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Authors: Sindy M. Paul, MD, MPH (Medical Director of the New Jersey Board of Medical Examiners); Virginia Allread, MPH (freelance public health consultant)

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OPIOID MISUSE, ABUSE AND ADDICTION

Part 2: Opioid Prescriber Responsibilities and Resources*

By Sindy M. Paul, MD, MPH & Virginia Allread, MPH

* This is the second article in a two-part series on opioid misuse, abuse and addiction. Part 1 “Current Trends” was published in January 2017 as a mid-issue online article, available at www.MDAvantageonline.com/MDAdvisor.
Opioid misuse, abuse and addiction are major public health issues. As described in Part 1 in this series “Opioid Misuse, Abuse and Addiction: Changing Trends,” the number and rate of drug overdose deaths in the United States have increased unabated since 2000. In 2015 alone, there were 33,091 drug overdose deaths in the United States. The death rate due to opioid overdoses increased sharply across the country in 2015 (in comparison to 2014) and even more alarmingly in New Jersey where the increase was 16.4 percent within a single year. The number of overdose deaths in 2016 is expected to continue the upward trend due to an increase in deaths from the opioid drug fentanyl.

One facet contributing to this epidemic is opioid prescribing. An estimated 20 percent of patients who present at physicians’ offices with non-cancer-related pain or pain-related diagnoses are prescribed opioids. Opioid prescriptions increased by 7.3 percent from 2007 to 2012, with 259 million opioid prescriptions written in 2012. This article describes new opioid prescribing guidelines and regulations, as well as treatment options for patients with substance abuse disorders.

**LEARNING OBJECTIVES**

At the conclusion of this activity, participants will be able to:

1. Provide an overview of the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain.
2. Describe the New Jersey Board of Medical Examiners prescribing requirements.**
3. Discuss the features of the New Jersey Prescription Monitoring Program.
4. Understand other initiatives in New Jersey that aim to prevent or treat substance abuse disorders or decrease the risk of overdose-related mortality.

**At the time of publication, the NJ Attorney General has notified the BME of upcoming changes that will impose tough restrictions on the prescription of painkillers.

The Centers for Disease Control and Prevention (CDC) monitors the prescription and illicit opioid epidemic and keeps the public and professionals informed. In mid-March 2016, the CDC published “CDC Guideline for Prescribing Opioids for Chronic Pain–United States, 2016” in an attempt to bring clarity in a context of multiple competing recommendations. A summary of the new guidelines (which was written for primary care physicians, nurse practitioners and physician assistants) follows.

**GUIDELINES FOR DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN:**

1. Preferred for chronic pain are nonpharmacologic therapy (e.g., physical therapy), weight loss for knee osteoarthritis, psychological therapies (such as cognitive behavioral therapy) and nonopioid pharmacologic therapy (e.g., acetaminophen, nonsteroidal anti-inflammatory drugs and selected
antidepressants and anticonvulsants; or pregabalin, gabapentin or carbamazepine). Consider opioid therapy only if the expected benefits for pain and function are anticipated to outweigh the risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

Although opioids can reduce pain during short-term use, there is insufficient evidence to determine whether pain relief is sustained and whether function or quality of life improves with long-term use. Thus, opioids should not be considered first-line or routine therapy for chronic, non-cancerous pain.

**2** Before starting opioid therapy for chronic pain, establish treatment goals (e.g., improvement in pain relief and function (function is patient-defined and might be something like walking around the block or returning to work), including realistic goals for pain and function, and consider how opioid therapy will be discontinued if the benefits do not outweigh the risks. Continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs the risks to patient safety.

**3** Before starting and periodically during opioid therapy, discuss with patients the known risks and realistic benefits of opioid therapy, as well as patient and clinician responsibilities for managing therapy. Involve patients in decisions to start or continue opioid therapy. Ensure patients are aware of the potential benefits of, harms of and alternatives to opioids before starting or continuing opioid therapy.

**2** When opioids are started, prescribe the lowest effective dosage. Carefully reassess the evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day and avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day. Although there is no dosage threshold below which overdose risk is eliminated, holding dosages <50 MME/day will likely reduce risk among a large proportion of patients who would experience a fatal overdose at higher prescribed dosages.

**3** Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, prescribe the lowest effective dose of immediate-release opioids and prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less is sufficient; more than seven days is rarely needed.

**4** Evaluate the benefits and harms with patients within one to four weeks of starting opioid therapy for chronic pain or dose escalation. Evaluate the benefits and harms of continued therapy with patients every three months or more frequently. If the benefits do not outweigh the harm of continued opioid therapy, optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

**GUIDELINES FOR ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE:**

**1** Before starting and periodically during continuation of opioid therapy, evaluate risk factors for opioid-related harm. Incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose (such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day) or concurrent benzodiazepine use) are present. See guidelines for specific recommendations for people with sleep-disordered breathing,
pregnant women, patients with renal or hepatic insufficiency, older patients (≥65 years), patients with mental health conditions and those with substance use disorders.

2 Review patient history of controlled substance prescriptions using prescription monitoring program (PMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Review PMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every three months.

If a patient is found to have high opioid dosages, dangerous combinations of medications or multiple controlled substance prescriptions written by different clinicians, discuss this safety concern with the patient, consider tapering to a safer dosage and consider offering naloxone.

If selling of opioids is suspected, consider urine drug testing to assist in determining whether opioids can be discontinued without causing withdrawal.

3 When prescribing opioids for chronic pain, use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications, as well as other controlled prescription drugs and illicit drugs.

4 Avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible as both cause central nervous system depression and can decrease respiratory drive.

5 Offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

NJ STATE BOARD OF MEDICAL EXAMINERS PRESCRIBING REQUIREMENTS

The New Jersey State Board of Medical Examiners (BME) requires practitioners to have a controlled dangerous substance (CDS) registration in addition to their U.S. Drug Enforcement Administration (DEA) registration to prescribe CDSs, including opioids. The BME also requires practitioners to have a bona fide provider–patient relationship with persons to whom a CDS is prescribed. The BME holds practitioners accountable for their quality of care, including CDS prescribing. These regulations (13:35-7.6 Limitations on Prescribing, Administering, or Dispensing of Controlled Substances; Special Exceptions for Management of Pain) are summarized here.

Before prescribing a CDS, practitioners need to ensure that the patient records are accurate and include the following information:

- A recognized medical indication for the use of the CDS: patient’s medical history, physical examination and any other evaluations and consultations, including an assessment of physical and psychological function, underlying or coexisting diseases or conditions, any history of substance abuse and the nature, frequency and severity of pain
- Treatment plan objectives
- Evidence of informed consent
- Treatments and drugs prescribed or provided; if a CDS is prescribed, then the name of that drug, dosage, strength, quantity and instructions on frequency of use
- Any agreements with the patient
- Periodic reviews conducted

In reference to Schedule II prescriptions (i.e., drugs with a high potential for abuse that may lead to severe psychological or physical dependence), which include opioids, the BME requirements set prescription limitations. The BME requirements state that the practitioner is limited to prescriptions that are no more than 120 dosage units or a 30-day supply in the treatment of non-cancer chronic pain (the pending change limits this supply to five days). The regulations state that a practitioner may give the patient multiple prescriptions authorizing up to a 90-day supply, as long as the following conditions are met:

- The practitioner includes written instructions on each prescription (other than the first prescription if it is to be filled immediately) indicating the earliest date on which a pharmacy may fill each prescription.
- The practitioner determines that providing the patient with multiple prescriptions in this manner does not create an undue risk of diversion or abuse.

Patients who require more than three months of medication must consult with the practitioner to review: 1) the course of treatment, any new information about the etiology of the pain...
and the patient’s progress toward the treatment objectives, 2) possible problems associated with physical and psychological dependence and 3) efforts to reduce potential for abuse or dependence, such as decreased dosage, alternative drugs, such as nonsteroidal anti-inflammatories, or other treatment modalities (unless clinically contraindicated).

If the treatment objectives are not being met, the practitioner is expected to assess the appropriateness of continued CDS treatment or undertake a trial of other drugs or treatment modalities. The practitioner should also consider referring the patient for independent evaluation or treatment to achieve the treatment objectives.

PRESCRIPTION BLANK SECURITY CHANGES

In February 2014, the New Jersey Division of Consumer Affairs (DCA), Department of Law and Public Safety, announced new regulations that determine the look and security features of prescription blanks. The old prescription blanks were phased out as of November 2014. The purpose of this new regulation is to make it more difficult to sell prescriptions for cash and to prevent forgery and counterfeiting. The new security measures are illustrated in Figure 1.

PRESCRIBER EDUCATION

Prescriber education continues to be an important component of the New Jersey response to the opioid epidemic. This includes New Jersey DCA provision of medical student education and enduring articles, such as this one and others that have appeared in NJ AIDSLine/HIVLinks, MDAadvisor and the Journal of Medical Regulation. A short tutorial is part of the required New Jersey Prescription Monitoring Program registration for all New Jersey practitioners holding a CDS registration and for the Do No Harm symposium series.

PRESCRIPTION MONITORING PROGRAMS

Nationally, prescription monitoring programs (PMPs) were created through funding from Congress in 2002. The purpose of PMPs is to help prevent and detect the diversion and abuse of pharmaceutical CDSs by enhancing the ability of state-level regulatory and law enforcement agencies to collect and analyze CDS prescription data through a centralized, state-administered database. PMPs focus on the retail level where prescribed medications are purchased. As of June 2016, 49 states, the District of Columbia and one U.S. territory (Guam) had legislation authorizing the creation and operation of a PMP.

The NJPMP was established in 2011 and is maintained by the NJ DCA; it includes prescription data on human growth hormone, as well as CDSs dispensed in outpatient settings in New Jersey and by out-of-state pharmacies.
dispensing into New Jersey. As of April 2016, the NJPMP contained nearly 59 million records of prescription drug prescribing and dispensing. Each record contains the names of the patient, doctor and pharmacy; purchase date; type, dosage and amount of medication; and method of payment. Pharmacies are required to report information to the NJPMP on a daily basis.\(^5\)

Since 2015, CDS prescribers and pharmacists have been required to register for NJPMP access. Practitioners who renewed their NJ CDS registration last year had an NJPMP account automatically created. As of April 2016, more than 96 percent of all licensed physicians were registered.\(^6\)

In a letter from Steve C. Lee, Director of New Jersey Consumer Affairs, and from the New Jersey Office of the Attorney General in September 2015, prescribers were informed that they are required to review PMP information when they prescribe a Schedule II medication to a new or current patient for acute or chronic pain, the first time they prescribe and quarterly thereafter. Patient information in the NJPMP is intended to supplement the evaluation of a patient, confirm a patient’s drug history or document compliance with a therapeutic regimen. When a practitioner or pharmacist identifies a patient as potentially having an issue of concern regarding drug use, they are encouraged to help the patient locate assistance and take any other action deemed appropriate.

In response to a statutory change, regulations were published in the New Jersey Register on November 7, 2016, expanding NJPMP access to practitioners’ delegates.\(^7\) The new regulations define a “delegate” as a registered nurse, licensed practical nurse, advanced practice nurse (APN), physician assistant (PA), dental hygienist, registered dental assistant or certified medical assistant who is a licensed healthcare professional within the State of New Jersey and has completed the requirements under N.J.S.A. 45:1-44. Delegates may also be a medical or dental resident authorized by a practitioner or faculty member from a medical or dental teaching facility. APNs and PAs cannot be prescribers and delegates in the NJPMP system. If they are registered as prescribers, they will need to look up information as a prescriber and will be unable to be registered as a delegate.

Before being able to request information from the database, delegates need to be linked to a practitioner registered with the NJPMP who will be responsible for supervising the delegate’s activities. Practitioners should review the regulations before delegation.

Physician responsibilities related to the delegate include the following:

- Before delegate designation, confirm the education, training and license or certification requirement of each delegate.
- Ensure that the delegate understands the limitations on disclosure of PMP information and federal and state laws, rules and regulations concerning patient information confidentiality.
- Ensure delegate compliance with the recordkeeping requirements.
- At least every six months, monitor the delegate’s PMP use for potential misuse.
- Report unauthorized access to the NJ DCA within five business days of discovery.
- Terminate the delegate’s PMP access when a delegate, for any reason, is no longer authorized to be a delegate.

THE DELEGATE HAS SOME RESPONSIBILITIES, INCLUDING BUT NOT LIMITED TO THE FOLLOWING:

- All persons granted access to the PMP shall access the PMP using their own unique user login ID and password, which shall not be shared with any other person or entity.
- A delegate shall share PMP information with only his or her delegating practitioner. The delegate shall not share access to the PMP with any other person or entity.
- All delegates shall identify the practitioner on whose behalf they are accessing the prescription monitoring information.
- A delegate may be an authorized delegate for more than one practitioner.
- An individual who is no longer employed at the practice setting at which the practitioner practices is no longer authorized to be a delegate or to access the PMP on behalf of that practitioner.
The NJPMP information can be used by individual registrants to do a self-lookup to assess their prescribing practices and to determine if prescriptions have been filled that have not been written by them—through prescription blank theft, for example. Prescription blank theft needs to be reported to the police, the DEA and the New Jersey Drug Control Unit. There are anecdotal instances in which a practitioner, through self-lookup, has identified prescription blank theft through this mechanism, reported it and the NJPMP was able to alert pharmacies about the theft.


**TARGETING CONSUMERS: PROJECT MEDICINE DROP**

Project Medicine Drop allows members of the public to dispose of unused and expired medications anonymously, 365 days a year, at prescription drug drop boxes located within the headquarters of participating police departments, sheriff offices and New Jersey State Police barracks. As of January 1, 2016, practitioners and pharmacies are required to provide notice about drug take-back programs upon dispensing a CDS (see Figure 2). As of October 2016, there were 213 Project Medicine Drop boxes across New Jersey. For information about drop box locations, visit the DCA website (www.njconsumeraffairs.gov/meddrop/Pages/Locations.aspx), contact a local police department or call the NJ DCA at 800-242-5846.

The American Medicine Chest Challenge and the National Prescription Drug Take-Back are statewide, one-day events to dispose of unused medications. Both are sponsored in New Jersey by the DEA, Partnership for a Drug Free New Jersey and the Sheriffs’ Association of New Jersey.

**OVERDOSE PROTECTION ACT AND NALOXONE**

In May 2013, the New Jersey Overdose Protection Act was signed into law. This legislation takes the following two-prong approach to prevent drug overdose deaths in New Jersey:

1. **Provision of legal protection to people who are in violation of the law while they are attempting to help a drug overdose victim.** This provision encourages witnesses and victims of drug overdoses to seek medical assistance without fear of criminal or civil liability.

2. **Elimination of negative legal action against healthcare professionals, bystanders or family**
members who administer overdose antidotes in life-threatening situations.

In April 2014, the BME approved a Certificate of Waiver to ensure that physicians understand that they are relieved of certain obligations when prescribing naloxone to first responders or to family and friends of a person at risk. Under the Act, the prescription may be issued in the name of a person who is not the intended end user of the medication. There is no need for an examination before or follow-up afterward of the person to whom naloxone is administered after the issuance of the prescription, as required by existing BME rules, N.J.A.C. 13:35-7.1A and 7.2. In February 2015, the Overdose Prevention Act was expanded, giving immunity to first responders, including police and EMTs, who administer and dispense naloxone.9

Although pharmacies in New Jersey order and dispense naloxone when a prescription is presented, CVS and Walgreens, as well as other independent pharmacies, are making naloxone available for purchase without a prescription.10

**NALOXONE**

Naloxone is an opioid antagonist that can be used to counter the effects of an opioid analgesic or other opioid (including heroin) overdose. Administration of naloxone counteracts life-threatening depression of the central nervous system and respiratory system. It may be injected in the muscle or vein, under the skin or sprayed into the nose. It is a temporary drug that wears off within 20 to 90 minutes. Although naloxone is a prescription drug, it is not a controlled substance and has no abuse potential. It can be administered by minimally trained laypeople.


**TARGETING USERS AND THOSE AT RISK: OORP AND OOPP**

The Department of Human Services Division of Mental Health and Addiction Services (DMHAS) recognized early that the naloxone program is a Band-Aid approach. Naloxone saves lives but does not address the underlying substance abuse or mental health issues. To address this issue, the DMHAS created the Opioid Overdose Recovery Program (OORP) that puts recovery specialists and patient navigators in hospitals to respond to individuals reversed from opioid overdoses and treated at hospital emergency departments as a result of the reversal. The OORP provides support and treatment for long-term recovery. In 2016, DMHAS funded the OORP project in six New Jersey counties; based on the success of these initial projects, it is being expanded to other counties.

The Opioid Overdose Prevention Program (OOPP) is a similar, statewide program, started in 2014 and expanded in 2015, that includes an educational component, outreach to at-risk individuals, collaboration with interested stakeholders and distribution of naloxone rescue kits. The program targets those at risk for an opioid overdose, their families and friends who are taught to recognize an opioid overdose and to provide life-saving rescue measures to reverse the overdose.

**TARGETING USERS: SYRINGE ACCESS PROGRAMS**

In 2006, the State of New Jersey—by passing Public Law 2006, c. 99, the Blood-borne Disease Harm Reduction Act—created up to six demonstration Syringe Access Programs (SAPs) across the state. Between November 2007 and July 2009, five SAPs were established in areas with a high prevalence of HIV attributable to injection drug use. The SAPs provide patients with clean needles and syringes in exchange for used needles and provide access to a range of healthcare services.

The Access to Reproductive Care and HIV Services (ARCH) nursing program is co-located with all of the SAPs, supporting
the provision of services required by the 2006 legislation. ARCH nurses provide harm-reduction counseling and referral for care, including pregnancy testing. The SAPs are located in Atlantic City, Camden, Jersey City, Newark and Paterson, New Jersey. Despite positive results over the past 10 years, the syringe exchange program has yet to be expanded beyond the original five sites. However, New Jersey state lawmakers are now pushing to expand the programs’ reach to communities around the state.

TARGETING USERS: TREATMENT

Although nearly two decades of treatment research have shown that proper treatment is effective and results in a clinically significant reduction in or abstinence from alcohol and drug use and accompanying criminal activity, a treatment gap remains in New Jersey. The number of treatment slots—both inpatient and outpatient—are still insufficient to meet demand. Addiction affects one in 10 Americans, yet 90 percent of those affected do not receive effective treatment.

An analysis by NJ Advance Media shows that there are only 2,375 licensed residential treatment beds in New Jersey. In 2015, DMHAS estimated the size of New Jersey’s 2014 resident adult population in need of treatment for drug abuse or dependence at 349,996 persons. Of these 349,996 people, only 78,942 wanted substance abuse treatment. Of those who wanted treatment, 47,664 received it, resulting in an unmet demand of 31,278—a gap of 39.6 percent. The National Council on Alcoholism and Drug Dependence (NCADD) claims that each year, more than 50,000 New Jersey residents have sought treatment and were denied because 1) their insurance plan did not cover it, or 2) they could not afford it or 3) there was a lack of treatment capacity.

NEW SOURCES OF FUNDING FOR DRUG TREATMENT

With more than 1.7 million New Jersey residents enrolled in state Medicaid (as part of the Affordable Care Act) or the Children’s Health Insurance Program as of December 2015 (a 33 percent increase in two years), one could expect an increase in the number of people in need of drug treatment who now have insurance. This Medicaid expansion was expected to provide additional access to substance abuse treatment and services. According to personal communication with Ellen Lovejoy, spokeswoman for the state Department of Human Services, “Medicaid expansion is providing coverage for more people in addiction treatment, but the DHS data system does not automatically capture the total number of treatment beds filled by Medicaid recipients” (October 9, 2015). Advocates have criticized Medicaid by stating that treatment funded by this mechanism is often insufficient in length and quality. Additionally, the historical “Institutions for Mental Diseases (IMD) exclusion” limits Medicaid from paying for residential treatment in facilities with 16 or more beds; as a result, many facilities have to deny service access to their Medicaid clients.

In 2015, there were other state-funded initiatives to expand drug treatment:

- The New Jersey 2017 fiscal year budget included nearly $64 million to support the expansion of the Drug Court program from nine vicinages (Ocean, Hudson, Somerset/Hunterdon/Warren, Passaic, Mercer, Atlantic/Cape May, Bergen, Burlington and Monmouth) to the final three (Essex, Cumberland/Salem/Gloucester and Middlesex).
- The 2017 budget also included a $127 million investment in substance use and mental health treatment to raise reimbursement rates and expand access to high-quality healthcare providers for individuals with substance abuse and behavioral health needs. Another $2 million will be invested in re-opening the Mid-State Correctional Facility in 2017 as the state’s first fully dedicated drug treatment center for inmates.
- In August 2015, legislation was signed requiring four-year public colleges and universities—at which at least a quarter of undergraduate students live on-campus—to establish a supportive substance abuse recovery housing program within four years.

MEDICATION-ASSISTED TREATMENT

Patients on medication-assisted treatment (MAT) have been consistently shown to use fewer illicit opiates, commit fewer crimes and reduce their odds of contracting...
infections, such as hepatitis C virus (HCV) and HIV, compared with those not taking substitution. MAT, which combines behavioral therapy and medications to treat substance use disorders, can be prescribed by physicians who are registered with the DEA to dispense controlled substances. MAT can include methadone, buprenorphine (a combination opiate mimic and blocker that can be taken as a sublingual tablet), Suboxone (buprenorphine combined with naloxone to discourage abuse as it does not produce a “high” if injected or snorted) or Vivitrol (an extended-release formulation of naltrexone, an opioid receptor antagonist).

Organizations in New Jersey, such as the Drug Policy Alliance, advocate for “making both methadone and buprenorphine more accessible through changing attitudes, laws, regulations and health insurance policies. Funding must be increased for access to methadone and buprenorphine through the public health system for those who cannot afford it otherwise.” Issues limiting use of MAT include prevailing attitudes and specific state laws.

**CONCLUSION**

New Jersey has shown laudable commitment to addressing the opioid epidemic in this state. The BME prescribing requirements are clear and thorough and complement the CDC’s 2016 Guideline for Prescribing Opioids for Chronic Pain. Prescription blanks have undergone security changes to make them more difficult to sell for cash or counterfeited, the NJPMP is up and running and all CDS prescribers are required to register. Project Medicine Drop has expanded across the state, and practitioners and pharmacies are required to provide notice about drug take-back programs upon dispensing a CDS to a patient.

New Jersey has expanded or created a number of effective programs that target the drug user, including the Overdose Protection Act, which legalizes the prescription of naloxone to individuals who are not the intended end user, as well as the OOPP, the OORP and other initiatives. However, New Jersey still does not have sufficient drug and alcohol treatment slots to meet the need nor has it expanded the syringe exchange program despite a decades-old pilot scheme that has yielded positive results. There is also much untapped potential in expanding MAT, which, when prescribed and monitored properly, is effective, safe and cost-effective and reduces the risk of overdose.

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able at www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm]


According to the “CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016”:
a) Opioids may be considered a first-line therapy for chronic, non-cancerous pain in patients who are also diagnosed with depression.
b) Opioids may be considered a first-line therapy for chronic, non-cancerous pain if the prescription is limited to fewer than four days.
c) Opioids should not be considered first-line or routine therapy for chronic, non-cancerous pain.
d) Opioids may be considered a first-line therapy for all acute, non-cancerous pain.

When prescribing opioids for chronic pain, the 2016 CDC Guidelines recommend prescribing the lowest effective dosage. Holding dosages below what morphine milligram equivalent (MME)/day will likely reduce risk among a large proportion of patients who would experience a fatal overdose at higher prescribed dosages?
a) 60 MME.
b) 50 MME.
c) 40 MME.
d) 20 MME.

When are prescribers required, at a minimum, to review the New Jersey Prescription Monitoring Program (NJPMMP) information when prescribing a Schedule II medication?
a) The first time the Schedule II medication is prescribed.
b) Quarterly while continuing to prescribe the Schedule II medication.
c) Reviewing the NJPMMP is not required when prescribing a Schedule II medication.
d) A and B.

Which of the following healthcare professionals licensed in New Jersey can be a delegate for the NJPMMP?
a) Advanced practice nurse.
b) Licensed practical nurse.
c) Registered nurse.
d) All of the above.

Physician responsibilities related to the NJPMMP delegate include which of the following?
a) Before designation, confirm the education, training and license or certification requirement of each delegate.
b) Ensure the delegate understands limitations on disclosure of PMP information and federal and state laws, rules and regulations concerning patient information confidentiality.
c) At least every six months, monitor the delegate’s PMP use for potential misuse and report unauthorized access to the NJ DCA within five business days of discovery.
d) Terminate the delegate’s PMP access when a delegate, for any reason, is no longer authorized to be a delegate.
e) All of the above.

According to the Overdose Prevention Act, a physician can prescribe naloxone (Narcan) to family members and peers of a person at risk. To do so, which of the following is/are required by the BME?
a) The physician can write the prescription only in the name/address of the person to whom the opioid antidote will be administered.
b) The physician is required to write the prescription in the name/address of the person to whom the prescription is issued, rather than the person to whom the opioid antidote will be administered.
c) The physician is required to document opioid abuse in someone known to the prescriber before a prescription can be written.
d) The physician is required to follow up with the person to whom the prescription was issued to document naloxone use.

According to the BME prescribing regulations, before prescribing a CDS, practitioners need to ensure that patient records are accurate and include which of the following?
a) A recognized medical indication for the use of the CDS.
b) The patient’s medical history, physical examination and any other evaluations and consultations, including underlying or coexisting diseases or conditions, any history of substance abuse and the nature, frequency and severity of pain.
c) Any agreements with the patient.
d) All of the above.

As of January 1, 2016, practitioners and pharmacies are required to provide notice about which of the following programs upon dispensing a CDS?
a) The availability of naloxone under the Good Samaritan Law.
b) The drug take-back programs, namely, Project Medicine Drop.
c) The phone number for the New Jersey Addictions Hotline.
d) A and C.

Which of the following best explains syringe access programs (SAP) in New Jersey?
a) Eligible providers are allowed to register with the state Department of Health to sell, furnish or accept for disposal hypodermic needles and syringes.
b) Most pharmacies in New Jersey are allowed to provide clients with clean hypodermic needles and syringes in exchange for used ones.
c) The SAP includes a total of six independently managed projects in which clients are provided with clean hypodermic needles/syringes in exchange for used ones and can access a range of healthcare services.
d) B and C.

According to the article, patients on what treatment or therapy “have been consistently shown to use fewer illicit opiates, commit fewer crimes and reduce their odds of contracting infections, such as hepatitis C virus (HCV) and HIV”?
a) Medication-assisted treatment, such as methadone, buprenorphine or Suboxone.
b) Outpatient counseling followed by 12-step programs.
c) Detox followed by cognitive behavioral therapy with motivational interviewing.
d) Detox followed by inpatient/residential treatment.
REGISTRATION AND EVALUATION FORM
(Must be completed in order for your CME Quiz to be scored – Deadline for Response: February 1, 2018)

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ANSWER SHEET Circle the correct answer.

Number of hours spent on this activity _______ (reading article and completing quiz)

I attest that I have read the article “Opioid Abuse, Misuse and Addiction – Part 2: Opioid Prescriber Responsibilities and Resources” and am claiming 1.0 AMA PRA Category 1 Credit.™

Signature Date

EVALUATION Completed by ☐ Physician ☐ Non-Physician
1. The content of the article was: Excellent___ Good___ Fair___ Poor___
2. The authors’ writing style was: Excellent___ Good___ Fair___ Poor___
3. The graphics included in the article were: Excellent___ Good___ Fair___ Poor___
4. The stated objectives of this program were: Exceeded___ Met___ Not met___

Was this article free of commercial bias? Yes _______ No _______
If not, why not ___________________________________________________________________________________

Please share your name and contact information so that we may investigate further.
Participant Name __________________________ Telephone/E-mail: __________________________

5. Will the knowledge learned today affect your practice? Very Much____ Moderately____ Minimally____ None____
6. Based on your participation in the CME activity, describe ways in which you will change the way you practice medicine.
   _Yes Describe __________________________
   _No Why not __________________________
   _N/A Were you the wrong audience for this activity? __________________________

7. Did this CME activity change what you know about:
   • The 2016 CDC Guideline for Prescribing Opioids for Chronic Pain.   Yes ☐ No ☐
   • The New Jersey Board of Medical Examiners prescribing requirements.   Yes ☐ No ☐
   • The features of the New Jersey Prescription Monitoring Program.   Yes ☐ No ☐
   • The initiatives in New Jersey that aim to prevent or treat substance abuse disorders or decrease the risk of overdose-related mortality.   Yes ☐ No ☐

8. Based on your participation today, what barriers to the implementation of the strategies or skills taught today have you identified?

Suggested topics for future programs: ___________________________________________________________________________________