PRESIDENT’S LETTER

Michael Weisz, M.D.

In an effort to address the opioid crisis in Oklahoma, Mike Hunter, Oklahoma Attorney General, has established the Oklahoma Commission on Opioid Abuse. OSMA President Kevin Taubman, M.D. was appointed to serve on the commission as well as Layne Subera, D.O., from the Tulsa area. The nine-member panel will work to evaluate and make recommendations for policy changes to help address the problem of opioid abuse. The Commission will issue a final report in January.

Oklahoma Watch, a nonprofit whose mission is to produce in-depth and investigative journalism on public policy and quality of life issues facing the state, published a report in the Tulsa World last month indicating that according to BNDD, a record 899 Oklahomans died from drug overdoses in 2016, a 68% increase since 2007. On a positive note, the article reported Oklahoma’s prescriptions for controlled, dangerous drugs dropped to 9.3 million in 2016 after peaking at 10 million three years prior. Dr. Taubman was quoted in the article, emphasizing that opioids are a necessary part of some patients’ care and he said “You don’t want people to come in and put onerous limitations on your practice…it’s the routine use we need to think about.”

Aaron Lane, D.O., is the Director of the Emergency Medicine Residency Program at the Oklahoma State University Center for Health Sciences where he also serves as Vice-Chairman and Clinical Associate Professor of Emergency Medicine. Dr. Lane said “We are losing too many people to this epidemic. It is time for us, as physicians, to take action. Use the PMP. This can help us in deciding whether to prescribe a controlled substance to a patient, and above all follow the prescribing guidelines. Guidelines are an important tool to prevent over-prescribing and to identify the signs of addiction, while meeting the needs of patients in pain. The opioid epidemic cannot be solved by physicians alone. It will require the engagement and leadership of all segments of society.” Dr. Lane serves on the Coalition Against Prescription and Substance Abuse of Tulsa (CAPSAT), an organization working to prevent prescription drug abuse.

Linda Johnston, Director of Tulsa County Social Services, is responsible for managing the George Prothro, M.D. Pharmacy of Tulsa County. She is leading a committee whose goal is to introduce legislation to require electronic prescribing over a phased in time frame. The fact that you can go to the office supply store and buy prescription paper leads to a large number of fraudulent prescriptions in Oklahoma.

Some of the issues that need to be considered around the e-prescribing requirement are, would the system be housed in the Prescription Monitoring Program, or in each physician’s/hospital’s electronic health record system? Who would bear the costs to install the necessary upgrades? Who, if anyone should be exempt from e-prescribing requirements? Are community pharmacies equipped to handle the transition to e-prescribing?

For your information we have included the Oklahoma Opioid Prescribing Guidelines published by the Oklahoma State Department of Health as an insert in our newsletter and a checklist for prescribing opioids for chronic pain is on page 2.

The OSMA, in conjunction with a number of health care stakeholders, will offer a CME program, “What Physicians Need to Know: The Opioid Epidemic and How We Change This”, at the Tulsa Marriott Southern Hills, on Friday, November 17th from 8 am to 5 pm. The fee for the program is $75 if you register before October 16th and $95 thereafter. For more information about the program contact Sandy Deeba at deeba@okmed.org.

As a pharmacist and a physician I have a great interest and concern about the impact of drug misuse in our community and our country. I am hopeful the initiatives mentioned above, as well as the national, state and local dialogue we are now having will improve the current situation and as a result improve the health of our citizens. We all need to remember that the first experience for many patients with an opioid use disorder started with a legal prescription. We should always consider non-opioid options for pain management, including non-drug treatments, such as physical therapy. At a minimum, it is our responsibility to provide clear expectations and limit quantities of opioids, particularly at the onset of their use.
**Checklist for prescribing opioids for chronic pain**

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

**CHECKLIST**

When CONSIDERING long-term opioid therapy

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

If RENEWING without patient visit

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

When REASSESSING at return visit

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

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

**REFERENCE**

**EVIDENCE ABOUT OPIOID THERAPY**

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

**NON-OPIOID THERAPIES**

Use alone or combined with opioids, as indicated:

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

**EVALUATING RISK OF HARM OR MISUSE**

Known risk factors include:

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

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

**Prescription drug monitoring program (PDMP)**: Check for opioids or benzodiazepines from other sources.

**ASSESSING PAIN & FUNCTION USING PEG SCALE**

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

**Q1:** What number from 0–10 best describes your pain in the past week?
- 0 = “no pain”, 10 = “worst you can imagine”

**Q2:** What number from 0–10 describes how, during the past week, pain has interfered with your enjoyment of life?
- 0 = “not at all”, 10 = “complete interference”

**Q3:** What number from 0–10 describes how, during the past week, pain has interfered with your general activity?
- 0 = “not at all”, 10 = “complete interference”
Woodcarving Party
A Wizardly Tale

When Sheryl and Graham Chadd attended the 2016 TCMS Foundation Art RX event they wanted to support Project TCMS by making a purchase and they chose a Woodcarving Party donated by our resident woodcarver extraordinaire, Dr. Robert Block.

Dr. Block wasn’t sure who purchased the item but thought at some point he would perhaps be called upon for a tween birthday party. He was pleasantly surprised to receive a call from Sheryl Chadd a couple of weeks ago to schedule a party at her home. Sheryl and her husband, Dr. Graham Chadd, are from Zimbabwe, South Africa. They moved to Tulsa in 1999 and have both been active in TCMS, OSMA, Alliance to the TCMS and the OSMA Alliance.

Sheryl and Graham are well known in the TCMS family for generously supporting events and initiatives and making others welcome to the community both inside and outside of the medical field. They support a group that opens their home to others who move to Tulsa from South Africa and have made many friends from their homeland. Sheryl is also well known for her culinary skills. Her food preparation and presentation are truly a form of art.

Back to the woodcarving...Dr. Block joined Sheryl, Graham, their twin daughters, Phillipa Chadd and Jennifer Wiebourn, Jennifer’s husband Andrew and Phillipa’s friend Sriki Vourganti for a lovely evening on the patio. On the left are photographs of the woodcarving in action as well as the finished wizards, which took about 1 ½ hours to complete (no band aids required).

Dr. Block began his hobby of woodcarving shortly after he arrived in Tulsa in 1975 and joined the pediatric department at the University of Oklahoma-Tulsa, now the OU School of Community Medicine. Since then he has spent thousands of hours making wood come to life. More than 100 hours went into the creation of an intricate bust of a cowboy. Each year Tulsa hosts a woodcarving event that showcases many forms of wood working including wood burning which has become more popular over the last ten years. In fact, attending a show was how Dr. Block began his journey with wood. Tulsa County Medical Society is honored to display Dr. Block’s “Country Doctor” in our lobby. Dr. Jerry and Julie Gustafson purchased the piece at the 2016 Art RX event and gifted it to TCMS.

Sheryl Chadd, master gardener and fabulous chef, told me she now has a new hobby, woodcarving. Sheryl discovered the delight of each new feature of the piece as it was revealed throughout the carving process. She, like Dr. Block, finds the art of wood carving both therapeutic and fascinating.

Thank you to Dr. Block and to Dr. Graham and Sheryl Chadd for supporting Project TCMS and for sharing your story about this experience.

Thank you to Dr. Jerry & Julie Gustafson for giving us a treasured gift.

Mona Whitmire, Executive Director
TCMS-TCMS Foundation

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OKLAHOMA OPIOID PRESCRIBING GUIDELINES

Note: These guidelines do not replace clinical judgment in the appropriate care of patients. They are not intended as standards of care or as templates for legislation, nor are they meant for patients in palliative care programs or with cancer pain. The recommendations are an educational tool based on the expert opinion of numerous physicians and other health care providers, medical/nursing boards, mental and public health officials, and law enforcement personnel in Oklahoma and throughout the United States. 1, 2, 3

Opioid Treatment for Acute Pain

1. Health care providers are encouraged to consider non-pharmacological therapies and/or non-opioid pain medications. Opioids should only be used for treatment of acute pain when the severity of the pain warrants that choice.

2. By Oklahoma law, it is mandatory that providers check the Oklahoma Prescription Monitoring Program (PMP) prior to prescribing and every 180 days prior to authorizing refills for opiates, synthetic opiates, semi-synthetic opiates, benzodiazepines, or carisoprodol. More frequent checks of the PMP are recommended.

3. When opioids are started, providers should prescribe the lowest possible effective dose. Prescribe no more than a short course; most patients require opioids for no more than three days.

4. Avoid prescribing opioids to patients currently taking benzodiazepines and/or other opioids.

5. Patients should be counseled to store medications securely, never to share them with others, and to dispose of medications when the pain has resolved.

6. Long-acting or extended-release opioids should not be prescribed for acute pain.

7. Providers should provide screening, brief intervention, and referral to treatment, if indicated.

8. Continued opioid use should be evaluated carefully, including assessing the potential for abuse, if pain persists beyond the anticipated period of acute pain.

9. In general, health care providers should not provide replacement prescriptions for opioids that have been lost, stolen, or destroyed.

Opioid Treatment for Chronic Pain

1. Alternatives to opioid treatment should be tried, or previous attempts documented, before initiating opioid treatment for chronic pain.

2. By Oklahoma law, it is mandatory that providers check the Oklahoma Prescription Monitoring Program (PMP) prior to prescribing and every 180 days prior to authorizing refills for opiates, synthetic opiates, semi-synthetic opiates, benzodiazepines, or carisoprodol. More frequent checks of the PMP are recommended.

3. A comprehensive evaluation should be performed before initiating opioid treatment for chronic pain.

4. The health care provider should screen for risk of abuse or addiction before initiating opioid treatment.

5. Patients should be counseled to store medications securely, never to share them with others, and to dispose of medications when pain has resolved.

6. Long-acting or extended-release opioids are associated with an increased risk of overdose death, and should only be prescribed by health care providers familiar with their indications, risks, and need for careful monitoring.

7. A written treatment plan should be established that includes measurable goals for reduction of pain and improvement of function.

Learn more: poison.health.ok.gov
8. The patient should be informed of the risks, benefits, and terms for continuation of opioid treatment, ideally using a written and signed treatment agreement. Consider co-prescribing naloxone for patients with increased risk of opioid overdose.

9. Opioids should be initiated as a short-term trial to assess the effects of opioid treatment on pain intensity, function, and quality of life. The trial should begin with a short-acting opioid medication.

10. During the titration period, regular visits for evaluation of progress toward goals should be scheduled and the PMP should be checked more frequently.

11. Continuing opioid treatment should be a deliberate decision that takes into consideration the risks and benefits of chronic opioid treatment for that patient. Patients and health care providers should periodically reassess the need for continued opioid treatment, weaning whenever possible. A second opinion or consultation may be useful in making that decision.

12. Opioid treatment should be tapered or gradually discontinued if adverse effects outweigh benefits or if aberrant, dangerous, or illegal behaviors are demonstrated. Care should be taken when tapering opioid treatment, particularly in patients on higher dosages, the elderly, and patients who are pregnant. Abrupt discontinuation of opioids should be avoided.

13. Health care providers should consider consultation for patients with complex pain conditions, serious co-morbidities, mental illness, or a history or evidence of current drug addiction or abuse.

14. In general, health care providers should not provide replacement prescriptions for opioids that have been lost, stolen, or destroyed.

15. Health care providers 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.

Resources

