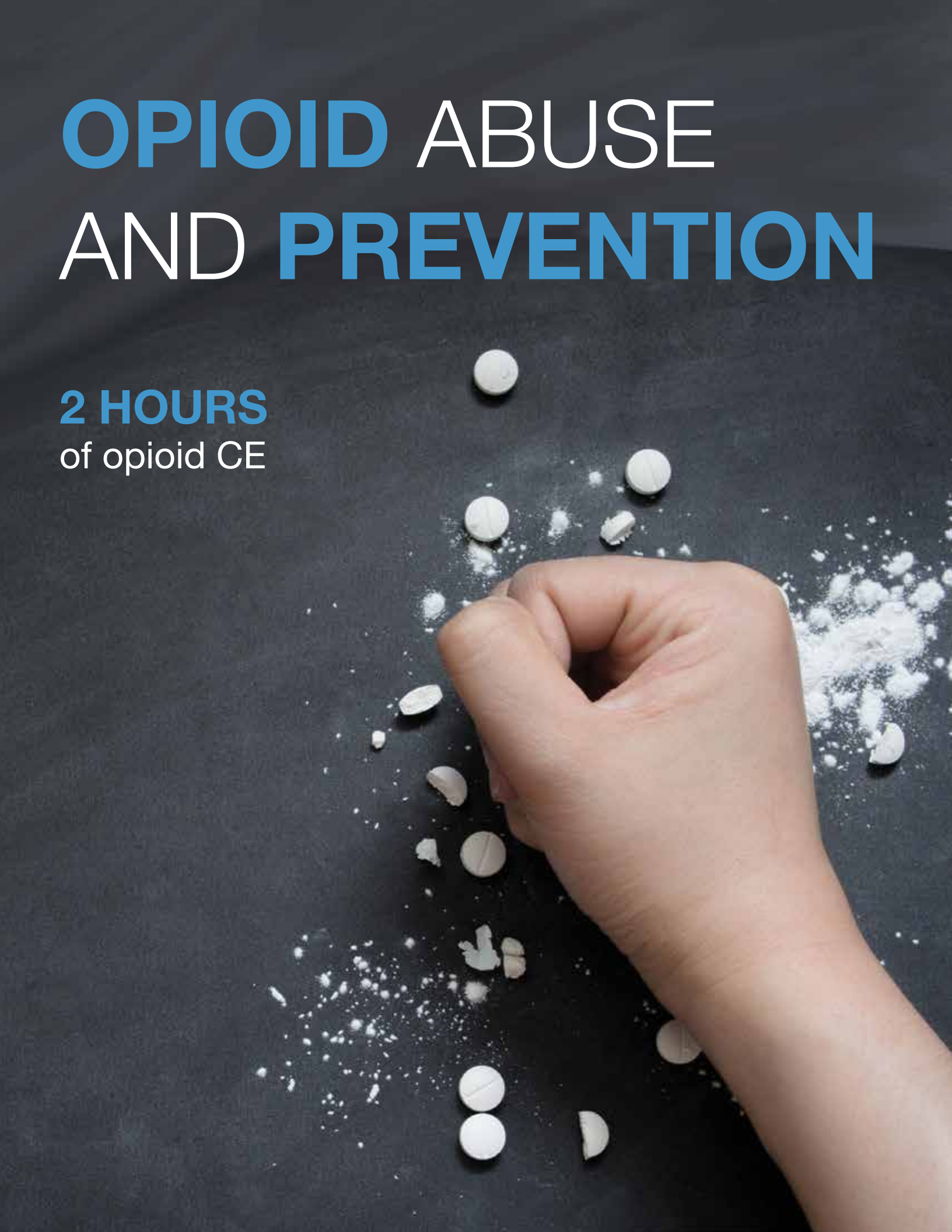
OPIOID ABUSE AND PREVENTION

2 HOURS
of opioid CE



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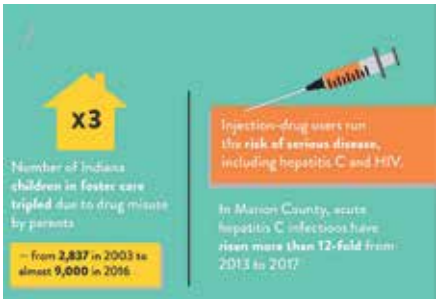
35 

Indiana's Opioid Epidemic Infographic

How to Receive Credit for this CE Issue

Thank you for taking the time to read this IDA self-study CE publication in opioid abuse and prevention. Any Indiana dentist who holds or applies for a CSR must obtain two hours of opioid abuse CE by the next license renewal date of March 1, 2022, but this is an excellent CE opportunity for any dentist, regardless of CSR status.

Now that you have finished reviewing this publication, you are ready to take the online quiz and receive two hours of continuing education credit. The cost of the quiz and certificate of completion is $30 for member dentists and $200 for non-members. To access the online quiz, visit our website:

www.indental.org/opioids

If you prefer a paper or PDF version of the quiz, email kate@indental.org. Regardless of how you choose to take the quiz, upon completion with a score of 80 percent or higher, you will receive a certificate from IDA. You may re-take the quiz up to two times if you are not satisfied with your score.

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Use of this publication for CE purposes expires on October 31, 2023.

The Case for Non-Opioid Analgesics Instead of Opioid Analgesics in the Treatment of Dental Pain

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Tom Viola, R.Ph. has over 30 years experience as a pharmacist, educator, speaker and author. His national presentations focus on the most prevalent oral and systemic diseases and the most frequently prescribed drugs used in their treatment. He can be reached at Tom@TomViola.com.

Combination formulations containing an opioid analgesic and a non-opioid analgesic have been widely used in dentistry for management of moderate to severe dental pain. Orally administered opioid analgesics include codeine, oxycodone, and hydrocodone, and are formulated as combinations of an opioid and a non-opioid analgesic. The synergistic combination of acetaminophen with hydrocodone has demonstrated greater efficacy in providing pain relief than either ingredient used individually.

However, high doses of these combination opioid formulations carry an increased risk of respiratory depression (from the opioid) as well as an increased risk of liver toxicity (from the acetaminophen). Additional side effects of opioid analgesics include dizziness, sedation, sleep disturbances, nausea and vomiting, and constipation.

Misuse of prescription opioids often, but not always, accounts for the initial event for the majority of individuals with opioid addictions. Reducing the number of opioid prescriptions, and instead recommending or prescribing non-opioid analgesics, might therefore reduce the potential for addiction, misuse, and diversion of opioids.

The opioid components of combination analgesic formulations are well known for producing serious adverse effects, such as central nervous system depression, respiratory depression and gastrointestinal upset. These adverse effects may be additive when combined with other medications that cause similar adverse effects, such as benzodiazepines and gabapentinoids. Thus, combination analgesic products that contain only non-opioid ingredients are attractive alternatives.

Non-opioid analgesics useful in the treatment of dental pain include the non-steroidal anti-inflammatory drugs (NSAIDs, such as ibuprofen and naproxen) and acetaminophen (Tylenol). Many patients believe that since these agents are available without a prescription, they are inferior in their ability to relieve dental pain, when compared to the opioid analgesics (such as hydrocodone and oxycodone). However, many studies have concluded that the opposite is true. At regular doses, non-opioid analgesics are as effective as opioid analgesics in relieving dental pain, without the potential for producing serious adverse reactions (such as respiratory depression) and without the potential for dependence and addiction.

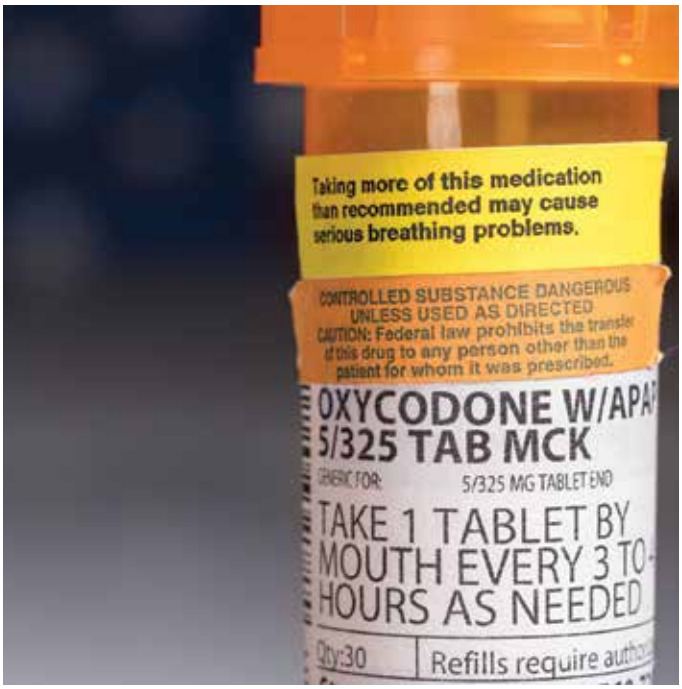
NSAIDs are similar to aspirin in their antipyretic (fever-reducing), analgesic (pain relieving) and anti-inflammatory activity. These effects are seen in order of increasing dose. For example, ibuprofen has a relatively low maximum dose for its analgesic effect. While doses of up to 400mg are effective for treating cases of mild to moderate dental pain, higher doses, up to 600mg to 800mg, are effective for treating cases of moderate to severe dental pain. At these higher doses, ibuprofen also produces its anti-inflammatory effect, and almost all cases of moderate to severe dental pain involve some degree of inflammation.

NSAIDs inhibit the formation of an enzyme, cyclooxygenase-2 (COX-II). This enzyme is responsible for the production of prostaglandins which, in turn, produce pain, fever and inflammation. Thus, by inhibiting COX-II, NSAIDs produce their therapeutic antipyretic analgesic and anti-inflammatory effects.

However, NSAIDs also inhibit the formation of another enzyme, cyclooxygenase-1 (COX-I). This enzyme is responsible for the production of prostaglandins which, in turn, produce numerous beneficial effects, such as the production of the gastrointestinal mucous lining, regulation of normal platelet activity, bronchodilation and maintenance of adequate blood flow to the kidneys. Thus, by inhibiting COX-I, NSAIDs also produce adverse effects such as gastrointestinal upset and mucosal injury, irregular platelet aggregation, bronchospasm and renal toxicity, especially with long-term use.

Long-term use of NSAIDs should also be avoided in patients with hypertension and congestive heart failure. NSAIDs may produce sodium and water retention, which may exacerbate these conditions. In addition, NSAIDs decrease the production of prostaglandins necessary for adequate renal perfusion and function, which is often compromised in patients with cardiovascular disease. This is usually not a concern in the short-term use of NSAIDs, such as in the treatment of dental pain, except in patients with documented renal dysfunction.

NSAIDs reduce the production of a specific prostaglandin, thromboxane A2, which normally causes platelet aggregation. Thus, NSAIDs have antiplatelet effects. This has given rise to speculation that NSAIDs might also be



useful in the prevention of thrombotic events, such as heart attacks and strokes. However, the antiplatelet effects of NSAIDs are reversible and are lost when the drug is cleared from the body. Only aspirin has been proven effective in preventing such thrombotic events, since its antiplatelet effects are irreversible and persist for the life of the platelet, long after aspirin has been cleared from the body. Although NSAIDs may cause an increased risk of bleeding, due to their antiplatelet effects, this is usually not a concern for patients undergoing minor dental surgical procedures.

The use of NSAIDs should be avoided in patients taking antiplatelet agents (such as clopidogrel) and anticoagulant agents (such as warfarin and rivaroxaban). This is not due to the antiplatelet effects of NSAIDs but, rather, their propensity for causing gastrointestinal mucosal injury, which may result in a greater risk of internal bleeding in patients taking these antithrombotic agents.

Interestingly, studies have shown that ibuprofen competitively inhibits the cardioprotective antiplatelet effects of low dose aspirin when both agents are used together. However, since aspirin exerts its antiplatelet effects immediately after absorption, this interaction can be avoided by delaying the administration of ibuprofen by two hours until after the aspirin has been absorbed.

NSAIDs decrease the production of prostaglandins necessary for maintaining proper fetal circulation during pregnancy and for uterine contraction during delivery. Thus, their use should be avoided during pregnancy. NSAIDs may increase the production of leukotrienes. These inflammatory substances may produce a variety of symptoms of allergic response, including bronchospasm. Thus, it might be advisable to avoid the use of NSAIDs in patients with severe respiratory disease.

While the question is obviously quite common, there is no definitive evidence to support the conclusion that one NSAID is superior to another in its ability to relieve dental pain. However, there is considerable evidence to support the conclusion that the preoperative use of NSAIDs decreases the intensity of postoperative dental pain.

Many studies have demonstrated that the combination of acetaminophen and an NSAID is more effective in the prophylaxis and treatment of dental pain than either acetaminophen or the NSAID alone. Acetaminophen and NSAIDs have similar but different mechanisms of action and, so, a combination of the two ingredients offers a synergistic approach to pain relief.

Acetaminophen is often referred to as APAP, which is an acronym for its chemical name (N-acetyl-para-aminophenol). Acetaminophen has analgesic and antipyretic activity that is equivalent to that of aspirin, but very weak anti-inflammatory effects when compared with aspirin or NSAIDs.

While its exact mechanism of action is not known, it is thought that acetaminophen, like NSAIDs and aspirin, inhibits prostaglandin synthesis. It appears that acetaminophen's main effects are on the central nervous system, perhaps increasing pain threshold. However, acetaminophen's analgesic effect is limited in the treatment

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of moderate to severe postoperative pain resulting from other dental procedures, especially at high doses.

For patients for whom aspirin and NSAIDs are contraindicated, acetaminophen is usually the drug of choice. Acetaminophen has long been considered the "safe" analgesic because it produces few side effects, is well tolerated at usual adult doses and generally causes very few drug interactions. However, studies have demonstrated that, at high doses, acetaminophen may interact with warfarin, which can result in an abnormally high INR.

The most serious adverse effect associated with acetaminophen is drug-induced hepatotoxicity, due to an acute or chronic overdose with the drug. In addition, while it is well known that acetaminophen may cause acute liver toxicity at overdose levels (supratherapeutic doses), high therapeutic doses of acetaminophen may still result in hepatic injury. Maximum daily doses of 3000 to 4000mg have been recommended. In addition, the FDA has notified healthcare professionals and patients that acetaminophen, like ibuprofen, has been associated with a risk of Stevens-Johnson syndrome and toxic epidermal necrolysis.

Several nonprescription combination analgesics contain caffeine. Caffeine is not thought to possess any analgesic properties on its own; however, it can be included with traditional analgesics such as acetaminophen, ibuprofen, and aspirin. Studies have demonstrated that the addition of caffeine to these analgesics provides an increase in analgesic effect. As a result, a combination analgesic containing acetaminophen and ibuprofen may well contain caffeine as an adjunct.

Management of acute dental pain is often accomplished through an approach that incorporates opioid and/or non-opioid analgesics. Studies have shown that non-opioid medications and combinations of non-opioid medications are at least as, or more effective, than opioid medications. In addition, in situations where opioids are indicated, the addition of non-opioid medications can increase efficacy and reduce the overall dose of opioid required.

For more information on Tom Viola and his online courses, visit **www.tomviola.com/ce**

One surgeon's perspective: **Acute Pain Management in Dentistry: Chronic Pain in the Practice**

Dr. Patrick Kelly

ABOUT THE AUTHOR

Dr. Patrick Kelly is an oral surgeon practicing in Indianapolis and Kokomo. He has received extensive awards and professional recognition for his research and expertise.

If you are like me you may occasionally dread the process of acute pain management in dentistry. It is a necessary evil and has not always given dentistry the best reputation with today's options. Do we over prescribe? Do we under prescribe? The numbers are still not looking good for dentistry in regards to opiate prescription writing. Narcotics, NSAIDs, local and regional pain management, patients on pain meds or opiate agonists/antagonists for addiction; all topics of frustration at times especially with new patients or those with atypical pain. That being said, there is great reward and practice growth in making the process pain free or reduced and or alleviating the pain brought on by the nature of our work and its inherent negative side effects. There is certainly an ethical component to this topic as well as our societal-professional agreement but our focus in this piece is largely on acute pain and peri-operative patient management.

In this article we will focus on acute pain situations and tools for managing the patient experiencing acute pain related to dental care. In my office the questions, "Is this gonna hurt?" or "How long can I expect this to be painful?" are asked on a 15-minute rotation. My response is "pain associated with any surgical procedure is to be anticipated. The body's natural inflammatory phase whether you have a mole removed on your back or a tooth removed from your mouth is three to five days on average, and this is associated with pain, swelling, bleeding, bruising, and throbbing; anything outside of this time period is worth examining as there may be some local measures useful to reduce post-operative pain and its duration." Setting expectations is a crucial part of pain

management in dentistry. Attempts to convince patients procedures will be painless does not usually bode well when attempting to limit or reduce post op appointments or on-call communications. I often tell surgical patients that just because their last extraction or implant was painless and or painful it does not mean that subsequent identical procedures at alternate sites will mimic that experience. Don't forget, TIME HEALS ALL WOUNDS.

Delayed pain due to dry socket and or infection may still be acute in nature, however at this point we know these processes are inflammatory and infectious respectively and there are medications used to directly modulate these biological responses. Anti-inflammatory medications, as the name suggests are going to be the main event when it comes to dry socket. As we all know "dry socket" is medically referred to as alveolar osteitis and anything ending in "itis" is inflammatory. Medications altering these biological pathways will treat the problem, not just the pain. Infections can be painful due to swelling and inflammation but antibiotics reducing the bacterial load will indirectly result in pain management. These are more affirmations to provide your patient in pain when asking why they aren't being prescribed "a pain medication" or if you are concerned they may be "seeking" one.

Another valid point for attempting non-steroidal therapy as a first line treatment is the poor side effect profile of narcotics. Explaining that pruritus, constipation, lethargy, and, if chronic, the risk of dependence and or addiction and abuse by family and friends aware of the prescription is eliminated with alternative pain reducers is a big selling point, especially in the eyes of parents of adolescents. Studies are showing that the vast majority of narcotic medications are going unused as evidenced by the patients who state they had pain but took a few Percocet from the last procedure they had until they could come see you to control it. I tend to only prescribe enough to cover the first three to five days (eight to twelve total). That way any unused medication will be scant. Lower doses like 5mg Norco can be doubled or halved as needed. I also inform the patient that any unused medication should be discarded and old medication will likely be less efficacious if used outside of the life of the prescription.

Mounds of data exist on the correlation between postoperative discomfort and length of its course relating to length of procedure. Often I will base my clinical decision on pain management based on such. If a tooth is routinely extracted in a few seconds or minutes its likely that narcotic pain management may be overkill. If a peristome is used to peal an impacted third molar with concurrent infection off of the inferior alveolar nerve in a 50 year old and you need to take a break between passes with the mallet to book your chiropractor out of scheduled appointment, it may be pertinent to throw a few oxycodone that patient's way, including a refill. Sadly there is no end-all magic pill to manage every patient's pain. I also explain this during consultation. We aim to keep our community opiate naive but not all pain is the same, and based on our receptors and type of pain we may have varying responses. I have had patients, although rare, tell me that Percocet did not help or worsened the post-operative experience and Meloxicam fixed the problem completely. Pain scores are very pertinent when collecting data and selecting pain management. I typically reserve narcotics for scores 6 or greater within a week of the procedure. I explain that scores of 10 suggest your standing on the edge of a building

and gravity is your best option for pain management and you cannot be a 9 unless there are tears as you are approaching the tenth floor stairs.

Anyone in tears from pain is being mismanaged and my first line is to offer immediate in-office consultation with the option of local anesthesia as first line until pharmacological or local measures can be initiated to control the situation. If a patient declines this offer, that needs to be noted in your medical record. If you are not willing to receive a infiltration shot of Bupivicaine to get out of pain for several hours, hopefully resulting in accommodation and or at least a few hours of rest, you are not really in the dire state you claim to be, in my opinion. You will also be surprised at how many patients will accept this offer and are grateful, especially if administered after hours and on weekends. One time, try offering doing one in their home and see how many neighbors show up in your office over the next year. This can come back to bite you if they all think you're a concierge dentist but for the most part has been very gratifying for me to participate in the time honored "house call."

After expectations are set, the beginning of managing peri-operative pain is the anesthetic plan. Local (short, long and very long acting) should be in the armamentarium of every practitioner. Topical, environmental conditioning, music, nitrous oxide, and other anesthetic plans should be discussed. Oral and IV sedation have a whole new set of risk factors for the patient and dental community at large and are not discussed here. The majority of my patients think that IV anesthetics are used for anxiety and or improved patient experience. While that plays a tremendous factor in the anesthetic plan decision tree, I usually explain that I want them to have the best experience they can have and that IV administration of toradol and decadron in applicable patients vastly reduces post-operative narcotic consumption and starts pain-management prior to the initiation of the physiological process. Another option to be aware of is the intramuscular administration of these medications. You, too, can inject IM meds. Its a lot easier than a IAN block! I have also given many of these medications submucosal adjacent to anesthetized sites with very good results and continued oral therapy thereafter. The onset may be delayed but via this route elimination of its effects is also prolonged. Advil and Tylenol prior to the start of the procedure shutdown that arachidonic acid pathway and without the synthesis of prostaglandins much of that painful inflammatory experience is reduced or non-existent if not managed best by brief continuation of those same medications for a few days after.

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The acronym RICE is very popular among first year residents of any hospital based residency. This stands for REST, ICE, COMPRESSION, and ELEVATION. These simple non pharmacological measures are time tested and true. I like to ask my patients if they can visualize the meaning of human paperweight or embody the idea of a bump on a log. Those who comprehend the fact that they are recovering from surgery and respect the post operative period often require less post op in office care. Those who go back to practice, the mall, or work tend to be more regulars in the after care column on the schedule. I like to pretend I am doing my patients a favor by giving them a prescription for frosties and Netflix or ESPN, whatever your flavor is. It's those who can personify the role of victim and allow others to care for them and milk the invalid condition for all its worth that do best. This is why those teenage boys in dire need for a combined barber-laundromat rarely get dry sockets. Its hard to lyse the clot holding down a couch while playing Xbox. I even advise my third molar teenagers to get a small bell to ring when running low on Haagan-Dazs.

If patients report "allergies" to the medications above, it's important to interview them for the possibility that they experienced an adverse reaction and weigh the benefits and risks with them. GI related events can sometimes be managed with peri-operative use of proton pump inhibitors or H2 blockers. For itching, use Benadryl. Benadryl is also noted to be a pain reliever and I have personally used it as a local anesthetic with good results. Start with 25mg and 50mg is acceptable. Can certainly help patients sleep through the night! Consultation with a primary care is usually advised if the reaction was severe and to make sure there are no other systemic contraindications. I have several cases where I'm backed by the primary care provider or a medical specialist and all of a sudden the patient feels much more comfortable and reports improved outcomes.

Outlining a plan of what to do if adverse reactions occur is also helpful (call your doctor!).

Administration of local anesthesia is something I have noticed through questions from patients, colleagues, and everyone in between can be uncertain. Administering more than the minimum dose and allowing for adequate time of onset, understanding pharmacodynamics of local and supplementing with multiple anesthetics (almost all of my patients receive a local infiltration of Marcaine at the conclusion of any surgical procedure on top of the Septocaine block, yes I said it, or lidocaine) will improve the experience of patients under local. Knowledge of the onset and half-life will help appropriately time the procedure and estimate the onset of acute post op pain. New products such as Exparel, a lyposomal encapsulated Bupivicaine injection, can give patients greater than 24 hours of local anesthesia. Note that this can be costly, but not necessarily more costly than multiple in office post op visits. Knowledge of anatomy, administering locals sub periostal, and explaining to the patient that this may be the worse part of the procedure and that it is the least favorite part of your job can help excuse the unpleasant experience of properly administered local. Being ginger on the local administration is not necessarily being kind to your patient and time costly in the chair and on the phone after hours.

Instruments that take advantage of the The Gated Theory of Pain, distraction techniques, can also be helpful or empowering even if occasionally only a placebo and lets your patient know you are doing all you can.

For the new dentists, understanding the procedure will help keep the operative time down. Even if this is a new procedure for the you it is not a bad idea to let the patient know your experience with the procedure, show your knowledge and understanding and again give a realistic idea of the peri operative course. They will often be more understanding if objectionable outcomes occur. Knowledge of when to refer, although I do not wish to admit it, may also relieve some the PRACTITIONER'S post op pain when patients have a history of poorly controlled pain or anxiety.

When trapped or hand tied after a good old college effort, I am never ashamed to refer to a local pain specialist. I prefer to ask my medical colleagues over Google search for referrals to pain specialists, as some of these will come with contracts and patients can end up in chronic pain management with narcotic pain contracts. Follow up or advanced consultation via phone to let the referred know you are committed to this patients outcome is advised. I also ask the pain specialists to provide documentation for our record keeping. It's critical to ask how the pain

management experience unfolded for that patient and if they would recommend it to a friend. I often steal these pain management pearls and with research find many of them are approachable and easy to manage. So often we hesitate to utilize tools we did not use in school or training when supervised to mitigate risk. Use of a pharmacological manual or website keeps me practicing within guidelines and standards of care weekly. I excuse myself from treatment or consultation regularly to tell a patient that I need to double check the sig or prescribing guidelines if that medication is not one of my "regulars." Let your patient know this is not a medication often used in your practice but is indicated but due to their uncontrolled pain, a different modality is necessary and they need to contact you if therapy is not going according to plan and of course DOCUMENT.

Opiate tolerant and patients taking opiate agonists and agonist/antagonists are another subset worth mentioning that often require a team approach with the prescribing doctor. I have participated in discussions about these patients and they tend to get lumped together. Opiate tolerant patients are accommodated to a steady intake of opiate pain medication. This is their baseline to feel normal (pain score 0) like you or I would without pain or Percocet. Introducing pain stimulus with Percocet on board actually means they need more and their accommodation to their long term prescription makes them tolerant to much higher doses than an opiate naive person. 10-20mg of Percocet PO q4-6h is not uncommon, unfortunately. Supplementation with more opiates is often the best mechanism for acute pain control if they are unable to use non-narcotic meds. The prescribing pain management doctor will likely need to increase this dose to avoid violating and existing pain contracts.

Patients in recovery from opiate use disorder or chronic narcotic use may be on medications like buprenorphine. Long acting regional anesthetics (Exparel) are my first line of therapy in these instances. Non narcotics are key in the role of pain management even during the anesthetized period. If the route of discontinuation of partial agonist/antagonist therapy is chosen, naltrexone should be stopped 72 hrs in advance of surgery. Side effects of discontinuation can be quite harmful and lead to relapse or sometimes, rarely, illness. New research suggests that maintaining buprenorphine peri operative at modified doses around 8-12mg daily and supplementing with opiate agonists is efficacious. Counseling patients successful in recovery on the fear of introducing short term opiates can be difficult however due to the partial blockade at the mu receptor and activation of kappa and delta receptors the patient is likely to experience pain control without the "high" associated with abuse. This counseling should be performed by a licensed addiction specialist with experience in prescribing buprenorphine. If pain is not managed, a hospital setting may often be best and coordinating admission with a pain and or addiction service is required. Powerful mu receptor agonists like hydromorphone (Dilaudid) are needed to overcome the tightly bound Burenoprhine. You will get a phone call from the pharmacy if you try to prescribe Dilaudid in an outpatient dental setting. These circumstances are obviously the rarity and usually in higher, although still rare, instance in oral

Benadryl is also noted to be a pain reliever and I have personally used it as a local anesthetic with good results. Start with 25mg and 50mg is acceptable.

surgical procedures. Other medications that target NMDA receptors like low dose ketamine are also effective. Gabo-receptor modulators work, as well, but its important to review the therapeutic course and side effects associated with these medications as they can alter mental status and cause lethargy among many other side effects.

Long story short, our colleagues, patients and our medical providers trust us to triage, diagnose, treat, and manage our patients oral conditions. The more you treat, the more sticky situations you find yourself in, the more you learn. The practitioner without complications or difficult cases with hard outcomes has likely not practiced enough. I'm often fearful of the complications I haven't yet crossed but excited for that time that its management feels like second nature. If you feel you cannot manage the post operative complications of a procedure, including pain, its safe to say that may not be the procedure for you at this juncture of your practice. Maybe you will grow into it. Maybe you won't. These situations are not for everyone and that's why referral to specialists, not just dental but medical, is always a very serious pain management tool for your patient and you, and should not be overlooked. The adage, *treat your patient as you wish to be treated* will get you to the goal 10/10 times. Limit your pain exposure and less pain you will experience (read in Yoda voice).

Key Points in Acute Pain Management

- Any surgical procedure will have associated pain
- Setting expectations is a crucial part of pain management
- Pruritus, constipation, lethargy, and the risk of dependence and addiction are just some of the side effects of opioids
- Anyone in tears from pain is being mismanaged
- RICE (Rest, Ice, Compression, and Elevation) is also relevant in recovery from oral surgery
- Patients who return too quickly to work, school, social life, etc., tend to have the most post-operative problems

INSPECT: A Dentist's Responsibility

Indiana created the INSPECT Prescription Monitoring system in 2006 as a way to track prescriptions for controlled substances. Initially it was voluntary for dentists to utilize, but in 2019 the use of INSPECT became mandatory for any practitioner who holds a controlled substance registration (CSR) and prescribes a controlled substance. INSPECT is a key component in the fight against opioid abuse, "doctor shopping," and excessive opioid prescriptions.

Indiana INSPECT is an online secured database that both registered practitioners and dispensers can access to check patient prescribing histories and to enter records of their patient prescriptions. This database collects a patient's controlled substance prescribing history in one location to assist with patient care and to help with any abuse or diversion of controlled substances. All Indiana controlled substance prescriptions are required to be submitted within 24 hours by the pharmacists/pharmacy. Many upload directly in real time via a secured system. Indiana INSPECT also interfaces with other states' prescription monitoring programs.

The INSPECT database is private and secured since it includes each patient's name, address, ID numbers, date of birth, national drug codes, dispensed dates, quantity dispensed and both the prescriber's and the dispenser's United States Drug Enforcement Agency (DEA) registration numbers. INSPECT helps ensure that only those who have properly prescribed opioids have access to them. It gives you valuable information when determining whether or not to prescribe opioids because it serves as a tool to identify patients who are "doctor shopping" for opioids.

There are several groups who have access to the information collected by INSPECT, including health professionals who are licensed to prescribe or dispense controlled substances, prescriber delegates (advance practice nurse and nurse practitioner), law enforcement, court staff/probation officers, the Attorney General's office and licensing boards. Patients do not have access to this information.

Below are the key responsibilities related to dentists and INSPECT:

- **Register for INSPECT:** Dentists who hold a CSR must register with Indiana INSPECT under current Indiana and federal laws. It is a good tool in stopping "doctor shopping" drug seeking behavior. Registration is connected to your CSR and you can get more information at the Indiana INSPECT website: **www.in.gov/pla/inspect/.**

- **Check INSPECT:** Each time you are prescribing a controlled substance, you are legally required to check the patient's prescription record in INSPECT. The report will provide you with accurate information to assist with diversion, prevention and the best patient care.

- **View your own prescribing record:** Occasionally you should check your own prescribing history to make sure there are no improprieties, known as diversions, on your CSR/DEA registration.

THE OPIOID EPIDEMIC BY THE NUMBERS

70,630
people died from drug overdose in 2019[2]

10.1 million
people misused prescription opioids in the past year[1]

1.6 million
people had an opioid use disorder in the past year[1]

2 million
people used methamphetamine in the past year[1]

745,000
people used heroin in the past year[1]

50,000
people used heroin for the first time[1]

1.6 million
people misused prescription pain relievers for the first time[1]

14,480
deaths attributed to overdosing on heroin (in 12-month period ending June 2020)[3]

48,006
deaths attributed to overdosing on synthetic opioids other than methadone (in 12-month period ending June 2020)[3]

SOURCES

1. 2019 National Survey on Drug Use and Health, 2020.
2. NCHS Data Brief No. 394, December 2020.
3. NCHS, National Vital Statistics System. Provisional drug overdose death counts.

Updated February 2021. For more information, visit: http://www.hhs.gov/opioids/

HHS.GOV/OPIOIDS

Oral Health Care Call to Combating a Public Health Issue: The Dental Overdose Education and Prevention with Narcan (Naloxone)

Dr. Shanika Maddox

ABOUT THE AUTHOR

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We as a nation are currently fighting a declared drug epidemic, as there has been a notable increase in opioid-related deaths in the past decade. According to the Centers for Disease Control, "nearly 841,000 people have died since 1999 from a drug overdose. In 2019, 70,630 drug overdose deaths occurred in the United States. Opioids were involved in 49,860 overdose deaths in 2019 (70.6 percent of all drug overdose deaths)" This statistic speaks volumes to the fact that on average in 2019, an average of 136 people died per day from an opioid-related overdose accident nationwide.

Importance of the Problem

As oral health care providers, we must be willing to stand up and join the fight in curbing this crisis through prevention training and educating our patients and the public on the importance of our current nation's health. Dr. William Reynolds, DDS, MD, stated in his research, "In 2016, U.S. dentists wrote more than 11.4 million opioid prescriptions while dentists in England only wrote 28,082" (Reynolds, 347). Prescription reform has been on the rise within the oral health care sector. An effort is being made to help educate our profession on appropriately addressing pain management in our patients with alternative methods. Unfortunately, in the past, dentists were known to be the most accessible source of prescription pain pills from drug-seeking patients. As a result, we as a profession suffered the consequences of being blamed for the spike in the number of overdoses that were occurring. Research has shown that adolescents aged 11-18 are at an increased risk of future misuse of opioids when given a prescription for longer than three days for pain management (Reynolds, 347). The addictive pathways built consequentially from long-term use of opioids

can be life-threatening but fatal in overdose and misuse; therefore, we must be willing to educate ourselves as providers and commit to competence to help restrain this crisis from rising.

Indiana Opioid Statistics

Indiana has been at the forefront of the opioid epidemic. According to National Institute on Drug Abuse, "in 2018, Indiana providers wrote 65.8 opioid prescriptions for every 100 persons, compared to the average U.S. rate of 51.4 prescriptions" (Hedegaard, 2020). Figure 1 illustrates these statistics. Figure 2 unfortunately shows a corollary statistic of higher than average deaths in Indiana.

Both figures show that as providers, we must be open to this public health call and learn to make a pivotal change. Prescription opioids are only a tiny piece of the epidemic pie, but with a reduction in prescribing, we can make a significant effect getting these drugs off of the streets.

The other part of combating this epidemic is being fully educated in overdose prevention through alternative prescription means and proper Naloxone training.

What Are Opioids and Their Sources?

According to the Indiana State Department of Health, Opioids interact with the opioid receptors in the body.

Opioids can be:

- Natural (derived from opium) or synthetic
- Prescription medications or illegal drugs
- Pills, capsules, powder, or liquid
- Swallowed, smoked, snorted, or injected

Continued on page 18 ▶

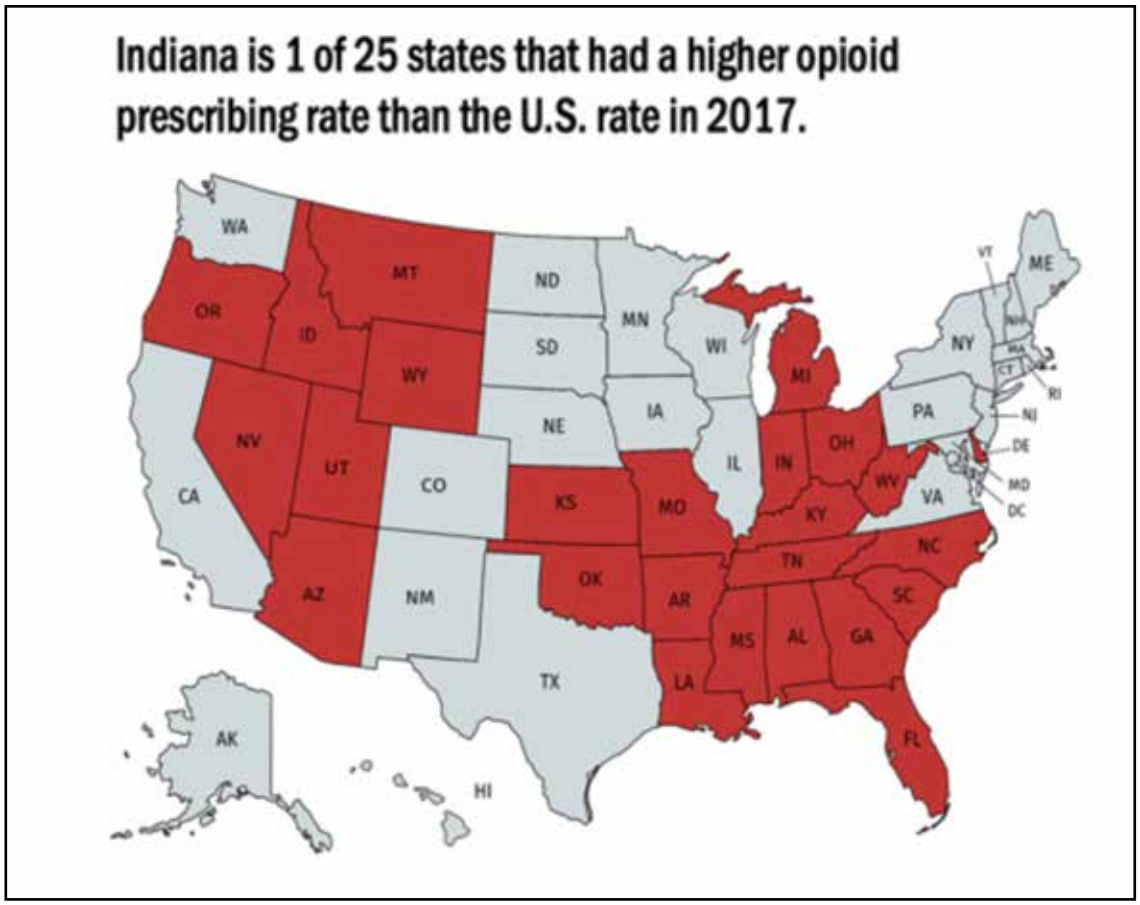

Figure 1

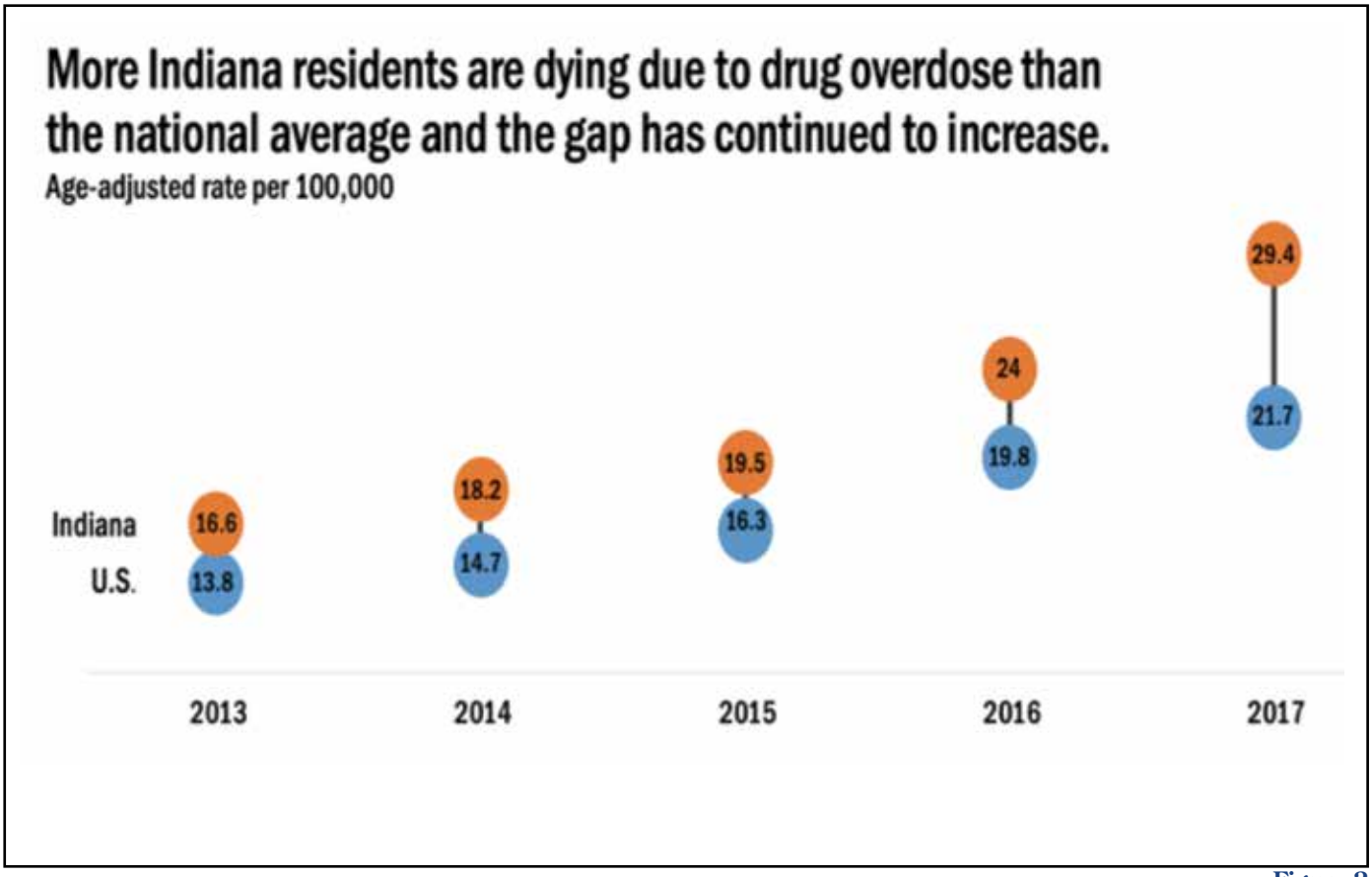

Figure 2

Signs of Opioid Overdose

- Slow breathing or no breathing
- Pinpoint pupils
- Vomiting
- The face is pale and clammy
- Blue lips, fingernails, or toenails
- Slow, erratic, or no pulse
- Snoring or gurgling noises while asleep
- No response when you yell the person's name or rub the middle of their chest with your knuckles

What Is Naloxone?

Naloxone, often called by its brand name Narcan, is a medication that reverses an opioid overdose by restoring breathing. **Naloxone is only effective in reversing opioid overdoses.** It does not prevent overdose.

Indiana Legislation and Aaron's Law

Aaron's Law is an Indiana law that allows Hoosiers to obtain a prescription for Naloxone if they believe someone they know is at risk of an opioid overdose. Prior to this law, only emergency workers were allowed to carry Naloxone. The bill was signed into law April 2015 and named after Aaron Sims, a young Hoosier who lost his battle with heroin addiction.

The law, I.C. 16-42-27, stipulates the following:

- Expands the use of Naloxone to the general public.
- Establishes a statewide standing order from state health commissioner and removes the need for prescriptions.
- The person administering Naloxone must be trained.
- The person administering Naloxone must immediately alert 911.
- The patient must receive information about addiction services (including MAT).
- The person administering Naloxone must register and report annually to optIN.

How to Access Naloxone for Your Practice

Naloxone can be easily accessed at your local pharmacy or health department for storage in your practice. By contacting your local health department, you will be able to get information about how to access the substance and the training needed to administer this reversal agent.

Alternative Prescribing Methods

Figure 4 is an excellent guide and resource constructed by Dr. W. Reynolds and his colleagues for pain management prescription and alternative methods.

For More Information

For more information regarding Naloxone training and opioid overdose prevention, you can contact the Indiana State Department of Health directly:

Cassidy Johnson, Naloxone Program Manager
CasJohnson@isdh.in.gov

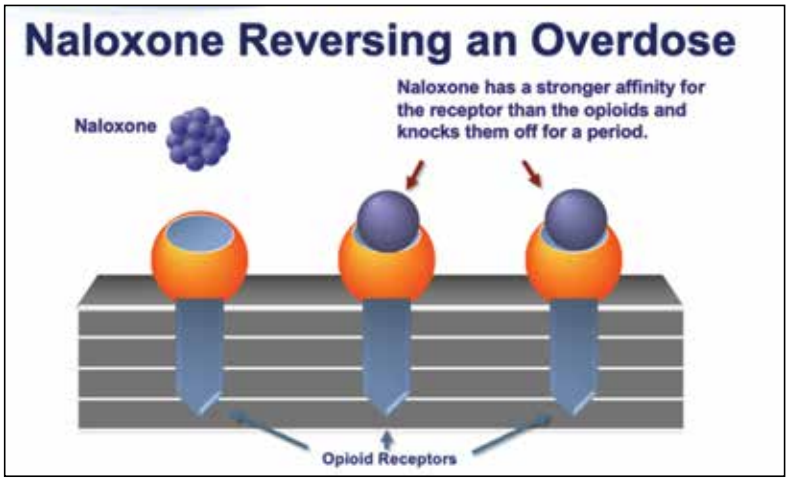

Figure 3

Table 1. Pharmacologic Recommendations for Post-Operative Dental Pain

Pain Severity	Therapeutic Intervention
Mild	Ibuprofen 200-400 mg q 4-6 hours
Mild to Moderate	Ibuprofen 400-600 mg q 6 hours for 24 hours Ibuprofen 400 mg q 4-6 prn pain on POD #1 (after first 24 hours)
Moderate to Severe	Ibuprofen 400-600 mg with APAP 500 mg q 6 hours for 24 hours. Ibuprofen 400 mg with APAP 500 mg q 6 hours on POD #1 (after first 24 hours)
Severe	Ibuprofen 400-600 mg with APAP 650 mg and Hydrocodone 5 mg q 6 hours for 3 days; then Ibuprofen 400-600 mg with APAP 500 mg q 6 hours on POD #4 (after first 72 hours).
If NSAIDs are contraindicated	
Mild	APAP 650-1000 mg q 6 hours for pain
Moderate	APAP 650-1000 mg with hydrocodone 5 mg q 6 hours for 3 days; then APAP 650-1000 mg q 4-6 hours (after first 72 hours)
Severe	APAP 650 mg with hydrocodone 5 mg q 6 hours for 3 days, then APAP 650-1000 mg q 6 hours (after first 72 hours)

APAP acetaminophen (Tylenol)
Ibuprofen maximum daily dose is 2400 mg
APAP maximum daily dose is 3000 mg
Adapted from References: [4,7,11,13,14]

Figure 4

Barriers Presented by the Stigmatization of Substance Use Disorder

Justin Phillips
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In America, an estimated 20 million Americans aged 12 or older have a Substance Use Disorder (SUD) related to their use of alcohol or illicit drugs and 51 million have a mental illness. Co-occurring disorders are common, with 9.5 million Americans having both a SUD and a mental illness.[1]

Substance Use Disorder, or addiction, is not a moral failure, but a chronic medical disease with similarities to other diseases such as diabetes, hypertension, and asthma. Addiction is a brain disease with a neurobiological basis that causes lasting changes in the brain. The negative stigmatism that has been placed on addiction has formed a barrier for individuals who may want to seek treatment.

What Is Substance Use Disorder?

Substance Use Disorder is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences.

People with SUD use substances or engage in behaviors that become compulsive and often continue despite harmful consequences. Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases.[2]

As with many chronic diseases, the sooner you intervene, the better the outcome, yet stigma causes patients and families to keep the disease a secret for fear of being judged and marginalized. This delay in treatment allows the disease to progress, often requiring a more intensive intervention and further patient health decline and mortality risk.

What Is Stigma?

Sociologist Erving Goffman was one of the first in his field to discuss stigma. In 1963, he defined stigma as the negative attribute signaling that one is flawed or condemned, leading to rejection and avoidance by others.

Factors that can influence stigma include:

- Blame in that people focus on bad behavior and the apparent moral failing rather than seeing the public health problem.
- Stereotypes of the individuals with the disease.
- Knowledge (or lack thereof) of the disease.
- One's contact and experience with individuals of a certain stigmatized group.
- Media emphasis on addiction rather than recovery and use of negative images when portraying those with substance use disorder.
- Race, ethnicity, and culture can also impact stigma.[3]

Figure 1

The Associated Press-NORC Center for Public Affairs Research recently found that 44 percent of Americans surveyed said opioid addiction (opioid use disorder) indicated a lack of willpower or discipline, a third regard it as a character defect or the result of bad parenting, and four in five said they were unwilling to associate closely with someone with an opioid addiction.

One of the most substantial reason why addiction is stigmatized is because most people don't understand it. It is human nature to fear (and stigmatize) what we don't understand, and when it comes to addiction, most people don't see it as the disease it is.

In fact, more than 76 percent of Americans believe that substance addiction is nothing more than a moral problem.[4]

Education comes through experience. Those with experience with addiction, either themselves or through a loved one, are more likely to view a substance use disorder is a medical problem to be treated than those without such experience (62 percent vs. 50 percent).[5]

Applying a Socio-Ecological Model to Stigma

Stigma can be found and propagated at many levels. We use the socio-ecological model [Figure 1] to help describe the different levels in which stigma is manifested. The two-way arrows illustrate how the different levels of society both receive and perpetuate beliefs.

Those with SUD can be singled out and negatively affected by policies.

Further, SUD research and community work is grossly underfunded. Communities can also hold general negative perceptions or stereotypes about people living with addiction. For example, communities might ban needle exchange programs or recovery homes within their community because they may view SUD as a moral failing rather than a chronic disease.

People with SUD might discover that there are very few trained addiction professionals and also a lack of support for non-addiction healthcare professionals. These findings would be examples of organizational stigma.

People with SUD might also feel stigmatized by their families, friends, and peers, which would be interpersonal stigma. Friends and family might stop inviting them to social events, especially public ones, so they can avoid stigma-by-association.

Lastly, individuals with substance use disorder might self-stigmatize, which we discussed in the previous section.

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Figure 2

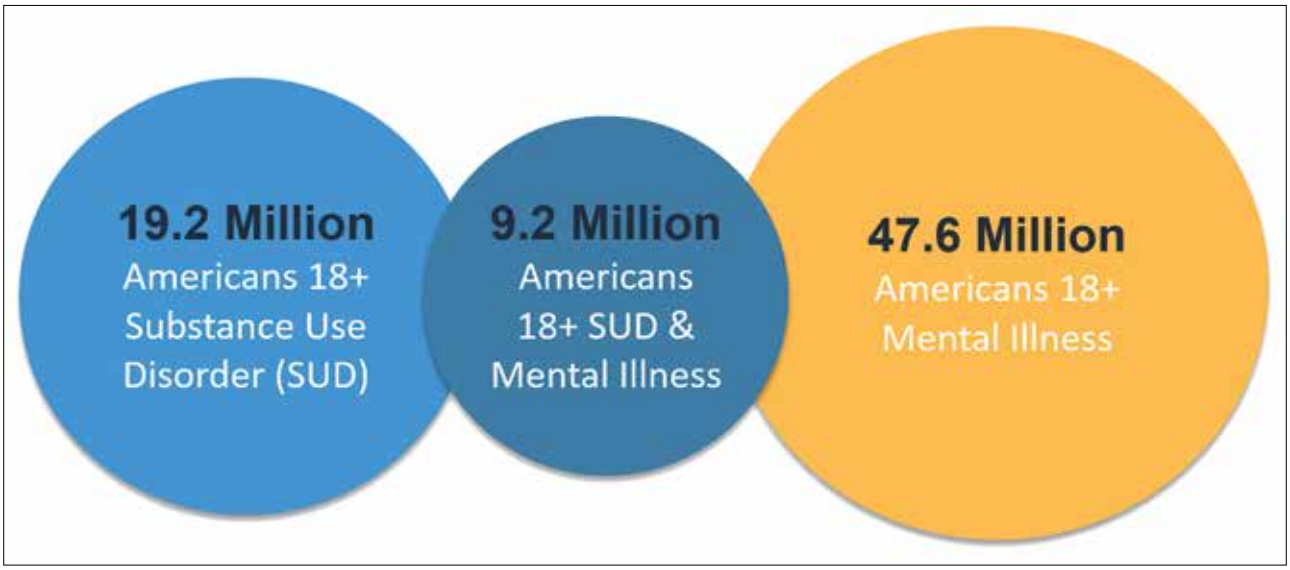

Figure 2 demonstrates applying a socio-ecological model to SUD stigma.

Assumptions and Preconceived Notions

There are many misconceptions that surround SUD. These include:

- **Willpower is all one needs to beat addiction:** "They can just stop it." Reality: Prolonged substance use alters the way the brain works. The brain sends signals of powerful and intense cravings, which are accompanied by a compulsion to use. These brain changes make it extremely difficult to quit and often medical treatment is required.[6]

- **Addiction is a choice.** Reality: Addiction is not a choice. The first time a person tries a substance, they might like how it makes them feel. If the person continues to use the substance, after a while they might keep taking the substance just to feel normal, although it starts hurting their lives.

- **There is no cure for this disease, so treatment is useless.** Reality: Substance use disorder is chronic, but it is treatable. This is also true of many other long-term illnesses, such as diabetes and hypertension. Recovery is a lifelong process. Treatment can help an individual manage and live with the illness.

- **You can't force someone into treatment; if treatment is forced, it will fail.** Reality: Treatment does not need to be voluntary to be effective. People who are mandated to treatment are just as likely to benefit as those who enter treatment voluntarily.[7]

Stigma in Diseases and Medical Conditions

In the past, cancer carried a stigma due to its association with death. There was a hesitancy to discuss cancer, even to the extent that patients' diagnosis was not shared with them. This is less true today.

Certain cancers carry more stigma, particularly lung cancer. This is due to its link to tobacco use and the perception that patients hold some responsibility for their disease, although not all lung cancer patients have a history of smoking.

This negative perception is even reflected in the fact that lung cancer receives less research funding than other similarly common cancers, such as breast cancer, and that perceptions of its controllability are linked to the people's willingness to support funding.

The effects of cancer stigma include lesser treatment, insurance hassles, tense patient/doctor interaction, lower research budgets and activity, and the patient's perception of self based on the discrimination they experience.[8]

For people with a SUD, stigma disproportionately influences health outcomes and mental well-being. Fear of being judged and/or discriminated against can prevent people with substance use disorders, or who are at risk of substance use disorders, from getting the help they need. It can also prevent caregivers and others in the position to help from providing needed services, including medical care.

Stigma and discrimination have similar effects across diseases and illnesses.[9]

For the individual:

- Generates fear, guilt, shame, and a sense of hopelessness.
- Hinders willingness to be open to family/friends.
- Creates isolation.
- Creates barriers for integration into a community/ support group.

On treatment and recovery:

- Early diagnosis and treatment
- Management and adherence to treatment
- Increased complications
- Early death

Healthcare and institutional:

- Access to healthcare and treatment
- Insurance barriers
- Healthcare openness to treat individuals with disease
- Research funding and activity

Stigma causes marginalization and isolation from the very support systems the patient needs to recover.

Many studies have demonstrated that individuals with SUD report fear of stigma as the primary reason for not seeking treatment or delaying treatment. Once they finally seek treatment, those with SUD describe the high levels of rejection that they feel and experience. Most of the general population does not consider Medication-Assisted Treatment, or MAT, an evidence-based best practice form of treatment for opioid use disorder. Unfortunately, even some addiction professionals stigmatize MAT and those that use it.

Most people believe that methadone is just a substitute for illicit opioids and that abstinence is the only path for treatment. Since MAT does use medication, it is in direct conflict with the 12-step principles of abstinence. Therefore, individuals using MAT have difficulties finding recovery housing because MAT is not allowed in most recovery homes. Unfortunately, even among others in recovery, the use of pharmaceutical therapies is heavily stigmatized. Because individuals using MAT are isolated even within the recovery community, they lack positive peer support. All of these different components of stigma can make the path to treatment and eventually recovery very difficult and lonely.[10]

Figure 3 further illustrates the stigma and treatment for individuals with SUD.

Education as a Solution

Education is probably the most discussed in terms of solutions to counteract the stigma of substance use

Figure 3

disorder. Nora Volkow, M.D., Director of the National Institute of Drug Abuse (NIDA), said, “If we embrace the concept of addiction as a chronic disease where drugs have disrupted the most fundamental circuits that enable us to do something that we take for granted—make a decision and follow it through—we will be able to decrease the stigma, not just in the lay public, but in the health care system, among providers and insurers.”

Language as a Solution

Words matter and continued use of stigmatizing language perpetuates false stereotypes, spreads misinformation, and keeps people out of care.

"Research shows that the language we use to describe [addiction] can either perpetuate or overcome the stereotypes, prejudice and lack of empathy that keep people from getting treatment they need."

- Michael Botticelli, leading addictions expert and former Director of the White House Office of National Drug Control Policy

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More About Overdose Lifeline, Inc.

Overdose Lifeline, Inc. is a 501(c)(3) nonprofit organization dedicated to helping individuals, families, and communities affected by the disease of substance use disorder. Our objective is to remove the stigma of addiction and provide those at risk the proper care and access to treatment through education, advocacy, and support. Visit www.overdoselifeline.org to learn more.

The Overdose Lifeline web resource page has video testimonials from individuals in recovery who share their experience with stigma and barriers to recovery. The page also has educational offerings and a stigma-free language guide: www.overdoselifeline.org/remove-the-stigma.

Do You Know How to Identify Drug-Seeking Patients?

The phenomenon of patients seeking out opioid prescriptions from different providers is a persistent problem and often known as "doctor shopping." This behavior often has consistent characteristics that pinpoint to drug seeking habits. Use this guide to educate yourself and your office staff on identifying and coping with patients seeking out opioid prescriptions to satisfy an addiction.

Common Tactics of Drug-Seeking Patients

- Claiming they need to replace a lost or stolen prescription.
- Assertive, demanding personality.
- Claiming to have been the patient of dentists or physicians who have died or retired.
- Misrepresenting or exaggerating their symptoms.
- Unwillingness or inability to provide a complete health history or contact information for previous physicians. Medical history that is provided may include providers in a variety of other cities or even other states.
- Happens to be passing through town or visiting relatives when the pain arose.
- Extensive knowledge of symptoms and pain medications beyond their profession or educational background.
- Over- or under-dressed for a dental appointment.
- Claiming allergies to non-narcotic analgesics.
- Reluctance to try a different medication than the one requested or previously prescribed.
- Insisting on taking the final appointment slot of the day.
- Odd behavior may include a lack of impulse control, rapid speaking and incoherent conversation.
- Physical signs of drug abuse may include skin tracks and related scars on the neck, axilla, forearm, wrist, foot and ankle, as well as "pop" scars from subcutaneous injections. Tracks and scars are usually multiple, hyperpigmented and linear. New lesions may be inflamed.

When Confronting a Drug-Seeking Patient:

- Don't forget to check the patient's information on the INSPECT database. See page 14 for more information on INSPECT.
- Document symptoms, patient claims and examination results.
- Request photo ID and Social Security number. Photocopy these documents and include in the patient's record.
- Call a previous practitioner, pharmacist or hospital to confirm the patient's story.
- Confirm a telephone number, if provided by the patient.
- Confirm the current address at each visit.
- Write prescriptions for limited quantities.
- Don't just "take their word for it" if you are suspicious.
- Don't dispense drugs just to get rid of drug-seeking patients.
- Don't prescribe, dispense or administer controlled substances outside the scope of your professional practice.
- Your office may have to involve law enforcement if the patient is overly aggressive or threatening to staff members.

Best Practices for Opioid Prescribing

- Always check INSPECT for prescription history
- Ask lots of questions of patients and other health care providers
- Consult with pharmacists and physicians when you have questions
- Consider opioids as a last resort in pain management
- When you do prescribe, be conservative in amounts, daily supplies and dosages
- Never prescribe opioids to children, to yourself or outside your scope as a dentist

Opioid Prescribing in Dental Medicine

Elena Hill, MD, MPH

ABOUT THE AUTHOR

Elena Hill, MD, MPH received her MD and Master's of Public Health degrees at Tufts Medical School and completed her family medicine residency at Boston Medical Center. She is currently an attending physician at Bronxcare Health Systems in the Bronx, NY where she works as a primary care physician as well as part-time in pain management and integrated health.

There are about 1.7 million[1] Americans per year who live with opioid use disorder. There are also about 1.6 million Americans per year[2] who misuse prescription opioids for the first time and over 10 million[2] Americans per year who misuse them overall. Of these people, nearly 50,000[1] Americans die each year from opioid overdoses. These numbers are from before the COVID-19 pandemic, and unfortunately, most experts believe that opioid misuse has increased during the pandemic.

Opioid Prescriptions by Medical Specialty

Opioids are prescribed by dentists and physicians to treat pain that is not well-controlled by other medications. In the U.S., dentists prescribe about 8.6 percent of prescription opioids. To put this in perspective, pain medicine physicians prescribe 8.9 percent, internal medicine physicians 15.7 percent, and family physicians 20.5 percent of total opioid prescriptions.[3] However, for the past few years all medical specialties, including dentists, have been re-examining the use of opioids and reducing the number of prescriptions when possible.

How Do the U.S. and U.K. Compare?

The proportion of opioid prescriptions written by dentists in the U.S. is **37 times higher** than that of dentists in the U.K.[4] This is despite the U.S. and the U.K. being extremely similar when it comes to oral health and dental treatment. In addition to this tremendously large difference in opioid prescribing practices between U.S. and U.K. dentists, the types of opioids prescribed are very different. While most dental prescriptions for opioids in the U.S. are for hydrocodone and oxycodone, all dental prescriptions for opioids in the U.K. are for dihydrocodeine,[4] which has a lower potential for abuse.

What Happens With All Those Opioids?

Research has repeatedly shown that U.S. patients do not usually take their entire prescriptions.[5] For example, recent research shows that only 46 percent of opioid pills prescribed after dental surgical tooth extractions

are taken as prescribed, while the other 54 percent go unused three weeks after the extraction. This means that over 100 million opioid pills prescribed by dentists for tooth extractions go unused every year.[5] In 2016, the CDC issued guidelines on opioid prescribing, recommending caps on dosage and days prescribed.

In a study that analyzed over 1.4 million U.S. dental visits, it was found that 29 percent of opioid prescriptions from dentists exceeded the dose sizes recommended by the CDC.[6] In addition to dose sizes, the CDC also recommended that opioids prescribed at dental visits be for only a few days' worth of the medication; it turns out that over half of these opioid prescriptions exceeded this amount.[7] We know from other research that 70 percent of misused prescription opioids originally came from a leftover prescription directly prescribed to that user or to their friends or family.[8]

COVID-19 Worsening the Opioid Crisis Nationwide

As mentioned above, the COVID-19 outbreak unfortunately appears to have worsened opioid abuse. In February 2021, Harvard University's T.H. Chan School of Public Health declared that 2020 is likely to be the deadliest year on record for opioid overdoses. Author Chris Sweeney noted, "The pandemic is in many ways a perfect storm for anyone who is struggling with substance use disorder. People have lost their jobs. Social and family interactions have been limited. And the pandemic itself is depressing and anxiety provoking. These are all stimuli that can stress the psyche and the finances of someone who has an addiction. In some cases, it could push a person who was getting their addiction under control back toward substance use. In other cases, the pandemic might be the trigger that actually makes someone consider initiating drug use, which could end up becoming an addiction and being harmful."[9]

COVID-19's Effect in Indiana

Sadly, the national trend of opioid abuse during COVID-19 was clearly evident in Indiana. Steve Smitherman, president of CareSource Indiana, wrote an article for Inside Indiana Business detailing the impact of COVID-19 on Substance Abuse Disorder in Indiana. CareSource, one of the nation's largest Medicaid managed care plans, says that 2019 and 2020 saw an increase of 68 percent of Indiana Medicaid members with a substance use-related service.[10] In Marion County alone, EMS calls for accidental overdoses increased by 43 percent, and calls for service with Narcan administration increased 61 percent after the stay-at-home order in March 2020.[10]

Continued on page 30 ▶

What Can Dentists Do?

The dentistry profession has recognized the opioid problem and has been actively working to fix it. In 2018, the ADA issued a statement on opioid prescribing in dentistry. The ADA statement supported mandatory continuing education for dentists on opioid prescribing best practices, a limitation of seven days for prescriptions, and expansion of state prescription drug monitoring systems. As a result of this intervention, more and more dentists prescribe opioids only as a last resort and only after patients have tried other medications. In addition, many dentists have begun encouraging patients to bring their leftover opioid prescriptions back to their pharmacies to avoid them being lost or stolen. Most dentists now also communicate to patients that pain is expected after many of these procedures; research has found that as long as patients know what to expect, they tend to handle the pain better.

Resources

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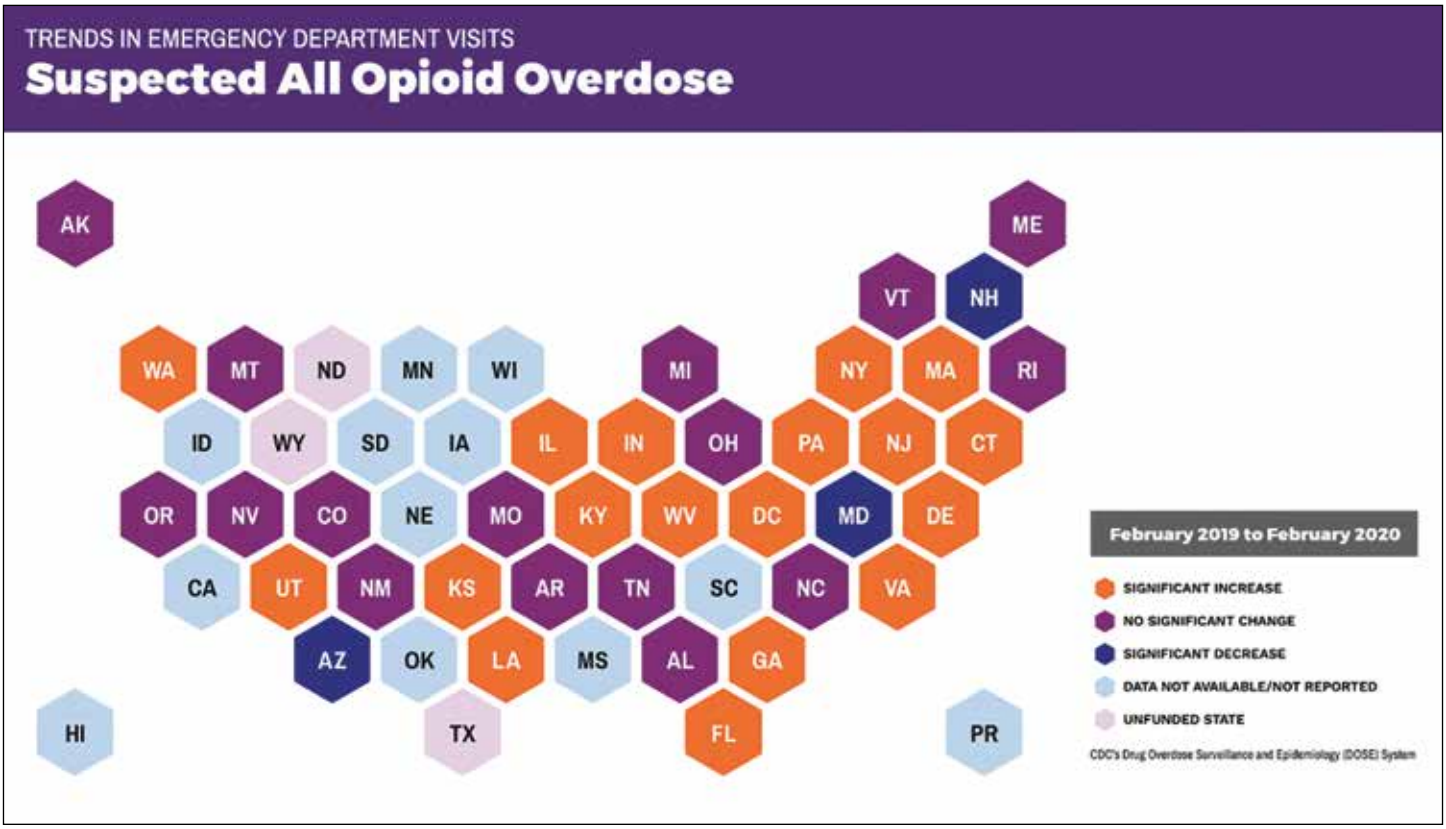
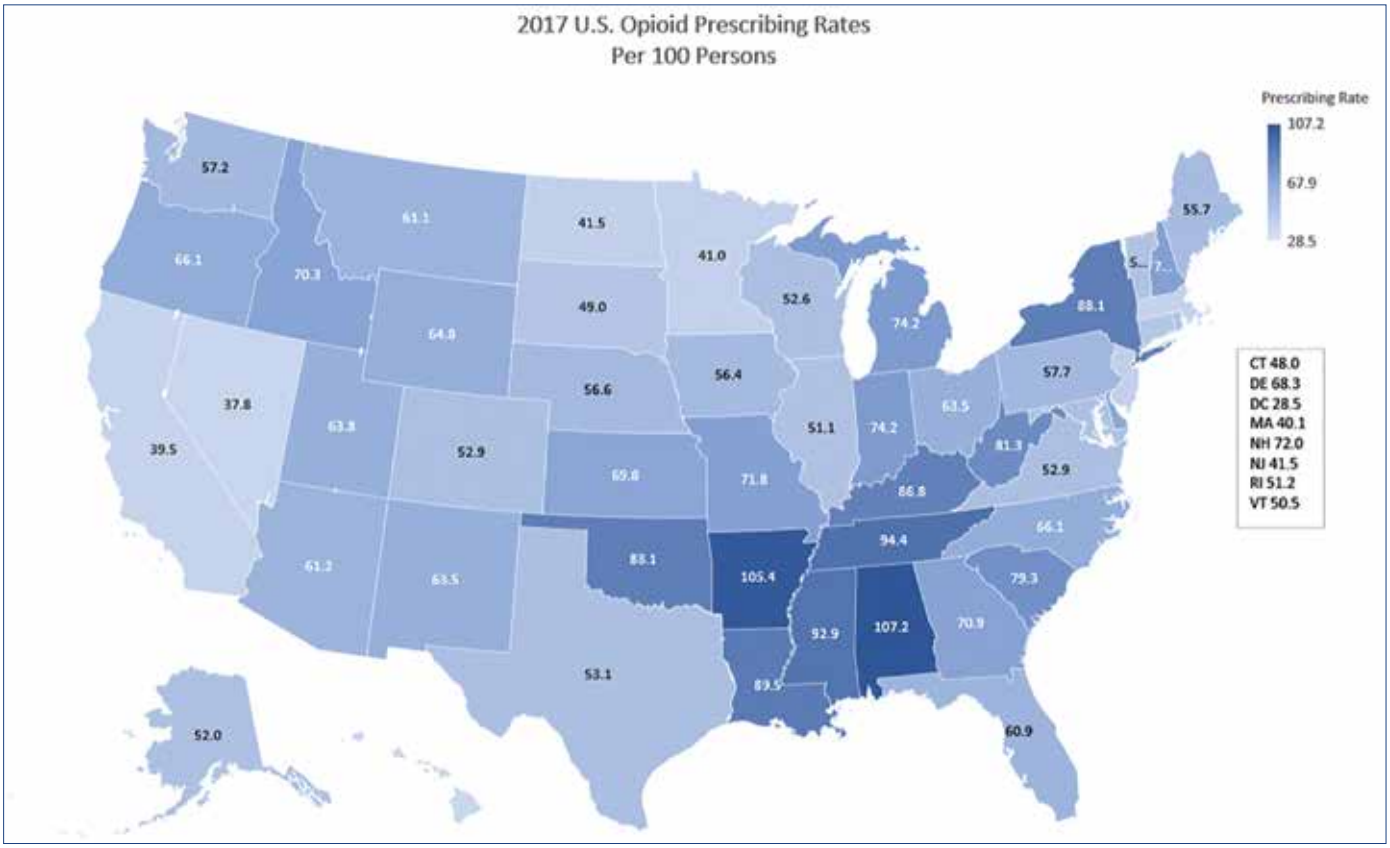
Content provided by Bicycle Health, a telemedicine Substance Abuse Disorder (SUD) treatment provider. www.bicyclehealth.com

Key Opioid Statistics: US and Indiana





Top: A CDC map of opioid overdoses from February 2019 to February 2020
Bottom: A CDC map showing 2017 opioid prescribing rates per state

Talking With Patients About Opioid Abuse: ADA Recommendations

ABOUT THE AUTHOR

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Do you know how to speak to a patient or a patient's parent about opioids and their abuse? Dentists know that opioids are effective in relieving pain, but abuse of these drugs has been a nationwide problem for years. The ADA has helpful talking points for explaining the dangers of abusing and sharing opioids. You play an important role in keeping prescription medications from becoming a source of abuse in your patients' households and in the community. To help prevent these medications from becoming a source of abuse, encourage patients and their parents to take the following steps:

Communicate

Talk with your family members about the dangers of using prescription drugs for non-medical purposes. Be sure they understand that prescription drugs are not necessarily safe (or safer) just because they are legal. Prescription drugs can be just as addictive and dangerous (even fatal) as illegal street drugs. They are also only legal for the person for whom they are prescribed.

Secure

Properly secure your prescription medications. Do not leave them in predictable, accessible places like your medicine cabinet. Hide them in unexpected places or, better yet, lock them up to ensure you do not become your teen's supplier.

Monitor

Be mindful of whether anyone else—especially your child and his or her friends—may have been taking your pills. Take note of how many pills are in each of your prescription bottles or pill packets and keep track of your refills. This goes for your own medicine, as well as for your teens and other members of the household.

Dispose

Properly dispose of your unused, unwanted or expired prescription medications. Not sure how? Follow these guidelines from the Federal Drug Administration and the White House Office of National Drug Control Policy:

- Follow any disposal instructions on the label or patient information you get with your prescription.
- Don't flush medicines down the toilet or pour them down the sink unless the disposal instructions say to do so. (You can also consult this list from the FDA.)
- If there are no disposal instructions, participate in a drug take-back day or find a Controlled Substance Public Disposal Location near you.
- If you are unable to attend a drug take-back day, take unwanted prescription medications out of the original bottle and mix them with coffee grounds or kitty litter in a sealed bag or closed container. This makes pills less appealing and less recognizable to anyone who can see your trash—including your kids.
- Remove all personal information from prescription bottles to protect your privacy.

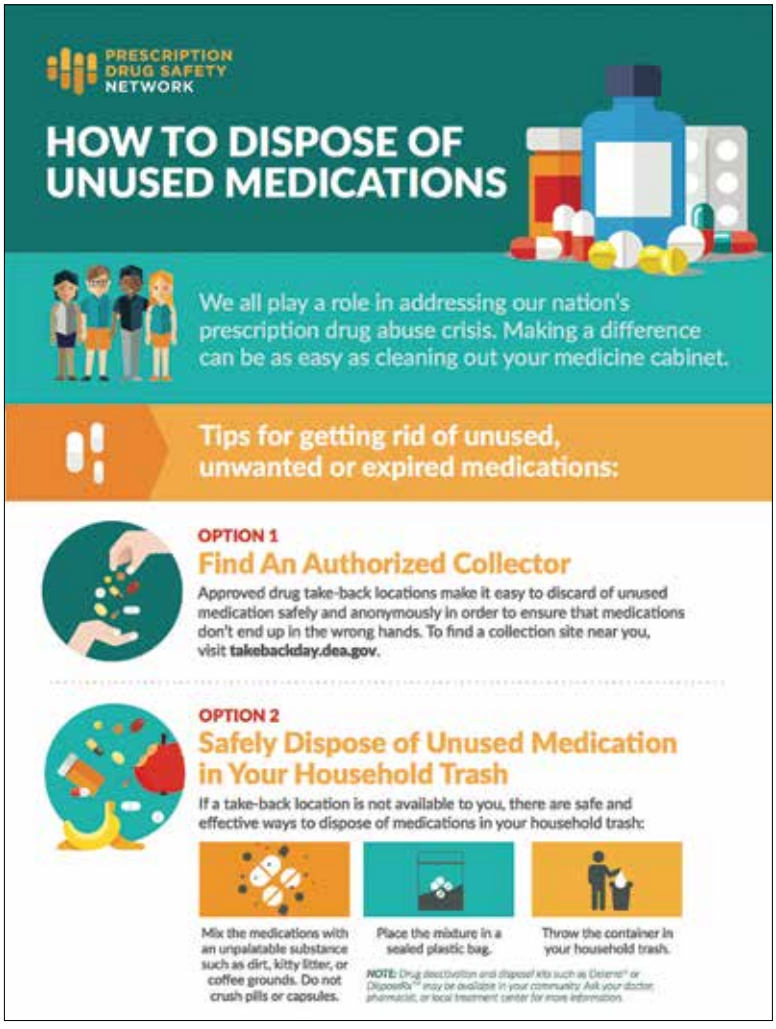
Spread the Word

Tell your family, friends and neighbors about how teens are now using prescription drugs to get high. Encourage them to talk with their children, safeguard their medicines and tell others in their communities.

Get Help

If you or someone you love is struggling with addiction, call the Substance Abuse and Mental Health Services Administration hotline at 1-800-662-HELP (4357). It's confidential, free and available 24 hours a day, 365 days a year.

Information from www.mouthhealthy.org/en/az-topics/p/prescription-drugs



Prescription drug safety visuals for your office. Image at top © American Dental Association. Image above © Prescription Drug Safety Network.

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INDIANA'S OPIOID EPIDEMIC IS BECOMING DEADLIER AND COSTING THE STATE BILLIONS

OPIOID USE IN INDIANA CONTINUED TO WORSEN THROUGH 2017

In 2017, **1,700** Hoosiers died from drug overdose

An all time high and a **75%** increase since 2011

in Marion County from drug overdoses in 2017

An all time high and a **123%** increase since 2011

Opioids are responsible for **81%** of drug overdose deaths in Marion County

Deaths from fentanyl, a powerful synthetic opioid, have surged. The presence of fentanyl in Marion County overdoses increased from **6%** to **46%** between 2013 and 2017

HUMAN TOLL GOES BEYOND DEATHS

Infants exposed to opioids during pregnancy can suffer from:

NAS (Neonatal Abstinence Syndrome)

Experiencing symptoms such as: tremors, sleep problems, poor feeding, vomiting and diarrhea

NAS Rates have risen **87%** in Marion County and **86%** in Indiana from 2013-2014 to 2015-2016

x3

Number of Indiana **children in foster care tripled** due to drug misuse by parents

– from **2,837** in 2003 to almost **9,000** in 2016

Injection-drug users run the **risk of serious disease,** including hepatitis C and HIV.

In Marion County, acute hepatitis C infections have **risen more than 12-fold** from 2013 to 2017

OPIOID USE COSTS INDIANA BILLIONS OF DOLLARS EACH YEAR

Economic damages statewide over the past 15 years

$4.3 BILLION

Economic damages in 2017 in Indiana

$1 BILLION Direct Damages (e.g., acute hospitalizations, incarceration, treatment of NAS and foster care)

$3.3 BILLION Lost productivity

$7.4 BILLION Damages over the past 15 years in Marion County *($7,759 per resident)*

Note: All 2017 data are preliminary.

Sources
Indiana University Richard M. Fairbanks School of Public Health. The Changing Landscape of the Opioid Epidemic in Marion County and Evidence for Action, October 2018.

The Past Year Has Been Unpredictable, Your Supply Costs Don't Have To Be

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- Increased **Financial Predictability** (Thanks To Locked-In Pricing)
- **NO** Service Trip-Fees & **Service Appointments** Are Billed In 15-Minute Increments
- Additional **Savings On Purchased Services** (Accounting/Banking, HR, IT, Marketing, etc.)
- Access to **Continuing Education Programs**

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