From: Fraser Cobbe [mailto:fcobbe@cobbemanagement.com]
Sent: Wednesday, December 16, 2015 5:16 PM
To: Cannon, Gary
Cc: Ann Margaret McCraw
Subject: Narcotics Use Advisory Committee

Hi Gary,

I hope this email finds you well.

I wanted to provide you with some feedback from the Executive Committee of the SCOA on the proposed recommendations to be considered by the Narcotics Use Advisory Committee. I know our comments were due on the 11th and I apologize for missing that deadline. Given the serious nature of the narcotic issue, I wanted to get some physician input from our board prior to sending you some thoughts.

Overall the SCOA Executive Committee shares the concern with the overuse of opioids. Our national organization, AAOS, is developing some educational materials to guide orthopaedic surgeons on best practices and guidelines for prescribing narcotics for post-surgical pain. We will be investing significant resources in that arena over the coming months and years.

The SCOA Executive Committee is concerned however that routine acute pain relief may get drawn into the more stringent (and appropriate) requirements for long term chronic pain management including drug screening, contracting, etc. We are concerned if the difference between acute pain and chronic pain is not articulated, that all workers compensation patients may have to be treated as if they had chronic pain rather than the more frequent interactions we have with patients which is short duration acute pain relief.

Specifically our concern is with recommendation number 4 and how that recommendation appears to apply to both Chronic and Acute pain. We would ask the Committee to make a differentiation between the two so we can more accurately target the chronic pain patients.

Our proposed language would be something like the following:

4. For the treatment of chronic pain the following guidelines are recommended. (The treatment of acute pain is exempt from these recommended guidelines below. Acute pain is defined as the normal, predicted physiological response to an adverse chemical, thermal, or mechanical stimulus and is associated with surgery, trauma, and acute illness. It is generally time-limited (less than 90 days) and is responsive to opioid therapy, among other therapies. These guidelines would not apply to a physician who is primarily providing time-limited surgical services to relieve acute pain.)
   a. The mandatory registration and utilization of the SC PMP/SCRIPTs program.
   b. Prescribers who treat patients with chronic and acute pain are strongly encouraged to be knowledgeable about addiction, including behaviors that indicate addiction and circumstances under which to refer patients for addiction evaluation and treatment.
   c. Prescribers should comply with the essential elements of appropriate pain management which includes:

1) Evaluation of the Patient.
    a) A medical history and physical examination must be obtained, evaluated and documented in the medical record, to include but not be limited to, nature and intensity of the pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function and history of substance abuse.
    b) The use of a toxicology screen, a urine drug screen, should be utilized prior to prescribing opioids for treatment of chronic pain.
2) Consideration of alternative treatments.
    a) The prescriber of the patient should have knowledge of available treatment options which should be explored and documented as part of the routine evaluation.
    b) Other treatments modalities should be considered before using opiates.
3) Development of a treatment plan and goals individualized to the patient's needs.
    a) The decision to initiate opioid therapy should be the prescriber and patient's joint decision.
    b) A treatment plan and goals should be established early and revisited regularly.
4) Informed consent and a treatment agreement.
    a) A written informed consent memorializing the joint decision to prescribe should be established and include the elements set forth in the Guidelines.
    b) A treatment agreement memorializing the treatment plan and goals should be established.
        i) The agreement should outline the joint responsibilities of the prescriber and the patient and should include the elements set forth in the Guidelines.
5) Initiation of treatment on a trial basis.
    a) Consideration of the safer alternative treatments should be considered before initiating opioid therapy.
    b) A trial test of no more than 90 days with specific evaluation points.
    c) Prescriber should develop and implement safe practices and if necessary abuse deterrent formulations for at risk patients.
6) Periodic review and possible drug testing.
    a) The prescriber has the responsibility for determining the patient's progress toward treatment goals and assessments of substantial risks or adverse events.
    b) Continuation, modification or termination of the therapy should be contingent upon this periodic evaluation.
    c) The prescriber must re-establish informed consent and a new treatment agreement if the patient is prescribed 80 Morphine Equivalent Dose (MED) for longer than three continuous months.
    d) The prescriber should consider the use of drug testing for monitoring adherence to a treatment plan and detecting the use of non-prescribed drugs.
7) Consideration of drug diversions.
    a) Prescribers who prescribe chronic opioid therapy should be knowledgeable about substance use disorders and be able to distinguish substance use disorder from physical dependence on opiates.

b) Should misuse, abuse or addiction be suspected, the prescriber should write prescriptions for limited quantities and increase frequency of visits and drug screenings.

We hope the Committee may consider these comments as they finalize recommendations to the Commission.

Sincerely,

Fraser Cobbe
SOUTH CAROLINA ORTHOPAEDIC ASSOCIATION
1215 E. Robinson Street
Orlando, FL 32801
Telephone: 813-949-3121
Fax: 813-949-8994
Cell: 813-215-7140