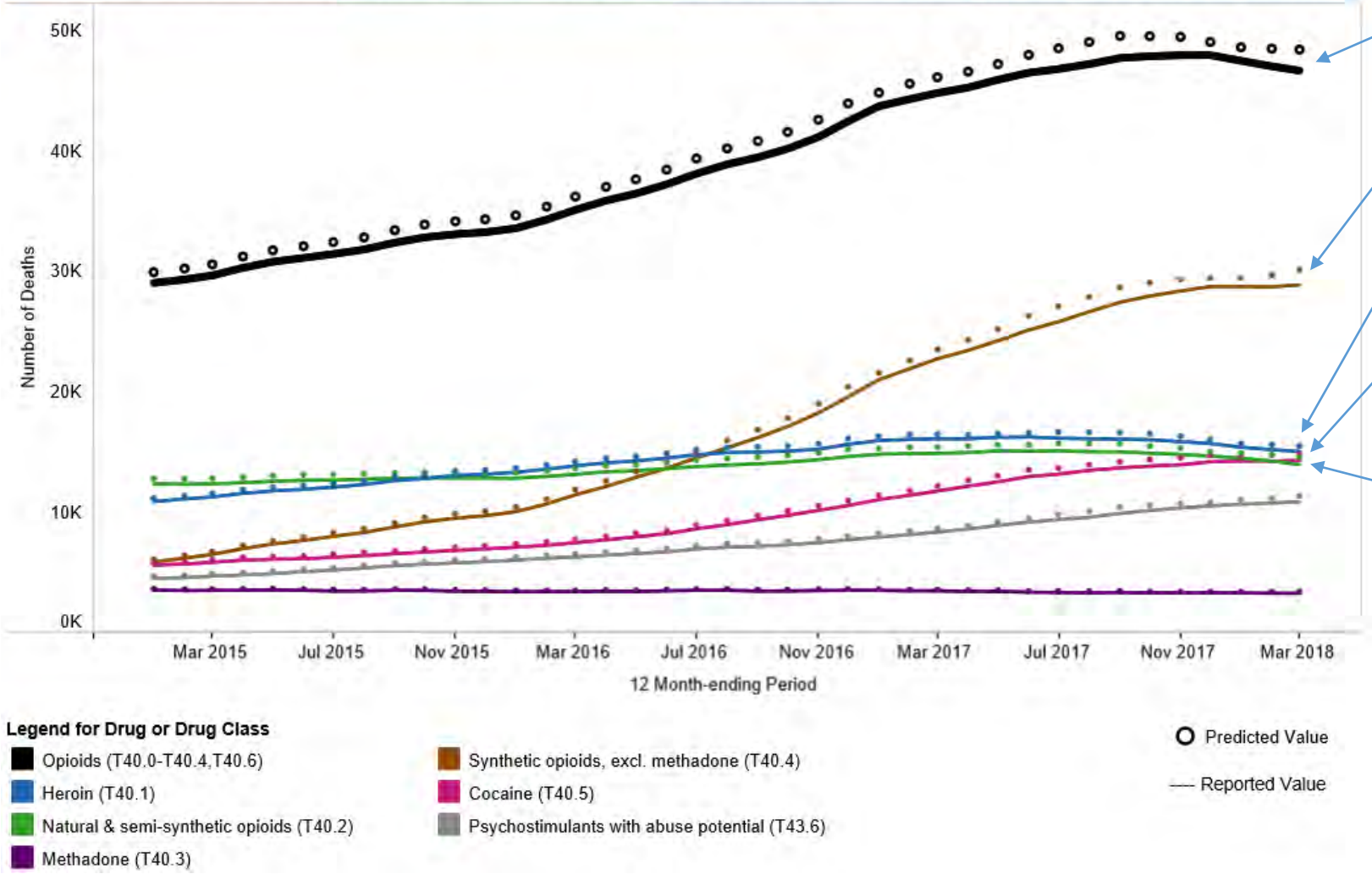


https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm Accessed 10/18/18

National Center for Health Statistics
NVSS Vital Statistics Rapid Release
Provisional Drug Overdose Death Counts

12 Month-ending Provisional Number of Drug Overdose Deaths by Drug or Drug Class

Figure 2. 12 Month-ending Provisional Number of Drug Overdose Deaths by Drug or Drug Class: United States



Opioids (T40.0-T40.4,T40.6)
Predicted number of deaths: **49,038**
Reported number of deaths: **47,944**

Synthetic opioids, excl. methadone (T40.4)
Predicted number of deaths: **29,395**
Reported number of deaths: **28,686**

Fentanyl/ Fentanyl Analogues

Heroin (T40.1)
Predicted number of deaths: **15,950**
Reported number of deaths: **15,616**

Natural & semi-synthetic opioids (T40.2)
Predicted number of deaths: **14,934**
Reported number of deaths: **14,573**

Prescription Opioids

Cocaine (T40.5)
Predicted number of deaths: **14,639**
Reported number of deaths: **14,095**

Psychostimulants with abuse potential (T43.6)
Predicted number of deaths: **10,695**
Reported number of deaths: **10,429**

Methamphetamine/ Amphetamines

https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm Accessed 10/18/18

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

Morbidity and Mortality Weekly Report (*MMWR*)

The U.S. opioid epidemic in 2018 is now characterized as having three distinct waves:

1)the first wave of opioid overdose deaths began in the 1990s and included prescription opioid deaths,
2)a second wave, which began in 2010, was characterized by an increase in heroin related deaths
3)a third wave started in 2013, with deaths involving highly potent synthetic opioids, particularly illicitly manufactured fentanyl (IMF) and fentanyl analogs.

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

This is an official

CDC HEALTH UPDATE

Distributed via the CDC Health Alert Network
July 11, 2018, 1300 ET (1:00 PM ET)
CDCHAN-00413

Rising Numbers of Deaths Involving Fentanyl and Fentanyl Analogs, Including Carfentanil, and Increased Usage and Mixing with Non-opioids

Number of drug submissions testing positive for fentanyl analogs and U-47700 in NFLIS in 2016 and during January–June 2017.

Fentanyl analog/synthetic opioid	2016*	January–June 2017^
Carfentanil	1,251	2,268
Furanylfentanyl	2,273	3,322
3-methylfentanyl	427	432
Acrylfentanyl	26	1,508
U-47700	533	1,087

*NFLIS Brief: Fentanyl and Fentanyl-Related Substances Reported in NFLIS, 2015–2016 & NFLIS 2016 Annual Report for U-47700.
^NFLIS 2017 Midyear Report. These data are preliminary, and may change in the Annual Report for 2017.

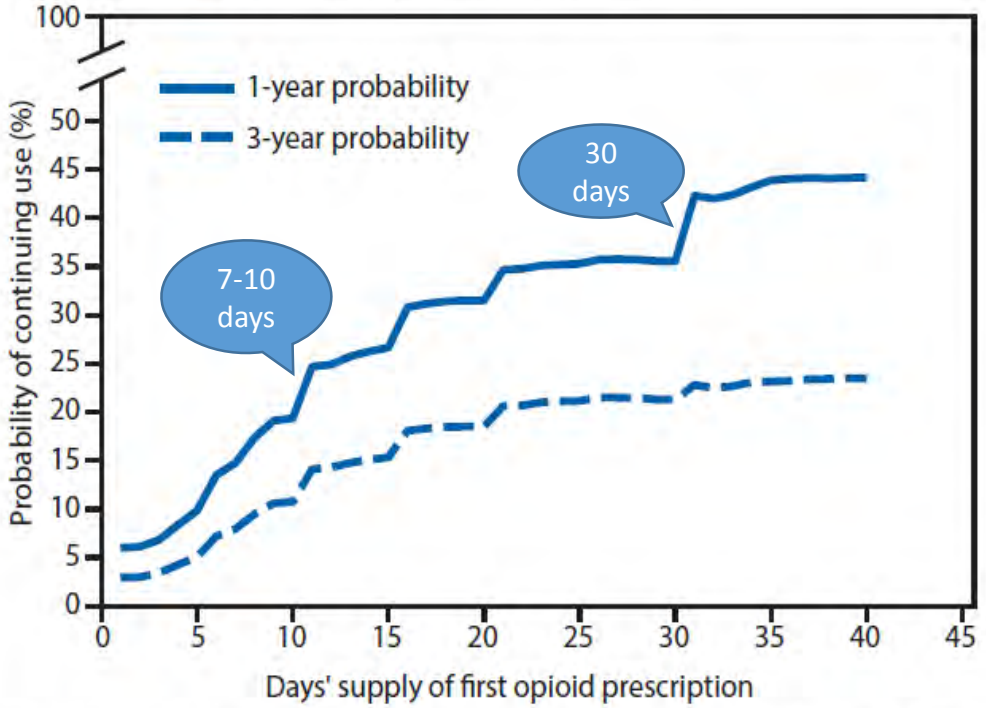
Four Primary Root Causes for The Epidemic in 2018

- When the Opioid Prescription is the Problem
  - Too much opioid being prescribed for acute and chronic pain over the last 20 years
    - Unintended consequence of treating "Pain as the 5th Vital Sign" and HCAPS Surveys
    - The Good News -- Prescription Rates are Going Down Nationally, in Michigan and in Medicaid by Double Digits in the last two years
- When Diversion of the Prescription Opioid is the Problem – National Drug Threat Assessment Survey
  - 2/3– 3/4 of Prescribed Opioids are Bought, Stolen or Given Away
  - Leakage in the Distribution System - Lost in Transit, Armed Robbery, Night-time Break-ins and Employee Pilferage
  - Illegal Backdoor Sales and Distribution – Informal Networks and Organized Crime
- When Heroin is the Problem
  - Largely distributed by 6 Mexican Cartels of Which Two are in Michigan
  - $300 Billion Dollar Global Business Where Revenues Are Only Outpaced by Walmart Global Sales
- When Illicitly Manufactured Fentanyl (IMF) is the Problem
  - Mostly made in China and sold in the US over the internet
  - Some brought across the border from Mexico or Canada
  - Reassembled by smuggled reassembled pill presses
  - Prepared for inhalation (including vaping devices) or IV injection

The Opioid Epidemic in 2018: When the Prescription is the Problem

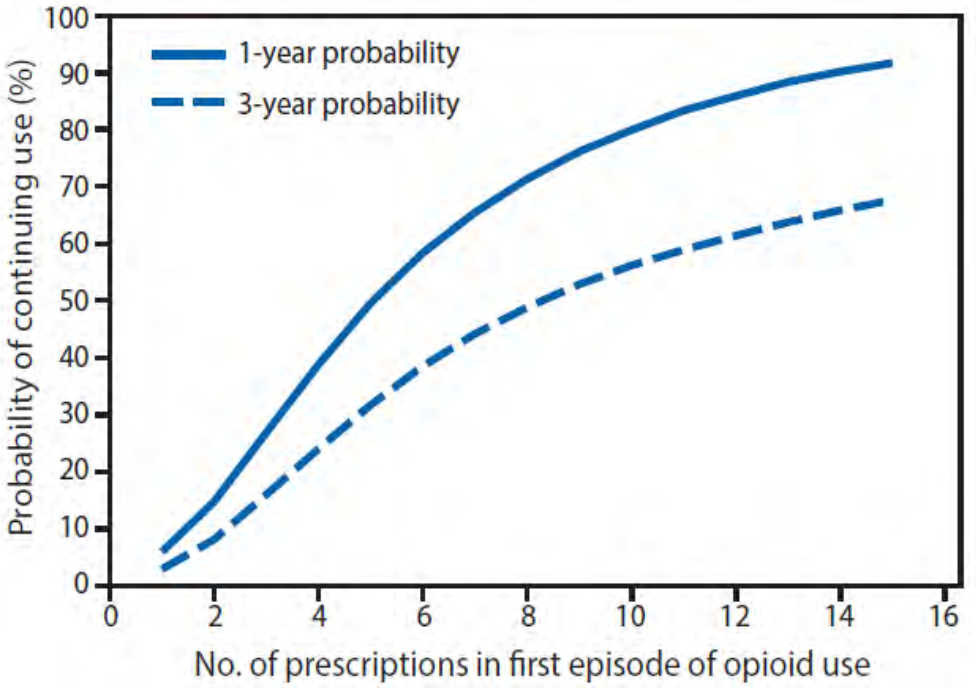
The Risk for Continued Opioid Use Goes Up with Days Supply and Number of Prescriptions in the First Episode of Care

FIGURE 1. One- and 3-year probabilities of continued opioid use among opioid-naïve patients, by number of days' supply* of the first opioid prescription — United States, 2006–2015



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

FIGURE 2. One- and 3-year probabilities of continued opioid use among opioid-naïve patients, by number of prescriptions* in the first episode of opioid use — United States, 2006–2015



* Number of prescriptions is expressed as 1–15, in increments of one prescription.

National Opioid Prescription Rates are Continuing to Shrink

The IMS Institute is now the IQVIA™ INSTITUTE for Human Data Science

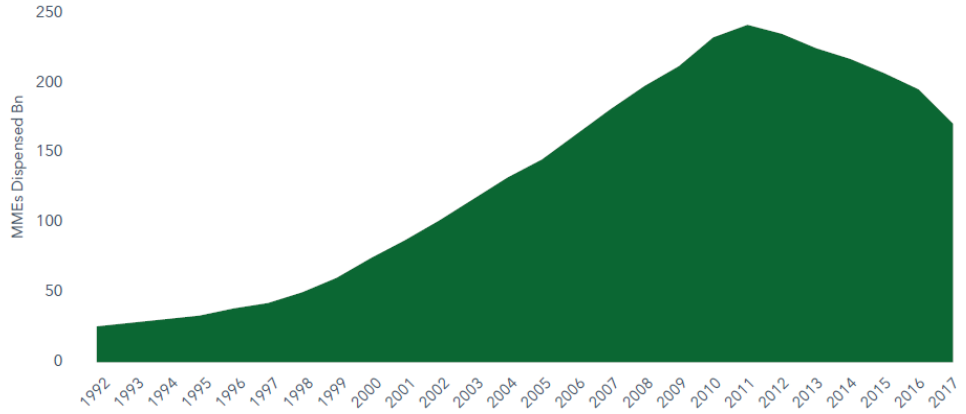
APRIL 2018

Medicine Use and Spending in the U.S.

A Review of 2017 and Outlook to 2022

Prescription opioid volume peaked in 2011 at 240 billion milligrams of morphine equivalents and have declined by 29% to 171 billion

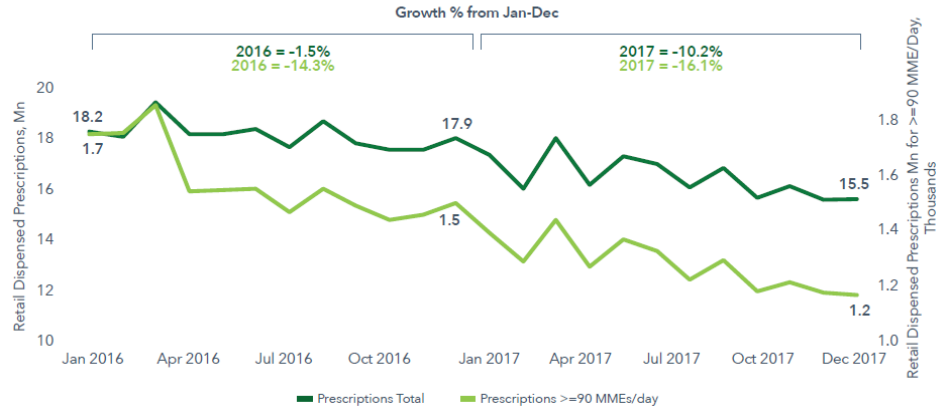
Chart 16: Narcotic Analgesic Dispensed Volume in Morphine Milligram Equivalents (MME) Bn



Source: IQVIA "SMART – Launch Edition", Dec 2017

The decline in the number of retail opioid prescriptions accelerated to 10.2% during 2017, while high doses declined by 16.1%

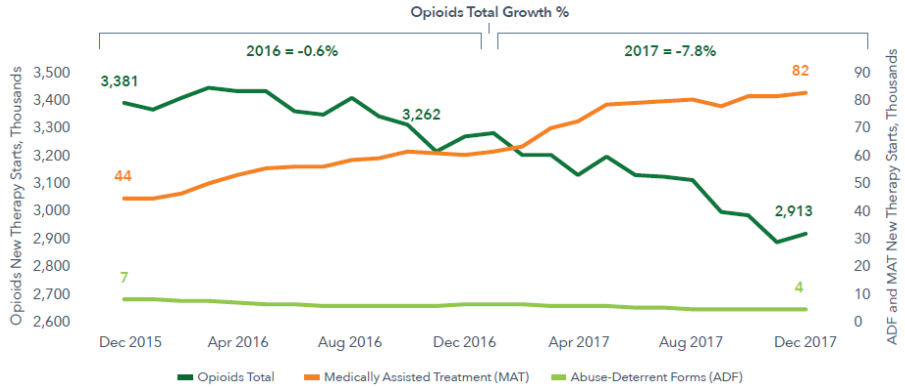
Chart 17: Monthly Retail Opioid Prescriptions and Prescriptions Dispensed at >= 90 MMEs per Day



Source: IQVIA National Prescription Audit, Xponent, IQVIA Institute, Mar 2018

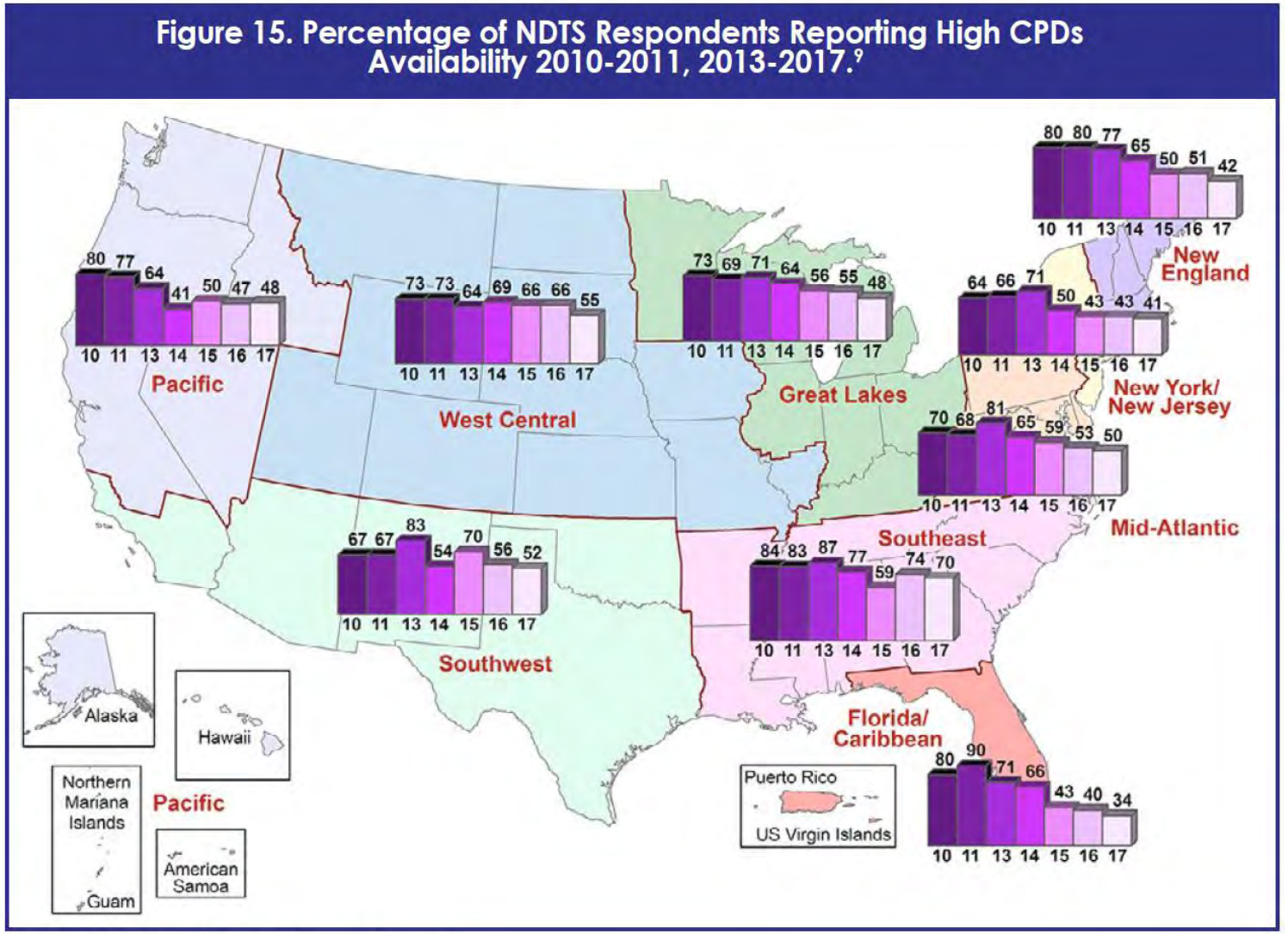
Opioid new therapy starts fell to 2.9 million per month at the end of 2017, while medically assisted treatment starts increased sharply

Chart 18: Rolling 3-Month Average of New Therapy Starts Thousands



Source: IQVIA National Prescription Audit, Mar 2018

Availability Of Controlled Prescription Drugs (CPDs) has Dropped by ~1/3

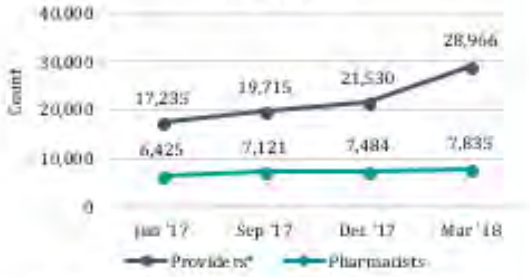


Source: National Drug Threat Survey

2017 National Drug Threat Assessment

Deidentifed MAPS Data provided by LARA in parternship with Appriss Health & MDHHS

Controlled Substances Licensed Provider and Pharmacist Registration in MAPS



*Provider count includes only those providers with controlled substances prescribing privileges. This does not represent the total number of providers registered in MAPS.

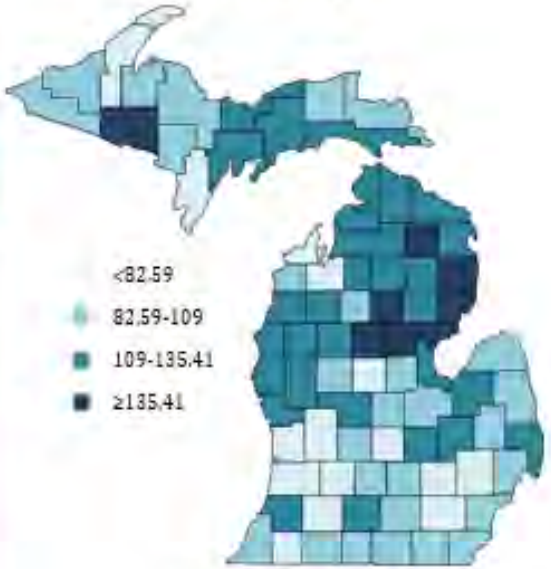
239,608 fewer

Michigan residents received an opioid prescription in Mar '18, than in Mar '16

The percent of patients receiving an opioid prescription with avg. daily dose >90 Morphine Milligram Equivalents

decreased from 10.4% of patients in Mar '16, to 6.3% in Mar '18

2017 Opioid Prescription Rate per 100 Population



Source: Michigan Automated Prescription System-MAPS 2017 Yearly Drug Utilization Report

Rate of multiple provider episodes* for prescriptions opioids, per 100,000 residents

*Multiple provider episode is defined as seeing 5 or more providers and filling a prescription at 5 or more pharmacies within the 6 months

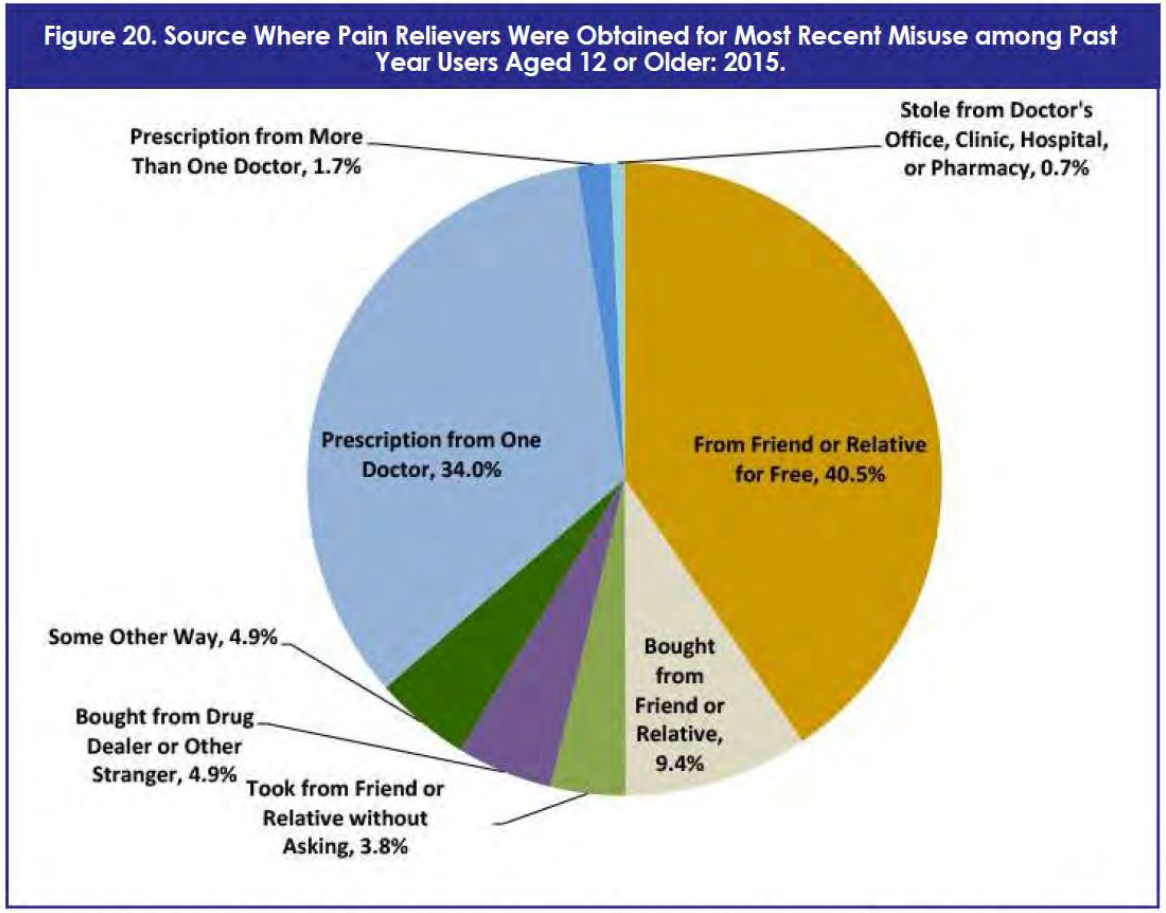
Produced by: MDHHS Injury and Violence Prevention Unit (IVP)

Data Source: LARA Michigan Automated Prescription System-MAPS Quarterly CDC Indicator Reports, 2016-2018; Prescription rate data collected from 2017 MAPS Yearly Drug Utilization Report.

The Opioid Epidemic in 2018: When the Prescription Diversion is the Problem

Data From Drug Users Responding to the DEA NDTA Survey – 2/3 of Prescription Opioids Were Obtained For Free, Bought or Stolen

- Much of This Use Started for Recreational and Not Medicinal Purposes

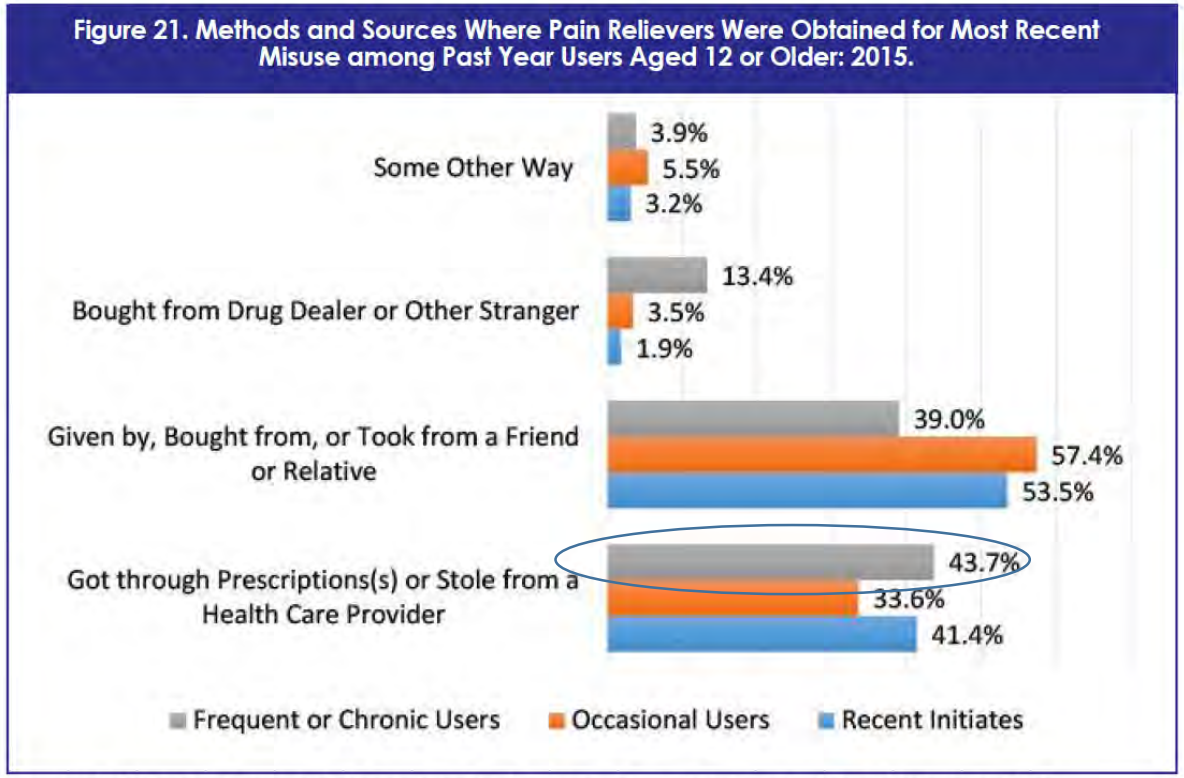


Source: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health (NSDUH)

2017 National Drug Threat Assessment

About 40% of Frequent Chronic Misusers and Recent Initiates Still Receive Their Prescription Opioid From A Provider – By Prescription or Stealing It

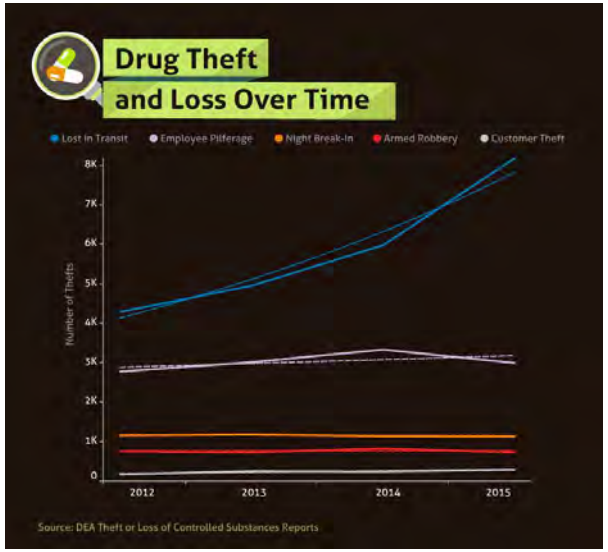
Goal is to decrease prescription rates that propagate continued misuse without clear cut indication to treat ongoing pain

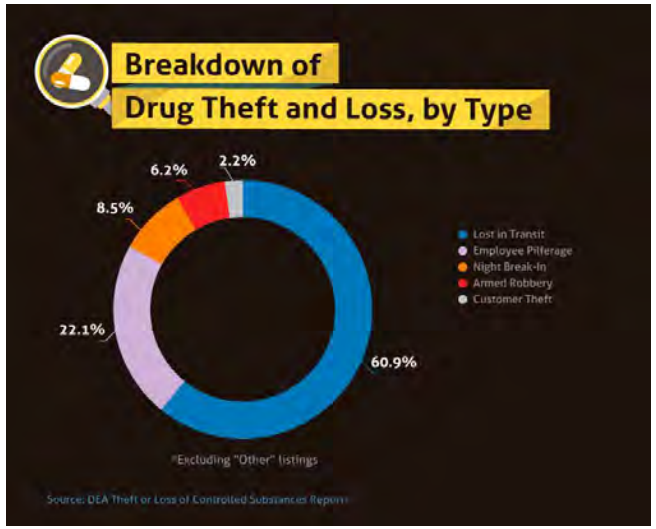


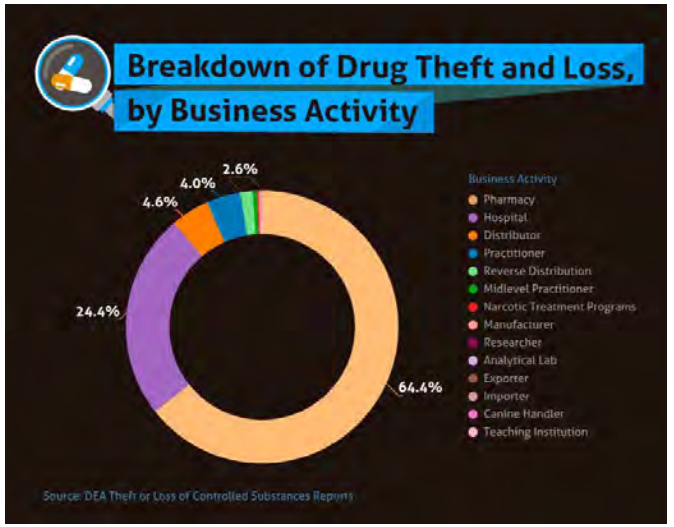
Source: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health (NSDUH)

2017 National Drug Threat Assessment

Other Forms of Prescription Opioid Diversion





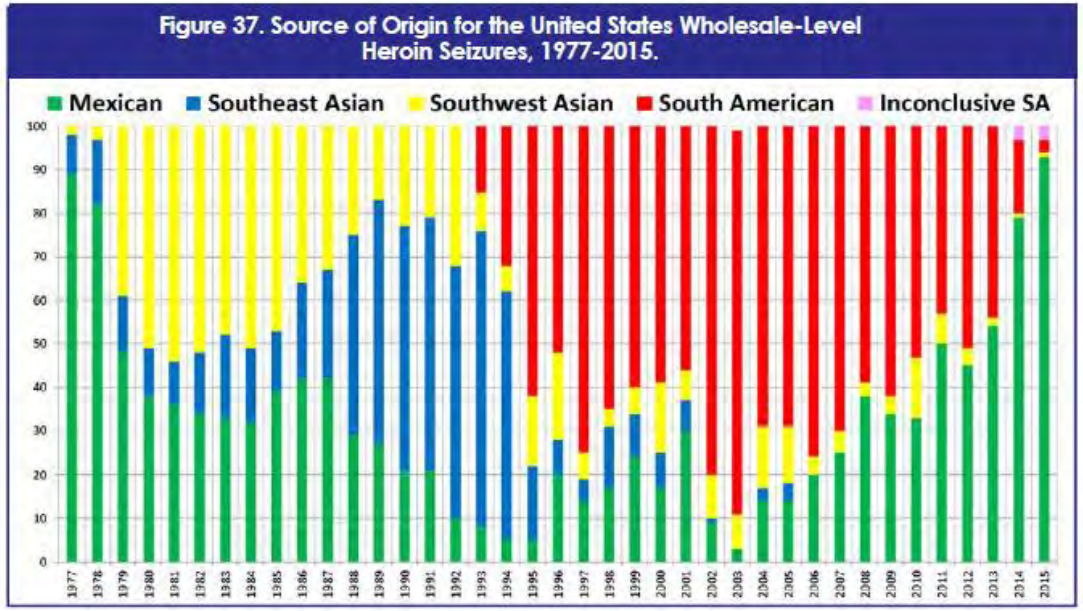


DEA 2016

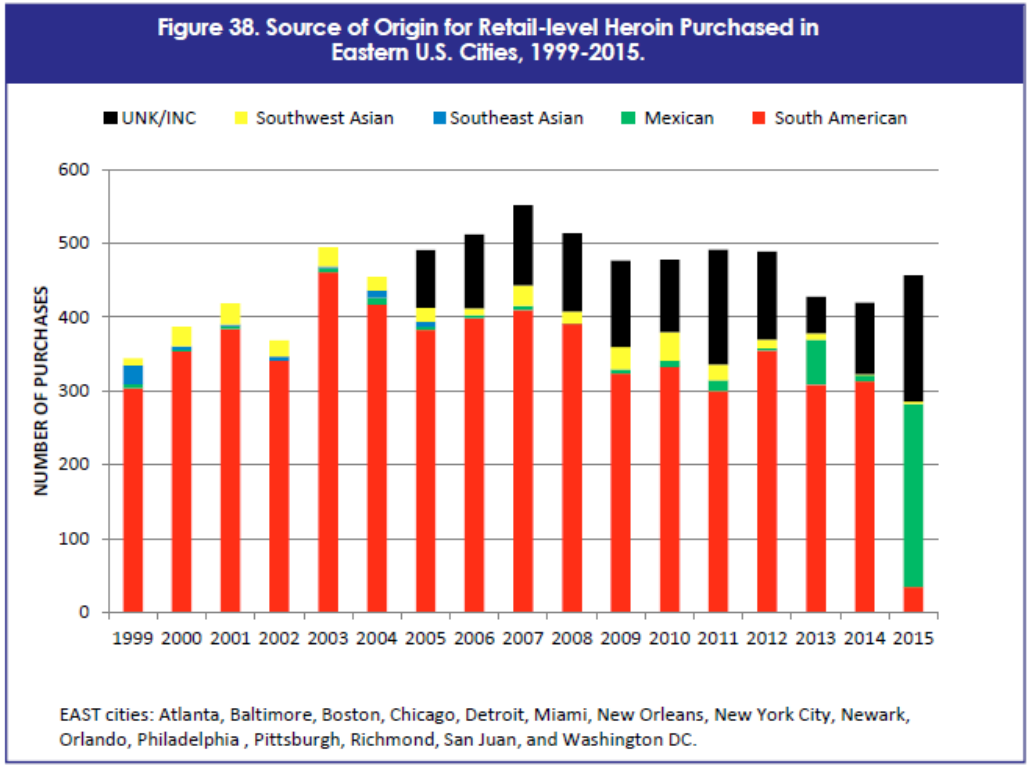
The Opioid Epidemic in 2018: When Heroin is the Problem

Most Heroin in the US Comes From Mexico

$300 Billion Dollar Industry



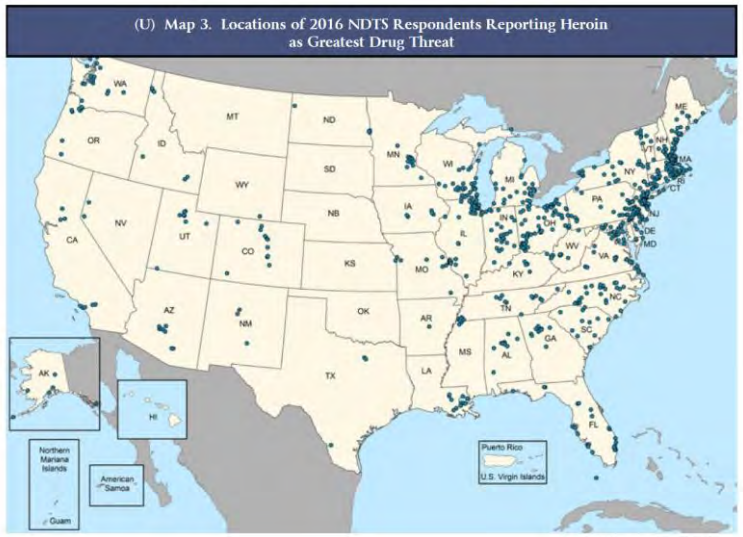
Source: DEA

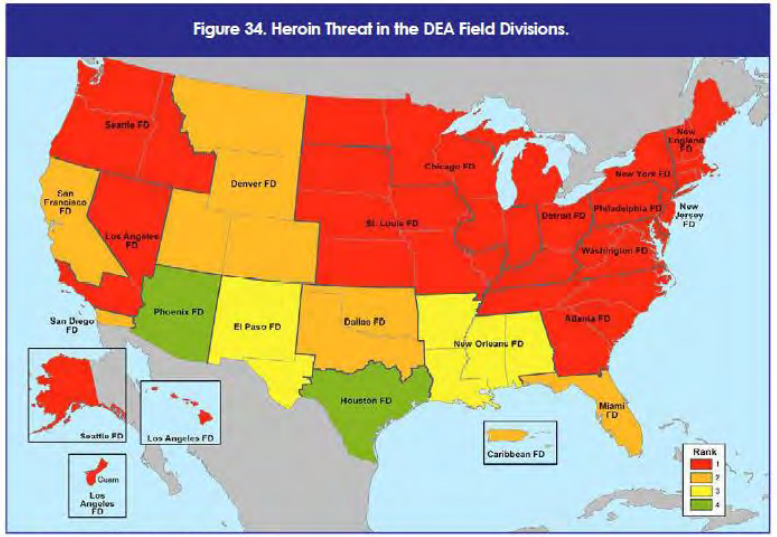


Source: DEA

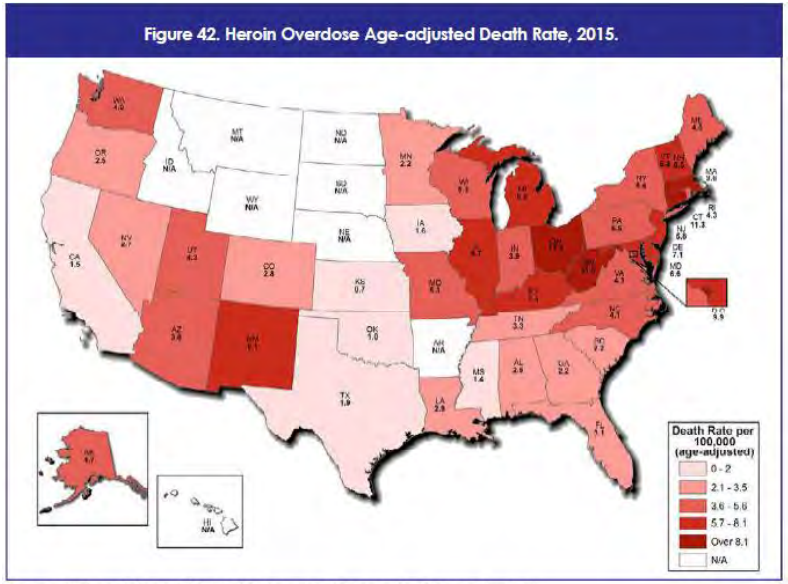
2017 National Drug Threat Assessment

The National Heroin Threat is the Greatest in the Northeast Corridor, Mid-Atlantic States and the Midwest



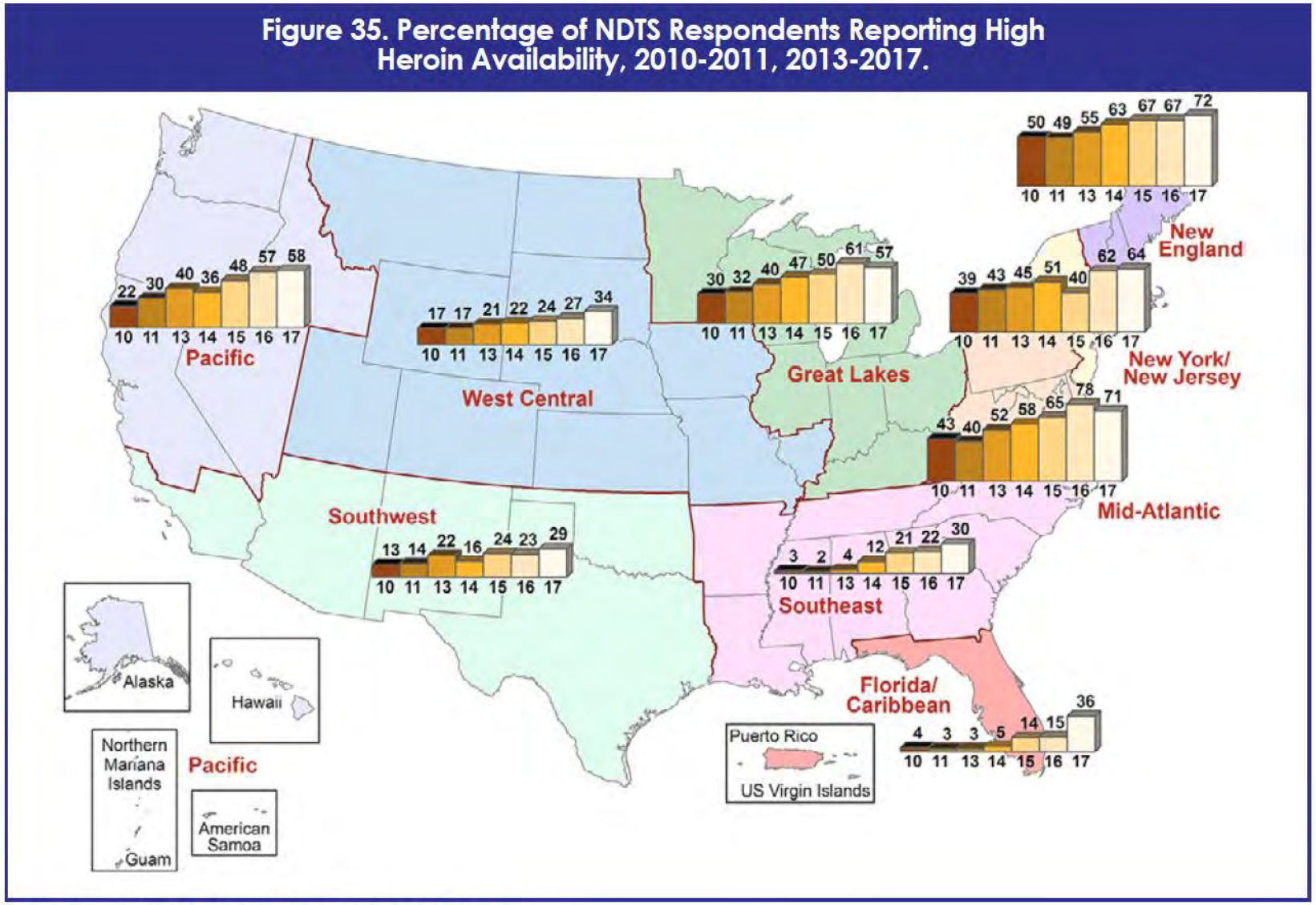


Source: DEA Field Division Reporting



Source: National Center for Health Statistics/Centers for Disease Control

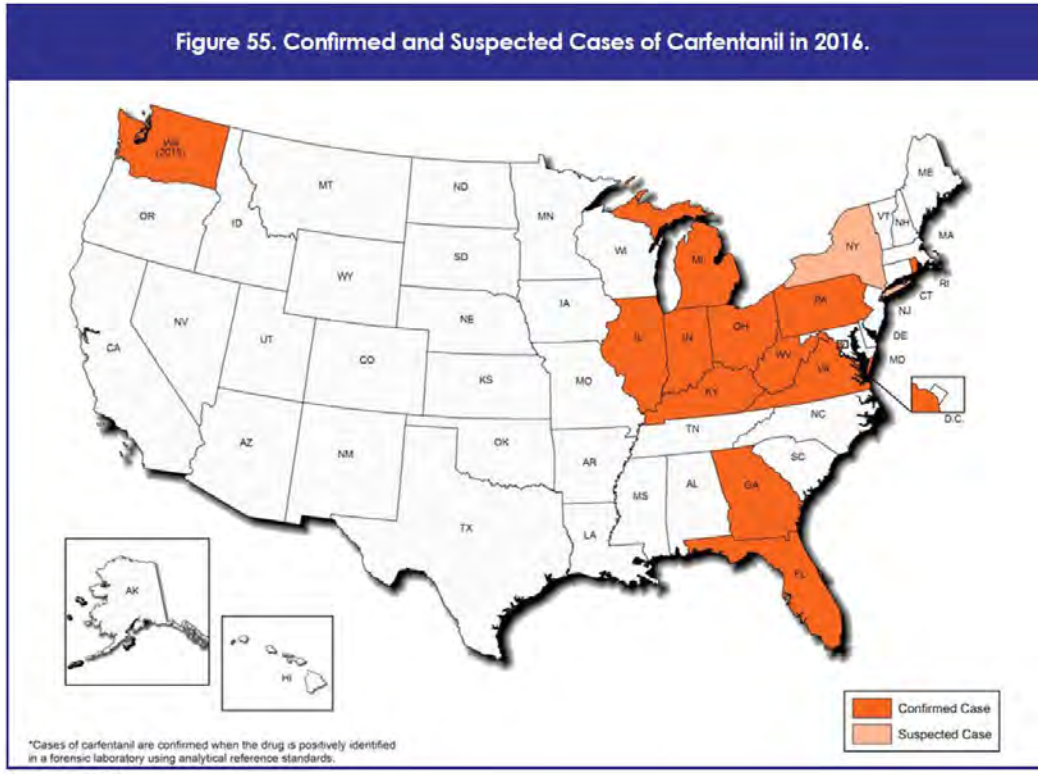
Heroin Availability Remained High in 2017



Source: 2017 National Drug Threat Survey

The Opioid Epidemic in 2018: When Fentanyl and Fentanyl Analogues Are the Problem

Carfentanyl & U-47700 Deaths in Michigan



Source: DEA

- **August 19-24, 2016** – Cincinnati area experienced 174 opioid carfentanyl overdoses
- **September 15, 2016** – First documented carfentanyl overdose seen in Kent County
- **October 6, 2016** – 19 confirmed carfentanyl overdose deaths in Wayne County since July
- **October 5, 2016** – First documented U47700 (aka, U-4 or pink) overdose seen in White Lake, MI

2017 National Drug Threat Assessment

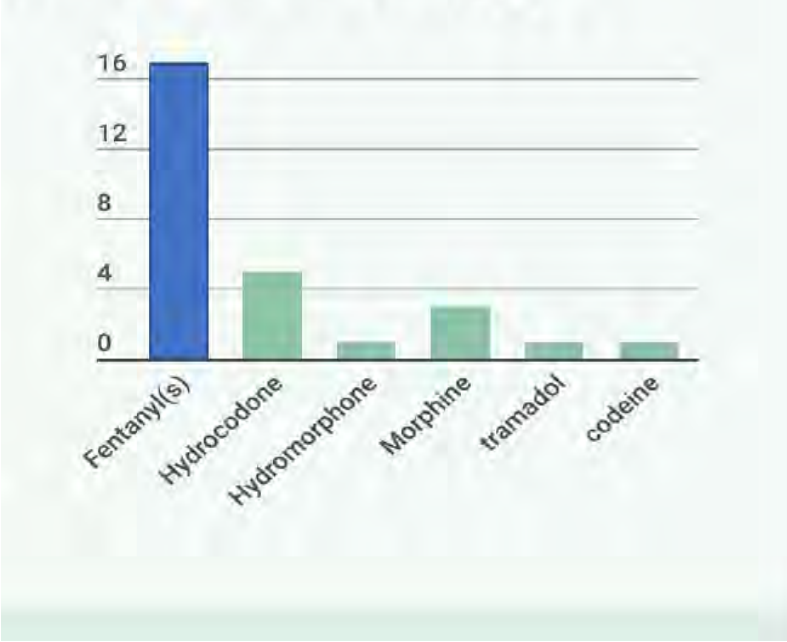
MI 2017 Overdose Deaths - Bay County Health Department

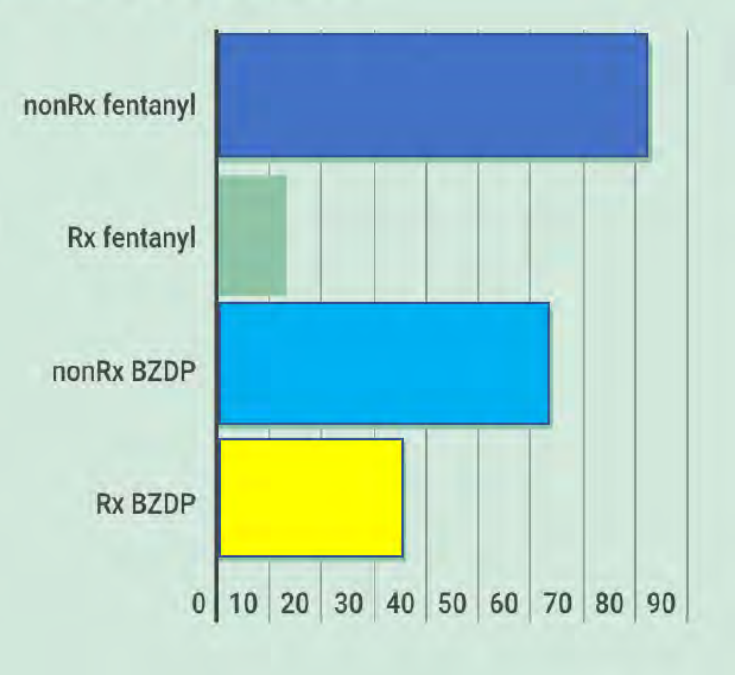
The Value of Linking Toxicology Screens to MAPS/NarxCare

30 deaths that were overdose of any kind

- 28 had an opioid
- 17 of 28 (60%) opioids were fentanyl or fentanyl family
- 14 of 17 (80%) fentanyl deaths were bootleg non pharmaceutical fentanyl
- No fentanyl was identified 4 years ago

When Fentanyl Analogues Were Found





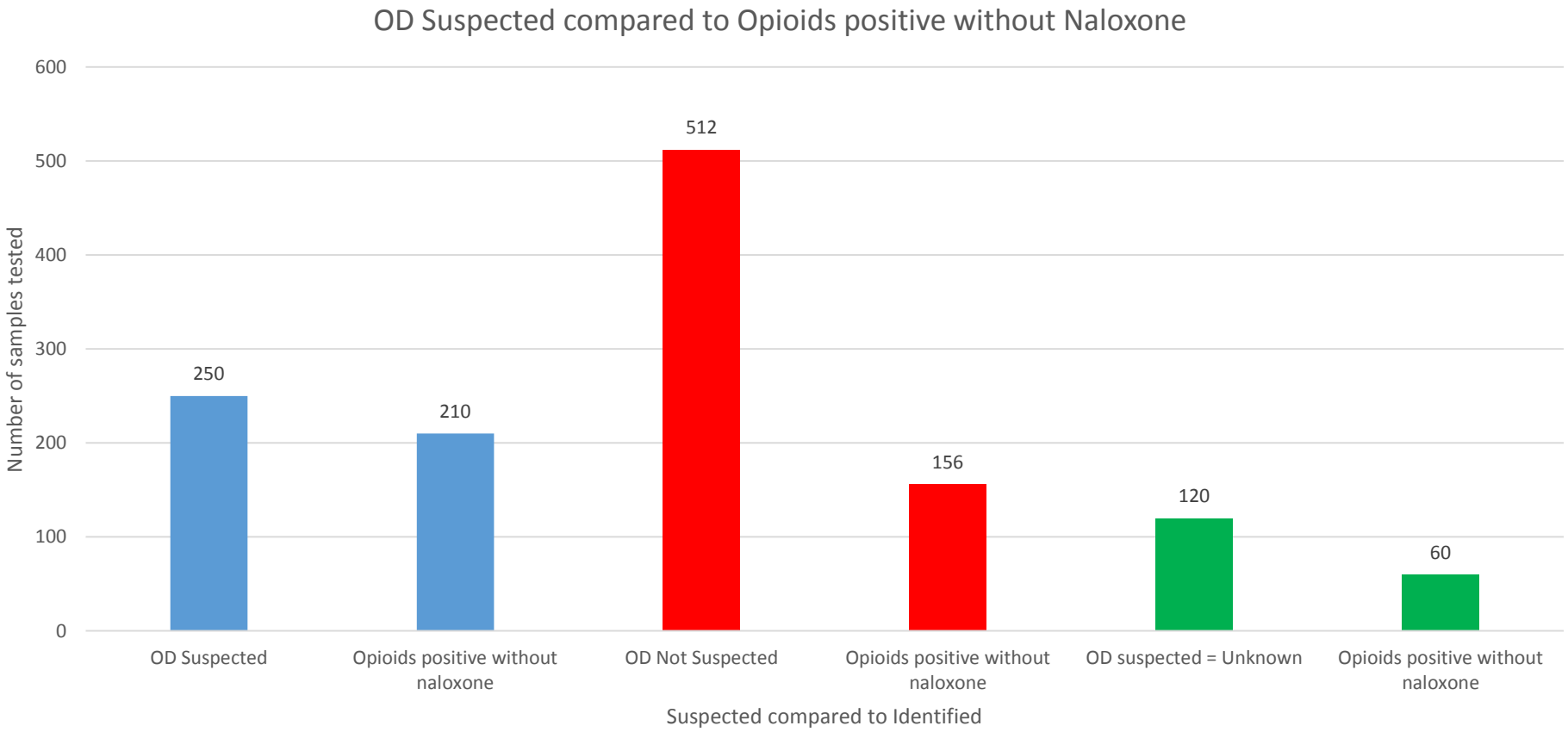
Courtesy of William Morrone, DO, Bay County Medical Examiner

2017 – Non-suicide drug deaths

County	Total	Opioids	Opioid %	Illicit	Illicit %
Allegan	12	6	50%	4	33%
Calhoun	49	44	90%	38	78%
GT/Leelanau	20	14	70%	13	65%
Kalamazoo	66	50	76%	40	61%
Mason*	6	2	33%	2	33%
Muskegon	50	39	78%	32	64%
St. Joseph	7	6	86%	6	86%
Van Buren	14	10	71%	9	64%
Total	224	171	69%	144	60%

Courtesy of Joyce deJong, DO, Chair, Pathology Department, WMU Homer Stryker School of Medicine

882 Samples from Michigan Opioid Rapid Testing (MORT) Project – 36 Counties

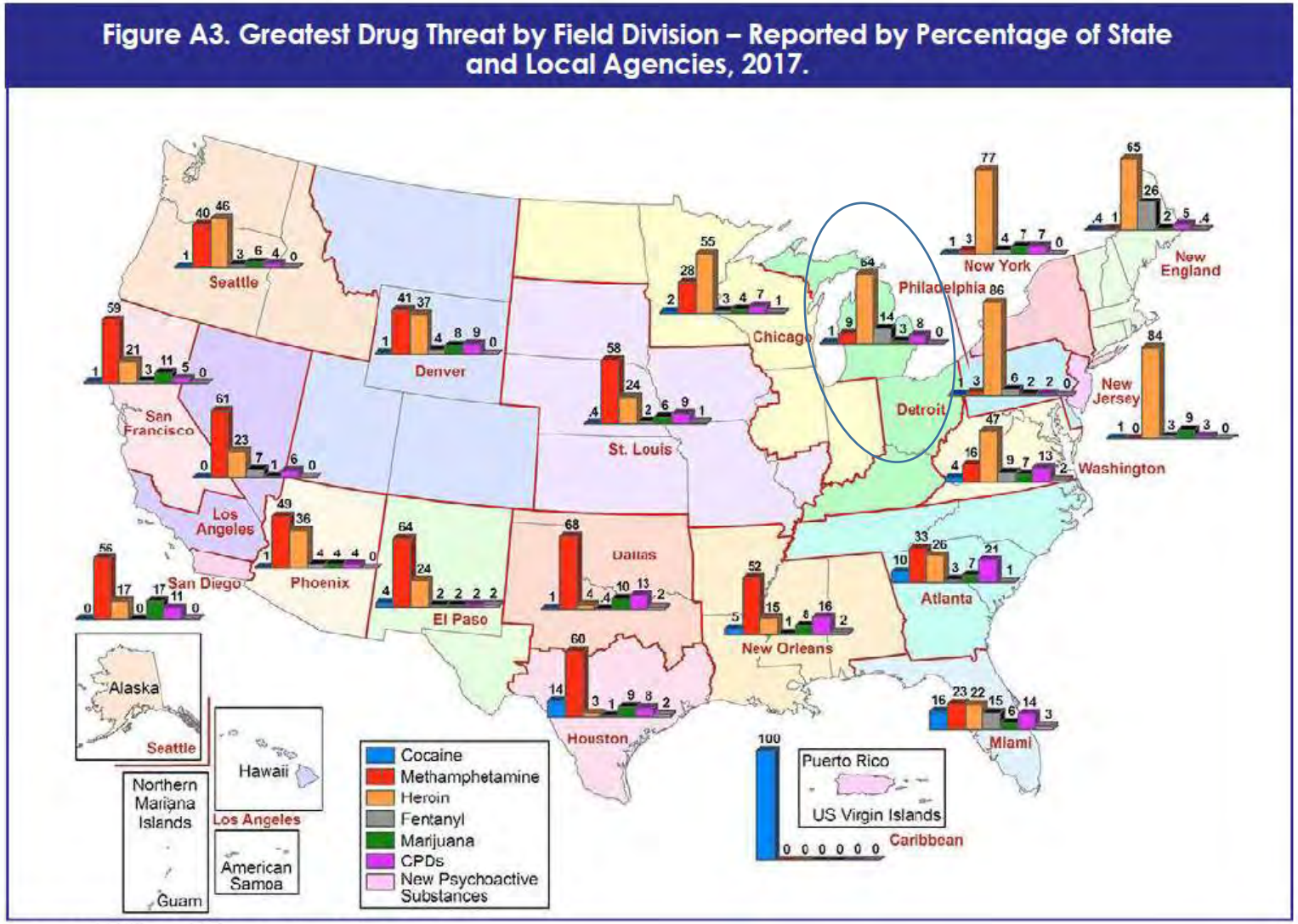


- 84%: OD suspected and opioids found
- 30%: OD not suspected and opioids found
- 50%: OD unknown and opioids found

Courtesy of Joyce deJong, DO, Chair, Pathology Department, WMU Homer Stryker School of Medicine

Heroin and Fentanyl Analogues Are the Two Largest Drug Threats in the Detroit Field Division Area – 78% Combined

Figure A3. Greatest Drug Threat by Field Division – Reported by Percentage of State and Local Agencies, 2017.



Source: National Drug Threat Survey

2017 National Drug Threat Assessment

Grey Death in GA, FL, OH and WV

- May 4, 2017 - Gray Death is a combination of several powerful substances such as Heroin, Fentanyl, Carfentanil and a synthetic opioid called U-47700
- The drug has the appearance of a concrete rock. It is chunky and solid, created from compressed and cooked powder
- At least 50 people have reportedly overdosed, some dying after their first dose of the drug

How We Are Modifying Our Strategy to Address the Dual Epidemic Within One

Creating a Learning Health System* to Improve Quality of Care and Create Teachable Moments

AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

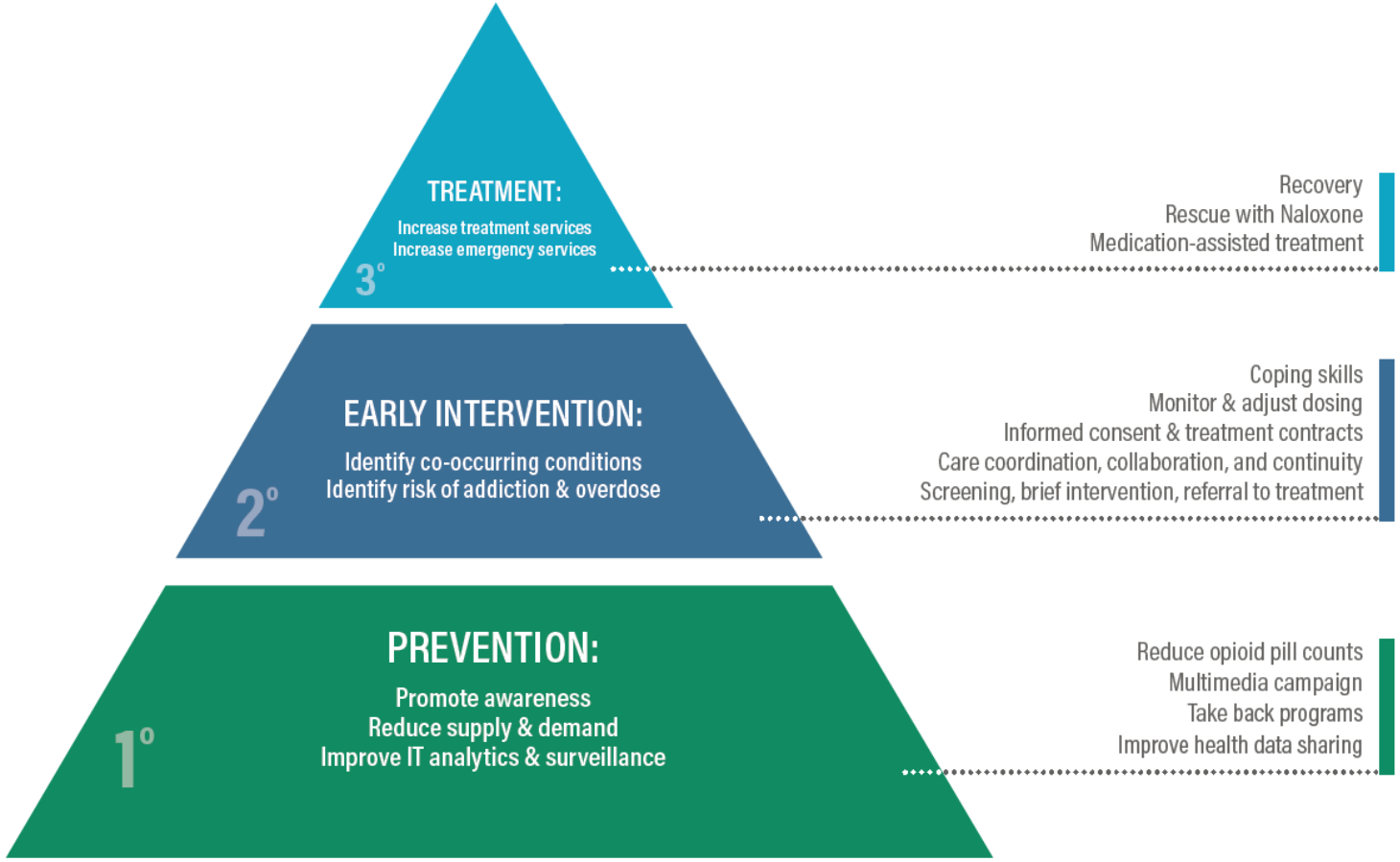
https://www.ahrq.gov/professionals/systems/learning-health-systems/index.html

*Embraced by the Medicaid Medical Directors Network (MMDN), AHRQ, the National Academy of Medicine and CMS (November, 2017)

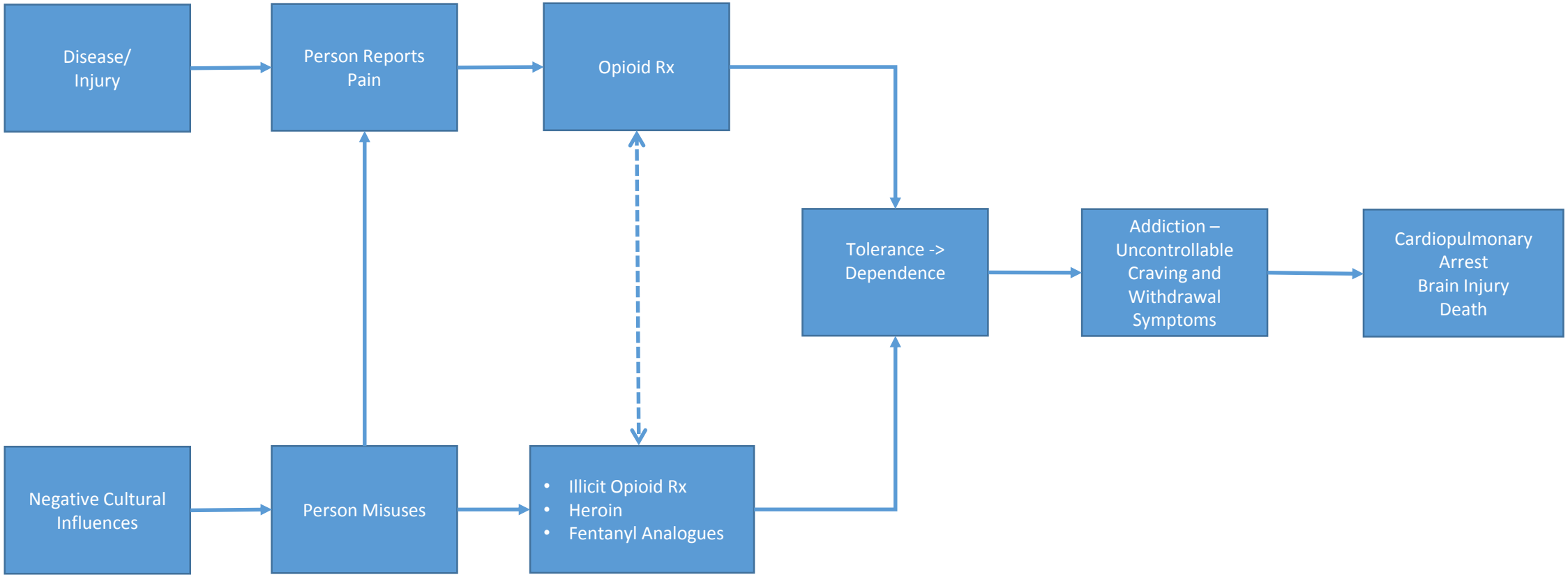
MDHHS
Michigan Department of Health & Human Services

MDHHS Public Health Approach to the Opioid Crisis

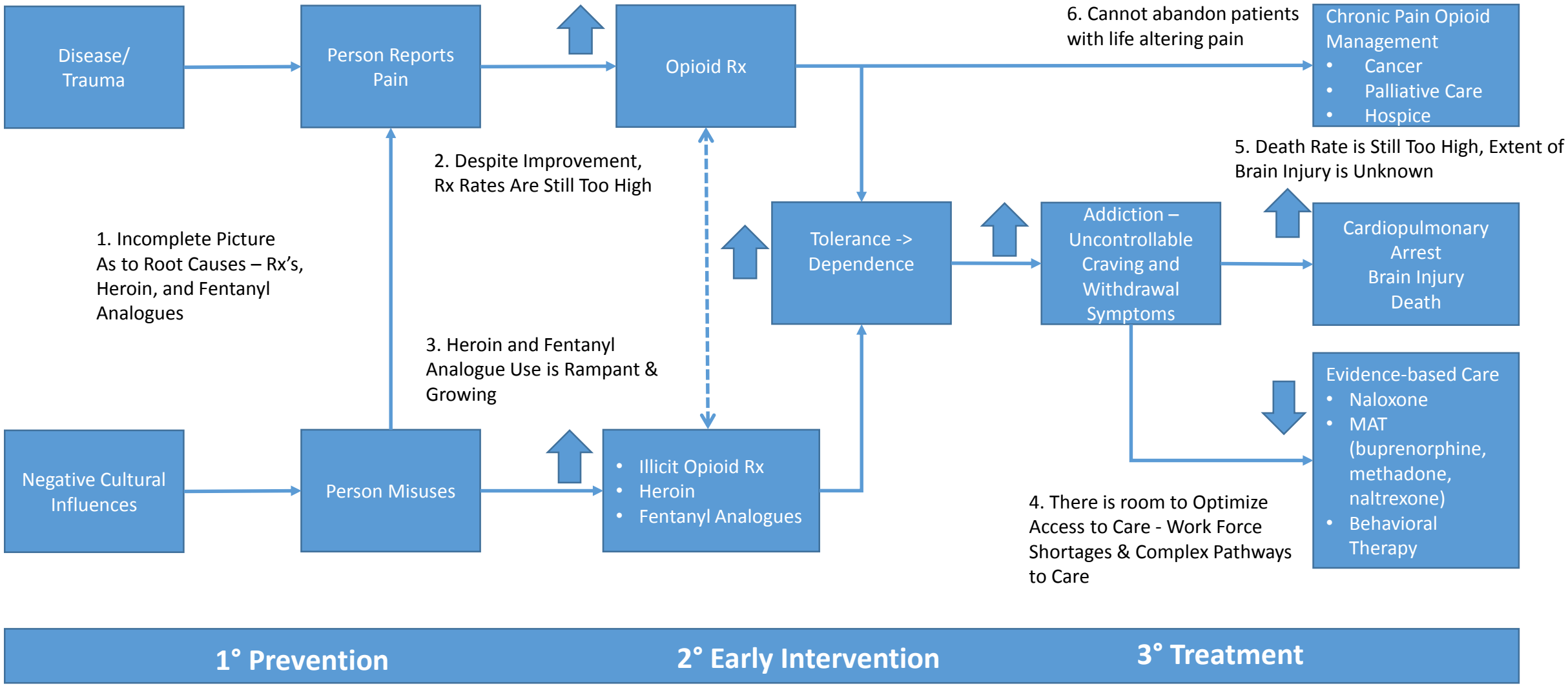
Data Drives Decisions



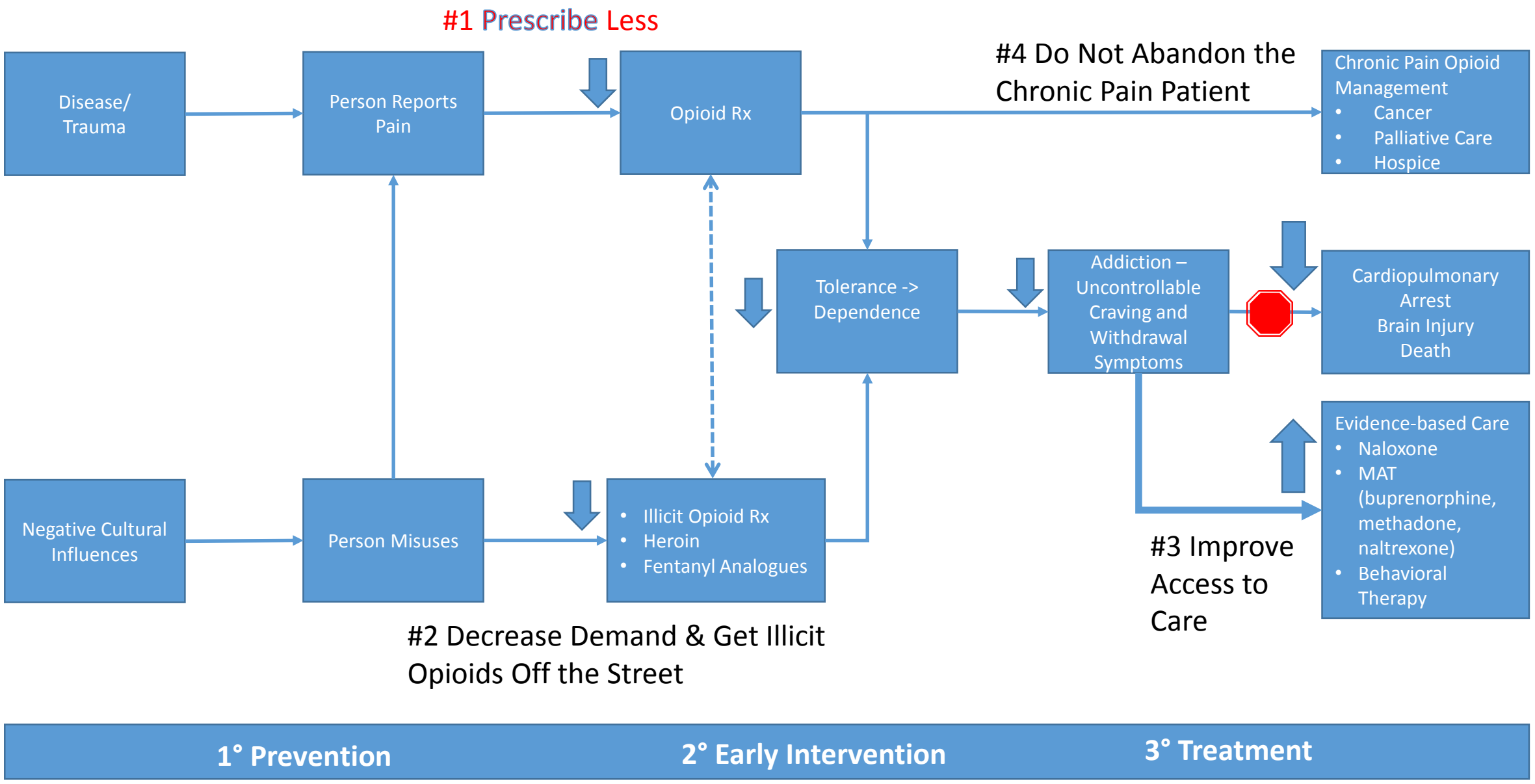
The Opioid Mortality Crisis Is Two Epidemics Within One (An Evolving Model)



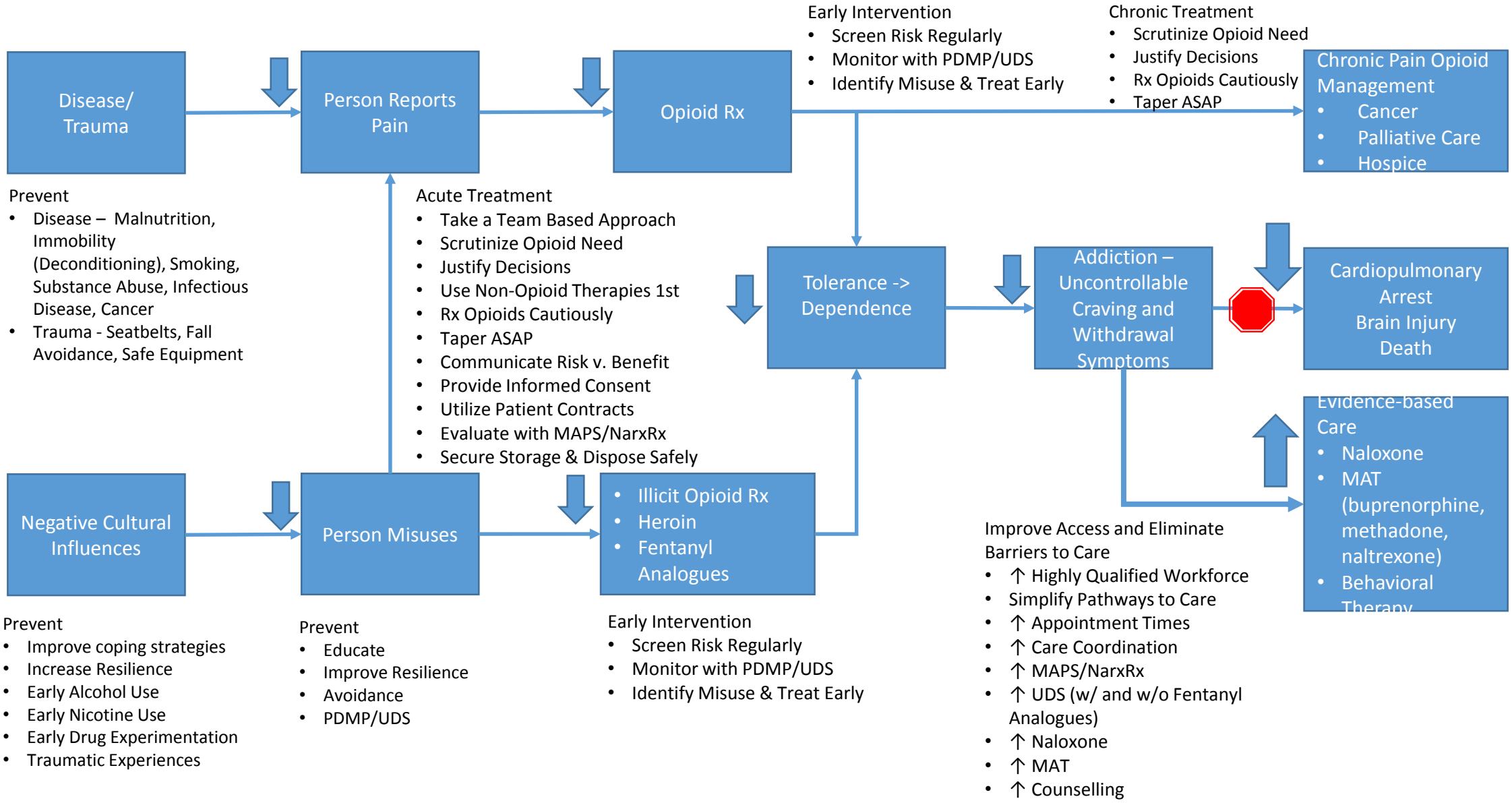
Address 6 Key Issues (An Evolving Model)



Focus on 4 Key Objectives (An Evolving Model)



Solution – Optimize Care (An Evolving Model)



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

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

Access the full CDC guideline for prescribing opioids for chronic pain at:
https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

Medications Approved in the Treatment of Opioid Use Disorder*

Pharmacologic Category

Extended Release Injectable Naltrexone	Methadone	Buprenorphine
Opioid antagonist 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.	Opioid agonist Patients starting methadone should be educated about the risk of overdose during induction onto 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 (http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214)	Opioid partial agonist 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.

Who May Prescribe or Dispense

Extended Release Injectable Naltrexone	Methadone	Buprenorphine
Any individual who is licensed to prescribe medicines (e.g., physician, physician assistant, nurse practitioner) may prescribe and/or order administration by qualified staff.	SAMHSA-certified Opioid Treatment Programs dispense methadone for daily administration either on site or, for stable patients, at home.	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 waivered physician.

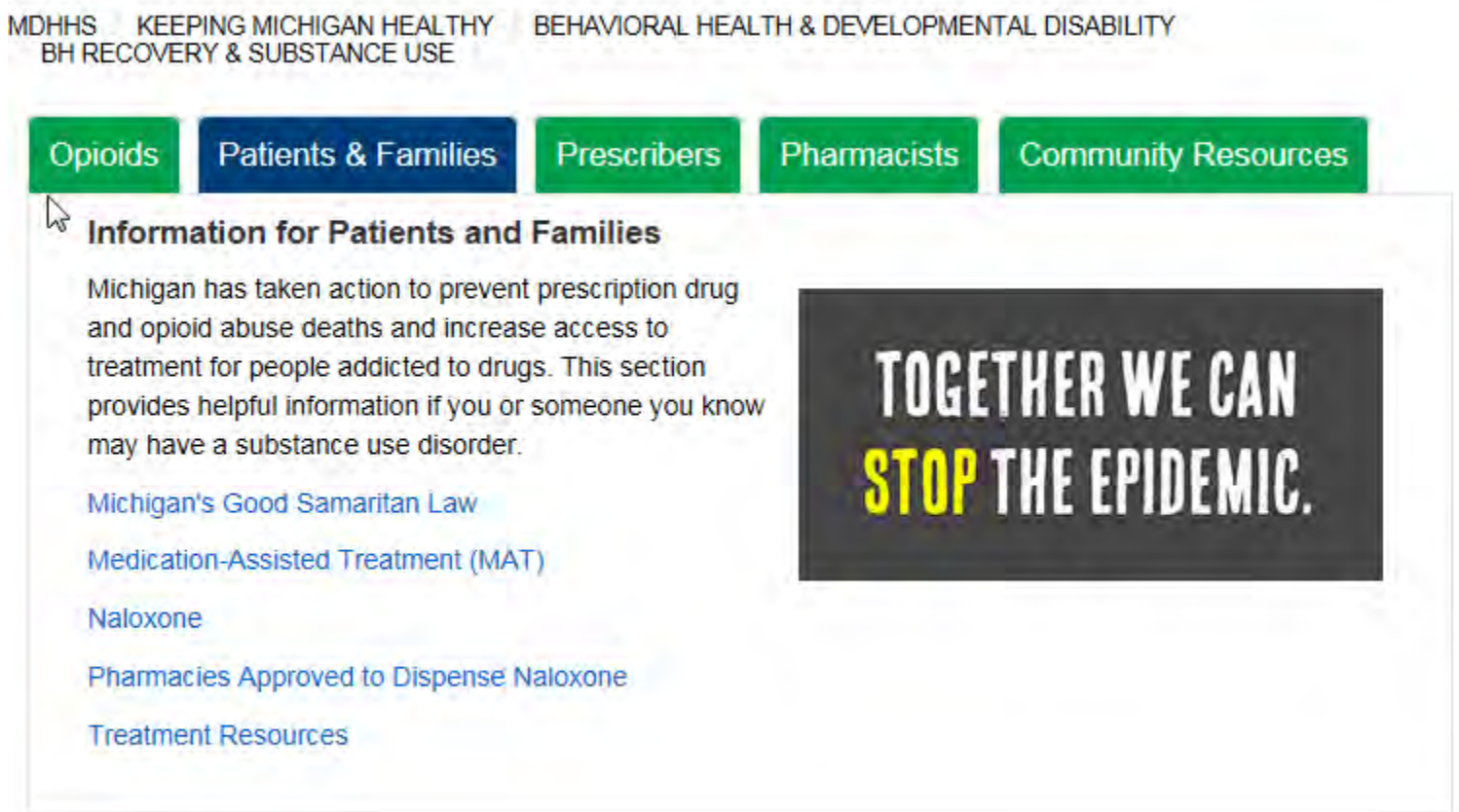
Take 10 Steps To Improve Clinical Practice and Patient Engagement

1. First – Do **NO** Harm
2. Remain vigilant that heroin and illicitly manufactured fentanyl (IMF) availability is high on the streets
3. Identify Opioid Addiction regardless where it's coming from and treat early
   - Naloxone 1st, MAT and Cognitive Therapies
4. Continue Talking with Patients and Families About Risk and Benefits of Using Opioids of Any Sort
5. Teach Patients How to Securely Store and Properly Dispose Of Their Medications
6. Take a Team Based Approach with Early Consultation or Referrals – don't "go it alone"
7. Learn More on How to Use Fewer Opioids From 1st to Last Prescription and Use More Non-opioid Pain Solutions
   - When treating acute pain, stop them ASAP
   - Carefully justify when transitioning from acute pain to chronic pain management and avoid doses ≥ 90 mg MEDD
   - Initiate a patient-centered tapering conversation early with patients taking chronic opioids and titrate them down slowly, particularly at high doses
   - Consider referral or switching over to MAT if craving or withdrawal signs become uncontrollable
8. Utilize Patient Contracts w/Informed Consent
9. Use MAPS/NarxCare & Urine Drug Screening Routinely to Assess & Reduce Risk
10. Document Carefully – Justify Reasons for Care

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 Michigan-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” here in Michigan
6. Health professionals are well positioned to help lead the way

michigan.gov/stopoverdoses

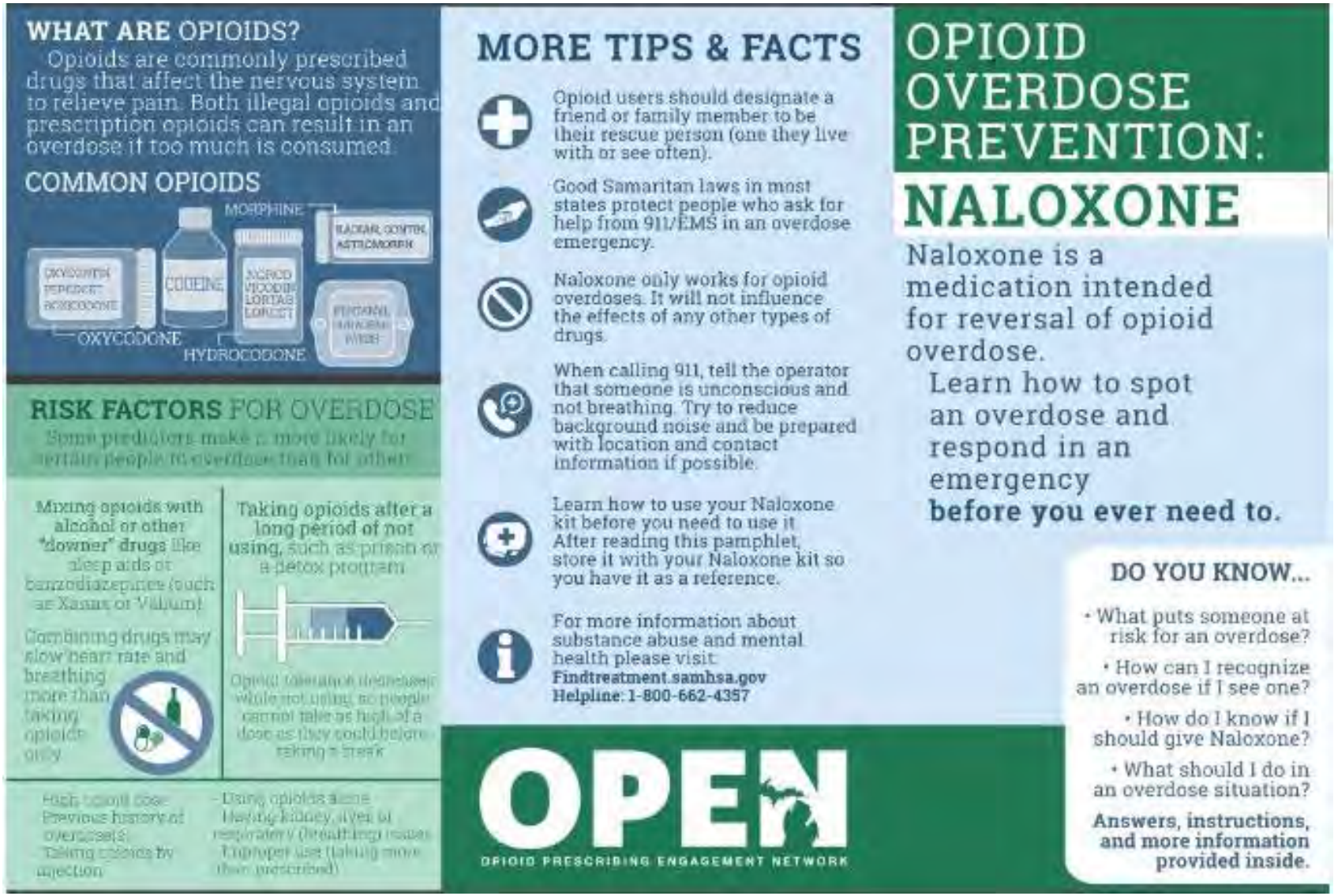


THANK YOU!

For more information contact:

David Neff, DO
neffd2@Michigan.gov
Cell Phone: 517-290-1079

Additional Resources



http://michigan-open.org/

OPEN
OPIOID PRESCRIBING ENGAGEMENT NETWORK

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: suzannlk@med.umich.edu

Household Medication Disposal Event

9/7/2017

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

OPERATION PREVENTION

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

DEA

DEA EDUCATIONAL FOUNDATION

Discovery EDUCATION

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.

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.

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.

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.

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.

Student Learning Module

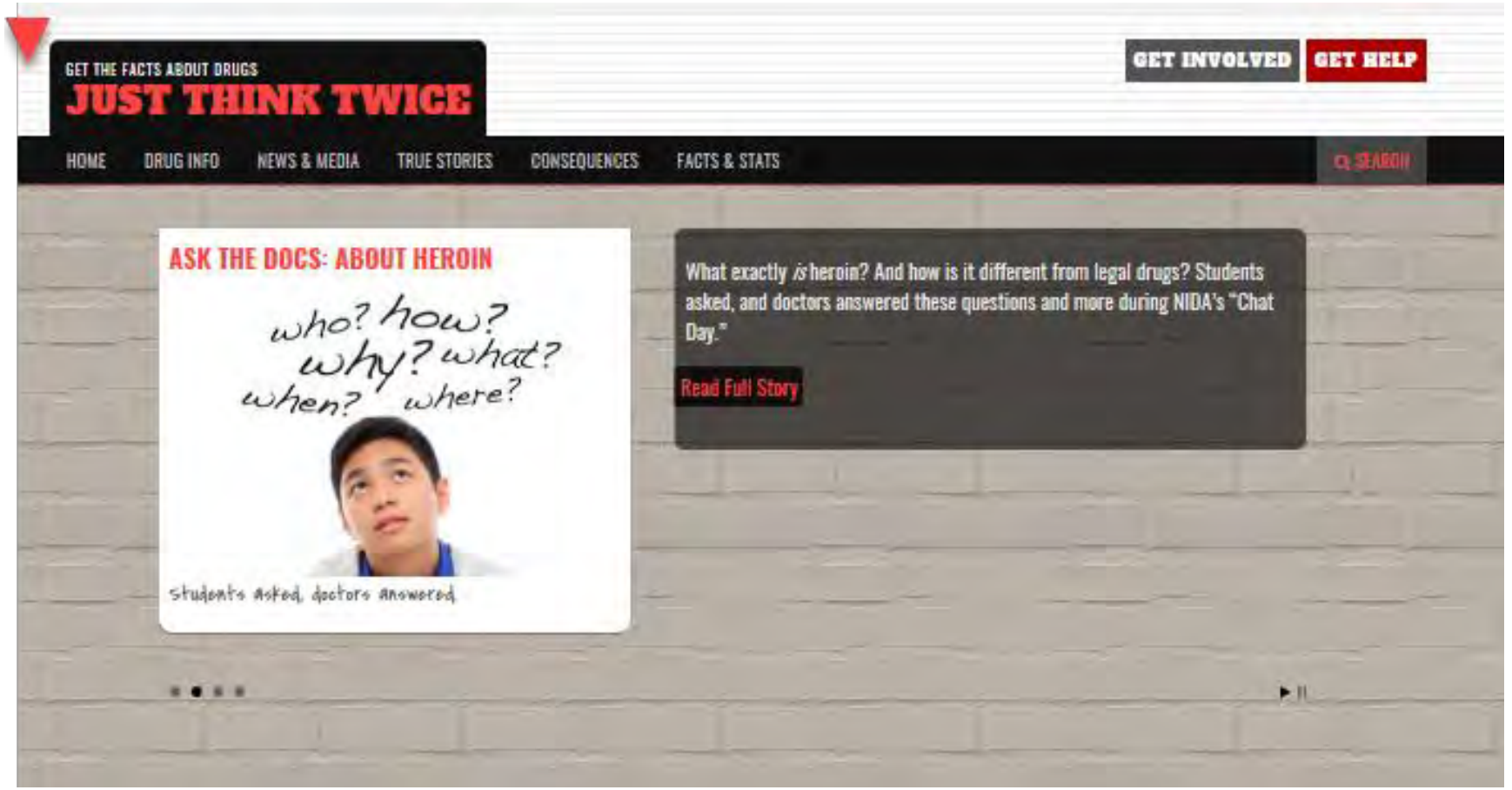
Students become scientists in The Science of Addiction: The Stories of Teens. Investigate the impacts of heroin and prescription opioids on the brain and body through a self-paced scientific exploration. Available in English and Spanish.

Check out these resources and more at OperationPrevention.com

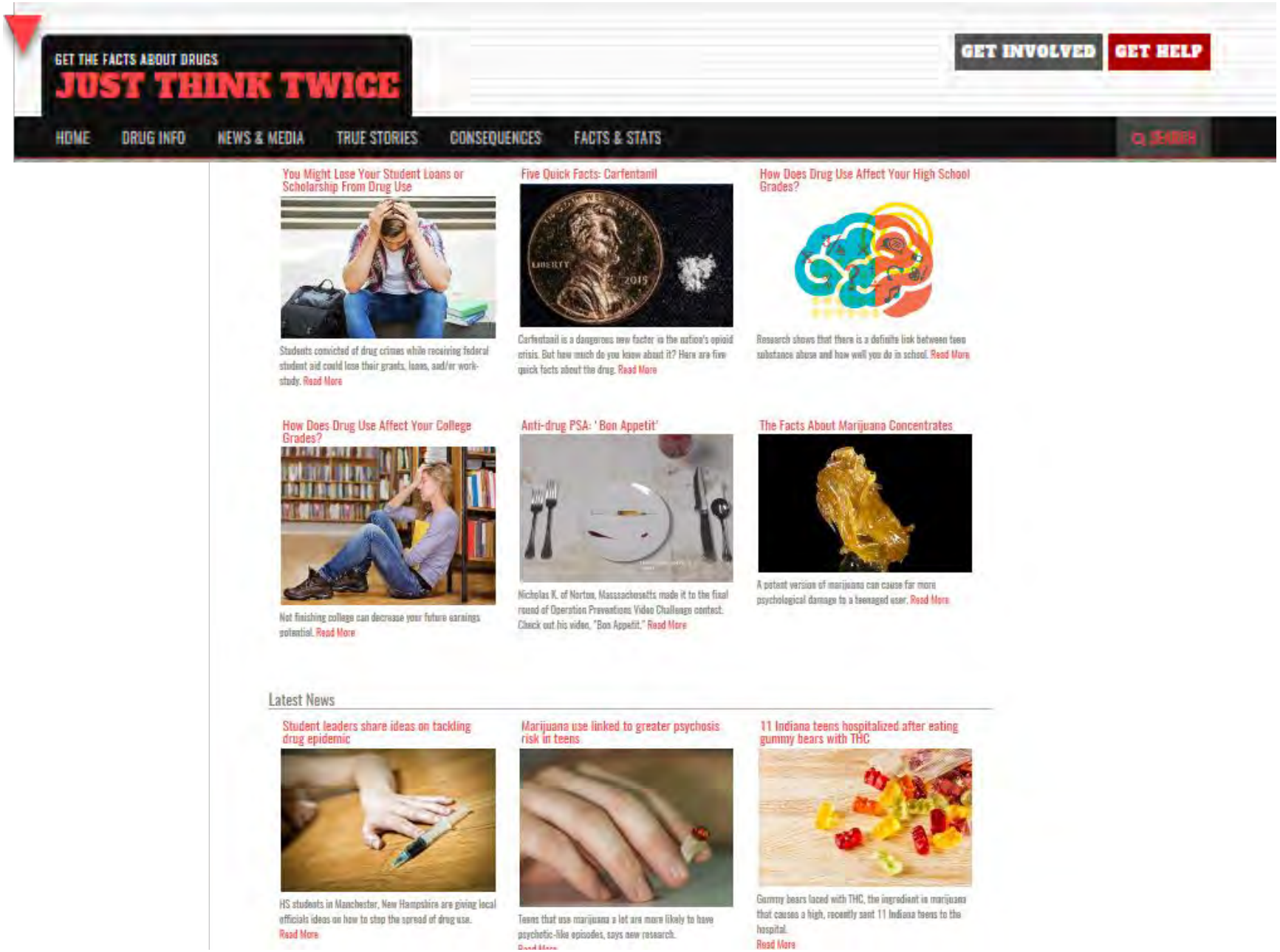
DEA

DEA EDUCATIONAL FOUNDATION

Discovery EDUCATION



https://www.justthinktwice.gov/



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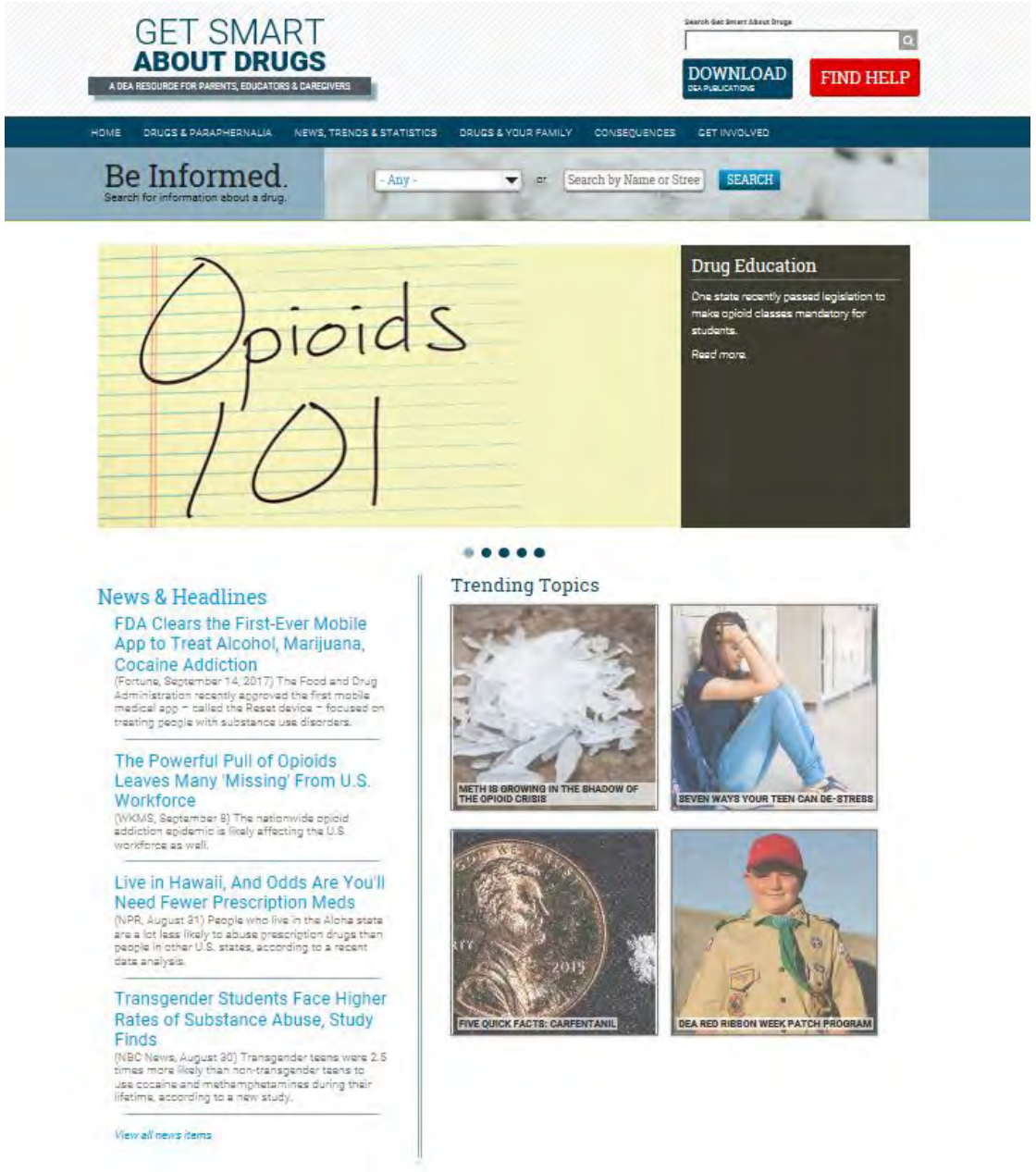
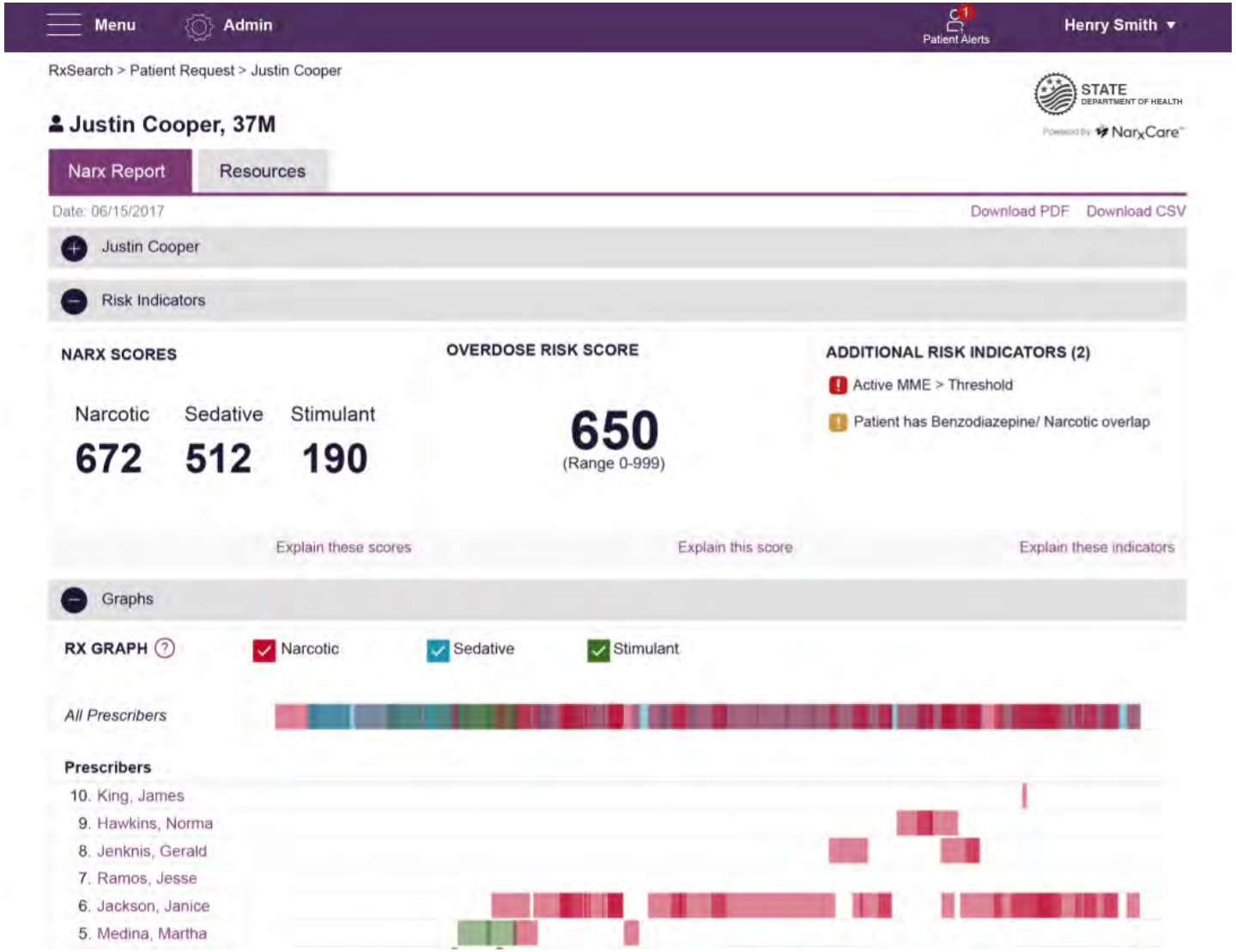


https://www.getsmartaboutdrugs.gov/

Latest Improvement for MAPS Starting 11/1/17 - Sample Risk Score for the Electronic Health Record



https://michigan.pmpaware.net

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