Tennessee Chronic Pain Guidelines and Controlled Substance Efforts Symposia

Mitchell Mutter, M.D. Director of Special Projects
Tennessee Department of Health

October 6, 2016
I, Mitchell Mutter, DO NOT have a financial interest/arrangement or affiliation with one or more organizations that could be perceived as a real or apparent conflict of interest in the context of the subject of this presentation.
Misconceptions From the Public
Chattanooga Times, April 10, 2016

BARRED FROM RELIEF

PRESCRIPTION DRUG CRACKDOWN MAKES IT HARD FOR PEOPLE IN PAIN TO GET PILLS
## Future Plans for Education

### 11 Symposia
March – November 2016

- Sullivan County
- Johnson City
- Knoxville
- Nashville (2)
- Memphis (2)
- Jackson
- Hardin County
- Upper Cumberland
- Chattanooga

### 4 Law Enforcement Meetings
6 Key Indicators

1. Mandatory Prescriber Education
2. Opioid Prescribing Guidelines
3. Eliminating Pill Mills
4. Prescription Drug Monitoring Programs (PDMPs)
5. Increased Access to Naloxone
6. Availability of Opioid Use Disorder (OUD) Treatment
A ROADMAP FOR
STRENGTHENING LAWS & REGULATIONS

Nationwide Implementation

- 47 States NEED TO IMPROVE!
- 28 States are “Failing”
- 4 States are “Making Progress”
# Overall Utilization of Pharmaceuticals by State

## A State Comparison: Annual Prescriptions per Capita 2015

<table>
<thead>
<tr>
<th>Rank</th>
<th>State</th>
<th>Rx per Capita</th>
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</table>

All states = **12.4 annual prescriptions per capita**

USA total All Products prescriptions 2013 = 3,811,367,683
USA total All Products prescriptions 2014 = 3,916,667,154

Copyright 2016  IMS Health, Inc. Plymouth Meeting, PA
## Opioid Utilization by State

### A State Comparison: Annual Prescriptions per Capita 2015

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<thead>
<tr>
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**All states = 0.7 annual prescriptions per capita**

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2015 USA total Opioid prescriptions = 227,780,915; TN total = 7,800,947

2014 USA total Opioid prescriptions = 244,457,347; TN total = 8,239,048

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## Growth in Opioid Utilization by State

### Percent Change in Filled Prescriptions, 2015 vs 2014

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<th>Rank</th>
<th>State</th>
<th>% Change</th>
<th>Rank</th>
<th>State</th>
<th>% Change</th>
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**All states = -6.8% annual percentage of change**
Why do you check the CSMD before prescribing?

**Prescribers**

- Mandatory check: 67%
- New Patient: 52%
- Other: 36%
- ED Visit: 15%
- Planned Surgery: 4%

**Dispensers**

- New Patient: 82%
- Suspected Doctor Shopping: 72%
- Suspected Pharmacy Shopping: 79%
- Suspected Alteration of Prescription: 27%
- Other: 30%

Source: 2015 CSMD Prescriber and Dispenser Survey
Regulatory and Controlled Substance Update

- TN Public Chapter 476
- Currently, the top 50 prescribers of controlled substances in the state are annually identified and sent a letter notifying them of their inclusion on this list and asked to respond with a justification for their prescribing patterns.
- Public Chapter 476 adds the top 10 prescribers from all of the combined counties having populations of fewer than 50,000 this process
- Effective/Signed May 18, 2015
Top 50 and Top 10 Prescribers

- Registered letter to identified prescriber
  - Significant control substances
  - Number of patients
  - Morphine Equivalents prescribed

- Prescriber must respond with an explanation justifying the amounts of control substance prescribe within 15 business days
Morphine Milligram Equivalent Prescribed by Top 50 Prescribers and Filled in 2013 - 2016*

*MME in 2013 and 2014 covered 12-month opioid prescriptions written by the top 50 prescribers from April 1 of preceding year to March 31 of current year; MME in 2016 covered opioid prescriptions filled by the patients of the top 50 prescribers during January 1, 2015 to December 31, 2015.
Top 50 Prescribers Identified in 2016
(based on data from Jan - Dec 2015 using CDC MME Conversion Tables)

Top 50 Identified in 2016
(Based on Data from Jan-Dec 2015)

- Medical Doctors (MD)
  - Repeat MDs 10
  - New MDs 5
  - Total: 15

- Osteopathic Doctors (DO)
  - Repeat DO 1
  - New DO 1
  - Total: 2

- Advance Practice Nurses (APN)
  - Repeat APNs 21
  - New APNs 8
  - Total: 29

- Physician Assistants (PA)
  - Repeat PAs 2
  - New PAs 2
  - Total: 4
## Licenses with DEA (9/21/15)

Total Number of DEA licenses = 32,031

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<th>Profession</th>
<th>Number of DEA licenses</th>
<th>Percentage</th>
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<td>MD, DO, Podiatry, Veterinarians, Optometry, Dentist</td>
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<td>APRN</td>
<td>7,042</td>
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<td>PA</td>
<td>1,507</td>
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### Total MME's for Top 50 (2016)

Total MME for Top 50 = 1,030,343,237

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<th>Percentage</th>
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<td>69,651,554</td>
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<td>MD</td>
<td>305,477,950</td>
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<tr>
<td>DO</td>
<td>40,249,971</td>
<td>3.91%</td>
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Number of Pain Management Clinics as of 10.3.2016

Total Number = 195
Total Number of Pain Clinics = 198
Public Chapter 623
“Naloxone”

- Licensed Healthcare Practitioner
- Patient, family member, friend of patient at risk for overdose death
- Naloxone Education is currently available on the Department of Health website
- Instruction how to administer
  http://www.tn.gov/health/topic/information-for-naloxone
Public Chapter 623
“Naloxone”

• Nasal Mist

HOW TO GIVE NASAL SPRAY NALOXONE

1. Pull or pry off yellow caps
2. Pry off red cap
3. Grip clear plastic wings
4. Screw capsule of naloxone into barrel of syringe
5. Insert white cone into nostril; give a short, vigorous push on end of capsule to spray naloxone into nose; one half of the capsule into each nostril.
6. If no reaction in 2-5 minutes, give the second dose.
Naloxone Injection: Evzio

**EVZIO**

- **Speaker**
- **LEDs**
- **Base**
- **Safety Guard**
- **Viewing Windows**

**Outer Case**

- **Outer Case**

**Instructions for Use**

Evzio naloxone HCl injection, USP 0.4mg auto-injector

Use for opioid emergencies such as suspected overdose. Seek emergency medical attention.

Instructions for use found inside on device includes voice instructions from a speaker.
Strategic Map

Public Health Approach to the Opioid Abuse Epidemic
Tennessee Department of Health Strategic Map, 2016

Reduce Opioid Misuse, Abuse & Overdose

A: Improve Primary Prevention
   - Improve education for consumers, families & HCWs
   - Expand use of optimal prescribing guidelines
   - Actively support community coalitions
   - Expand efforts to reduce NAS
   - Facilitate community interventions, including safe disposal of drugs
   - Reduce harm from needle use

B: Improve Monitoring and Surveillance
   - Optimize use of the CSMD
   - Link other data sources to the CSMD
   - Improve the high risk patient model
   - Develop a high risk prescriber model for individuals and practices
   - Develop a high risk dispenser model
   - Improve proactive use of clinical monitoring tools

C: Improve Regulation and Enforcement
   - Provide prescriber/dispenser education on regulation & enforcement
   - Improve collaboration with law enforcement
   - Expedite investigations supporting Board oversight of prescribers
   - Develop a high risk prescriber model for individuals and practices
   - Develop a high risk dispenser model
   - Improve proactive use of clinical monitoring tools

D: Increase Utilization of Treatment (2nd Prevention)
   - Destigmatize & approach addiction as a treatable chronic illness
   - Expand SBIRT training and use
   - Expand appropriate use of MAT
   - Expand treatment alternatives to incarceration
   - Partner with Mental Health to expand treatment options for opioid misuse
   - Advocate for Prescription for Success including treatment and care

E: Increase Access to Appropriate Pain Management
   - Require pain management clinic physicians to have specialty certification
   - Develop a model for desirable integrated pain practices
   - Increase access for uninsured
   - Work with academic partners to improve training of prescribers
   - Describe how patient care is impacted by sudden clinic closures
   - Expand the availability and use of Naloxone

Expand and Strengthen Key Partnerships and Collaborative Infrastructure

Secure/Realign Resources and Infrastructure to implement Comprehensive Approaches

Use Data, Evaluation and Research to Inform Interventions and Continuous Improvement
Improve Primary Prevention

- Improve education for consumers, families, and health care workers
- Expand use of optimal prescribing guidelines
- Actively support community coalitions
- Expand efforts to reduce NAS
- Facilitate community interventions, including safe disposal of drugs
- Reduce harm from needle use
Improve Monitoring and Surveillance

- Optimize use of the CSMD
- Link other data sources to the CSMD
- Improve the high risk patient model
- Develop a high risk prescriber model for individuals and practices
- Develop a high risk dispenser model
- Improve proactive use of clinical monitoring tools
Improve Regulation and Enforcement

- Provide prescriber/dispenser education on regulation and enforcement
- Improve collaboration with law enforcement
- Expedite investigations supporting Board oversight of prescribers
- Eliminate “Pill Mills”
- Improve legislation to allow proactive regulation
Increase Utilization of Treatment

- Destigmatize and approach addiction as a treatable chronic illness
- Expand SBIRT training and use
- Expand appropriate use of MAT
- Expand treatment alternatives to incarceration
- Partner with Mental Health to expand treatment options for opioid misuse
- Advocate for Prescription for Success including treatment and care
Increase Access to Appropriate Pain Management

- Require pain management clinic physicians to have specialty certification
- Develop a model for desirable integrated pain practices
- Increase access for uninsured
- Work with academic partners to improve training of prescribers
- Describe how patient care is impacted by sudden clinic closure
- Expand the availability and use of Naloxone
Neonatal Abstinence Syndrome Surveillance Summary
Week 39: September 25 – October 1, 2016

Year to Date Reporting Summary

<table>
<thead>
<tr>
<th>Year to Date Reporting Summary</th>
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<tr>
<td>Total Cases Reported:</td>
<td>772</td>
<td></td>
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<tr>
<td>Sex</td>
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<tr>
<td>Male</td>
<td>404</td>
<td></td>
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<tr>
<td>Female</td>
<td>368</td>
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Cumulative Cases NAS Reported

<table>
<thead>
<tr>
<th>Cumulative Cases NAS Reported</th>
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<tr>
<td>Number of Cases</td>
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<td>Week</td>
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Maternal County of Residence

<table>
<thead>
<tr>
<th>Maternal County of Residence</th>
<th># Cases</th>
<th>% Cases²</th>
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<tbody>
<tr>
<td>Davidson</td>
<td>53</td>
<td>6.9</td>
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<tr>
<td>East</td>
<td>167</td>
<td>21.6</td>
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<tr>
<td>Hamilton</td>
<td>14</td>
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<tr>
<td>Jackson/Madison</td>
<td>3</td>
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<tr>
<td>Knox</td>
<td>71</td>
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<tr>
<td>Mid-Cumberland</td>
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<tr>
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<tr>
<td>Shelby</td>
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<tr>
<td>South Central</td>
<td>39</td>
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<tr>
<td>South East</td>
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<tr>
<td>Sullivan</td>
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<tr>
<td>Upper Cumberland</td>
<td>80</td>
<td>10.4</td>
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<tr>
<td>West</td>
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<td>3.5</td>
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<tr>
<td>TOTAL</td>
<td>772</td>
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Source of Exposure

<table>
<thead>
<tr>
<th>Source of Exposure</th>
<th># Cases¹</th>
<th>% Cases</th>
</tr>
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<tbody>
<tr>
<td>Medication assisted treatment</td>
<td>528</td>
<td>68.4</td>
</tr>
<tr>
<td>Legal prescription of an opioid pain reliever</td>
<td>83</td>
<td>10.8</td>
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<tr>
<td>Legal prescription of a non-opioid</td>
<td>59</td>
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<tr>
<td>Prescription opioid obtained without a prescription</td>
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<tr>
<td>Non-opioid prescription substance obtained without a prescription</td>
<td>89</td>
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<tr>
<td>Heroin</td>
<td>19</td>
<td>2.5</td>
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<tr>
<td>Other non-prescription substance</td>
<td>123</td>
<td>15.9</td>
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<tr>
<td>No known exposure</td>
<td>8</td>
<td>1.0</td>
</tr>
<tr>
<td>Other²</td>
<td>41</td>
<td>5.3</td>
</tr>
</tbody>
</table>

2. Total percentage may not equal 100.0% due to rounding.
3. Multiple maternal substances may be reported, therefore the total number of cases in this table may not match the total number of cases reported.
4. Other exposure may include cases reported to the archived surveillance system with classifications not captured in the current system.
Women's Health

CHRONIC PAIN GUIDELINES ALGORITHM WOMEN’S HEALTH

WOMEN’S HEALTH
Women of Childbearing Age With Reproductive Capability

Pain Diagnosis Supported by Clinical Findings

Non-Opioid Treatment Plan (Physical Therapy, Acupuncture, Massage Therapy, etc.)

*Successful
Continue Non-Opioid Treatment

Unsuccessful
Pregnancy Test
Drivers of Heroin Use

75-85% have used prescription drugs

Drug Overdose Death, 2014

Rate per 100,000

Source: TN Department of Health
Public Chapter 430

- Chronic Pain Guidelines written by January 1, 2014
- All prescribers with DEA 2 hours CME every 2 years
- Prescribe 30 days at a time Schedule II-IV
- By January 1, 2014 the commissioner shall develop recommended treatment guidelines for prescribing opioids, benzodiazepines, barbiturates, and carisoprodol. That can be used in the state as guide for caring for patients.
Chronic Pain Guidelines Appendices

- Pain Medicine Specialist
- Risk Assessment Tools
- Pregnant women
- Use of Opioids in Worker's Compensation Medical Claims
- Tapering protocol
- Sample Informed consent
- Sample Patient Agreement
- Controlled Substance Monitoring Database
- Medication Assisted Treatment Program
- Morphine equivalents dose
- Psychological Assessment Tools
- Prescription Drug Disposal
- Safety Net
- Definitions
- Table of Frequently Prescribed Pain Medications
- Urine Drug Testing
- Special Consideration: Women of Child Bearing Age
Pain Specialist

- Board of Medical Specialties (ABMS) primary physician certification organization in US
- ABMS certifies pain medicine fellowship programs in Anesthesia, Physical Medicine and Neurology, Emergency Room Medicine, and Radiology
- American Board of Pain Medicine (ABPM) is not ABMS and does not oversee fellowship training programs.
- ABPM offers practice – related examinations to qualified candidates. Diplomates of ABPM have certification in Pain Medicine
- AOA Certification
- ABIPP
Converting Opioids to Morphine Milligram Equivalents

Formula for MME per day:

\[ \text{Strength (in mg)} \times \text{Morphine Equivalent} \times \text{Quantity} \]

\[
\text{Number of days}
\]

Conversions to Morphine Milligram Equivalents:

<table>
<thead>
<tr>
<th>Opioid name</th>
<th>Milligrams (mg) of opioid</th>
<th>Equivalent milligrams (mg) of morphine</th>
</tr>
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<tbody>
<tr>
<td>Buprenorphine (Oral)</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>1</td>
<td>7.2</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Methadone</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>1</td>
<td>1.5</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Morphine</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Codeine</td>
<td>1</td>
<td>0.15</td>
</tr>
<tr>
<td>Tramadol</td>
<td>1</td>
<td>0.1</td>
</tr>
</tbody>
</table>

Example: 80 MME

1 pill of 8mg Buprenorphine

2.5 pills of 8mg Hydromorphone

16 pills of 50mg Tramadol
CDC Guideline for Prescribing Opioids for Chronic Pain
Recommendations

**Tennessee Chronic Pain Guidelines**
- Prior to initiating opioid therapy for chronic non-malignant pain
- Initiating opioid therapy for chronic non-malignant pain
- Ongoing opioid therapy for chronic non-malignant pain

**CDC Guidelines**
- Determining when to initiate or continue opioids for chronic pain
- Opioid selection, dosage, duration, follow-up, and discontinuation
- Assessing risk and addressing harms of opioid use
# Tennessee Chronic Pain Guidelines VS CDC Guidelines

## I. Prior to Starting Opioids
- Non-opioid prescriptions with or without opioids
- H & P, testing, old records
- All women tested for pregnancy and discuss birth control
- Co-morbid conditions/risks
- Urinary drug test
- **No telemedicine**
- Goals for prescriptions
- **Diagnosis***

## I. When to Initiate Opioids
- Opioids with non-opioids when non-opioids are not enough; Risk vs Benefit
- Establish treatment goals for pain and function
- Risks vs Benefits
### II. Initiating Opioid Therapy

- Short acting – lowest dose
- **90/120 MME**
- No benzodiazepine
- **No methadone/ buprenorphine**
- Therapeutic trial
- **Treatment agreement**
- Informed consent
- Continuous monitor: UDT (2x/yr), PDMP, Signs 5A
- Women’s Health (See appendix)

### II. Opioid Selection – Dosage, Duration, Follow Up, and Discontinuation

- Immediate release not LA/ER
- Lowest effective dose – 50/90
- Long term DU begins with acute pain
- New prescription or increase dose – follow up in 1-4 weeks
III. Ongoing Therapy

- Single provider/dispenser
- Lowest dose – 90/120 MEDD
- **UDT 2x/yr or more frequently in increased risk**
- CSMD/UDT, 5A → continued Rx
- Communication with ED and/or PCP

III. Follow Up – Risk and Harms

- Continuously check risks for opioids harms- consider dose, naloxone, benzodiazepine
- Check PDMP at start of onset and every 3 months
- UDT at onset and a minimum annually
- Avoid opioids and benzodiazepines
- Offer MAT for OUD
• Requires that to qualify as a pain specialist you must have taken both ABIPP exam 1 & 2 after July 1, 2016
Pain Specialist

• Must be boarded through:
  – American Board of Medical Specialties (ABMS)
    • Subspecialty in Pain Medicine
  – American Board of Pain Medicine (ABPM)
  – American Osteopathic Association (AOA)
  – American Board of Interventional Pain Physicians (ABIPP)
    • ABIPP 1 & 2 (after July 1, 2016)
Public Chapter 1033

- Pain Management Clinics require licensure
  - Medical director holds license – Not transferable
  - A pain specialist is only eligible to be medical director
  - No pharmacy
  - Clinic can be suspended based on specific violation
    - No new patients
    - Monitored
  - Goes into effect July 1, 2017
Public Chapter 1002

- Prescription Safety Act 2016
  - Renewed
External Resources

Pain Management Clinic Registry Website
http://tn.gov/health/topic/PM-board

Legislative Report 2016

TN Chronic Pain Guidelines 2014

CDC Guidelines 2016
http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm
More Resources

Public Safety Act 2012

Public Chapter 1002

Public Chapter 1033
Thank you!
CDC Guidelines

Determining when to initiate or continue opioids for chronic pain
Recommendation 1

• Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.
Opioids not first-line or routine therapy for chronic pain

- Use nonpharmacologic therapy (e.g., exercise therapy, CBT) to reduce pain and improve function
- Use nonopioid pharmacologic therapy (e.g., NSAIDS, acetaminophen, anticonvulsants, SNRIs) when benefits outweigh risks, combined with nonpharmacologic therapy
- When opioids used, combine with nonpharmacologic therapy and nonopioid pharmacologic therapy to provide greater benefits
Recommendation 2

• Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
Establish and measure progress toward goals

• Before initiating opioid therapy for chronic pain,
  – determine how effectiveness will be evaluated
  – establish treatment goals with patients
    • pain relief
    • function

• Assess progress using 3-item PEG Assessment Scale*
  – Pain average (0-10)
  – interference with Enjoyment of life (0-10)
  – interference with General activity (0-10)

*30% = clinically meaningful improvement
Recommendation 3

- Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.
Ensure patients are aware of potential benefits, harms, and alternatives to opioids

- Be explicit and realistic about expected benefits
- Emphasize improvement in function as a primary goal
- Discuss
  - serious and common adverse effects
  - increased risks of overdose
    - at higher dosages
    - when opioids are taken with other drugs or alcohol
  - periodic reassessment, PDMP and UDT checks
  - risks to family members and individuals in the community
Opioid selection, dosage, duration, follow-up, and discontinuation
Recommendation 4

- When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.
Choose predictable pharmacokinetics and pharmacodynamics to minimize overdose risk

• In general, avoid the use of immediate-release opioids in combination with ER/LA opioids

• Methadone should not be the first choice for an ER/LA opioid; Only clinicians who are familiar with methadone’s unique risk profile and who are prepared to educate and closely monitor their patients should consider prescribing it for pain

• Only consider prescribing transdermal fentanyl if familiar with the dosing and absorption properties and prepared to educate their patients about its use
Recommendation 5

- When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to $\geq 50$ morphine milligram equivalents (MME)/day, and should avoid increasing dosage to $\geq 90$ MME/day or carefully justify a decision to titrate dosage to $\geq 90$ MME/day.
Start low and go slow

- Start opioids at the lowest effective dosage
- Increase dosage by the smallest practical amount
- If total opioid dosage $\geq 50$ MME/day
  - reassess pain, function, and treatment
  - increase frequency of follow-up
  - consider offering naloxone
- Avoid increasing opioid dosages to $\geq 90$ MME/day
- If escalating dosage requirements
  - discuss other pain therapies with the patient
  - consider working with the patient to taper opioids down or off
  - consider consulting a pain specialist
When patients are already receiving high dosages

- Offer established patients already taking ≥ 90 MME/day the opportunity to re-evaluate their continued use of high opioid dosages in light of recent evidence regarding the association of opioid dosage and overdose risk.
- For patients who agree to taper opioids to lower dosages, collaborate with the patient on a tapering plan (see Recommendation 7).
Recommendation 6

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

- Prescribe the lowest effective dose
- Prescribe amount to match the expected duration of pain severe enough to require opioids
- Often ≤3 days and rarely more than 7 days needed
- Do not prescribe additional opioids “just in case”
- Re-evaluate patients with severe acute pain that continues longer than expected to confirm or revise the initial diagnosis and adjust management
- Do not prescribe ER/LA opioids for acute pain
Recommendation 7

- Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.
Follow-up

Re-evaluate patients
- within 1 - 4 weeks of starting long-term therapy or of dosage increase
- at least every 3 months or more frequently

At follow up, determine whether
- opioids continue to meet treatment goals
- there are common or serious adverse events or early warning signs
- benefits of opioids continue to outweigh risks
- opioid dosage can be reduced or opioids can be discontinued
Tapering opioids

- Offer to work with patients to taper opioids down or off when
  - no sustained clinically meaningful improvement in pain and function
  - opioid dosages ≥50 MME/day without evidence of benefit
  - concurrent benzodiazepines that can’t be tapered off
  - patients request dosage reduction or discontinuation
  - patients experience overdose, other serious events, warning signs

- Taper slowly enough to minimize opioid withdrawal
  - a decrease of 10% of per week is a reasonable starting point

- Access appropriate expertise for tapering during pregnancy

- Optimize nonopioid pain management, psychosocial support
CDC Guidelines

Assessing risk and addressing harms of opioid use
Recommendation 8

Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should 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.
Risk factors increase susceptibility to opioid-associated harms

- Avoid prescribing opioids to patients with moderate or severe sleep-disordered breathing when possible
- Carefully weigh risks and benefits with pregnant patients
- Additional caution with renal or hepatic insufficiency, >65
- Ensure treatment for depression is optimized
- Consider offering naloxone when patients
  - have a history of overdose
  - have a history of substance use disorder
  - are taking central nervous system depressants with opioids
  - are on higher dosages of opioids (>50 MME/day)
Recommendation 9

Clinicians should review the patient’s history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.
If prescriptions from multiple sources, high dosages, or dangerous combinations

- Discuss safety concerns, increased risk of overdose with patient
- For patients receiving high total opioid dosages, consider tapering to a safer dosage, consider offering naloxone
- Discuss safety concerns with others prescribing to your patient
- Consider opioid use disorder and discuss concerns with your patient
- If you suspect your patient might be sharing or selling opioids and not taking them, consider urine drug testing to assist in determining whether opioids can be discontinued without causing withdrawal
- Do not dismiss patients from care—use the opportunity to provide potentially lifesaving information and interventions
Recommendation 10

- When prescribing opioids for chronic pain, clinicians should 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.
Use UDT to assess for prescribed opioids and other drugs that increase risk

- Be familiar with drug testing panels and how to interpret results
- Do not test for drugs that would not affect patient management
- Before ordering urine drug testing
  - explain to patients that testing is intended to improve their safety
  - explain expected results
  - ask patients whether there might be unexpected results
- Discuss unexpected results with local lab or toxicologist and patients
- Verify unexpected, unexplained results using specific test
- Do not dismiss patients from care based on a urine drug test
Recommendation 11

- Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.
Avoid concurrent opioids and benzodiazepines whenever possible

- Taper benzodiazepines gradually
- Offer evidence-based psychotherapies for anxiety
  - cognitive behavioral therapy
  - specific anti-depressants approved for anxiety
  - other non-benzodiazepine medications approved for anxiety
- Coordinate care with mental health professionals
Clinicians should 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.