



MINNESOTA  
MEDICAL  
ASSOCIATION



SPECIAL REPORT  
FROM THE MMA:

# The prescription opioid dilemma

A SUPPLEMENT TO  
**MINNESOTA  
MEDICINE**

SEPTEMBER 2014

# Prescription Opioids Special Report



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## MAKING A DIFFERENCE

### Physicians are rolling up their sleeves to prevent opioid abuse

Prescription opioid abuse is not a new problem. Over the years, MMA members have witnessed the effects of prescription opioid abuse firsthand in emergency departments, clinics and hospitals. By late 2012, though, the problem had become so widespread we knew it was time to take action.

We formed a task force to examine this issue in-depth. We populated the group with physicians from a range of specialties, from pain to emergency medicine, to give us a variety of perspectives. In 2013, we organized several forums across the state to gather additional opinions and insights from members regarding the problem. Then, we took part in a group led by the Institute for Clinical Systems Improvement (ICSI) to create an acute pain assessment and opioid prescribing protocol.

Our legislative team helped us make great strides at the Capitol. New laws were enacted this year that will strengthen the state's Prescription Monitoring Program, get naloxone into the hands of first responders and provide limited immunity to people who witness a drug overdose so that they call 911 in time to save a life. Equally important, we beat back overly broad and less effective proposals to mandate CME for all physicians.

Although the task force held its last meeting earlier this year, its work will continue to be felt in the form of the ICSI protocol, the legislation we helped pass and this special issue. The task force was influential in guiding much of the content of this publication. We hope it helps all of our members better understand the issue and is a useful resource for physicians and their patients.

Prescription opioid abuse is not a problem we expect will go away soon. That's the unfortunate reality. However, the MMA will continue to inform and educate its members about abuse of these drugs and what Minnesota physicians can do to curb it. And, many of our members are already working within their own practices to deal with the issue.

Together, we can stem the tide and, hopefully, one day beat prescription opioid abuse.

**CINDY FIRKINS SMITH, M.D.**  
MMA PRESIDENT

**DAVE THORSON, M.D.**  
MMA BOARD CHAIR

## TAKING AIM AT OPIOIDS

# MMA members come together to tackle opioid misuse

Trying to get your arms around the myriad issues related to opioid abuse, addiction and diversion can feel overwhelming. That, however, was the challenge put to the MMA's Prescription Opioid Management Advisory Task Force, when it formed in November 2012.

For 18 months, the task force delved into the many facets of opioid abuse as it sought to accomplish four key objectives: raising awareness about opioid abuse, addiction and diversion; exploring strategies for prescribing opioids; developing resources for physicians seeking information; and promoting community conversations around opioid-related issues.

## Building awareness

For task force members, just getting the word out about the problem of opioid abuse, addiction and diversion was the logical place to begin. To do that, the MMA held a series of member forums in Minneapolis, Rochester and Duluth in May of 2013. Carol Falkowski, a drug abuse expert formerly with the Minnesota Department of Human Services, was the guest speaker. Falkowski discussed the state of prescription drug abuse in Minnesota and the related rise in heroin use. The forums also highlighted the Minnesota Prescription Monitoring Program and the work being done to create a protocol for use of opioids when treating acute pain.

The forums were so well-received that the Emergency Physicians Professional Association reached out to the MMA to host one specifically for its physicians and staff.

## Ongoing support

In addition to creating awareness, task force members knew it was important to provide physicians with guidance on opioid prescribing. "As a

physician, you want to treat everyone the same; you don't want to be put in the position to have to call a patient a drug seeker or abuser," says Christopher Johnson, M.D., a physician with the Emergency Physicians Professional Association and task force member. "All physician groups need a way they can speak effectively to everyone. We need a uniform approach."

The task force partnered with the Institute for Clinical Systems Improvement (ICSI) to develop an acute pain assessment and opioid prescribing protocol. Johnson hopes this, along with other resources, will help the medical community better control how opioids are used.

Shortly after creating the task force, the MMA also added a section to its website ([www.mnmed.org/opioids](http://www.mnmed.org/opioids)) on opioid abuse, addiction and diversion with links to reports, resources and information, including the ICSI protocol. There is also an AMA pain management CME series online, which is a great starting

point for practicing physicians who wish to learn more about the issue.

## Many voices, one conversation

The task force strove to ensure that different voices and perspectives were heard.

"I think the most value the task force accomplished was bringing physicians from different specialties—from pain management to health care administrators to people like me in the ER on the front lines—together to understand that this is a very serious problem that needs an organized response," Johnson says.

The MMA task force met for the last time in May of this year, but Johnson says work

needs to continue. "The problem hasn't been fixed. We still have 16,000 Americans dying every year from an accidental opioid overdose," he says. "Until we start bending that curve backwards and reverse the trend of prescribing and abuse, the work is not done."

**"As a physician, you want to treat everyone the same; you don't want to be put in the position to have to call a patient a drug seeker or abuser"**

CHRISTOPHER JOHNSON, M.D.  
EMERGENCY PHYSICIANS  
PROFESSIONAL ASSOCIATION

## TASK FORCE MEMBERS

ALFRED ANDERSON, M.D.  
RICHARD ANDREWS, M.D.  
BETH AVERBECK, M.D.  
BETH BAKER, M.D.  
PAUL BIEWEN, M.D.  
ELISABETH BILDEN, M.D.  
WILLIAM DICKS, M.D.  
MARK EGGEN, M.D.  
HOWARD EPSTEIN, M.D.  
TOM FLYNN, M.D.

DONALD GROSSBACH, M.D.  
CHRISTOPHER JOHNSON, M.D.  
ZACH LOPATER, M.D. (RESIDENT)  
DAVID SCHULTZ, M.D.  
Yael SMILEY (STUDENT)  
KEITH STELTER, M.D.  
LINDSEY THOMAS, M.D.  
JOSEPH WESTERMEYER, M.D.  
DREW ZINKEL, M.D.



## TRACKING OPIOID USE

# A valuable resource at your fingertips

A patient is sitting in front of you complaining of serious pain and asking for drugs to alleviate it. He has no broken bone or obvious sign of injury. You want to help, but your gut is telling you something isn't right. What do you do? Consulting Minnesota's Prescription Monitoring Program (PMP) can be a good first step.

The PMP, created in 2010, is a state database that tracks Schedule II-V prescriptions filled in Minnesota. Reporting is required from all pharmacies and other dispensers in the state as well as from out-of-state pharmacies that ship controlled substances to Minnesota residents.

The idea for the PMP grew out of reports in the national media about OxyContin abuse, says Cody Wiberg, PharmD, RPh, executive director of the Minnesota Board of Pharmacy. "There was a real problem around the country. States in Appalachia didn't have heroin dealers. So instead of heroin, OxyContin became the drug of choice." Communities began seeing a rise in phony prescriptions and doctor shopping. In response, federal legislation was passed in 2005 to create the National All Schedule Prescription Electronic Reporting System or NASPER. The goal of NASPER was to have a coordinated prescription monitoring program in all 50 states.

Once NASPER was in place, the Minnesota Society of Interventional Pain Physicians reached out to then Sen. Linda Berglin (DFL-Minneapolis) and Rep. Jim Abeler (R-Anoka) to pursue legislation authorizing the PMP in Minnesota. The PMP bill passed in 2006. Data collection began in January 2010 and physicians gained access to it in April of that same year.

### How it works

Physicians who prescribe opioids can request access to the PMP online. There are certain requirements, such as having a valid DEA registration and being in good standing with licensing boards. Once access is granted, physicians can view critical information regarding a patient's prescriptions and refills.

#### FACT:

Opioid analgesics were involved in **more than 40 percent of drug poisoning deaths** in 2008.

NATIONAL ASSOCIATION OF STATE ALCOHOL AND DRUG ABUSE DIRECTORS (NASADAD)



Barbara Carter

PHOTO BY KATHRYN FORBES

Legislation passed this year expanded the data that will be available in the PMP and how it can be used. As of Aug. 1, all prescribers' names are visible on the report. "Nobody has to give us permission or can tell us they don't want to have their name included," says Barbara Carter, manager of the PMP. In the past, inclusion of the prescriber's name was voluntary.

"The number one request we get from physicians is to show the names of the other prescribers," Wiberg says. "Of the 49 states that have a prescription monitoring program in place or are developing one, Minnesota was the only one that was not allowed to release the name of the prescriber."

Some concerns have been raised over what this new level of prescriber transparency could mean.

"There are two potential problems," Wiberg notes. "There could be a chilling effect on legitimate prescribing. Physicians may be more reluctant to prescribe even

**“The number one request we get from physicians is to show the names of the other prescribers. Of the 49 states that have a prescription monitoring program in place or are developing one, Minnesota was the only one that was not allowed to release the name of the prescriber.”**

CODY WIBERG, PHARM.D, RPH  
EXECUTIVE DIRECTOR; MINNESOTA BOARD OF PHARMACY

if it is legitimate to do so because they would be worried about being investigated. Second, they just don't want to deal with the hassle of being investigated.” He adds that past investigations have resulted in considerable resources being used to uncover very minimal issues. Carter says the legislation included a provision requiring them to study the effect of this change.

## Minnesota's Prescription Monitoring Program

<http://pmp.pharmacy.state.mn.us/>

Another enhancement is the ability to analyze the data in order to identify patients who may be abusing prescription drugs. “We refer to the process as ‘unsolicited report-

ing,’” Carter says. It allows the PMP to be used to identify individuals who appear to be doctor shopping. Carter explains that the goal is not to make judgments, but to provide data-driven insights to prescribers and pharmacists, and encourage them to talk with their patients. This type of analysis won't begin until 2015.

### Improving access

Currently, about 35 percent of physicians and pharmacists use the PMP. Wiberg says that although the

percentage may sound low, it isn't when considering who is most likely to need it. “There are many types of physicians or prescribers who might not have much use for it,” he says. “A pathologist who works strictly in a medical laboratory has no reason to sign up for the PMP. Pediatricians would probably have very little use for it. Anecdotally, what we hear is that a large percentage of doctors who would have need for it have signed up.”

Carter says creating awareness and promoting the PMP is part of their ongoing work. She believes the next big opportunity to boost usage will come from within health care organizations and says they have been meeting with representatives to discuss integrating the PMP into their electronic health record systems.

Carter and Wiberg agree the future of the PMP lies in technological integration, but how quickly and to what extent it will happen will be dictated by those organizations. Both are confident, however, that Minnesota's health care community can work together to make the PMP an even more powerful tool in curbing prescription opioid abuse.

### FACTS:

**Among persons 12 years of age and older who misused or abused prescription pain relievers:**

- 60 percent** received them from a friend or relative for free\*
- 25.9 percent** purchased them from a friend or relative
- 10.1 percent** took them from a friend or relative without asking
- 27.3 percent** had a doctor's prescription for them
- 12.2 percent** received them from a dealer or stranger
- 1.1 percent** ordered them on the Internet.

\*Among those receiving drugs from a friend or family member for free, 79.2 percent of friends or relatives had a doctor's prescription for the drug  
(NASADAD)

## MISSION POSSIBLE

# Sorting through the complexity of pain management

Considering the many factors that can cause a patient's pain can be a daunting task. Add to that concern about prescription opioid abuse, and making the right decision can feel impossible. With the need to address Minnesota's prescription opioid abuse crisis, a number of groups have developed protocols, laws and resources to help physicians and other prescribers make good decisions related to prescription opioids and pain management.

Here's a look at those efforts.

### Prescribing for acute pain

One challenge is the fact that there hasn't been an agreed-upon approach for treating patients with acute pain. "There were different organizations trying to address the opioid crisis we are having," says Howard Epstein, M.D., chief health systems officer with the Institute for Clinical Systems Improvement (ICSI). "When we see parallel conversations taking place, it strikes us that it could result in misalignment of efforts and a duplication of energy and resources."

In order to keep that from happening, the MMA worked closely with ICSI and other stakeholders to create the Acute Pain Assessment and Opioid Prescribing Protocol, which provides guidance on when and how to write an initial prescription for a patient with acute pain. It outlines all pain management options (including opioids), recommends careful opioid risk assessment, and encourages shared decision-making with the patient prior to prescribing. It also provides risk assessment tools and guidelines for talking with patients about opioids.

"When people have pain, they want pain medication, and there are appropriate times to use opioids and there are inappropriate times," Epstein says. "If we just look at the pain as the problem and a prescription as the answer, we are missing other really important information that could affect the risk-benefit profile when using opioids."

Epstein believes better prescribing for initial acute pain will help diminish the prescription opioid abuse we are seeing today. "The most important thing in managing chronic opioid use is to prevent it in the first place," he says. "When we more appropriately use opioids in appropriate situations, we are narrowing that potential funnel of patients who wind up as chronic opioid use patients."

Epstein believes best practices need to be hard-wired into a physician's work systems. Organizations can make that happen by including the protocol in order sets within



PHOTO BY KATHRYN FORSS

Howard Epstein, M.D.

**If we just look at the pain as the problem and a prescription as the answer, we are missing other really important information that could affect the risk-benefit profile when using opioids."**

HOWARD EPSTEIN  
CHIEF HEALTH SYSTEMS OFFICER  
INSTITUTE FOR CLINICAL SYSTEMS IMPROVEMENT (ICSI)



their electronic health record system and disseminating information about it across sites.

“We have evidence that shows [doctors] are not good judges of whether people are lying,” Epstein says. “That also sets up an adversarial relationship between the patient and the provider.” He says using the protocol can prevent physicians from singling out patients and provide them with support when dealing with a patient who complains of pain.

### Managing chronic pain

Staff at the Minnesota Department of Labor and Industry (DLI) understand that workplace injuries that lead to chronic pain are common. So use of opioids to manage chronic pain is a top concern, especially in workers’ compensation cases.

“We see the same problems in the treatment of injured workers that everyone sees everywhere,” says William Lohman, M.D., DLI’s medical director. “Our intent is to recognize that certain patients do benefit from opioid treatment, but we want to make sure it is used appropriately and patients are carefully selected and monitored to minimize complications and negative outcomes.”

Last year, DLI directed renewed efforts toward developing a set of rules around the use of opiates for palliation of chronic pain in workers’ compensation cases. Those parameters were developed by a state-mandated group called the Medical Services Review Board (MSRB). The MSRB, which consists of members of the medical community and other stakeholders in the workers’ compensation arena, hopes to have them finalized by the end of the summer. (Then comes a gubernatorial review, a public comment period and final review by a judge before they can become law, which could happen by early 2015.)

The proposed DLI rules will ensure proper screening of workers’ comp patients who complain of chronic pain, outline the obligations of the provider and patient when using opioids to treat pain, and require ongoing assessment to make sure the patient is using the medication properly and that it’s meeting their treatment goals. Lohman is very clear the rules are not meant to inhibit the use of opiates but rather to make sure they are used appropriately. “We think there is a role for the use of opiates to palliate chronic pain in certain situations,” he says. “We are preserving access to this treatment for when it is justified.”

### Minding the gap

In just one year, the Minnesota Department of Human Services (DHS) saw 3,000 Medicaid patients go from not using opioids to being chronic users. “That was a significant concern because that is a lot of people who could become opioid dependent,” says Jeff Schiff, M.D., DHS’s medical director for Minnesota Health Care Programs.

After digging into the numbers a bit more, DHS staff discovered a gap between treatment protocols for acute pain and chronic pain. “There is a space between three- to five-day acute pain and 45- to 90-day chronic pain,” Schiff says. “That space we are calling the ‘post-acute space.’ There is very little in terms of protocols, and that is the space where people can become very dependent on opioids.”

There is growing consensus that this “space” needs more attention. “People will need pain medication, but when you go from acute medication to that space there are things that need to happen,” Schiff says. Individuals in the post-acute space need a pain management plan that includes physical therapy, behavioral therapy, diagnostics and screening for behavioral health and addiction issues in addition to opioids. “If we just create a protocol for acute and do nothing about this post-acute space, someone could come back in and meet a measure a week later and get a three-week supply. These things need to be done together,” Schiff says.

Community efforts are in development to advance the post-acute work.

#### FACT:

**Here’s how Minnesota ranks in terms of prescribing rates per 100 people:**

**Opioid pain relievers:** 61.6, rank in U.S. – 48th;

**Long-acting/extended-release opioid pain relievers:** 10.2, rank 35th

**High-dose opioid pain relievers:** 2.2, rank 49th

**Benzodiazepines:** 24.9, rank 48th

(IMS HEALTH, UNITED STATES, 2012)



PHOTO BY KATHRYN FORSS

Great progress on fighting prescription opioid misuse was made at the Capitol this past session.

## LEGISLATIVE PROGRESS

# Good session for prescription opioid fight

The fight to curb prescription opioid abuse took a step in the right direction this past legislative session. Several new laws were enacted that should decrease the number of overdoses.

The MMA went into the session in February with three goals: to improve the functionality of Minnesota’s Prescription Monitoring Program (PMP), to expand access to naloxone, and to create a Good Samaritan law in Minnesota. All three were accomplished.

Legislators also passed another bill that calls for mandatory reporting of drug diversion by health care workers.

Following are details on each piece of legislation.

### Strengthening the PMP

New legislation calls for establishing a system that alerts prescribers and dispensers when patients are potentially doctor shopping for opioids. The criteria for this system will be determined by the PMP Advisory Task Force.

The law also removes the requirement that a prescriber’s name be left off the PMP unless consent to display it is granted. Now a prescriber, using the PMP, can identify and potentially correspond with other prescribers about a particular patient’s medication use. This, too, should help in the effort to cut back on prescription opioid abuse.

In addition, the law:

- Adds tramadol and butalbital to the list of controlled substances reported through the PMP
- Adds a coroner/medical examiner to the PMP Advisory Task Force.
- Expands PMP reporting for prescription drugs dispensed in skilled nursing facilities or intermediate care facilities, for individuals receiving assisted

living services, intravenous delivery, home care, as well as for those receiving hospice and other palliative or end-of-life care. Previously, all of these scenarios were exempted.

- Authorizes the Board of Pharmacy to participate in an interstate PMP data exchange system
- Allows PMP and Board of Pharmacy staff access to identifiable PMP data for 24 months for the purposes of administering, operating and maintaining the PMP, and conducting trend analyses and other studies necessary to evaluate the effectiveness of the program. Data held longer than two years must be de-identified and destroyed after four years.
- Allows prescribers access, with patient consent, to PMP data for medical care not related to a specific controlled substance prescription.

The MMA went into the session in February with three goals: to improve the functionality of Minnesota’s Prescription Monitoring Program (PMP), to expand access to naloxone, and to create a Good Samaritan law in Minnesota. All three were accomplished.



- Grants pharmacists access to the PMP for providing pharmaceutical care with patient consent.
- Allows Health Professional Services Program (HPSP) staff access to PMP data for an individual enrolled in the HPSP with the enrollee's consent
- Requires the Board of Pharmacy and PMP Advisory Task Force to study and report to the Legislature on 1) requiring the use of the PMP when prescribing or dispensing prescription opioids; 2) using the PMP to identify potentially inappropriate prescribing; and, 3) encouraging access to appropriate treatment for prescription drug abuse. This report is due by December 15, 2014. The Board of Pharmacy and PMP Advisory Task Force will also study and report on the impact of the PMP on doctor-shopping by December 15, 2016.

### Opioid antagonists/immunity for Good Samaritans

This new law allows EMTs, peace officers and staff from community-based social service programs to administer opioid antagonists (naloxone) if a physician or prescriber has issued a standing order. It further requires that these individuals be trained to recognize the signs of overdose and administer the antagonist.

In addition, it releases from liability those who administer the antagonist while acting in good faith, as well as the prescribers of the antagonist. The law also grants immunity from prosecution for certain offenses to those individuals who seek medical assistance when witnessing a drug-related overdose.

### Mandatory reporting of drug diversion

This law mandates that employers of persons regulated by health-related licensing boards (physicians, nurses, pharmacists, etc.) report to the appropriate board if the licensee has diverted narcotics or controlled substances.

There are exceptions to this rule, however. Self-employed licensees are exempt from reporting. If the regulated person is a patient who divulges diversion in the course of a professional-patient relationship, it does not trigger the reporting requirement.

Knowledge of diversion reported by a Health Professionals Services Program worksite monitor or self-reported by the licensee does not trigger the reporting requirement either.

#### FACT:

Opioids are responsible for **three out of four prescription drug overdoses, and in 2008, they caused 14,800 deaths** – more than cocaine and heroin combined. (CDC)

#### FACT:

Emergency department visits involving the misuse or abuse of opioid pain relievers **rose 183 percent between 2004 and 2011**. (NASADAD)

#### FACT:

Opioid pain relievers are the **most commonly misused prescription drug**, accounting for 70 percent of misused prescription drugs during the past month. (THE NATIONAL SURVEY ON DRUG USE AND HEALTH - 2013)

#### FACT:

10 percent of young adults ages 18 to 25 years **misused prescription drugs during the past month**. (THE NATIONAL SURVEY ON DRUG USE AND HEALTH - 2013)

## FIGHTING ADDICTION WITH EDUCATION

# Grassroots efforts to teach medical students about opioids

With the rise of opioid abuse, addiction and diversion, you might assume medical schools would be educating future doctors thoroughly on pain management, addiction and the use of opioids. That's not the case, however, according to Charlie Reznikoff, M.D., a physician with the Division of Addiction Medicine at Hennepin County Medical Center (HCMC) and an assistant

professor of medicine at the University of Minnesota. She asked Reznikoff if they could do something on the University of Minnesota's campus for first-year students.

At Reznikoff's suggestion, Adams and another student launched a lecture series aimed at first- and second-year medical students. "The lectures are open to anyone, but we are targeting first- and second-year students who are on campus and have more time to attend," says Adams, who plans to go into emergency medicine.

"My goal is to give first- and second-year students a more solid foundation on pain management, so when they move into their clinical rotations they have a starting point on how to work with patients and think about how to manage those issues," Adams says.

The lectures are voluntary for the students and the presenters. Reznikoff says getting experts to present hasn't been an issue. "It has been easy to recruit people on the topic," he says. "There are a number of young energetic doctors in the community who want to change medical education."

### The next phase

The lectures take place on the U of M campus but are also recorded. For now, students interested in watching the recorded sessions have to reach out to Adams directly; but she hopes to make them available online.

Adams says they hope to do twice as many lectures this fall and touch on topics such as alternative treatment options for chronic pain, the psychology of pain, how to talk with patients about pain and how to approach patients with a history of addiction who need pain treatment.

Reznikoff will continue the medical student workshops at HCMC and the U of M lectures, but he also has bigger plans. With his connections to the federal Substance Abuse and Mental Health Services Administration, he is trying to develop pain and addiction resources for medical schools across the United States. In addition, there are plans in the works for Reznikoff to partner with the MMA and the Steve Rummier Hope Foundation to create an enduring medical education series for physicians that will be housed on the MMA's website.



Medical student Katie Adams and Charlie Reznikoff, M.D.

PHOTO BY KATHRYN FORSS

professor of medicine at the University of Minnesota.

"The University of Minnesota underprepares students," he says. "What I have found is that students have a lot of scientific knowledge, but don't have practical, applicable knowledge about treating pain."

### Getting to students sooner

A few years ago, Reznikoff started offering training to students on his own. He meets with about 20 third- and fourth-year medical students each month at HCMC. "We provide pragmatic, realistic lectures on how to manage and think about pain. We also hope to engage students and have fun," he says.

One of the students, Katie Adams, in her fourth year at the University of Minnesota Medical School, was inspired to extend the training beyond the walls of HCMC and

## HELPING YOUR PATIENTS

# Resources physicians can use and recommend

Many resources exist for patients dealing with an opioid addiction or who want to learn more about opioids (how to dispose of them, what to do in case of an overdose). Here are a few of them:

## Addiction treatment

The **Minnesota Department of Human Services** has a substance abuse division. Patients and physicians can find information on addiction treatment at (see web address in box, below).

The federal **Substance Abuse and Mental Health Services Administration's** website has a "treatment locator." Enter a ZIP code and it provides a list of treatment programs in the area. An individual can filter results based on the type of treatment needed and other factors.

## Proper handling/disposal

The following are resources for patients or physicians looking for information on the proper handling of prescription medications.

The **Food and Drug Administration** has a section on its website dedicated to the safe disposal of prescription medication. The section includes a Q&A and medication-specific instructions.

The **U.S. Department of Justice Drug Enforcement Agency** offers safe disposal

information and also provides links to rules around drug disposal. The DEA also sponsors a National Prescription Drug Take-back Day. Information is available online.

**Rethink Recycling** is an excellent resource for information regarding medicine and prescription drug disposal in Minnesota. It includes a list by county of places to take medications and contact information.

## Medication-assisted treatment

Medication-assisted treatment (MAT) for opioid addiction is now the standard of care. "We now have 50 years of research showing that the use of medication to treat opioid addiction provides a better outcome when compared to any other kind of approach that does not include the use of medication," says Gavin Bart, M.D., Ph.D., director of the Division of Addiction Medicine at Hennepin County Medical Center.

MAT involves using one of three FDA-approved medications – methadone, buprenorphine or naltrexone. Use of methadone for addiction treatment is heavily restricted. "Any doctor with a DEA license can prescribe

not clear if naltrexone is as effective as the other two drugs.

So, why aren't more physicians using MAT or referring patients? "Doctors are not trained about addiction during medical school or residency so many feel like this is uncharted territory," Bart says. "Because you aren't taught about the science of addiction, you aren't taught how to diagnose addiction and that may lead to a sense of futility or feeling that there aren't options that can work effectively."

Access can be another barrier. "There are not enough treatment slots available or medication-assisted treatment programs in the state," Bart says. "We don't have capacity to handle those

addicted that we already know of. For example, tribal territories have no treatment clinics yet have the highest rate of opioid addiction of any population in the state of Minnesota."

Bart encourages physicians to learn more about MAT and not be dissuaded by perceived barriers. If physicians can

increase their understanding, Bart believes the medical community can bend the curve on opioid abuse.

## Poison emergencies

If you suspect a child or adult has accidentally taken medication (including prescription opioids), contact the Minnesota Poison Control System (800-222-1222) for immediate assistance. The free service is available 24.7 and all calls are confidential.

### RESOURCES

[Minnesota Department of Human Services substance abuse division](http://mn.gov/dhs/partners-and-providers/health-care/)  
http://mn.gov/dhs/partners-and-providers/health-care/

[The federal Substance Abuse and Mental Health Services Administration](http://findtreatment.samhsa.gov/)  
http://findtreatment.samhsa.gov/

[The Food and Drug Administration](http://www.fda.gov/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/EnsuringSafeUseofMedicine/SafeDisposalofMedicines/default.htm)  
www.fda.gov/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/EnsuringSafeUseofMedicine/SafeDisposalofMedicines/default.htm

[The U.S. Department of Justice Drug Enforcement Agency](http://www.deadiversion.usdoj.gov/drug_disposal/takeback/)  
www.deadiversion.usdoj.gov/drug\_disposal/takeback/

[Rethink Recycling](http://www.rethinkrecycling.com/residents/materials-name/medicine-prescription-drugs)  
www.rethinkrecycling.com/residents/materials-name/medicine-prescription-drugs

methadone to treat pain, but no one can prescribe methadone to treat opiate addiction other than specifically licensed treatment facilities," Bart notes. Buprenorphine requires a special addendum to a physician's DEA license. To get the addendum, a physician must complete an eight-hour online course. Naltrexone is not a controlled substance and any health care provider who has the power to prescribe can do so. But Bart says it is



# OPIOIDS & NALOXONE PRESCRIBE TOGETHER

## STEVE'S LAW

## WHAT YOU NEED TO KNOW

- **Opioid overdose death** is a leading cause of accidental death in Minnesota - opioids include heroin, opium and pharmaceutical opioid analgesics
- **Steve's Law**, to prevent opioid overdose deaths, passed the Minnesota State Legislature unanimously and was signed into law May 9th, 2014
- By law, any doctor or advanced practice provider can **prescribe naloxone**, the antidote to opioid overdose, to those at risk for opioid overdose
- When naloxone is used **911 should be called** - those on the scene will have immunity to minor drug and paraphernalia charges
- **Prescribing naloxone does not replace** appropriate treatment for opioid addiction including buprenorphine, methadone or intramuscular naltrexone
- **Prescribing naloxone does not lessen** monitoring requirements or use of caution when prescribing opioids for pain
- Most **insurance** policies will cover naloxone but there will likely be a copay

## Who is a good candidate for naloxone?

- Those **misusing or addicted** to opioids
- Those on **high dose opioids** for pain but not misusing
- Those on opioids at risk for **impaired renal or pulmonary function**
- Those who have **overdosed on opioids in the past**
- **Friends or family** of such a patient willing to learn to administer naloxone in the event of an overdose

Further information for providers and patients  
can be found at:

[www.SteveRummlerHopeFoundation.org](http://www.SteveRummlerHopeFoundation.org)

