

FREE E-BOOK

ADDRESSING THE OPIOID EPIDEMIC

WHAT DOES
YOUR
PRACTICE
NEED TO
KNOW
AND DO?



INTRODUCTION



Our country is in the midst of an opioid crisis. Every day, 115 Americans die from an opioid overdose. Almost half of those deaths (46) occur from prescribed opioids, and research indicates that the majority of illicit opioid users (such as heroin and fentanyl) started with misusing prescription opioids.¹

Many states are passing legislation in response to the opioid epidemic, putting orthopaedic practice

professionals in a quandary – providing optimal patient care while facing growing regulations to address the crisis.

This e-book provides resources, samples, and peer advice for your practice in addressing the use of opioids. Also included are resources to understand your state’s legislation, as well as federal policies combatting the current crisis. And the e-book wraps up with an overview of AAOE position statements that you are encouraged to use with your legislators.

Thank you for downloading.

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¹ “Prescribing Policies: States Confront Opioid Overdose Epidemic,” National Conference of State Legislatures, 5 April 2018 (accessed June 19, 2018), <http://www.ncsl.org/research/health/prescribing-policies-states-confront-opioid-overdose-epidemic.aspx>.

CREATING AN OPIOID POLICY:

TIPS & ADVICE FROM HEALTHCARE PRACTICE PROFESSIONALS

Given the ongoing changes to opioid legislation and the variations from state to state, deciding what's right for your practice is no easy feat. Whether you have already started (or completed) the process of developing an opioid policy, or are unsure of where to start, it can be helpful to know what other orthopaedic practice executives are doing.

SET EXPECTATIONS UPFRONT

A good place to start? Set the right expectations with patients regarding your practice's opioid prescribing policy.

At Northern Arizona Orthopaedics (NAO) in Flagstaff, Arizona, all new patients are required to read and sign the Narcotics Prescription Policy during the intake process. The policy details when and how narcotics will be prescribed in various situations – for example, the different prescribing standards for a patient who is referred by a medical practitioner outside of NAO versus patients who are self-referred to NAO and are non-operative.

"Patients get this policy from the get-go so there's the expectation that we're serious about setting limits on narcotics prescriptions," explains Joianne Meyers, Executive Director of Care Processes and Staff Development at NAO.

St. Charles Orthopaedic Surgery Associates in St. Peters, Missouri, takes a slightly different approach, but with a similar goal. Patients must sign the Opioid Patient Agreement if they are in an unusual situation that requires an opioid prescription beyond what is routine for post-operative patients.

The document explains that St. Charles Orthopaedic Surgery Associates surgeons "do not provide long-term pain control for chronic conditions" and that "patients requiring long-term chronic pain control will be referred to a Pain Management Specialist." It then lists alternative solutions to help reduce pain, the side effects of prescription opioids, and the patient's responsibility when taking opioids.

Suzann Crowder, MBA, CMPE, Administrator at St. Charles Orthopaedic Surgery Associates, says that the form includes resources and information available from other sources, including those that have been shared from peers on AAOE's online community, Collaborate. When developing the form, she compiled important information specific to her practice's needs to create a document that was straightforward and easy to understand, but helpful to both patients and staff.

"From the get-go, there's the expectation that we're serious about setting limits on narcotics prescriptions."

– Joianne Meyers, Executive Director of Care Processes and Staff Development,

“If you set the expectation upfront, true drug seekers won’t waste their time with your practice,” Crowder says.

Nannette Neff, CMPE, Practice Administrator at Orthopaedic Associates of Reading, Ltd. in West Reading, Pennsylvania, has noticed a similar trend. Her practice’s [Prescription Medication Policy](#) is posted on their website and included in welcome packages, and patients are required to sign the policy at new appointments.

“One thing I can note is that when new physicians come to the practice, it gets very busy with patients trying to get in and wanting pain medicine,” Neff says. “We caution our new physicians on this, and we support them when they have a demanding patient. After a short time, it stops once it is realized the physician is not going to loosely prescribe.”

A HOLISTIC APPROACH TO PAIN MANAGEMENT

All new NAO patients sign the Narcotics Prescription Policy, but those needing further pain management can receive additional treatment through the Pain Wellness Clinic.

The Pain Wellness clinic is run by Michelle Boyer, PA-C, who has additional training and certification in pain management. A brochure for the clinic explains that their services provide a “comprehensive approach to pain management.” Meyers says that the name itself is important – focusing on pain *wellness* to address all the reasons that a patient might be experiencing pain, including physical, emotional, economic, and social factors.

“There are so many things that are involved in how a patient will experience pain,” Meyers says. “We’re all so different as humans and how we perceive pain.”

[The clinic’s brochure](#) explains that it is intended for patients “who are motivated by self-care and all available treatments beyond medication therapy.”

“For most people, there is a way to get off of those medications and there’s a right way to do it.”

– Joianne Meyers, Executive Director of Care Processes and Staff Development, Northern Arizona Orthopaedics

Boyer works with chronic pain patients and serves as a resource for surgeons who are performing surgery on patients who are at higher risk for experiencing pain post-surgery. She begins working with those patients prior to surgery and continues to work with them throughout their post-operative period to ensure their pain is managed and that they discontinue narcotic pain medication after surgery.

When someone becomes a patient of the Pain Wellness Clinic, they must sign the [Opioid Consent Form](#). The form lists the patient’s responsibilities in remaining part of the program. This includes consenting to random drug screenings. Meyers says that this helps physicians check if patients are taking the medication they have been prescribed to make sure they are not abusing other medications or sharing prescribed narcotics.

The Pain Wellness Clinic is an important component of NAO's narcotics program. "There are patients who are going to be on pain medication for the rest of their lives, but for most people there is a way to get off of those medications and there's a right way to do it," Meyers says. "We try and offer them tools."

GET STAFF AND PHYSICIAN BUY-IN

A program will only be as successful as the staff and physicians who are implementing it.

Physicians and staff were front of mind as Crowder was developing their patient agreement. She aimed to alleviate frustrations caused by patients who were misusing opioids and confronting staff.

"Before you start creating a policy, you need to know what problems staff are running into," Crowder explains.

This allows you to create a policy that solves those problems. You can then more easily introduce the policy to staff and gain buy-in. When pitching a policy to physicians, Crowder suggests preparing data that will show not only the policy's clinical advantages but also the benefits it will have to frontline staff dealing with patients.

Similarly, Meyers educated clinical staff on their narcotics policy before rolling it out. She shares that although new patients must sign the Narcotics Prescription Policy during the intake process, many of them will still need further explanation if an issue arises after the fact. This makes it essential that medical assistants and physician assistants have a thorough understanding of the policy and what it contains.

The Pain Wellness Clinic Physician Assistant, Michelle Boyer, was also involved in staff education. Boyer explained how to appropriately handle various patient requests that violate the policy. This includes offering patients other solutions if they are denied a prescription.

"We need to make sure that when we hang up the phone or close that visit, the patient has a next step and they understand that narcotics aren't always the answer," Meyers says.

"Before you start creating a policy, you need to know what problems staff are running into."

– Suzann Crowder, MBA, CMPE,
Administrator at St. Charles
Orthopaedic Surgery Associates

BEYOND STATE REQUIREMENTS

For both Crowder and Meyers, proactivity has been key in addressing the opioid epidemic.

NAO is in Arizona, which is a more highly regulated state. However, NAO's efforts began three years ago, before the state started requiring them. They have continued to monitor upcoming legislation to stay ahead of the

curve. Meyers says Arizona is implementing an ePrescribing requirement for narcotics in January, and NAO has already been researching and preparing for this requirement.

“Governor Doug Ducey has made battling the opioid crisis one of his top priorities and so we are closely following the news and making sure we’re aware of anything the governor’s office is doing, and making sure our surgeons and prescribers know what’s coming next,” she shares.

St. Charles Orthopaedic Surgery Associates is located in Missouri, a state with relatively less opioid legislation. Still, Crowder felt it was important to be proactive in setting expectations with patients and providing a tool for her physicians and clinical staff to use when dealing with potential opioid abusers.

“You read the stories and hear the horrible kind of heartbreaking stories about people addicted to opioid drugs,” Crowder says. “We didn’t want to contribute to the problem.”

Like Crowder, Meyers’ reasons for implementing their policies went beyond state legislation.

“If it’s not for your state’s requirements, it’s for the health of your population that you’re serving,” Meyers says. “We have a role that we play in our patient’s lives in our communities, and it’s something that we need to take seriously.”

SAMPLES AND RESOURCES

Learn more about the opioid epidemic and plan accordingly for your practice.

POLICY SAMPLES FROM PRACTICES

- [Pain Management: Taking on Opioids, A Virginia Mason Organizational Goal](#)
- [Northern Arizona Orthopaedics Narcotics Prescription Policy](#)
- [Spine & Pain Center at Northern Arizona Orthopaedics Opioid Consent Form](#)
- [Northern Arizona Orthopaedics Pain Wellness Clinic Providers Brochure](#)
- [Northern Arizona Orthopaedics Pain Wellness Clinic Consumer Brochure](#)
- [St. Charles Orthopaedic Surgery Associates Patient Education – Opioid Drugs for Pain](#)
- [Orthopaedic Associates of Reading, Ltd. Prescription Medication Policy: Narcotics, Opioids, General Pain Medication](#)
- [Orthopaedic Associates of Reading, Ltd. Pennsylvania Prescription Drug Monitoring Program](#)
- [Advanced Orthopaedics Sports Medicine Narcotics Prescription Policy](#)

AAOE EDUCATION

- [4-Part Opioid Education Series – Available now on-demand](#)

ARTICLES

- [“Reconciling the Opioid Crisis With Delivering Quality Patient Experience,” Patient Engagement HIT](#)
- [“Eight Ways Doctors Can Address the Opioid Epidemic,” Managed Healthcare Executive](#)
- [“BCBS Association: Use Alternative Pain Therapies Before Opioids,” Health Payer Intelligence](#)
- [“How to Host a Drug Take-Back Day,” Opioid Prescribing Engagement Network](#)
- [“A Third of Pain Patients Have Stopped Using Rx Opioids,” Pain News Network](#)
- [“Opioid Medications: Growing Source of Medical Malpractice,” Dolman Law Group](#)
- [“Doctors Increasingly Face Charges for Patient Overdoses,” CNN](#)

STATE POLICIES ON OPIOIDS

In the fields of public policy and political science, the states are often called “the laboratories of democracy” and in no policy field is this more true than in the ongoing opioid epidemic.



The states have implemented varying policies in an attempt to stem the flow of

prescribed opioid analgesics. The most common of these policies is requiring the use of prescription drug monitoring programs. This article looks at the different laws in the states governing opioid prescribing, using data from the National Conference of State Legislatures, the state legislatures themselves, and state health agencies.

Unfortunately, due to the nature of the opioid epidemic, the state of opioids regulation is constantly changing. What may be the law in your state at the time of this writing (June 12, 2018) may have changed by the time of publication. It is always a good idea to consult the relevant statutes or a practicing healthcare attorney.

State regulation of opioid prescribing typically falls into six policy solutions:

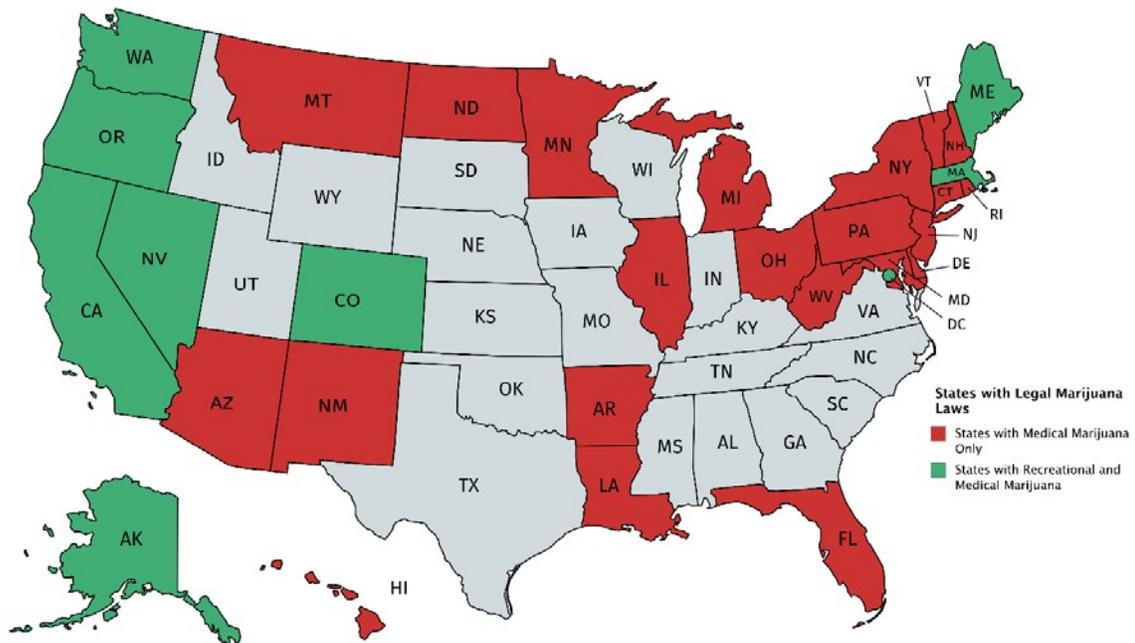
- Opioid alternatives (i.e. legalized marijuana for medical or recreational purposes, prioritizing opioid alternative analgesics, etc.);
- Prescription drug monitoring programs and the use of ePrescribing;
- Prescriber limits;
- Substance abuse disorder assessments prior to prescribing;
- Point of sale ID checks; and,
- Continuing medical education for clinicians prescribing controlled substances.

OPIOID ALTERNATIVES

While the scientific literature on marijuana and pain management is in its infancy (indeed, a 2017 clinical review of data in the National Library of Medicine found modest evidence that cannabinoid pharmacotherapy can be used in pain management regimens)², some states have been embracing alternative pain medicine therapies such as medical marijuana. Still others have gone so far as to legalize marijuana for recreational use which opens the potential benefits of marijuana use for pain to a larger population.

The graphic below shows the states that have embraced medical and recreational marijuana.

We expect the number of states permitting at least medical marijuana to increase as the opioid epidemic continues to rage on. This trend poses problems to employers across the country and especially those in the healthcare industry where drug testing of employees (and even clinical providers) is common. However, the goal of alternative pain therapies such as medicinal marijuana may be worth the disruption they cause.



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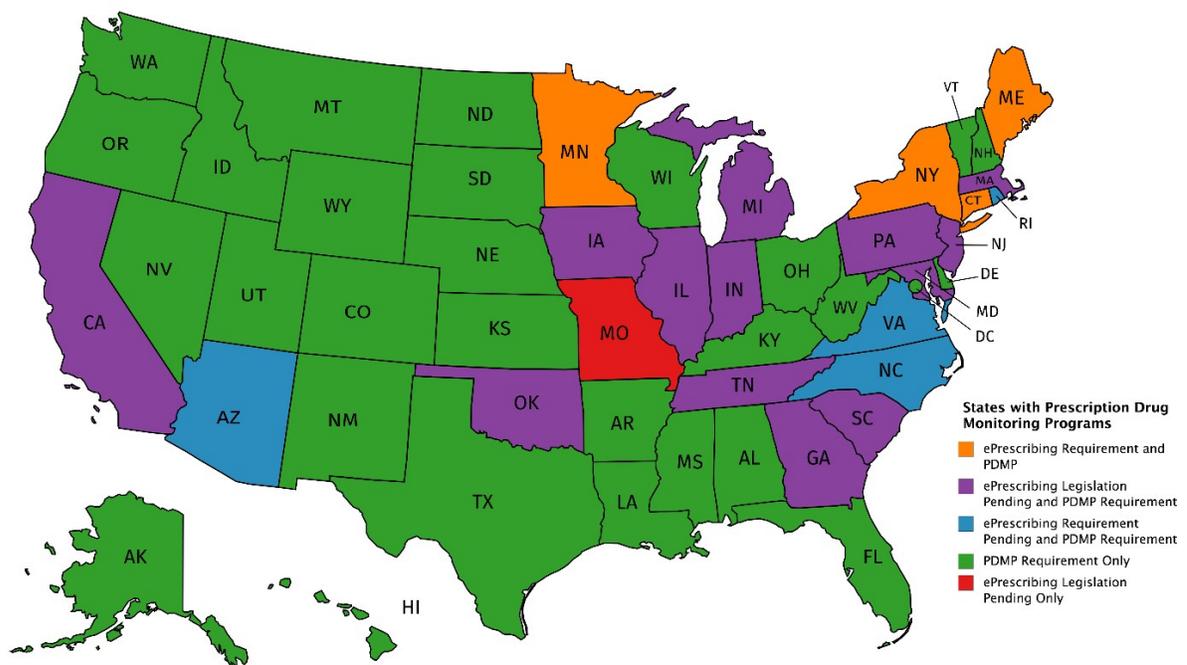
² Kevin P. Hill, et al., "Cannabis and Pain: A Clinical Review," in *Cannabis Cannabinoid Research*, 2017, Vol. 2, Issue 1, pp. 96-104, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5549367/> (accessed June 12, 2018).

PDMPS AND ePRESCRIBING

Prescription Drug Monitoring Programs (PDMPs) are state-run programs that collect and distribute opioid and other controlled substances' prescription data. These databases typically work to catch the abuse of controlled substances before a pharmacy fills the prescription for the abuser (they most often work to prevent doctor shopping for multiple opioid prescriptions). Some of these PDMPs are connected to regional databases that can prevent a drug seeker from traveling around the region and "gaming" the system.

ePrescribing works to remove the temptation for prescribers, non-physician practitioners, patients, and others with access to abuse a prescriber's prescription pad or to prevent a patient from selling or transferring the written prescription to another individual. Even if a state does not require ePrescribing for opioids, many practices and hospitals maintain it as a best practice to protect themselves from potential liability. ePrescribing also works to track a prescriber's prescribing habits and could allow for intervention if a prescriber is considered an outlier prescriber.

The graphic below shows states with current ePrescribing requirements, future requirements, introduced legislation, and PDMP requirements.



Created with mapchart.net ©

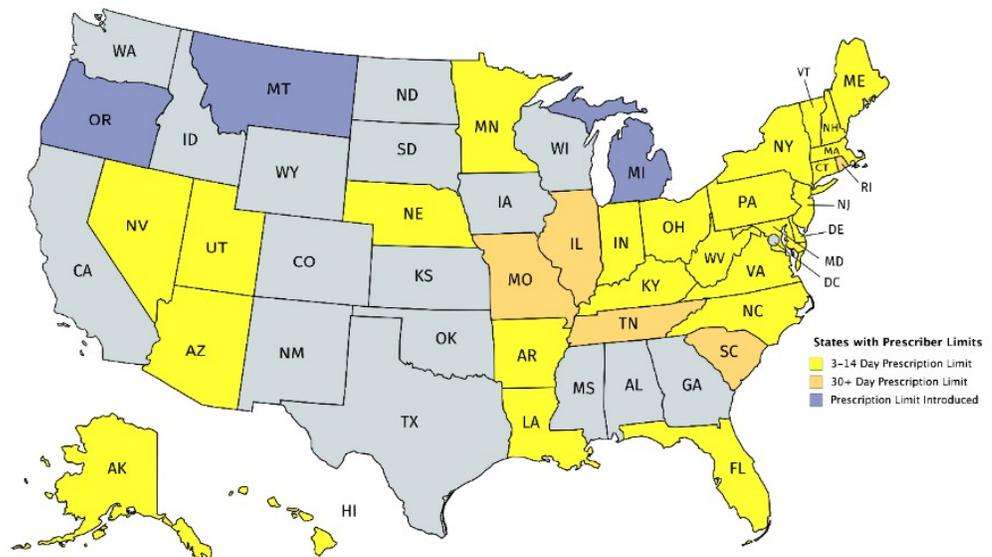
PRESCRIBER LIMITS

Prescriber limits are much more controversial as they inject the state into the realm of the clinical. Each state with prescriber limits has created them differently with some creating a three-day limit for acute pain and 14-day limit for post-surgical pain or a seven-day limit for an initial opioid prescription. One thing many of these states have in common is that they will frequently carve exceptions into the statutes for chronic pain, cancer, palliative care, hospice care, and/or provider judgement. Still other states will limit the prescription even further by specifying a morphine milligram equivalent (MME) that may be prescribed per day; and still others will combine these two policies into a MME and day limit (for example, Maine has a limit of 100 MME per day for 7 days. Maine is also one of the few states that does not have a provider judgement exception in the statute).

Many of these policies have been enacted in an attempt to force physicians to choose alternative methods of pain management and are within guidelines released by the federal Centers for Disease Control and Prevention (CDC). However, there is little broad, scientific evidence to show that prescribing limits actually prevent drug abusers from obtaining the opioids they seek. A recent study by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) found that almost 50% of people who misused opioids obtained them from a friend or relative.³

Ultimately, data like this is part of the problem. We know that after five days of opioid use during the initial prescription, the probability of developing a dependence on opioids increases.⁴ However, we know that drug abusers or potential drug abusers are likely to receive opioids from sources other than a physician which may render the prescribing limit moot. When policymakers pursue a prescribing limit, they are seeking to pick the low-hanging fruit even if it means sacrificing patient care and physician expertise.

The graphic on the right shows the states with prescriber limits for opioids.



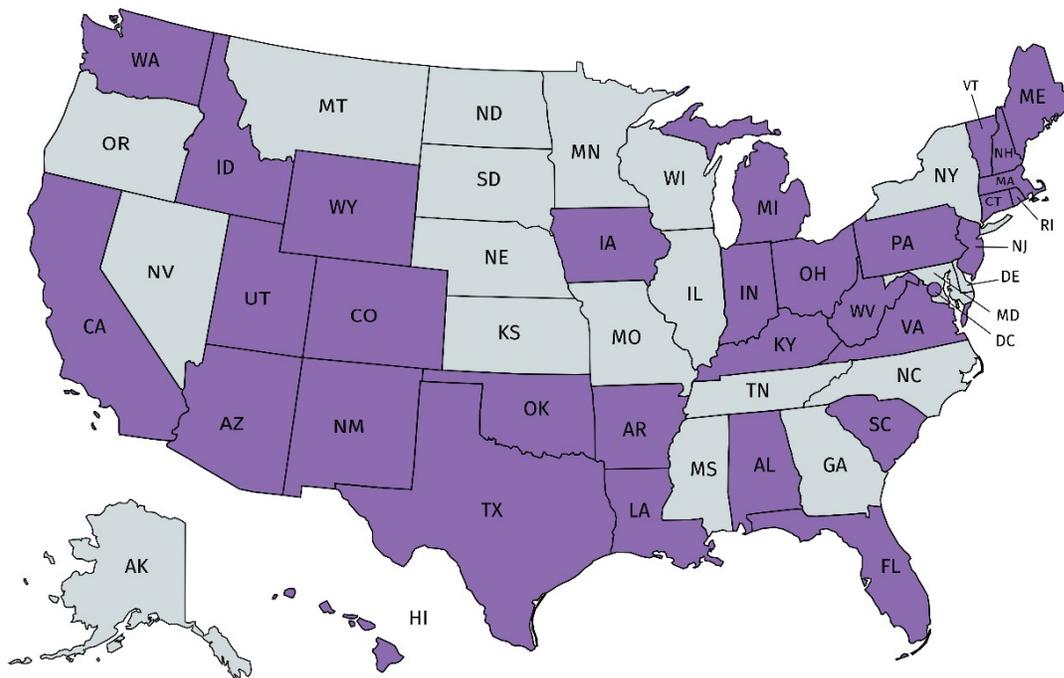
³ Rachel N. Lipari, PhD, et al. "How People Obtain the Prescription Pain Relievers They Misuse," in *The Center for Behavioral Health Statistics and Quarterly Report*, 12 January 2017, <https://www.ncbi.nlm.nih.gov/books/NBK424785/> (accessed: June 12, 2018).

⁴ Centers for Disease Control and Prevention, "Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use – United States, 2006-2015," in *Morbidity and Mortality Weekly Report*, 17 March 2017, issue 66, Vol. 10, 265-269.

SUBSTANCE ABUSE DISORDER ASSESSMENTS

Some states are beginning to require Substance Abuse Disorder (SAD) assessments prior to writing a prescription for opioids. These assessments are meant to provide the prescriber with another tool to identify those with a higher risk of opioid abuse. These can include a screening tool such as the [Opioid Risk Tool](#) or querying the patient's medical record for a history of opioid or substance abuse. Both methods have their own drawbacks. Any kind of screening tool may be gamed by a patient and reviewing a patient's medical history can be difficult if the files are not transferred appropriately and/or the patient has not reported all relevant data.

The graphic below shows the states with SAD assessment requirements (colored in purple).



FEDERAL POLICIES TO COMBAT THE OPIOID CRISIS

The opioid crisis, while hitting certain states harder than others, is a national epidemic and presents a unique policy dilemma to Congress; how much regulation is too much?

Between June 11 and June 22, 2018, the House of Representatives has been holding a “vote-a-rama” on opioid related bills. This is the culmination of months, if not years, of work from the House Energy and Commerce and Ways and Means Committees. As of June 17, 2018, 414 bills have been introduced in the 115th Congress concerning opioids.

Of these 414 bills, two that have received the backing of the committees of jurisdiction and are awaiting action on the chamber floors stand out as having potential for becoming law. In the Senate, the *Opioid Crisis Response Act of 2018* would, among other things, streamline federal requirements for state prescription drug monitoring programs (PDMPs) and require the creation of best practices for prominently displaying patient substance use disorder history in the electronic health record. These two provisions seek to address one of the primary concerns advocates have with current PDMP policies that state PDMPs are too fragmented, and that checking a PDMP is not a part of the existing clinical workflow.



In the House, the *Support for Patients and Communities Act* would increase pass through payments for three years to encourage the development and use of non-opioid analgesics as well as freezing ASC payments for non-opioid treatments for certain HCPCS codes to allow the Department of Health and Human Services to study whether the targeted treatments are as effective as opioids. This legislation predominantly aims to make treatment of substance use disorder more effective and only marginally attempts to prevent new addictions.

In addition to the omnibus opioid bills, the House has passed two controversial opioid bills. The first would require the United States Postal Service (USPS) to obtain advance electronic data for most shipments from overseas by 2020. This is an attempt to stem the flow of illegal drugs coming through legal ports of entry. Many of those addicted to opiates may have started their addiction with legally prescribed painkillers but once that supply gets cut off, they turn to illegal drugs coming predominantly from China. The other legislation would create a pilot program to reserve 1% of section 8 (low income) housing vouchers for those who are recovering from addiction.

All of the legislation that will be considered will focus on four areas of the opioid crisis: treatment (treatment for substance use disorder), demand (addressing the root causes of addiction), harm reduction (overdose reversals,

needle exchanges, safe injection sites), and supply (reducing over-prescription and reducing inflow of illegal opiates). These are the areas where there is general consensus that public policy can be most helpful.

Communities across the United States have been ravaged by opioid abuse posing a significant public health risk and costing the United States \$95 billion in 2016 alone.⁵ The epidemic has influenced everything from prescribing habits among physicians to the outcomes of our elections. One of the central tenants of the Trump campaign in 2016 was ending the opioid crisis in the United States.

UPDATE:

In October 2018, President Donald Trump signed the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patient and Communities Act of 2018. This legislation, like its predecessor in the House of Representatives (Support for Patients and Communities Act), focuses primarily on treating substance use-disorder (SUD). However, there are provisions of the new law that will impact orthopaedic practices:

Section 2003 – Every Prescription Conveyed Securely

This section amends the Social Security Act to require that a prescription for a covered part D drug under a Medicare prescription drug plan (including Medicare Advantage drug plans) for a schedule II, III, IV, or V controlled substance to be transmitted by the healthcare provider electronically as part of an electronic prescription program that conforms to existing law (existing requirements may be found at [42 U.S.C. 1395w-104\(e\)](#)).

The section gives the Secretary of Health and Human Services, currently Alex Azar, the authority to create exceptions for certain circumstances. These exceptions will be promulgated through the rulemaking process. **Look for rulemaking for these exceptions to be released in 2019, likely in the CY 2020 Physician Fee Schedule.**

Section 3002 – Evidence-Based Opioid Analgesic Prescribing Guidelines and Report

This section requires the Commissioner of Food and Drugs, currently Dr. Scott Gottlieb, to develop evidence-based opioid analgesic prescribing guidelines for therapeutic areas where guidelines do not already exist. **These guidelines will be subject to a notice and comment period for the solicitation of comments from the public.**

Section 6052 – Grants to Provide Technical Assistance to Outlier Prescribers of Opioids

This section authorizes the Secretary of Health and Human Services to award grants to eligible entities (organizations that have demonstrated experience providing technical assistance to health care professionals on a state or regional basis and quality improvement entities with a contract under Medicare Part B) to educate and provide technical assistance to outlier prescribers of opioids.

These entities will provide assistance with opioid prescribing best practices and increasing provider and patient access to non-opioid pain management therapies.

Section 6062 – Electronic Prior Authorization for Covered Part D Drugs

This section amends the Social Security Act to require that by January 1, 2021, the Centers for Medicare and Medicaid Services will require an electronic prior authorization request from a prescriber for the coverage of a covered part D drug for a part D eligible beneficiary (Medicare Advantage beneficiaries included). **Note:** The statutory language does not indicate that this section only applies to controlled substances. As such, it will likely apply to any covered part D drug prescription.

Section 6065 – Commit to Opioid Medical Prescriber Accountability and Safety for Seniors

This section amends the Social Security Act to require the Secretary of Health and Human Services to notify outlier prescribers of opioids of their designation. The Department (likely through the Centers for Medicare and Medicaid Services) will then be required to provide resources on proper prescribing methods and other information. The

notification is required to indicate how the prescriber compares to other prescribers within the same specialty and geographic area.

Section 6082 – Review and Adjustment of Payments Under the Medicare Outpatient Prospective Payment System to Avoid Financial Incentives to use Opioids Instead of Non-Opioid Alternative Treatments

This section amends the Social Security Act to require the Secretary of Health and Human Services to conduct a review (including the release of a request for information) of payments for opioids and evidence-based non-opioid alternatives for pain management with a goal of ensuring that there are no financial incentives to use opioids instead of non-opioid alternatives under the Outpatient Prospective Payment System (OPPS). This section is targeting bundled surgical services in the OPPS and ASC Covered Procedures List and is related to CMS' proposal in the CY 2019 Outpatient Prospective Payment System proposed rule to separately reimburse for the use of post-surgical non-opioid alternatives for pain management.

⁵ Corwin Rhyan, "Research Brief: The Potential benefit of Eliminating Opioid Overdoses, Deaths, and Substance Use Disorders Exceeds \$95 Billion Per Year," *Altarum*, 16 November 2017, [https://altarum.org/sites/default/files/uploaded-publication-files/Research-Brief Opioid-Epidemic-Economic-Burden.pdf](https://altarum.org/sites/default/files/uploaded-publication-files/Research-Brief%20Opioid-Epidemic-Economic-Burden.pdf) (accessed June 18, 2018).

AAOE POSITION STATEMENT: OPIOID DRUG USE, MISUSE, AND ABUSE

As the House and the Senate continue to move forward on their respective opioid related packages, the AAOE encourages Congress to keep the following AAOE priorities and positions in mind:

AAOE POSITIONS ON OPIOID INITIATIVES

- **Increase E-Prescribing**
Electronic prescribing of medications promotes patient safety. E-prescriptions for all controlled substances would help not only appropriate use and patient convenience, but they would provide data in a format better for surveillance of excessive, inappropriate, and non-therapeutic prescribing.
- **Caution re: Prescription Limits**
National standards without the requisite evidence could inappropriately limit patients' access to necessary pain management. Policies that interfere with the vital patient-physician relationship by applying blanket prescription limits to all procedures are inappropriate and should be avoided.
- **Improve Care Coordination**
It should be possible for a surgeon and pharmacist to see all prescriptions filled in all states by a single patient. Opioid use is best coordinated through a single prescribing physician/surgeon/practice so that other consulting physicians can then contact that prescribing physician/surgeon/practice to determine if an exception is warranted.
- **Increase Access to Comprehensive, Multimodal Pain Management**
We must remove bundled cost conflicts that foster an environment where it is more convenient to prescribe post-operative opioids over other evidence-based treatments with a safer risk profile.
- **Novel Pain Management Therapy Research**
Available therapies alone will not solve the opioid problem, and therefore, AAOE support additional research and increased funding for other non-narcotic and/or non-pharmaceutical (including nutritional) alternatives for pain management.
- **Prescriber Education**
Continuing Medical Education on opioid safety and optimal pain management strategies will help physicians reduce inappropriate opioid use, while still providing high quality musculoskeletal care. Individual medical professional organizations are best situated to provide relevant and meaningful education to its members and patients, in order to avoid adding another requirement that may do little to enhance patient care.

- **Mandatory Pharmacy Lock-In**

Opioid use is best coordinated with a limited number of prescribers and dispensers, especially for patients dealing with ongoing/chronic pain issues. However, the appropriate number of prescribers will vary from patient to patient, and putting too strict a limit on prescribers/pharmacies could inadvertently and inappropriately limit a patient's access.

- **Storage and Disposal**

Better means of disposing unused opioid analgesics is a critical way to reduce opioid diversion, misuse, and abuse and strongly supports a combination of patient education, chemical means to inactivate medications, and incentivizing drug take-back locations to significantly reduce the chances of opioid diversion and addiction.

Download the position statement for use with your legislators at aaoe.net/positions.



About the American Alliance of Orthopaedic Executives

Founded in 1969, AAOE is the premier practice management association serving the musculoskeletal industry. Membership includes more than 1,500 orthopaedic practice executives, administrators, physicians, and their staff. AAOE is dedicated to providing education, community, and resources to set the standard of professional knowledge and industry insight. For more information on AAOE or to inquire about membership opportunities, please visit www.aaoe.net.

About the American Association of Orthopaedic Executives

The American Association of Orthopaedic Executives (AAOE) is the educational arm of the American Alliance of Orthopaedic Executives (AAOE).