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DOCTORS

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Fall/Winter 2016

OPIOID PRESCRIBING

A Delicate Balance!

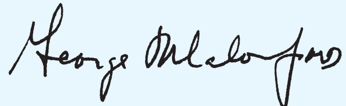
find out...

- How serious is the opioid problem?
- What are the state and federal laws concerning opioids?
- What resources are available for prescribing Doctors?

A LETTER FROM THE CHAIR OF THE BOARD

Dear Colleague:

The epidemic of opioid use and abuse has become a topic of nationwide attention and concern. Family Physicians, primary care providers and other specialists play a vital role in balancing their patients' pain management needs with the risk of drug misuse and abuse. This issue of *Doctors RX* will take a look at the problem and provide assistance to Maryland Physicians in adopting safe prescribing and treatment practices.



George S. Malouf, Jr., M.D.
Chair of the Board
MEDICAL MUTUAL Liability Insurance Society of Maryland

ISSUE HIGHLIGHTS

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DOCTORS RX

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All faculty/authors participating in continuing medical education activities sponsored by MEDICAL MUTUAL are expected to disclose to the program participants any real or apparent conflict(s) of interest related to the content of his presentation(s). John Sly has indicated that he has nothing to disclose.

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A PAINFUL LESSON

Our Physician, a family practitioner, treated a patient for lower back and knee pain for seven years. Upon taking the patient's history at the first visit, the Physician learned that she had a history of opiate dependency and depression. Although he did not perform a physical exam and did not document his medical rationale, he prescribed opioids for her pain. He **did** have the patient sign a pain medicine agreement, which specifically stated that if the patient violated the agreement the Physician would taper the opioids.

> "ALTHOUGH THE PHYSICIAN REFERRED THE PATIENT TO A PAIN MANAGEMENT SPECIALIST, HE CONTINUED TO PRESCRIBE OPIOIDS WHEN THE PATIENT CLAIMED THAT SHE COULD NOT AFFORD THE SPECIALIST'S FEES."

While under our Physician's care, the patient complained of increasing pain. The Physician increased the dosage of opioids, without documenting his medical rationale or making any physical examination of the patient. Although the Physician referred the patient to a pain management specialist, he continued to prescribe opioids when the patient claimed that she could not afford the specialist's fees. In a two-year span, the patient overdosed and was hospitalized three times. Claiming that she lost or accidentally spilled her pills down the sink, she asked for early refills. Despite the violation of the pain medication agreement and signs of drug-seeking behavior, the Physician continued to prescribe opioids. Eventually, the patient overdosed and died.

Our Physician was sued and in the malpractice case it was alleged that he was negligent in his treatment of the patient, that he failed to diagnose the patient's drug addiction and address the patient's drug-seeking behavior, and that he overprescribed the opioids that fueled the patient's addiction and ultimately caused her death.

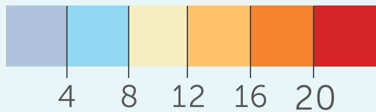
The feature article of this edition of *Doctor's RX* provides guidance for Physicians so that these scenarios do not happen to them.

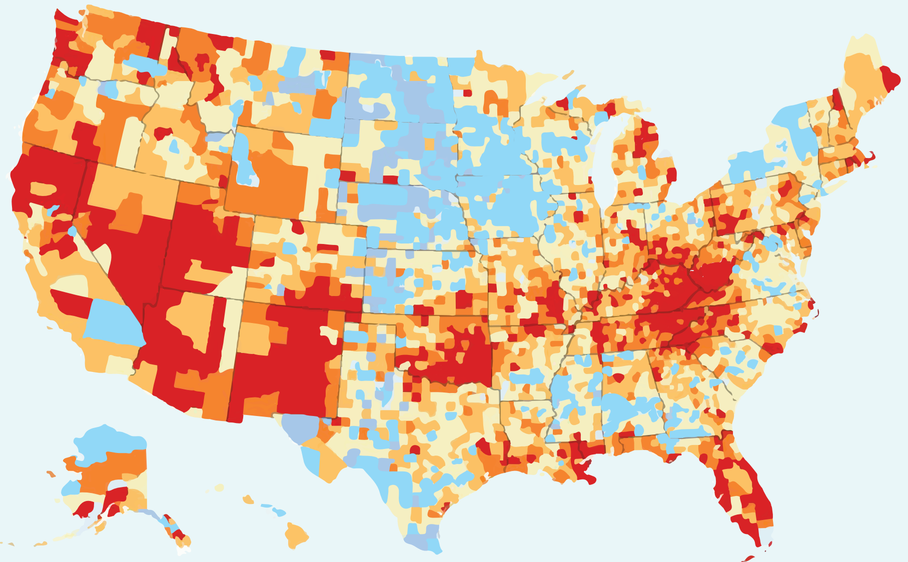
COULD THIS HAPPEN TO YOU?

A general practitioner prescribed opioid pain medication to a patient involved in a motor vehicle accident. The Physician intended it to be of short-term duration. No written plan was developed, no pain contract was executed and no blood or urine testing was performed. Months later, the practitioner found himself still prescribing opioids to a now-addicted patient who aggressively rejected all recommendations to reduce or eliminate opioids. Furthermore, the patient threatened that if the practitioner reduced or eliminated opioids, he would complain to the Maryland Board of Physicians that the practitioner had abandoned him and caused him to become addicted to opioids.

John Sly
The author of "Opioid Prescribing – A Delicate Balance!" is a partner with Waranch and Brown, LLC. He specializes in the defense of Physicians and health care facilities.

Overdose deaths in 2014 per 100,000





SOURCE: "Drug Poisoning Mortality: United States, 2002–2014" by Lauren M. Rossen, Brigham Bastian, Margaret Warner, Diba Khan and Yinong Chong, National Center for Health Statistics, Centers for Disease Control and Prevention

Prescription Pain Killers

Opioids are a class of drugs that include the prescription pain relievers oxycodone, hydrocodone, codeine, morphine, fentanyl and others.

THE PROBLEM

Opioids are a class of drugs that include the prescription pain relievers oxycodone, hydrocodone, codeine, morphine, fentanyl and others. Such drugs are chemically related to and interact with opioid receptors on nerve cells in the brain and nervous system that produce pleasurable effects and relieve pain.

One survey of 1,032 adults who were prescribed opioid painkillers indicated that:

60.6% had leftover opioid medication

61.3% of those with leftover opioids saved them for future use

20% shared their opioids with others

Nearly 50% said that nobody instructed them on the proper storage, handling and disposal of the opioids

Fewer than 7% said that they used the "take back" programs (i.e. turning in extra opioids to pharmacies, police departments or the Drug Enforcement Administration for proper disposal)

SOURCE: Johns Hopkins Bloomberg School of Public Health. (June 13, 2016). Six in Ten Adults Prescribed Opioid Painkillers Have Leftover Pills. [Press Release]. Retrieved from http://www.jhsph.edu/news/news-releases/2016/six-in-ten-adults-prescribed-opioid-painkillers-have-leftover-pills.html

Of the 21.5 million Americans age 12 or older who had substance abuse disorders in 2014, 1.9 million had substance abuse disorders involving prescription pain relievers.[1] Drug overdose is the leading cause of accidental death in the United States, with 47,055 lethal drug overdoses in 2014. Opioid addiction is driving this epidemic, with 18,893 overdose deaths related to prescription pain relievers, and 10,574 overdose deaths related to heroin in 2014.[2]

From 1999 to 2008, overdose death rates, sales of prescription pain relievers, and substance abuse disorder treatment admissions related to prescription pain relievers increased in parallel. The overdose death rate in 2008 was nearly four times the 1999 rate; sales of prescription pain relievers in 2010 were four times those in 1999; and the substance abuse disorder treatment admission rate in 2009 was six times the 1999 rate.[3] In 2012, 259 million prescriptions were written for opioids – enough to give every American adult his or her own bottle of pills.[4]

Alarmingly, four in five new heroin users started out misusing prescription painkillers. As a consequence, the rate of heroin overdose deaths nearly quadrupled from 2000 to 2013.[5] During this 14-year period, the rate of heroin overdose showed an average increase of 6% per year from 2000 to 2010, followed by a larger average increase of 37% per year from 2010 to 2013. In fact, 94% of respondents in a 2014 survey of people in treatment for opioid addiction said they chose to use heroin

because prescription opioids were “far more expensive and harder to obtain.”[6]

Opioid prescribing rates for adolescents and young adults nearly doubled from 1994 to 2007.[7] In 2014, 467,000 adolescents were current nonmedical users of pain relievers, with 168,000 having an addiction to prescription pain relievers.[8] Most adolescents who misuse prescription pain relievers are given them for free by a friend or relative, as people often share their unused pain relievers, unaware of the dangers of nonmedical opioid use.[9]

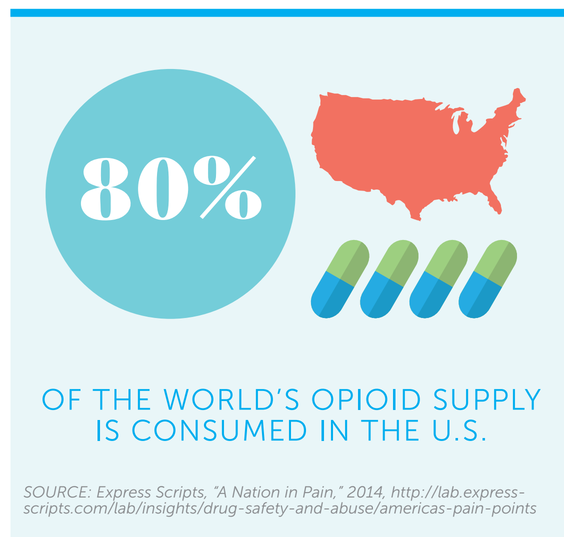
Women are more likely than men to have chronic pain and be prescribed prescription pain relievers, and they are likely to be given higher doses and use them for longer periods of time. Women also may become dependent on prescription pain relievers more quickly than men.[10] Between 1999 and 2010, 48,000 women died of prescription pain reliever overdoses.[11] Prescription pain reliever overdose deaths among women increased more than 400% from 1999 to 2010, compared to 237% among men.[12] Heroin overdose deaths among women have tripled in the past few years. From 2010 through 2013, female heroin overdoses increased from 0.4 to 1.2 per 100,000.[13]

The public now is acutely aware of this epidemic. High profile deaths of celebrities and public admissions by athletes, politicians and business people of addictions to opioids have dominated recent news. As a result, government has responded at both the State and Federal levels.[14]

MARYLAND

The Maryland Board of Physicians (BOP) took early public steps to stem the opioid prescription problem. In 1996, the BOP issued a Statement, in the form of a newsletter, outlining its concern about the prescribing practices of Physicians and reminded them that histories, physicals and documentation are **critical** to safe prescribing.[15] That newsletter remained the only State of Maryland guideline on opioid prescriptions until the issue was re-addressed in 2015. Until then, the only alternative guidance Maryland health care providers had was from the Federation of State Medical Boards, which issued its “Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain” in 1998, with published updates in 2004 and 2013. The “Model Policy” offered the most current evidence on pain management at the time and addressed the treatment of pain and the inappropriate use of opioids.

The BOP remained concerned about the rise in the number of drug overdose deaths, the growing public health threat and the potential role of prescribers. To address these concerns, the BOP has been actively working to develop continuing education resources for licensees and had mandated that Physician and physician assistant licensees complete **one** continuing medical education (credit hour) dedicated to opioid prescribing per renewal cycle. Due to actions of the Maryland State Legislature in the 2016 Legislative Session, this mandate was removed, effective October 1, 2016.



OF THE WORLD’S OPIOID SUPPLY IS CONSUMED IN THE U.S.

SOURCE: Express Scripts, “A Nation in Pain,” 2014, http://lab.express-scripts.com/lab/insights/drug-safety-and-abuse/americas-pain-points

Did you know?

Women are more likely than men to have chronic pain and be prescribed prescription pain relievers, and they are likely to be given higher doses and use them for longer periods of time.

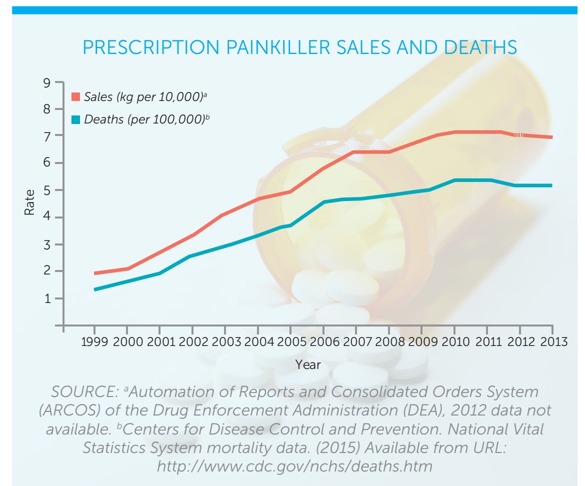
Executive Orders

In the face of rising addiction problems, Maryland Governor Larry Hogan issued two executive orders in 2015 to address the state's growing heroin and opioid crisis.

In the face of rising addiction problems, Maryland Governor Larry Hogan issued two executive orders in 2015 to address the state's growing heroin and opioid crisis. One order, Executive Order 01.01.2015.13, established the Inter-Agency Heroin and Opioid Coordinating Council. The Council is made up of multiple state agencies that now have the opportunity to share information with each other regarding the State's concerted effort to curb the heroin and opioid situation. Further, the Council was assigned to develop recommendations for policy, regulation or legislation that would facilitate this information sharing. Participating agencies include the Department of Health and Mental Hygiene (which chairs the Council), the Maryland State Police, the Department of Public Safety and Correctional Services, the Department of Juvenile Services, the Institute for Emergency Medical Services System, the State Department of Education, the Governor's Office of Crime Control and Prevention, and other state agencies at the request of the Chair. The Council will report to the Governor biannually and apprise him of what each agency is doing with regard to heroin and opioid treatment, overdoses, education and their strategy to curb the problem.

"THE PDMP COLLECTS AND SECURELY STORES INFORMATION ON DRUGS THAT CONTAIN CONTROLLED SUBSTANCES AND ARE DISPENSED TO PATIENTS IN MARYLAND."

The Governor's other order, Executive Order 01.01.2015.12, established the separate Heroin and Opioid Emergency Task Force and assigned it the role of developing a comprehensive plan to combat the state's heroin and opioid epidemic. The Task Force was assigned to meet regularly and solicit guidance and opinions from a variety of sources throughout the State on the subject. As one of 33 recommendations in its Final Report, issued on December 1, 2015, the Task Force recommended that the state of Maryland pass legislation that **requires** prescribers and dispensers of opioids to register with and use the Prescription Drug Monitoring Program (PDMP).

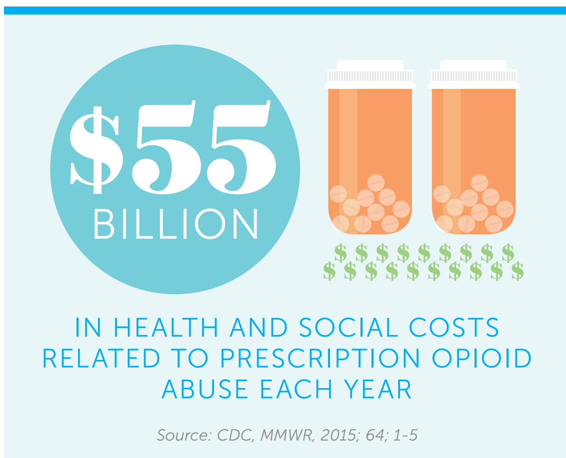


SOURCE: [a]Automation of Reports and Consolidated Orders System (ARCOS) of the Drug Enforcement Administration (DEA), 2012 data not available. [b]Centers for Disease Control and Prevention. National Vital Statistics System mortality data. (2015) Available from URL: http://www.cdc.gov/nchs/deaths.htm

Established by the Maryland Department of Health and Mental Hygiene, Behavioral Health Administration in 2011 to support health care providers and their patients in the safe and effective use of prescription drugs, the PDMP collects and securely stores information on

drugs that contain controlled substances and are dispensed to patients in Maryland. Drug dispensers, including pharmacies and health care practitioners, electronically report the information that is stored in the PDMP database.

Intentionally created to reduce the abuse of prescription drugs, the PDMP tracks the prescribing and dispensing of controlled and dangerous substances (CDS) in an electronic database. Specifically, the tracked medicines are drugs that contain Schedule II-IV CDS. These include but are not limited to: pain relievers such as oxycodone, hydrocodone and methadone; anti-anxiety and sedative medications such as alprazolam and diazepam; and stimulants such as Adderall and Ritalin.



IN HEALTH AND SOCIAL COSTS RELATED TO PRESCRIPTION OPIOID ABUSE EACH YEAR

Source: CDC, MMWR, 2015; 64; 1-5

Access to prescription data is made available at no cost to Physicians, nurse practitioners, pharmacists and others who provide pharmaceutical care to their patients. By law, health care providers may only access information on patients under their care. Use of prescription information improves providers' ability to manage the benefits and risks of controlled substance medications and identify potentially harmful drug interactions.

The information reported and stored in the PDMP includes the following:

1. **Drug:** Prescription number, date issued, refill information, National Drug Code, quantity dispensed, days' supply;
2. **Patient:** Name, address, gender, date of birth, ID number;
3. **Prescriber:** DEA registration number; and
4. **Dispenser:** DEA registration number.

This information must be reported to the PDMP by the dispenser within three business days after the medicine is dispensed.

To date, participation in Maryland's PDMP program has been voluntary. That is about to change. As a result of the previously mentioned Final Report recommendation, House Bill 437 was proposed and later signed into law by Governor Hogan during the 2016

Did you know?

Access to prescription data is made available at no cost to Physicians, nurse practitioners, pharmacists and others who provide pharmaceutical care to their patients.

CRISP

Once registered with CRISP, providers may securely access their patients' CDS prescription history, hospital and other clinical data.

General Assembly. The key points of the new legislation as it pertains to prescribers include the following:

1. As of October 1, 2016, prescribers of CDS must be registered with the PDMP either before they obtain a new or renewed state CDS Registration or by July 1, 2017, whichever occurs first. Prescribers include Physicians, physician assistants, and nurse practitioners, among others.
2. As of July 1, 2018, prescribers must screen their patients' PDMP data before they prescribe an opioid or benzodiazepine. In addition, prescribers must continue to review the patients' PDMP data at least every 90 days for as long as the opioid or benzodiazepine treatment continues.
3. Prescribers must document PDMP data query and review in patients' records.
4. Prescribers may delegate their health care staff to obtain user accounts and check PDMP data on their behalf. The health care staff may include those without prescriptive authority who are either licensed or non-licensed clinical staff who are employed where the prescriber practices.[16]

Currently, providers gain online access to patient data through the Chesapeake Regional Information System for our Patients (CRISP) health information exchange (HIE) query portal. CRISP is a state-designated, not-for-profit regional HIE that services Maryland and the District of Columbia. An electronic system connects all 46 acute care hospitals in Maryland. Once registered with CRISP, providers may securely access their patients' CDS prescription history, hospital and other clinical data.

650,000+

Rx

OPIOID PRESCRIPTIONS ARE DISPENSED EVERY DAY IN THE U.S.

Source: CDC, MMWR, 2015; 64; 1-5

FEDERAL

(1) The FDA

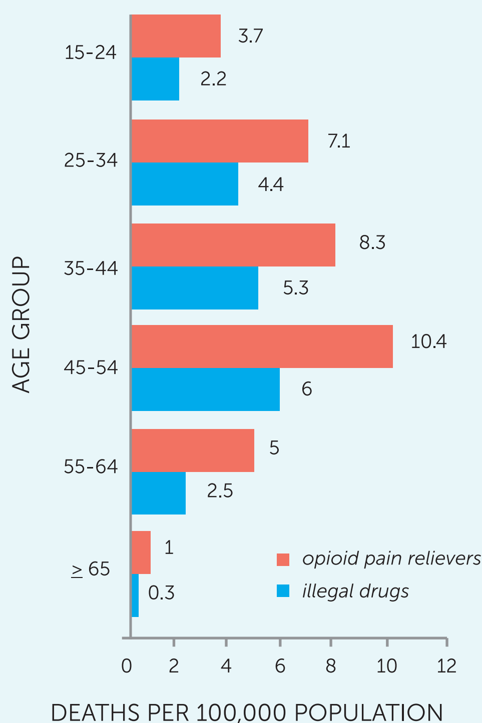
Early in 2016, a U.S. Food and Drug Administration (FDA) advisory panel concluded the following: Physician training on the risks of prescription opioids should be mandatory and include information on immediate-release (IR) as well as extended-release (ER) and long-acting (LA) formulations.

At a two-day joint meeting, the FDA's Drug Safety and Risk Management Advisory Committee and its Anesthetic and Analgesic Drug Products Advisory Committee unanimously voted to modify the ER/LA opioid analgesic Risk Evaluation and Mitigation Strategies.

In addition to most panel members recommending that the training be mandatory and include IR drugs, some suggested that it also focus on pain management rather than on opioids, be tied to the recently released Centers for Disease Control and Prevention (CDC) guidelines, and involve mental health and suicide screenings.

It remains to be seen whether any mandatory training will be instituted.

DEATHS FROM OPIOID PAIN RELIEVERS EXCEED THOSE FROM ALL ILLEGAL DRUGS



SOURCE: University of Michigan, 2014 Monitoring the Future Study

(2) The CDC

The aforementioned guidelines, entitled "Guidelines for Prescribing Opioids for Chronic Pain" were issued by the CDC in March of 2016.[17] While they do not establish the standard of care in Maryland, the guidelines may be used as evidence of what the standard of care requires. The new guidelines are for primary care providers who treat adult patients for pain in outpatient settings and, according to the CDC, prescribe nearly half of all opioid prescriptions. The CDC explained,

> This guideline provides recommendations for primary care clinicians who are prescribing opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. The guideline addresses 1) when to initiate or continue opioids for chronic pain; 2) opioid selection, dosage, duration, follow-up, and discontinuation; and 3) assessing risk and addressing harms of opioid use.[18]

The CDC guidelines have 12 recommendations. Practitioners are strongly encouraged to review them all.[19] However, some of the key points are:

Make a treatment plan: The Physician should explain his or her rationale behind the prescription, noting the patient's condition and what the Physician will prescribe. The treatment plan should state objectives by which treatment success can be evaluated, such as pain relief and/or improved physical and psychosocial function, and indicate if any further diagnostic evaluations or other treatments are planned. The prescriber should tailor drug therapy to the individual medical needs of each patient.

Prescribe proportionately: Only prescribe the amount of pain medicine reasonably expected to be needed.

Start an opioid trial: Advise your patient to try the medication for a specified period of time and re-assess.

Discuss the risks and benefits of opioid medication: Explain the risks and benefits of the pain medicine to your patients. Document that conversation in the medical record.

Electronically prescribe controlled substances: Make sure you upgrade your electronic health record system AND USE THE MARYLAND PDMP.

(3) The Comprehensive Addiction and Recovery Act of 2016

In a further attempt to combat the opioid problem in the United States, on July 22, 2016, President Obama signed into law Senate Bill 524, the Comprehensive Addiction and Recovery Act of 2016 (CARA). Supported by

Guidelines

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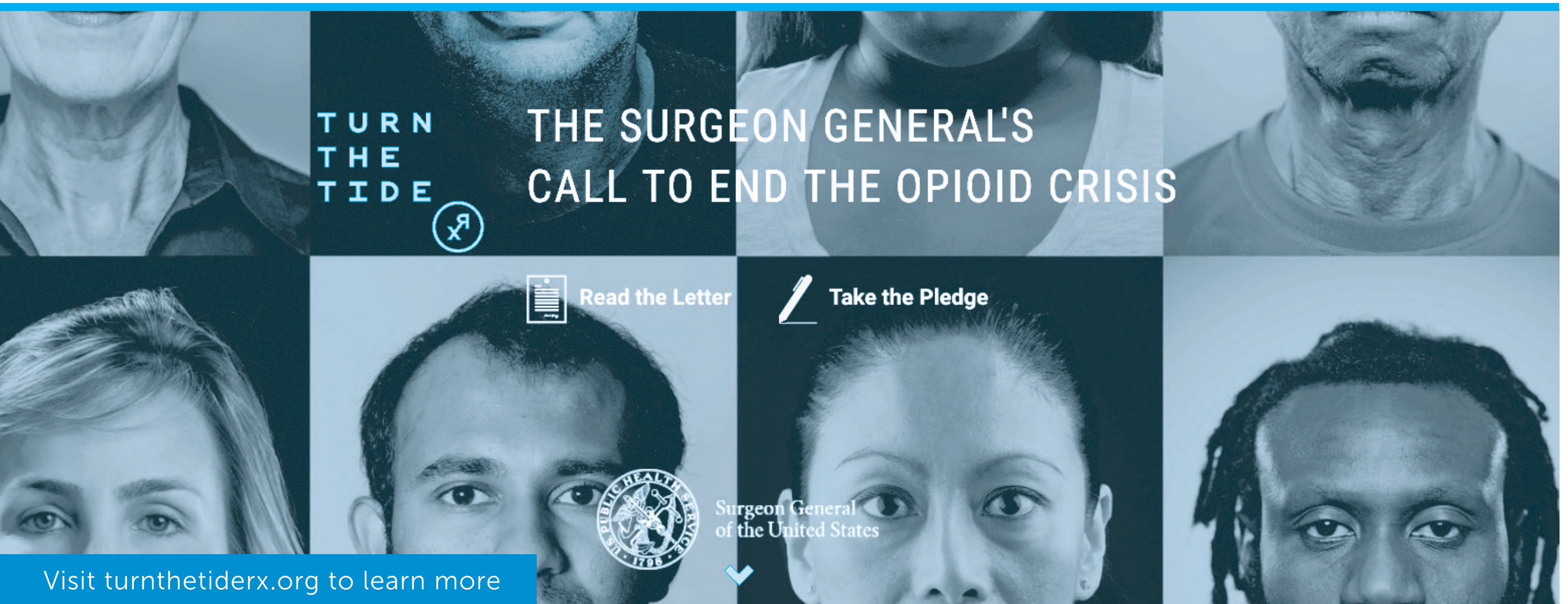

Did you know?

In a letter dated August 2016 that appears on turnthetiderx.org, Dr. Murthy urges Physicians to rethink their approach to pain management.

both parties in the House and Senate, the law expands access to care for individuals who struggle with substance abuse. As it pertains to prescribers, CARA improves state prescription drug monitoring programs in Department of Veterans Affairs facilities to help states monitor and track prescription drug diversions and help at-risk individuals access services. In addition, clinicians in Veterans Affairs facilities will receive more education and training on pain management and safer opioid prescriptions. Moreover, CARA will mandate that clinical teams work together to coordinate pain management therapy plans for patients with pain unrelated to cancer.

(4) The U.S. Surgeon General

In an unprecedented move, the U.S. Surgeon General, Dr. Vivek H. Murthy, wrote a letter to all Physicians about the opioid epidemic. In a letter dated August 2016 that appears on turnthetiderx.org, Dr. Murthy urges Physicians to rethink their approach to pain management. Acknowledging that for the past 20 years the medical community was encouraged to aggressively treat pain without proper training and with incorrect information, he called for Physicians to unite and forge a new path with regard to pain treatment and management. Dr. Murthy asked all Physicians to pledge their commitment "to turn the tide on the opioid crisis." His proposal included education on safe and effective pain treatment; screening for opioid abuse and referrals to treatment for addiction; and a characterization of addiction as an illness rather than a moral failure. He further encouraged Physicians to first attempt to treat pain with physical therapy and non-addictive medication before prescribing opioids. Should the need for more pain relief be present, he urged Physicians to prescribe low dosages for short periods of time to avoid triggering an addiction.

THE OPIOID RISK TOOL

Physicians may have a way to assess at-risk patients before they prescribe opioid medication to them. A self-administered assessment called The Opioid Risk Tool (ORT) may indicate a possible inclination towards opioid addiction. The ORT is:

> [A] brief, self-report screening tool designed for use with adult patients in primary care settings to assess risk for opioid abuse among individuals prescribed opioids for treatment of chronic pain. Patients categorized as high-risk are at increased likelihood of future abusive drug-related behavior. The ORT can be administered and scored in less than 1 minute and has been validated in both male and female patients, but not in non-pain populations.[20]

Physicians may want to consider administering the ORT form to their patients to assess the potential for addiction and abuse. A sample of the ORT can be found on the next page.

The Opioid Risk Tool

Use the Opioid Risk Tool to assess at-risk patients before prescribing opioid medication.

THE OPIOID RISK TOOL

Administer this tool to patients before beginning opioid therapy. Circle each number that applies and assess the patient's total score. A total of 3 or less indicates low risk for future abuse, a score of 4 to 7 indicates moderate risk, and a score of 8 or more indicates high risk.

CIRCLE EACH NUMBER THAT APPLIES	*Female*	*Male*
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16-45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1

SUMMARY

With increasing attention being given to the alarming rise of opioid-related deaths, Physicians must be extremely cautious when prescribing opioids or any controlled substance.

Physicians should do the following:

- Keep abreast of the CDC guidelines, as well as any state requirements;
- Before prescribing opioids, try to address the pain with non-pharmacological means or with non-controlled substances. Should those methods fail or prove to fall short in managing the patient's pain, only then should Physicians consider prescribing opioids;
- Prescribe opioids only for a legitimate need which is supported and documented by the medical history, physical exam and a verified reason for the diagnosis;
- Clearly explain the risks and benefits of the prescribed opioids along with the treatment plan to the patient and then document the discussion in the patient's medical record;
- Be conservative with the duration and dosage of opioids;
- After prescribing opioids, carefully assess and monitor the patient's progress, with the goal of weaning the patient off of opioids as soon as possible;
- Document your medical rationale for any deviation from state or federal regulations.

FOR ADDITIONAL INFORMATION AND RESOURCES ON OPIOIDS, VISIT **MMLIS.COM/OPIOIDS**

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[12] Id.

[13] Hedegaard MD MSPH, Chen MS PhD, Warner PhD. Drug-Poisoning Deaths Involving Heroin: United States, 2000-2013. National Center for Health Statistics Data Brief. 2015:190:1-8.

[14] See discussion in THE PRESCRIPTION OPIOID EPIDEMIC: AN EVIDENCE-BASED APPROACH November 2015, http://www.jhsph.edu/research/centers-and-institutes/center-for-drug-safety-and-effectiveness/opioid-epidemic-town-hall-2015/2015-prescription-opioid-epidemic-report.pdf (accessed June 28, 2016).

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[16] More information regarding the mandatory use of the PDMP is available on the DHMH website: http://bha.dhmh.maryland.gov/PDMP/Pages/Home.aspx

[17] Recommendations and Reports / March 18, 2016 / 65(1); 1–49.

[18] Recommendations and Reports / March 18, 2016 / 65(1); 1–49.

[19] https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

[20] https://www.drugabuse.gov/sites/default/files/files/OpioidRiskTool.pdf (accessed June 28, 2016).

CME TEST QUESTIONS

1. The Opioid Risk Tool requires a computer program to use.

   A. True B. False

2. Women have a lower risk of addiction to opioids.

   A. True B. False

3. Physicians must submit proof of Opioid CME completion to the BOP after October 1, 2016.

   A. True B. False

4. The CDC Opioid Guidelines establish the standard of care in Maryland.

   A. True B. False

5. It is recommended that prescriptions for opioids be handwritten.

   A. True B. False

6. Drug overdose is the leading cause of accidental death in the United States.

   A. True B. False

7. Once registered with CRISP, providers may securely access their patients' CDS prescription history, hospital and other clinical data.

   A. True B. False

8. As of July 1, 2018, prescribers must screen a patient's PDMP data before they prescribe an opioid or benzodiazepine.

   A. True B. False

9. Prescribers need not document PDMP data query and review in a patient's record.

   A. True B. False

10. As of July 1, 2018, prescribers must continue to review a patient's PDMP data at least every 90 days for as long as the opioid or benzodiazepine treatment continues.

    A. True B. False

Instructions – to receive credit, please follow these steps:

Read the articles contained in the newsletter and then answer the test questions.

1. Mail or fax your completed answers for grading:
   Med•Lantic Management Services, Inc. | Fax: 410-785-2631
   225 International Circle | P.O. Box 8016 | Hunt Valley, Maryland 21030
   Attention: Risk Management Services Dept.
2. One of our goals is to assess the continuing educational needs of our readers so we may enhance the educational effectiveness of the *Doctors RX*. To achieve this goal, we need your help. You must complete the CME evaluation form to receive credit.
3. Completion Deadline: March 31, 2017
4. Upon completion of the test and evaluation form, a certificate of credit will be mailed to you.

CME Accreditation Statement

MEDICAL MUTUAL Liability Insurance Society of Maryland is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for Physicians.

CME Designation Statement

MEDICAL MUTUAL Liability Insurance Society of Maryland designates this enduring material for a maximum of one (1) *AMA PRA Category 1 Credit*.™ Physicians should claim only the credit commensurate with the extent of their participation in the activity.

CME EVALUATION FORM

Statement of Educational Purpose

Doctors RX is a newsletter sent twice each year to the insured Physicians of MEDICAL MUTUAL/Professionals Advocate.®
Its mission and educational purpose is to identify current health care-related risk management issues and provide Physicians with educational information that will enable them to reduce their malpractice liability risk.

Readers of the newsletter should be able to obtain the following educational objectives:
1) Gain information on topics of particular importance to them as Physicians
2) Assess the newsletter's value to them as practicing Physicians
3) Assess how this information may influence their own practices

CME Objectives for "OPIOID PRESCRIBING A Delicate Balance!"

Educational Objectives: Upon completion of this enduring material, participants will be better able to:
1) Understand the evolving history of opioid prescriptions
2) Understand the current laws and regulations as they pertain to opioid prescribing practices
3) Prescribe opioids appropriately and safely for their patients

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Part 1. Educational Value:	Strongly Agree 5	4	3	2	Strongly Disagree 1
I learned something new that was important.	❏	❏	❏	❏	❏
I verified some important information.	❏	❏	❏	❏	❏
I plan to seek more information on this topic.	❏	❏	❏	❏	❏
This information is likely to have an impact on my practice.	❏	❏	❏	❏	❏

Part 2. Commitment to Change: What change(s) (if any) do you plan to make in your practice as a result of reading this newsletter?

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Part 3. Statement of Completion: I attest to having completed the CME activity.

Signature:______________________________ Date:____________________

Part 4. Identifying Information: Please PRINT legibly or type the following:

Name:______________________________ Telephone Number:____________________

Address:______________________________________

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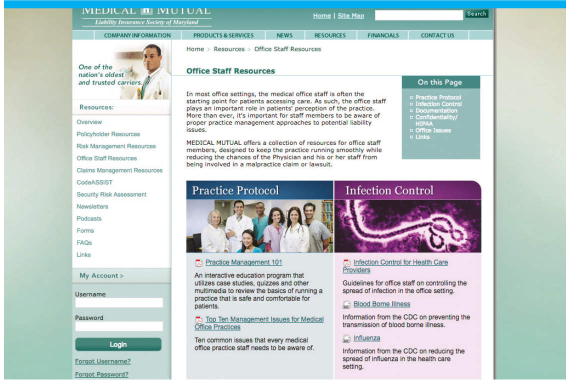
RISK MANAGEMENT NEWS CENTER



FIND RESOURCES DESIGNED FOR YOUR OFFICE STAFF

mmlis.com now has a section dedicated to resources for office staff, including tips on documentation, HIPAA, controlling infection, common office issues and more. Your office staff is the first impression your practice makes on many patients, so their professionalism and knowledge of potential claims risks are essential.

WE'RE HERE TO ANSWER YOUR LIABILITY QUESTIONS

Did you know that you can call our risk management department to ask about any liability concerns you have? Talk directly to our experts with extensive medico/legal backgrounds and receive instant advice and answers about liability questions as they arise. Contact us today at 410-785-0050 or toll free at 800-492-0193.

RISK MANAGEMENT PODCASTS ARE NOW AVAILABLE

We understand how much time you spend keeping up with your patients and your practice, which is why we have converted our most essential and popular risk management topics into podcasts! Now you can stay up-to-date even when you're on-the-go. Visit *mmlis.com* today to listen anywhere, from any device.

LET US FIND YOUR ICD-10 CODES FOR YOU

Finding the correct ICD-10 code can be time-consuming, but is necessary for effective patient care and timely claims payments. With our CodeASSIST ICD-10 Support, you can let us do the work. Visit *mmlis.com* to submit your coding inquiry and we will send you an accurate diagnosis code within two business days.

MEDICAL MUTUAL offers a variety of online tools and resources that are specially designed to help Doctors identify and address preventable issues before they escalate into potentially serious legal action.

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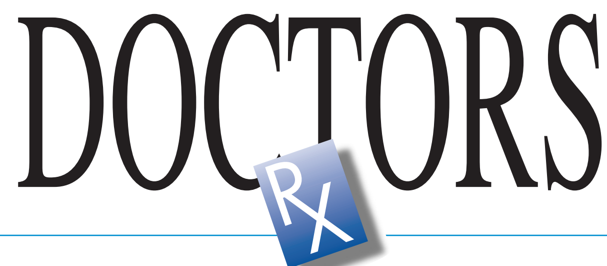

Publication of Medical Mutual / Professionals Advocate®

SECURITY RISK ASSESSMENT

TAKE THE GUESSWORK OUT OF YOUR CYBER SECURITY!

A security breach can be an enormous financial and time-consuming burden for a Doctor. Taking several minutes to evaluate your risk now could help save you thousands of dollars in legal fees by pointing out potential weaknesses in your security before it is too late.

FAST AND CONVENIENT

Evaluate the strength of your cyber security from the comfort of your own home or office! This 40-question online survey can be completed from any computer or device.

EFFECTIVE RISK MANAGEMENT ADVICE

The Security Risk Assessment was developed with the aid of cyber liability and security risk experts to help you identify and fix weak points in your security protocols. If any security weaknesses are found, you will receive practical advice on how to correct the problem.

ALL THE INFORMATION YOU NEED

At the end of the survey, additional information is provided on areas of risk such as Physician security and access controls, network security, employee access, storage and backup security, and policies and procedures.