Fulfilling our Obligation to Improve Opioid Safety

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Disclosures

- Volunteer member of Indiana Attorney General Task Force for Prevention of Prescription Drug Abuse, 2012-present
- We have no financial disclosures
- The content of this talk does NOT apply to any patient with a terminal illness, on hospice or receiving end of life care

Learning Objectives

1. Learn the specifics of Indiana's new acute pain opioid legislation and understand its goal of limiting opioid prescribing, recognize when it is to be applied, and learn documentation requirements to provide more than 7 days of supply.
2. Understand why extra precaution should be used when prescribing opioids for individuals under the age of 25, patients with personal history of substance misuse or addiction, patients taking benzodiazepines or other sedatives, patients with unstable mental health issues or patients with respiratory conditions.
3. Learn the reasons certain historical and physiologic factors must be considered when initiating or continuing prescribing opioids and identifying high risk clinical situations wherein opioids should likely not be continued, especially in primary care.

Balance Safety and Efficacy

2016 Pharmacy Dispensing Data by County, IN

County	# Opioid Rx/100 Hoosiers
Jasper	122.5
Howard	122.7
Knox	129.6
Floyd	131.9
Lawrence	132.8
Vanderburgh	137.8
Scott	149
US average	66.5
Indiana movement	83.9 from 109

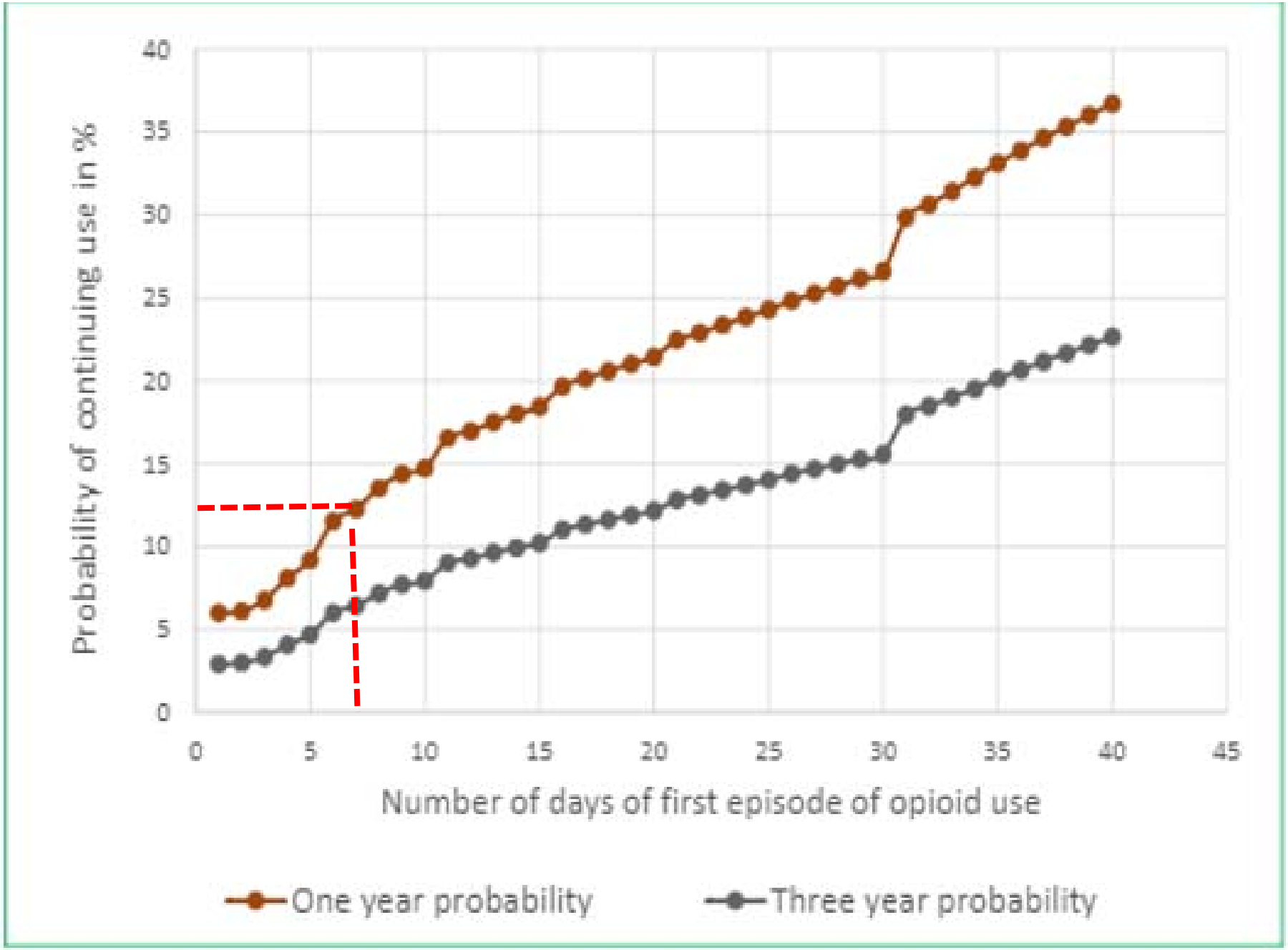
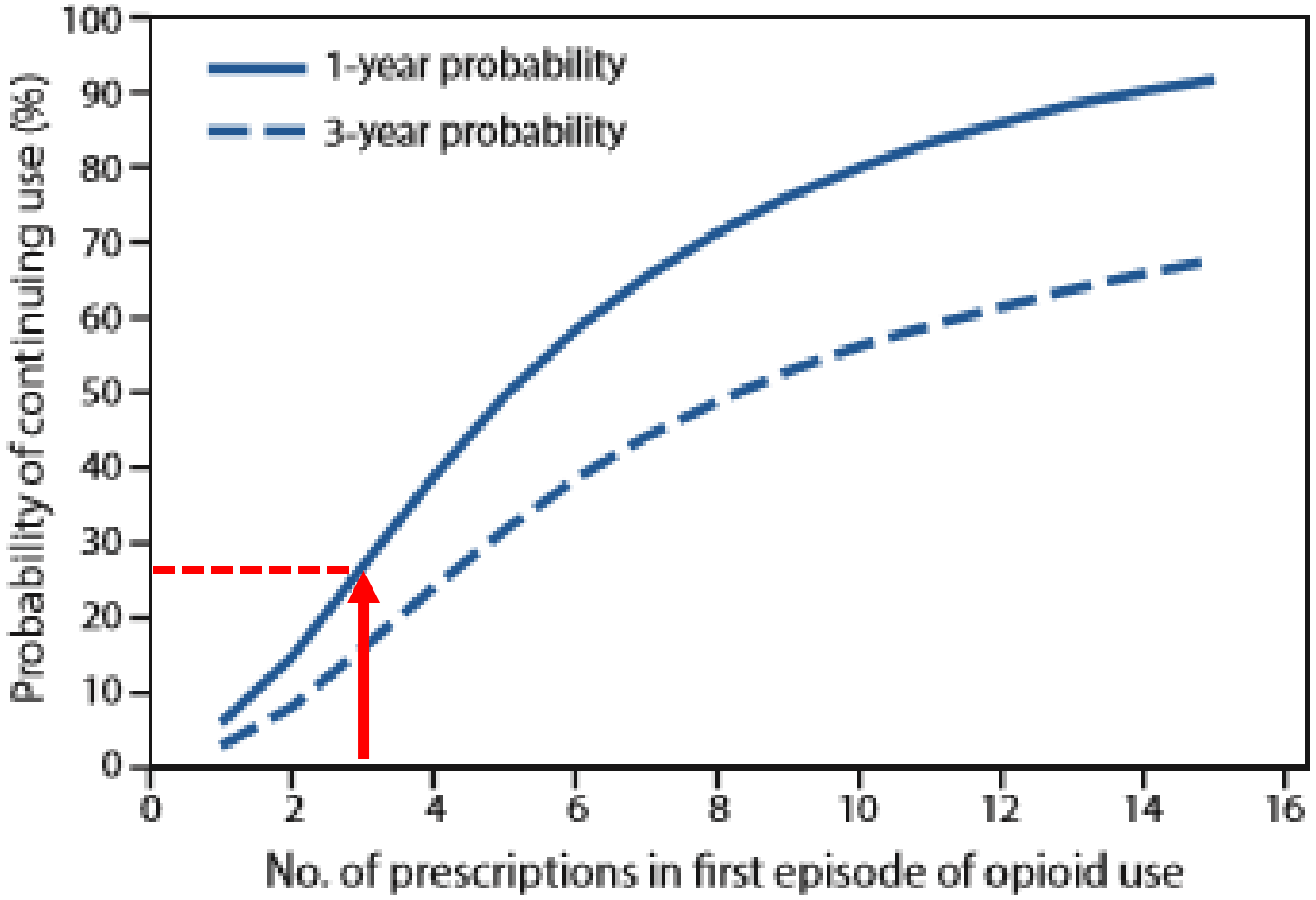

Probability of continuing use in %
40
35
30
25
20
15
10
5
0
0
5
10
15
20
25
30
35
40
45
Number of days of first episode of opioid use
One year probability
Three year probability

FIGURE 2. One- and 3-year probabilities of continued opioid use among opioid-naïve patients, by number of prescriptions* in the first episode of opioid use — United States, 2006–2015



General Surgery in Vermont

TABLE 2. Opioid Pills Taken

Operation	Partial Mastectomy	Partial Mastectomy With Sentinel Node Biopsy	Laparoscopic Cholecystectomy	Laparoscopic Inguinal Hernia Repair	Open Inguinal Hernia Repair
Surveys completed	20	21	48	20	18
Pills prescribed	415	490	1450	650	540
Pills taken	61 (14.7%)	126 (25.7%)	474 (32.7%)	189 (14.7%)	168 (31.1%)
Pills remaining	354 (85.3%)	364 (74.3%)	976 (67.3%)	461 (85.3%)	372 (69.9%)

- Data on 127 of 330 total patients
- pill= 5mg oxycodone
- Phone survey
- Based on patient recall
- 1.9% obtained a refill
- Careful…

General Surgery in Vermont

Ann Surg 2016

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	3	6	10	9	9.3

4 to 9 days for general surgery procedures
4 to 13 days for women's health procedures
6 to 15 days for musculoskeletal procedures

JAMA Surg. doi:10.1001/jamasurg.2017.3132

eSB 226: 7 Day *Emergency* Rules

- July 1, 2017
- Exclusions For Emergency Rule
  - MAT, cancer, palliative/hospice
- Adult 1st time Rx *by the prescriber*
- All persons < 18 yrs.
- Professional judgement out
- Partial Refill Request

eSB 226: 7 Day *Emergency* Rules

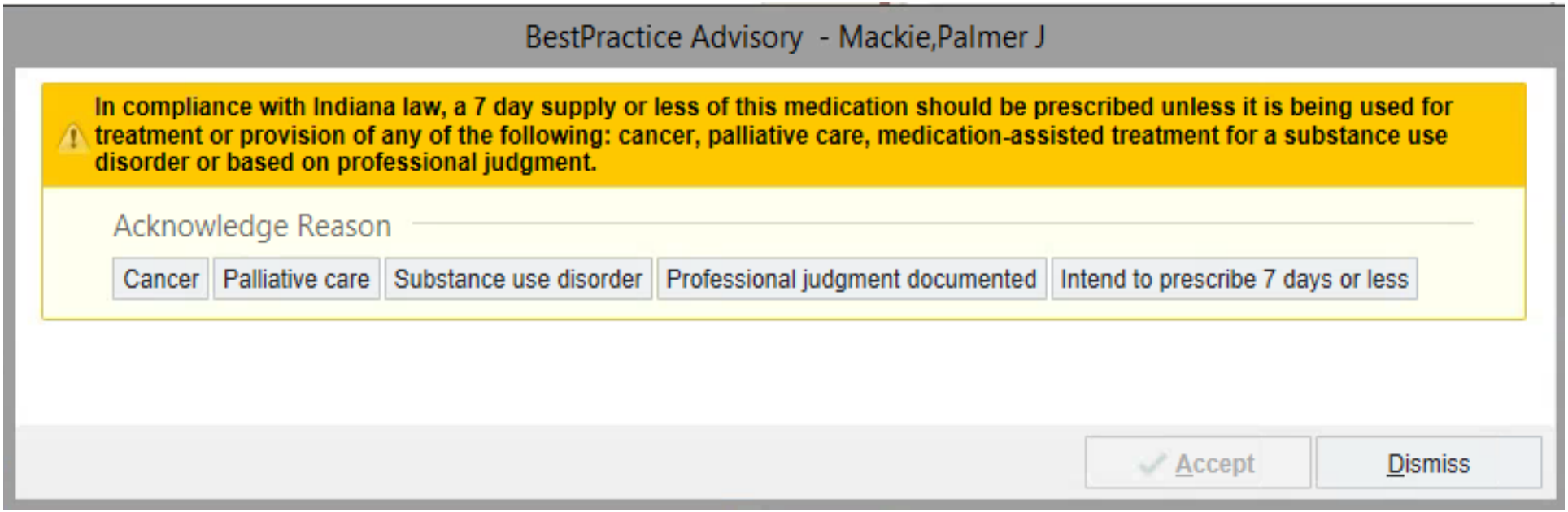
1) If the prescription is for an adult who is being prescribed an opioid for the first time by the prescriber, the initial prescription may not exceed a seven (7) day supply.

2) If the prescription is for a child who is less than eighteen (18) years of age, the prescription may not exceed a seven (7) day supply

- Partial Refill Request
  - Guardian/legal representative of patient or Patient
  - 30 days and then forfeit remainder
- Professional judgement out & document:
  - "professional judgement" on Rx

Epic and Eskenazi

"the prescriber shall document in the patient's medical record the *indication that a drug other than an opiate was not appropriate* and that the patient is receiving palliative care or that the prescriber is using the *prescriber's professional judgment for the Exemption*"



HOMETOWN CLINIC
John Doe, M.D.
Family Practice
1234 Your Address
YourCity, GA 98765
(987) 654-3210
Fax (987) 654-3211

Lic. #: A12345
DEA #: AA7654321
NPI #: 789456123

110922A12345 #00001

Name Ima Seguro DOB 12/17/57

Address _____ Date 10/31/17MF

℞ Oxycodone/APAP 7.5 mg/325 mg

Sig. 1 *po* each 6-8 hr for 3 days, 1 po each 8-12 hr x 3 days, 1 po each 24 hr prn for 3 days # 44 to last 14 days . Disp. Forty-four (44) Fill on 10/31/2017 (professional judgement > 7 days indicated)

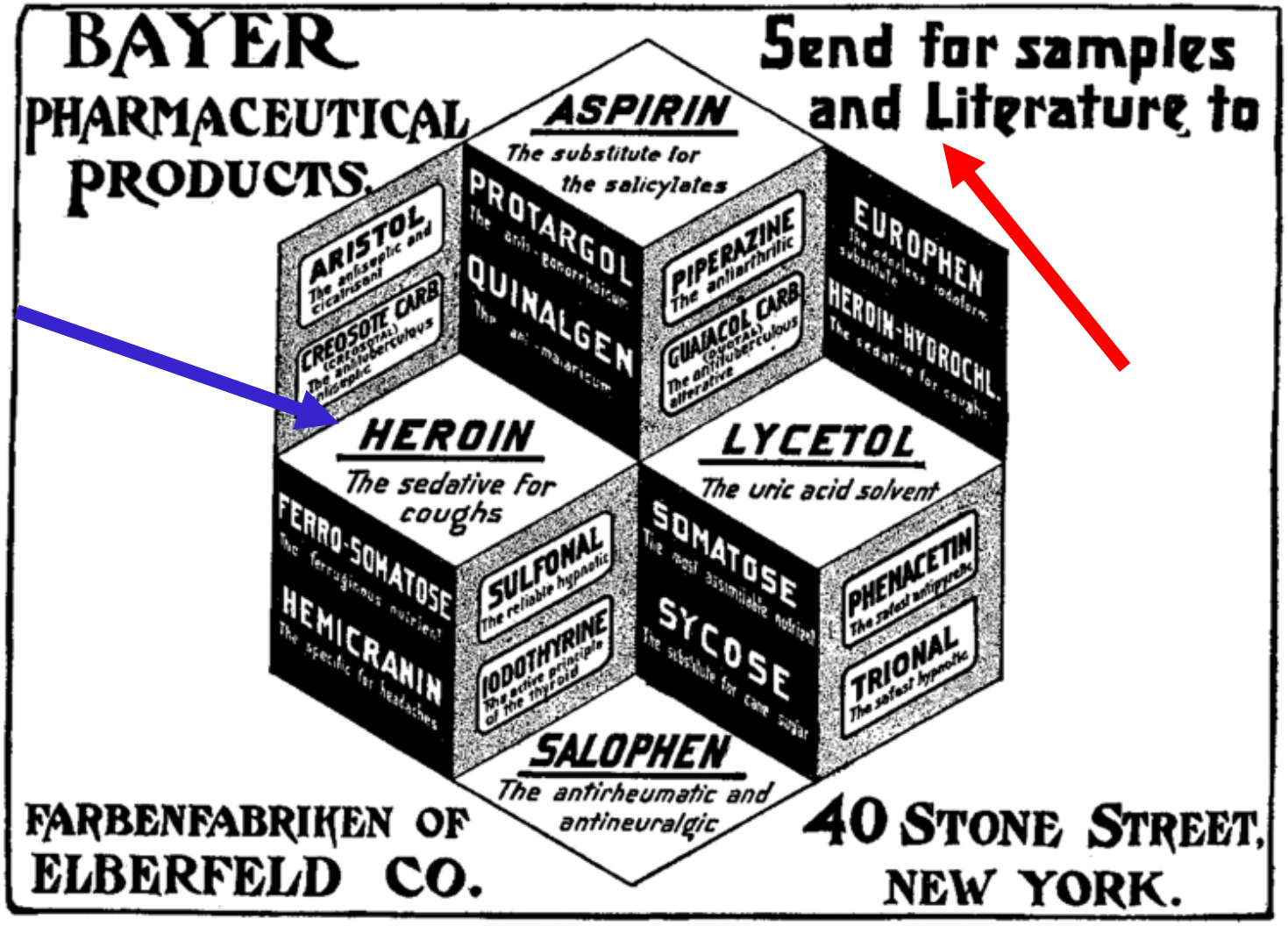
Refill NR 1 2 3 4 5 Void After _____ ☐ Spanish

☐ Do Not Substitute-Dispense As Written

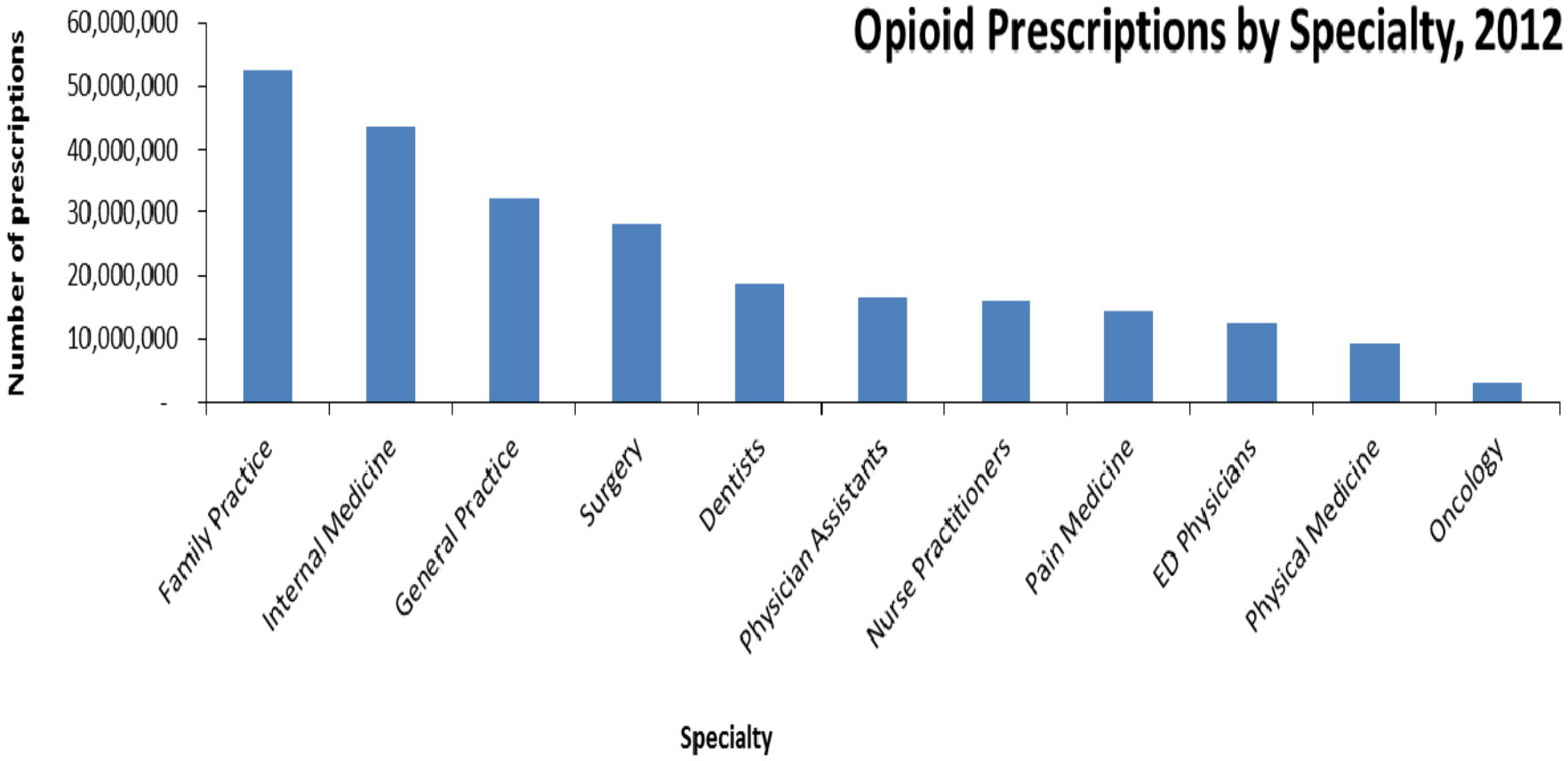
Anna Gesic MD

Signature

SEE BACK FOR LIST OF SECURITY FEATURES

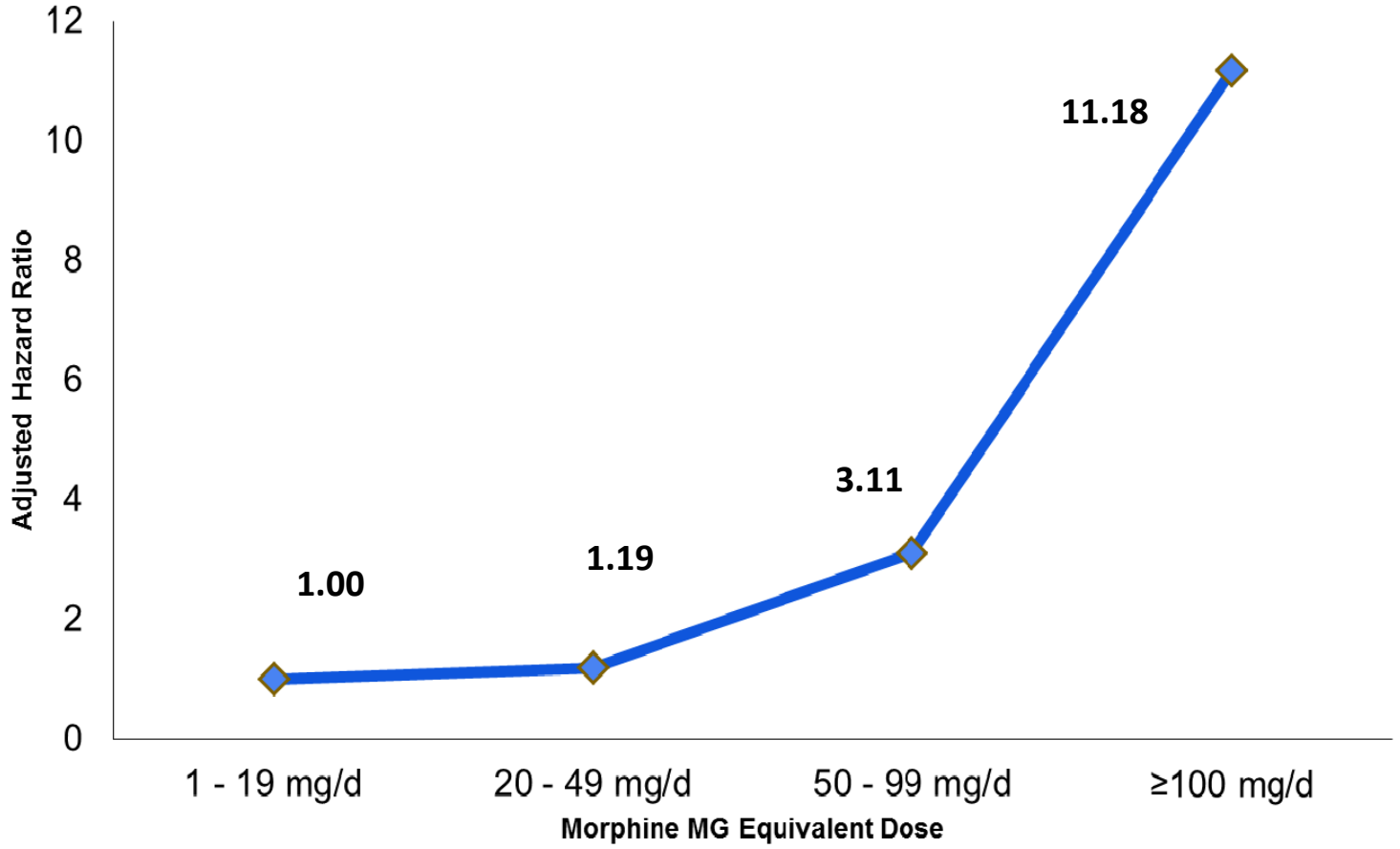

BAYER
PHARMACEUTICAL PRODUCTS.
Send for samples and Literature to
ASPIRIN
The substitute for the salicylates
ARISTOL
The antiseptic and cicatrisant
CREOSOTE CARB (CREOSAL)
The antituberculous antiseptic
PROTARGOL
The anti-gonorrhoicum
QUINALGEN
The anti-malaricum
PIPERAZINE
The antiarthritic
GUAIACOL CARB (DUOSAL)
The antituberculous alterative
EUROPHEN
The odorless iodoform substitute
HEROIN-HYDROCHL.
The sedative for coughs
HEROIN
The sedative for coughs
LYCETOL
The uric acid solvent
FERRO-SOMATOSE
The ferruginous nutrient
HEMICRANIN
The specific for headaches
SULFONAL
The reliable hypnotic
IODOTHYRINE
The active principle of the thyroid
SOMATOSE
The most assimilable nutrient
SYCOSE
The substitute for cane sugar
PHENACETIN
The safest antipyretic
TRIONAL
The safest hypnotic
SALOPHEN
The antirheumatic and antineuralgic
FARBENFABRIKEN OF ELBERFELD CO.
40 STONE STREET, NEW YORK.

Primary care providers prescribe the most opioids



IMS Health, National Prescription Audit, United States, 2012

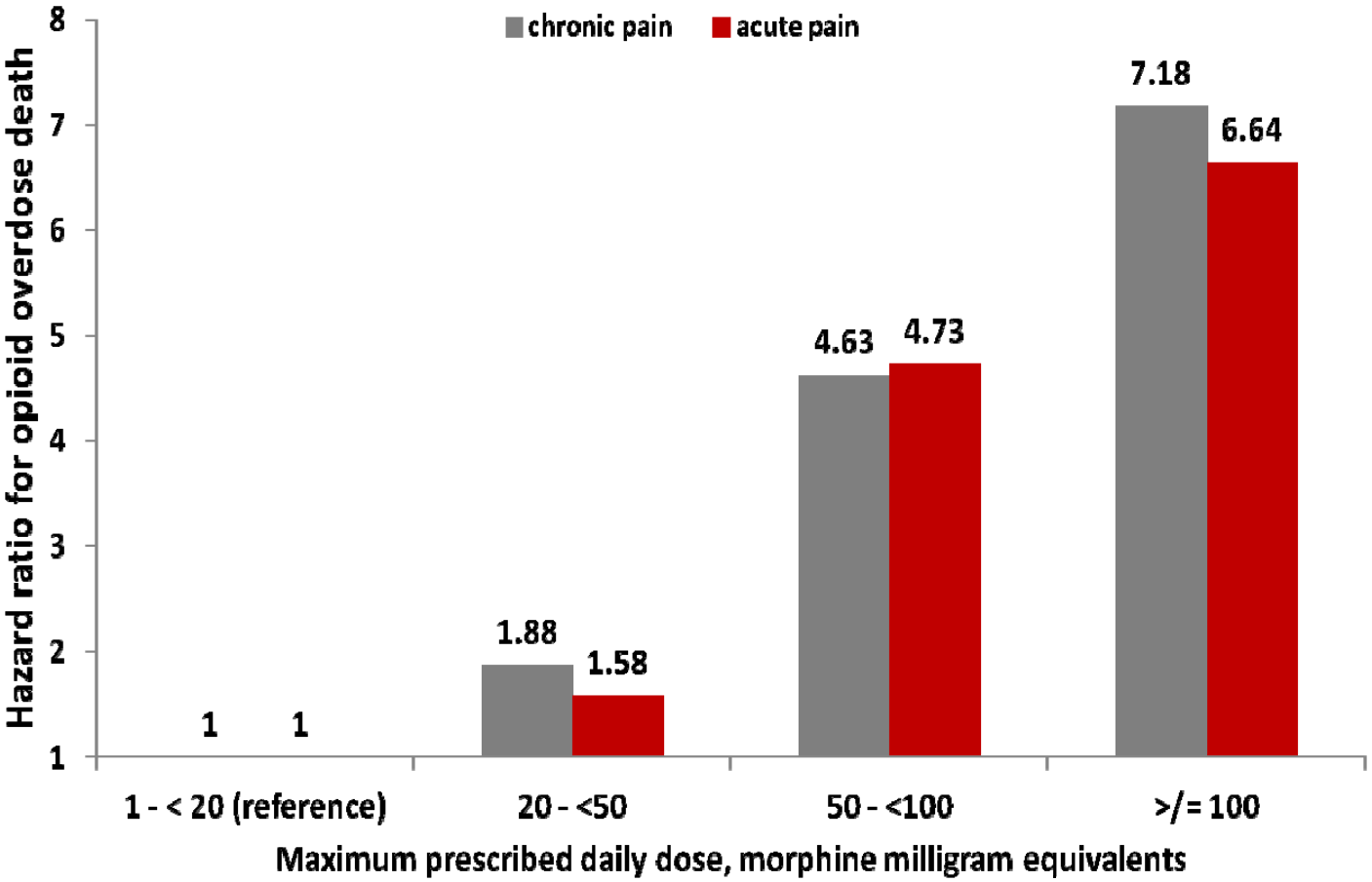
High Opioid Dose and Overdose Risk



* Overdose defined as death, hospitalization, unconsciousness, or respiratory failure

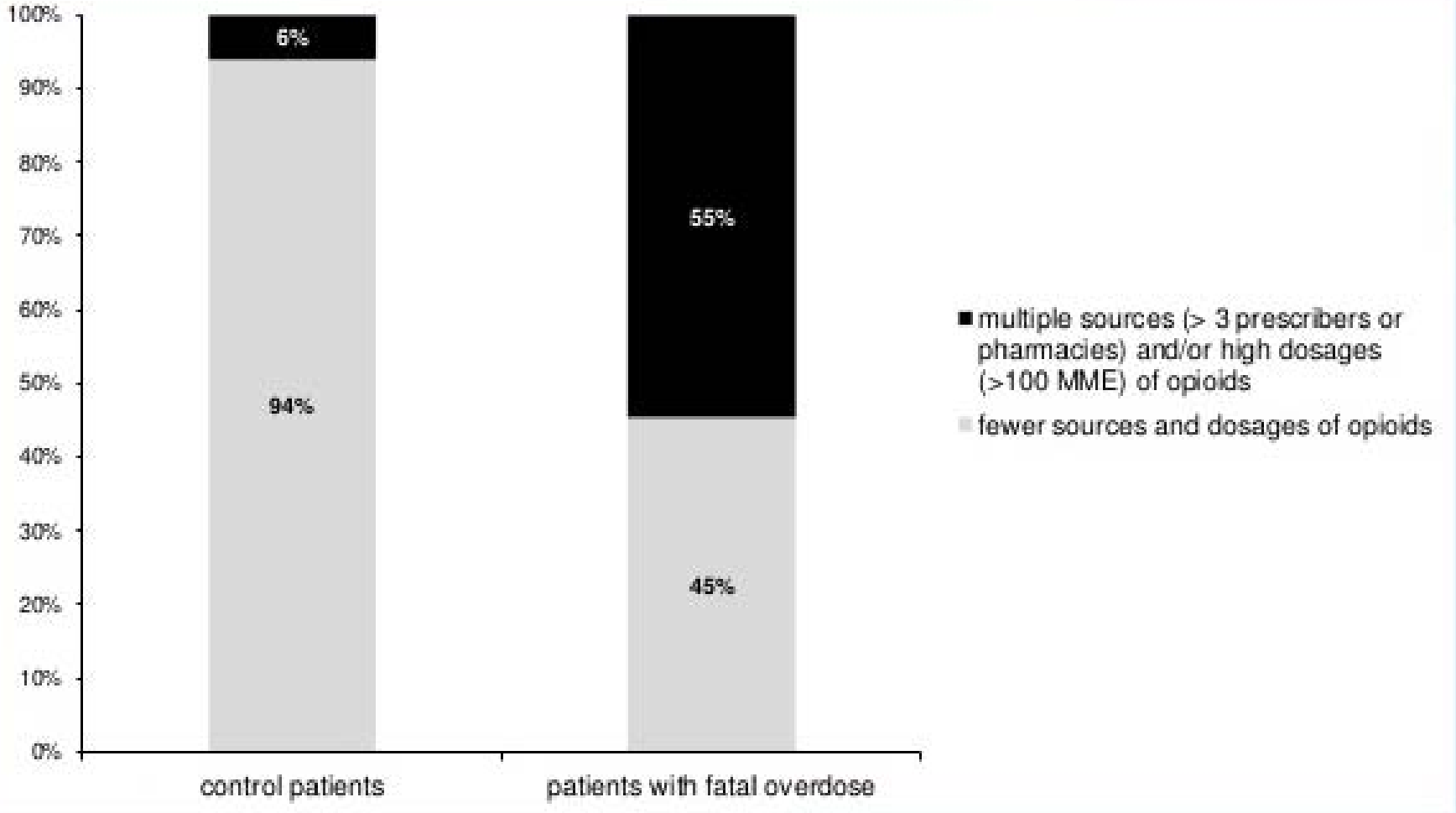
Ann Int Med 2010;152:85-92

Association Between Opioid Prescribing Patterns and Opioid Overdose-Related Deaths



JAMA 2011;305:1315-1321

Majority of opioid overdose deaths associated with multiple sources and/or high dosages



Intern Med 2014;174:796-801

Are Opioids Effective for Pain?

- Studies <16 weeks
- Opioids vs placebo for pain
  - Moderate reduction in pain
  - Small improvement in function
  - Limited by high-drop out rates, excluded patient with h/o SUD

American Academy of Neurology
Position paper
“Opioids for chronic non-cancer Pain”

"Whereas there is evidence for significant short-term pain relief, there is no substantial evidence for maintenance of pain relief or improved function over long periods of time without incurring serious risk of overdose, dependence, or addiction."

Neurology. 2014 Sep 30;83(14):1277-84

CDC Guideline for Prescribing Opioids 2016

- In summary " Evidence on long-term opioid therapy for chronic pain outside of end-of-life care remains limited with **insufficient evidence to determine long-term benefits**, though evidence suggests **risk of serious harms that appears to be dose – dependent**"

2016 - FDA Black Box Warning

Health care professionals should **limit prescribing opioid pain medicines with benzodiazepines or other CNS depressants** only to patients for whom alternative treatment options are inadequate. If these medicines are prescribed together, limit the dosages and duration of each drug to the minimum possible while achieving the desired clinical effect. Warn patients and caregivers about the risks of slowed or difficult breathing and/or sedation, and the associated signs and symptoms. Avoid prescribing prescription opioid cough medicines for patients taking benzodiazepines or other CNS depressants, including alcohol.

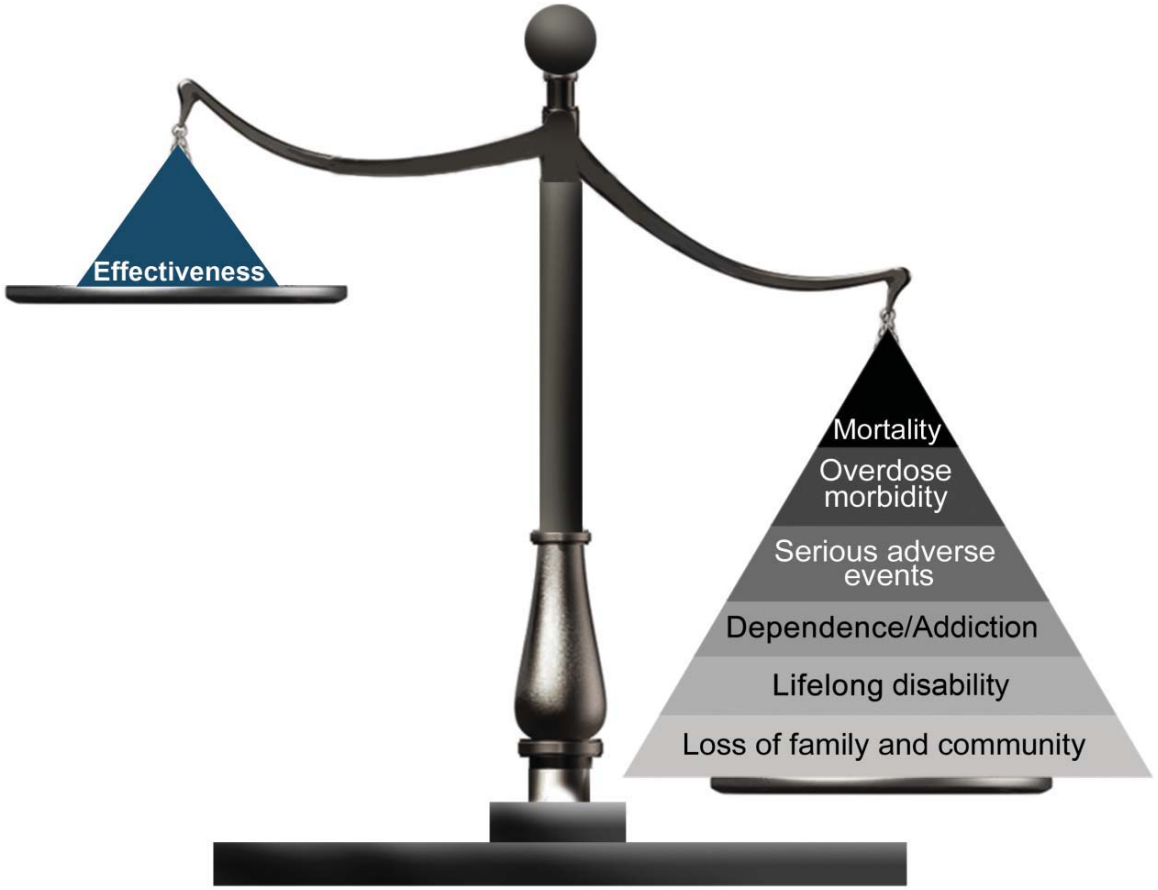
First, Do No Harm

Number of Americans on Long-term Opioids

10 Million

Ann Intern Med. 2017;167:181–191. doi: 10.7326/M17-0598

Universal Precautions for Opioids



Evidence Based Treatment

"Where medically appropriate, the physician shall use non-opioid options instead of opioids"

AVOID opioids in patients

- Chronic headache
- Chronic low back pain
- Chronic pelvic pain
- Fibromyalgia
- Functional bowel disorders

2014 Indiana Medical Licensing Rules- Chronic Pain

- Perform your own evaluation
- Risk for substance abuse
- Mental health assessment
- Review and Sign a Treatment Agreement
- Functional Goals
- Periodic Scheduled Visits
- INSPECT reports are required initially and annually
- UDM initially and annually
- Reassessment is required when MED ≥ 60 mg/d

Optimize Non-Opioid Medications

MSK/Inflammatory pain

- Acetaminophen
- NSAIDS
- Topical anesthetics (lidocaine)
- Anti-inflammatory cream
- Steroid injections
- Muscle relaxants

Restore Sleep

- Melatonin, TCA's
- Trazadone, doxepin

Neuropathic Pain

- TCA's (SOR-A)
- Topical anesthetics
- Neuropathic creams
- SNRI's (SOR-A)
- Anticonvulsants

Visceral pain

- NSAIDS/acetaminophen
- Antispasmodics

Non-Pharmacologic Interventions

- Counseling (CBT)
- Optimize sleep
- Good nutrition

  (influences weight/inflammation/mood)
- Exercise, stretching, yoga
- Ice/Heat
- PT/TENS therapy/hypnosis
- Manipulation/OT
- Massage/acupuncture
- Interventional pain modalities
- Self-care- mattress, shoes

Patient Education- Long-term Opioid Risks

- Hyperalgesia
- Mood Disorders
- Immunosuppression
- Amenorrhea/ Galactorrhea
- Androgen deficiency/Decreased libido
- Osteoporosis
- Opioid tolerance/dependence/addiction
- Respiratory Depression
- Death

Be wary of co-morbid risks with opioids

Patient **mortality risk** is more pronounced for patients with…

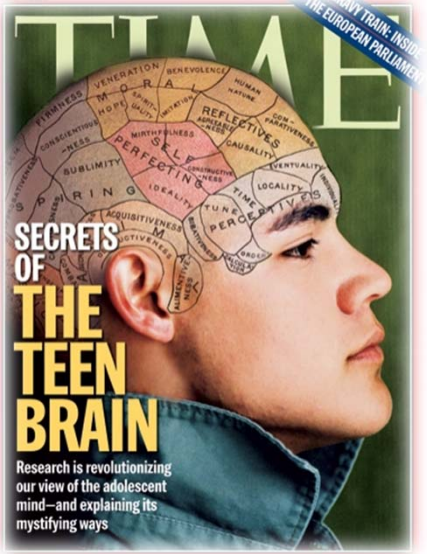
- **Benzodiazepine/ Alcohol Use**
- **Illicit substance use/abuse**
- **Untreated mental health issues**

  (e.g. PTSD, depression, anxiety)
- **Chronic respiratory problems**

  (e.g. Asthma, COPD, OSA, CHF)

Exercise additional precaution with Adolescent Brain (<24 years old)

- **90%** adults with substance abuse began smoking, drinking or using drugs < 18yo (tob./etoh & drugs)
  - Primed to take risks, Immature decision making, judgment, impulse control
- **Addictive substance use physically alter brain structure & function faster & more intensely than in adults**
  - Interferes with brain development
  - Further impairing judgment
  - Significantly increase the risk of addiction



CDC Guideline for Prescribing Opioids 2016

- Exercise Therapy
  - Can improve pain & function chronic low back pain
  - Can improve function & reduce pain in OA knee, OA hip
  - Can improve well being & physical function in fibromyalgia
- Cognitive Behavioral Therapy- small positive effect on disability and can improve pain & function
- Avoid short and long acting opioids (unless end of life)
- Use lowest dose, additional precaution at 50MED/day
- Avoid dosage >90MED/day (if not improved DC or taper)

One way to manage opioid dependent chronic pain patients in Primary Care

- Check Daily Morphine Dose
  - if **<15 MED**, solid diagnosis & indication for pain, follows all rules/functional, discuss risks/benefits, may continue therapy if B>R
  - If **15-60 MED**, obtain thorough history and physical, review records. Optimize non-opioid therapy and encourage lowest effective dose. Reassess risk vs benefit q 3 months. If indication is fibromyalgia/headaches- start slow wean.
  - If **>60 MED**, obtain thorough history and physical, review records. Optimize non-opioid therapy. Offer patient slow wean to 60 MED if provider feels benefit of opioid outweighs risk or offer patient to see specialist of their choice for second opinion.

Refer to MAT /addiction eval. if patient does not tolerate slow/compassionate wean

Is Opioid Weaning Safe & Effective

- Weaning more effective if patient engaged, feels dignified and respected
- Dose reduction must be balanced with stability of pain/function, avoiding harm related to mental health or medical issues
- 67 Studies evaluating LTOT tapering– limited by low-quality
- Common themes included multidisciplinary therapy, emphasis on nonphamacologic intervention & self care strategies
- Findings suggest that pain, function, & quality of life may improve during and after opioid dose reduction

Ann Intern Med. 2017;167:181–191. doi: 10.7326/M17-0598

Complex Persistent Dependence

- Grey area between dependence & addiction
- Patients (often on high-dose opioids/co-morbid psych conditions) who worsen with opioid taper
- Extended withdrawal symptoms
  - Anxiety, depression, sleep disturbance, fatigue, dysphoria, irritability, decreased ability to focus, deficits in executive function
- Poor pain control, psychiatric instability, functional decline, misuse
- If >100 MED, significant dysfunction, misuse, suggest Buprenorphine as mode to taper opioids
- If <100 MED and lower risk, use full agonist taper

Substance Abuse, DOI: 10.1080/08897077.2017.1381663

How to manage opioid dependent chronic pain patients

EDUCATION

- **Require "pain" specific appt for any patients on controlled substance**
- Inform patient & family about new safety data, info/laws regarding serious short & long term risks of chronic opioid use
- Educate office staff in order to do UDM, INSPECT & any forms (PHQ-9, pain inventory, COMM) before provider starts visit

Difficult Cases

- Develop Multidisciplinary Committee
  - Nurse, social worker, pharmacist, physicians
- **ALWAYS refer for Chemical Dependency Evaluation & Treatment if indicated**
- Non-judgmental
- Empathetic care
- **Do not abandon your patient**

Never start that which you will not stop: Exit Strategy at Onset

"It sort of makes you stop and think, doesn't it"

NSDUH (SAMSHA) Data 2015

- 51,200 people from 50 states and D.C.
- 38% (91.8 million)used an opioid in 2015
- Adults with opioid Rx
  - 12.5 % misuse & 16.7% indicated OUD
- Of all adults who reported misusing opioids
  - 40 % with & 60% w/o an Rx
  - 41 % of this group obtained opioids illicitly for free from friends and family
- Among adults who misused opioids 63% reported relief of pain as motivation

Annals of Internal Medicine 2017

Low Hanging Fruit?

- prevalence of opioid abuse in chronic pain patients ranges between 20-24% across health-care settings.
  - Pain 2010, 150(2):332–339

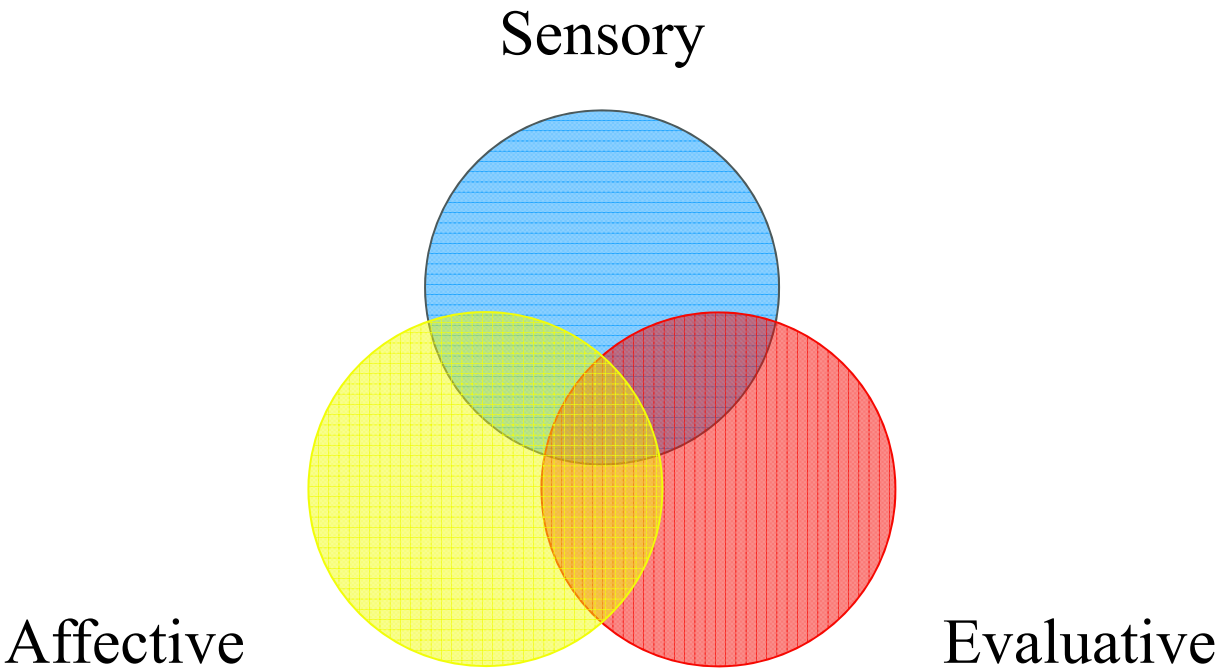
- Lifetime prevalence of DSM-V OUD those on chronic opioids
  - 9.7 % moderate & 3.5 % severe OUD
  - Substance Abuse and Rehabilitation 2015:6 83–91

4-18% - my opinion for prevalence
in those on opioids for chronic pain

No mindless, know mindful

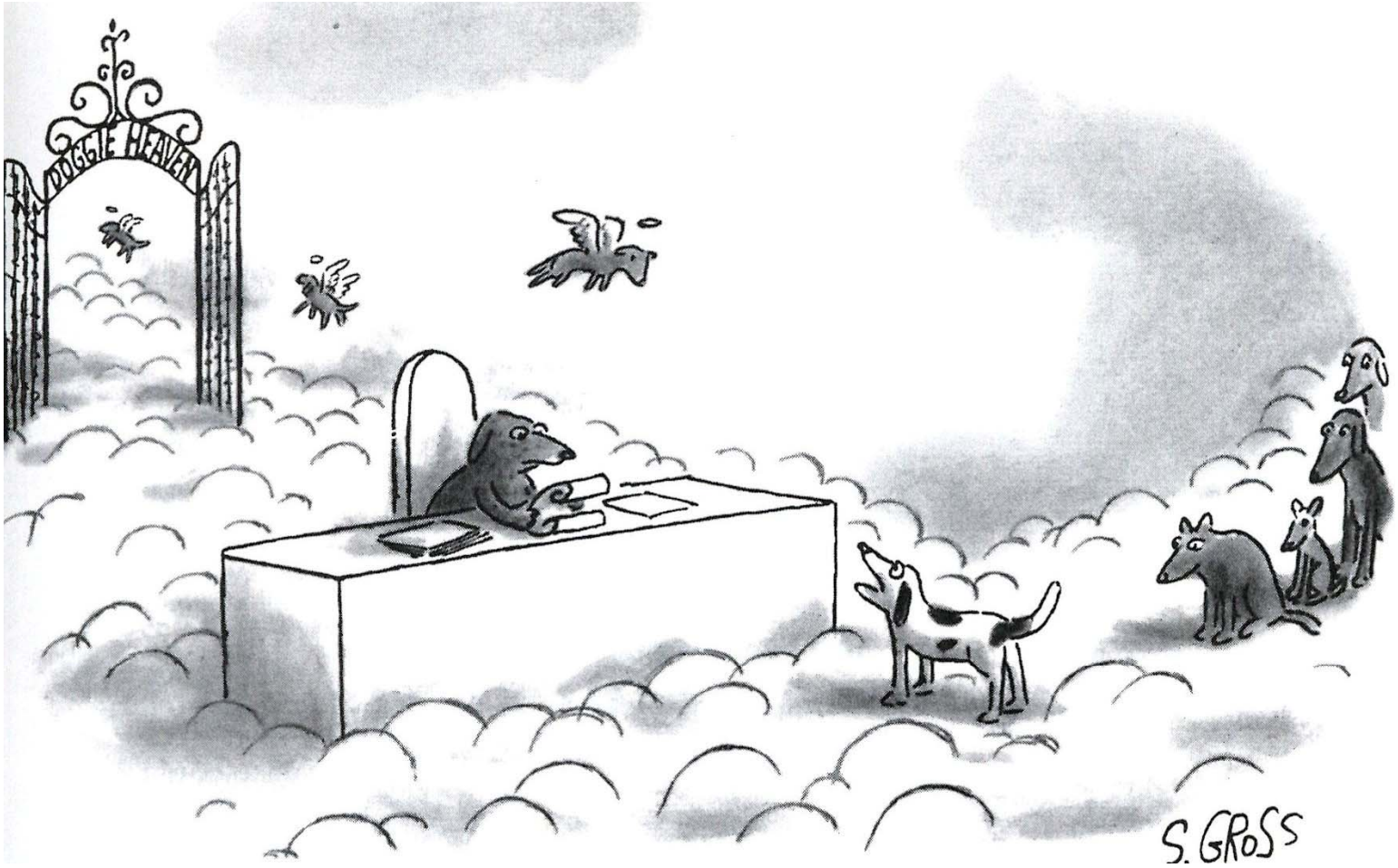
1. Know the patient & contextual
2. Know the internal milieu
3. Know more than opioids
4. No more needless risks
5. Know and communicate with others

Bio-psycho-social Model



Control not Cure

New Normal with Realistic Optimism



Is there any chance of getting my testicles back?

Risk Stratification
More Than Classic Aberrancy

- Physical
- Family history
- Social/Domestic
- Mental Health
- PDMP
- Stable housing?
- Toxicology data
- Releases from Providers
  - “fired”

- Age <45, esp. < 25
- Tobacco (first 30 min)
- Chaos/ Life Trauma Hx
- Legal history
  - Web inquiries EZ
- Abuse (sexual) history
  - Esp. when young
- Repeated traumas
  - Non-sports related

The Person in Pain

- 34 female tob. use arrives from PCP
- Neck pain, T4 pain > LBP
- COT for > 4 years post-MVA
- Profoundly deconditioned
  - Bradykinetic & dysarthric
  - Rx impaired
  - Catastrophizer
- PTSD, sex abuse
- Some marital discord
- Husband on O2, smoking, angry and demanding
- Alprazolam 1 mg 4-8 tablets per day
- Oxycodone 10 mg 6-10 tablets per day

The Dissaster

- 34 female tobacco smoker arrives from PCP
- Alprazolam 1 mg 4-8 tablets per day
- Oxycodone 10 mg 6-10 tablets per day
- Husband on O_2, smoking, angry and demanding
- Some marital discord
- PTSD from abduction, sex abuse
- Neck pain, T_4 pain >>> LBP
- Profoundly deconditioned
  - Bradykinetic & dysarthric
  - Rx impaired
  - Catastrophizer

The Conversation

- 34 female tobacco smoker arrives from PCP
- Alprazolam 1 mg 4-8 tablets per day
- Oxycodone 10 mg 6-10 tablets per day
- Husband on O2, smoking, angry and demanding
- Some marital discord
- PTSD, sex abuse
- Neck pain, T4 pain and LBP
- Profoundly deconditioned
- Bradykinetic & dysarthric
- Rx impaired
- Catastrophizer

Naloxone and warm handoff

Your heart knows the way.
Run in that direction.

Rumi

Population-based, observational study using data from many sources

- Substance abuse indicators decedents 94%
- Prevalence of diversion decedents 18-24%
- Opioid analgesics used decedents 93%
- Multiple substances implicated 79%
- Had Past Med history of SUD 78 %
- Rx from 5 or more clinicians in the year prior to death was more common among women

JAMA. 2008;300(22):2613-2620

Opioid SR and Benzo

1. greater pain, pain interference with life, and lower feelings of self-efficacy with respect to their pain
2. being prescribed “higher risk” (>200 MED)
3. antidepressant and/or antipsychotic medications
4. substance use (including more illicit and injection drug use, alcohol use disorder, and daily nicotine use)
5. greater mental health comorbidity and Health Costs

Pain Medicine 2015; 16: 356–366

Naloxone or Flumazenil

- W.VA, N= 1,049,000 on controlled Rx
- Forensic data base, N=600 RIP
- Rx for opioid/benzo 6 mo. antecedent to being a decedent

Medication(s)	OR of RIP
Benzo	7.2
Opioid	3.4
> 1 Rx for both	14.9

Med Care 2012;50:494–500

Polyneuropathy

- N 2892 with polyneuropathy
  - 1464 treated with opioids < 90 days
  - 545 treated with opioids > 90 days
- Control 14435 with 780 on opioids > 90 days
- 82 % written by Int. Med and Fam. Med
- 52% for MSK pain and 24% for polyneuropathy
- > 90 day group 56% female and > co-morbidity
  - MI, CHF, PVD, CVA, *dementia*
  - DM, Renal Dz & *COPD*

JAMANeurol.2017;74(7):773-779

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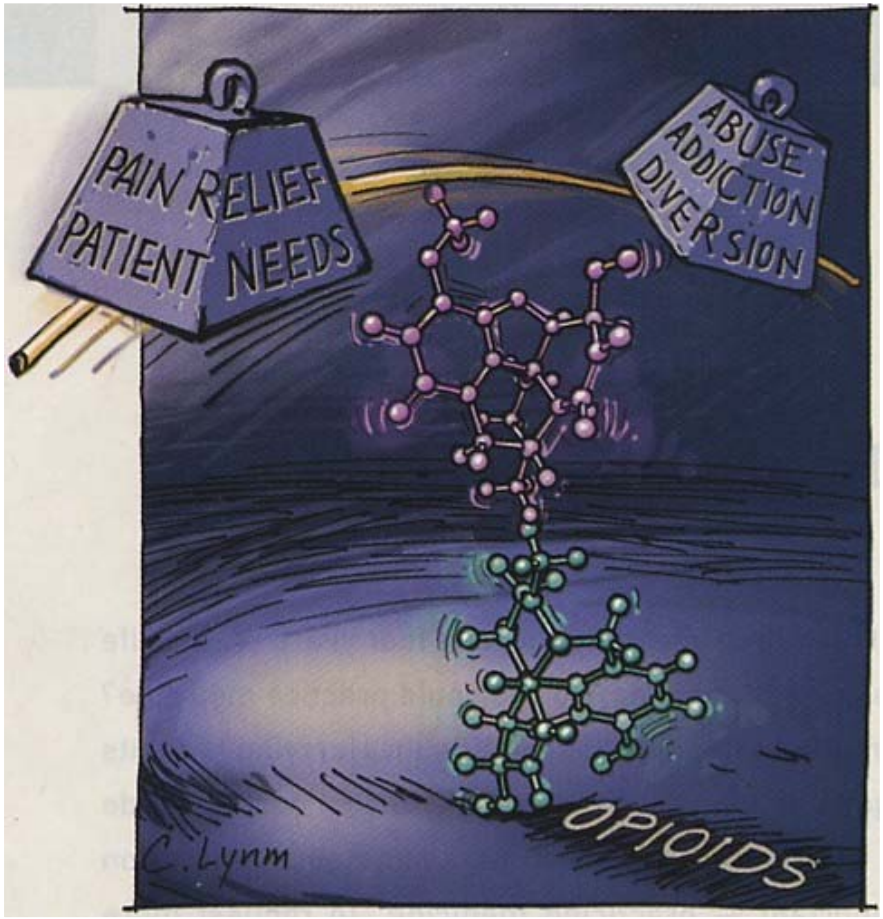
  - MI, CHF, PVD, CVA, dementia, DM, Renal Dz & COPD

No functional status markers were improved by long-term use of opioids

Of all the remedies it has pleased almighty God to give man to relieve his suffering, none is so universal & so efficacious as opium

Measure	Adj. Odds Ratio
Require assist device	1.9
Trouble with ADL	1.7
No longer working	1.3
Depression	1.53
Opioid OD	5.12
Opioid Dependence	2.85
Continues with pain	2.5
Trouble bathing	1.6
Opioid Abuse	3.97

Disingenuous Dichotomy



Morphia:
Hyperalgesia & Allodynia

If any man want to learn sympathetic charity, let him keep pain subdued for six months by morphia, and then make the experiment of giving up the drug. By this time he will have become irritable, nervous and cowardly. The nerves, muffled, so to speak, by narcotics, will have grown to be not less sensitive, but *acutely, abnormally capable of feeling pain* and of *feeling as pain a multitude of things not usually competent to cause it.*

S.W. Mitchell

Condition	Prevalence Chronic Pain Patients
Depression	33% - 54%[22,23]
Anxiety Disorders	16.5% - 50%[22,24]
Personality Disorders	31% - 81%[25,26]
PTSD	49% veterans[27]; 2% civilians[24]
Substance Use Disorders	15% - 28%[22,25]

PTSD, posttraumatic stress disorder.

Gen Hosp Psychiatry. 2012;34(1):46-52
Curr Psychiatry Rep. 2006;8(5):371-376.
J Clin Psychol Med Settings. 2011;18:145-154
SCOPE of Pain Boston Universtiy

16% with mental illness get 51% of opioids

J Am Board Fam Med 2017;30:407– 417

I wish I could show you,
when you are lonely or in darkness,
the astonishing light of your own being

Hafiz

Associated with Risk of Opioid OD or SUD

Table 3. Factors Associated with the Risk of Opioid Overdose or Addiction.

Factor	Risk
Medication-related	
Daily dose >100 MME*	Overdose,[8] addiction[8]
Long-acting or extended-release formulation (e.g., methadone, fentanyl patch)	Overdose[14,41]
Combination of opioids with benzodiazepines	Overdose[42]
Long-term opioid use (>3 mo)†	Overdose,[43] addiction[44]
Period shortly after initiation of long-acting or extended-release formulation (<2 wk)	Overdose[45]
Patient-related	
Age >65 yr	Overdose[46]
Sleep-disordered breathing‡	Overdose[47]
Renal or hepatic impairment§	Overdose[48]
Depression	Overdose, addiction[49]
Substance-use disorder (including alcohol)	Overdose,[50] addiction[49]
History of overdose	Overdose[51]
Adolescence	Addiction[52]

N Engl J Med 2016;374:1253-1263.

Three Objectives:

Any truth is better than indefinite doubt

1. Prescription Drug Monitoring Program
   - INSPECT
3. Drug Monitoring
   - Urine
   - Blood
   - Saliva
2. Pill Counting
   - Early and late
   - Providers- hands-off

4/21

THC Clean

THE ULTIMATE CHEAT SHEET FOR THC DETOX & PASSING YOUR DRUG TEST

National Surprise Drug Test Day

Making Pill Counts Count
Adherence and Diversion

- Write for 28 days, not 30 days
- Time *Rx*s such that the person will have some medication left at next appt.
- Request to bring in *Rx*s to each appt.
- Require 24 hr show for immediate counts
  - Day 24-26
  - Day 7-9
  - Pill Identifier(Pill finder) – Drugs.com
  - *www.drugs.com/pill_identification*

Prescription Drug Monitoring Program

- Use PDMP regularly for new and established patients to detect unsafe patterns of medication acquisition.

- PDMP is free and easy to use; www.in.gov/inspect

- PDMP query @ initiation

- *Min. 4 times per year (CDC)*

Thank you Pharmacists !

Risk of OUD

Compared to no opioid prescription, the adj. odds ratios were

- 15 for 1- 36 MED/day
- 29 for 36-120 MED/day
- 122 for ≥120 MED/day

Clin J Pain.2014;30(7):557-564

53 and 9 years of COT

- Lost in BLDG, missed appt.
- + “O” sign in Lobby
- Lumbar trauma in accident
  - Intoxicated at time
  - Severe DDD L2-3
- Anxiety/depression/fibromyalgia
- 600 MSER & IR
  - “brand necessary”
- 3-5 mg alprazolam (Psych.)
- Surgically enhanced model
- Can’t work, pain

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"Too horrible"

- Reduced MSER by 100 mg/day
- alprazolam reduced to 3 mg each day
  - She did not reduce
- Took Napro/ASA and had GI bleed
- Missed appt. when time for UDM

"still hurts where Dr. MacKie poked me"

DP departs for known Provider

- Down to 300 MED, never engaged
- Declined SUD evaluation
- We informed her of intent to wean
- "Dr. M is way better than MacKie.
  Dr. M treats pain."
- INSPECT alert sent
- Dr. M never requested ROI and did not respond to my unsolicited INSPECT alert

Mr. William Stone

- 55 Chronic LBP pain >10 yrs.
- COT for ~ 3.5 yrs.
- Knee
  - Mild-moderate tricompartment
- Facet degeneration, DDD
- L4-5 fusion in 2015
- Hydroc. 7.5/325 each 6-8 hr “prn”
- tramadol, 4/day Miralax, PPI, CPAP, Paroxetine, “T”
- Temazepam 15 mg/ night

William B. Stone

- Care-giver to mother, 83
- Disability 2016**
  - Half-Price Books
- 2 early RFs in last 8 months
- 2016- UDM + hydrocodone
  - No metabolites or tramadol
- Etoh- 230, 198, 347 (1987-1995)
- Cocaine + 1997
- FHx Etoh and cocaine

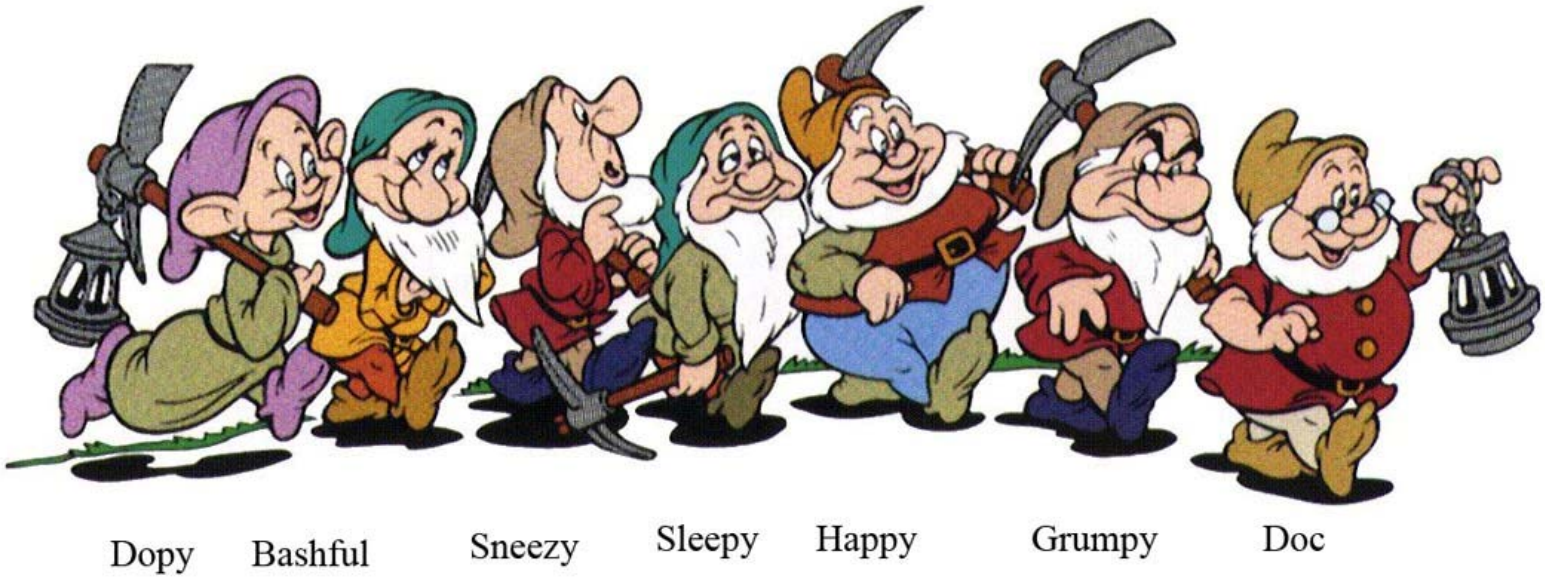
Willie B. Stone

Now

What?

62 male artist with pain since mva in 1994. multiple pelvic/ sacral fractures difficulties w/ bowel/bladder since - had 8" colon paralysis & R sided penile numbness. Left para-spinal pain and some wrap around R hip to thigh to "acid burning in calf"

7.5 hydro/APAP 42/28 d	**10 mg tid**
• Wt. 202 lbs	• wt 192
• Phq9=14	• Phq9= 0
• Vit D = 19	• Vit D = 53
• Yard- county warning	• Yard and garden and fence
• Pottery- rare	• Teaching and had show
• Second Helpings- too painful	• Regular and enjoyable
• Crying at times, sour affect and not engaged	• Not crying, laughing and engaged
• + inversion table	• +inversion table
• Cannabis use	• Urine Tox all fine > 18 months



Heigh-ho heigh-ho its off to Refill Status Quo

Naloxone, Education and Rx

Sweet Endings

Year	Total Spending on Halloween Candy**
2016	$8.4 billion
2015	$6.9 billion
2014	$7.4 billion
2013	$6.9 billion
2012	$8.0 billion

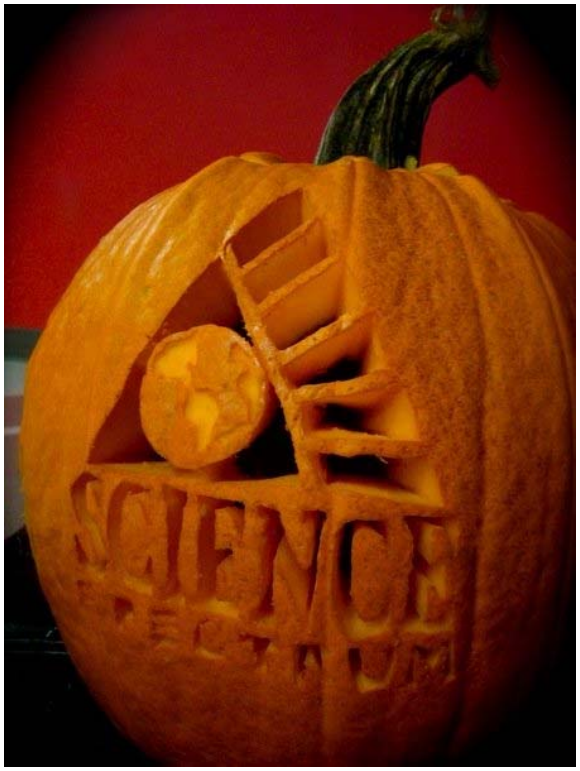
https://www.thebalance.com/halloween-spending-statistics-facts-and-trends-3305716

Sour Reality…Tooth and Cultural Decay

Year	Total Spending on Chronic Pain Research*	Total Spending on Prescription Drug Abuse Research*	Total Spending on Halloween Candy**
2016	$481 million	$49 million	$8.4 billion
2015	$463 million	$48 million	$6.9 billion
2014	$499 million	$40 million	$7.4 billion
2013	$475 million	$33 million	$6.9 billion
2012	$479 million	$33 million	$8.0 billion

*NIH Categorical Spending accessed at https://report.nih.gov/categorical_spending.aspx

The End



Thank you

ACLahood@stvincent.org
pmackie@iu.edu

Resources

- MLB Final Rules
- http://www.in.gov/legislative/iac/irtoc.htm?id=2.3&hdate=20141105&ldate=20141105
- Poster/Flyer—Bitterpill.IN.gov
  - http://www.in.gov/bitterpill/files/First_Do_No_Harm_Poster.pdf
- CDC Guidelines
  - https://www.cdc.gov/drugoverdose/pdf/guidelines_factsheet-a.pdf