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Patient-Centered Opioid Prescribing: Balancing Safety, Preventing Harm

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Sept 24, 2022

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Disclosures

Consulting:

- AppliedVR
- Emergent
- Hisimatsu
- Neurana

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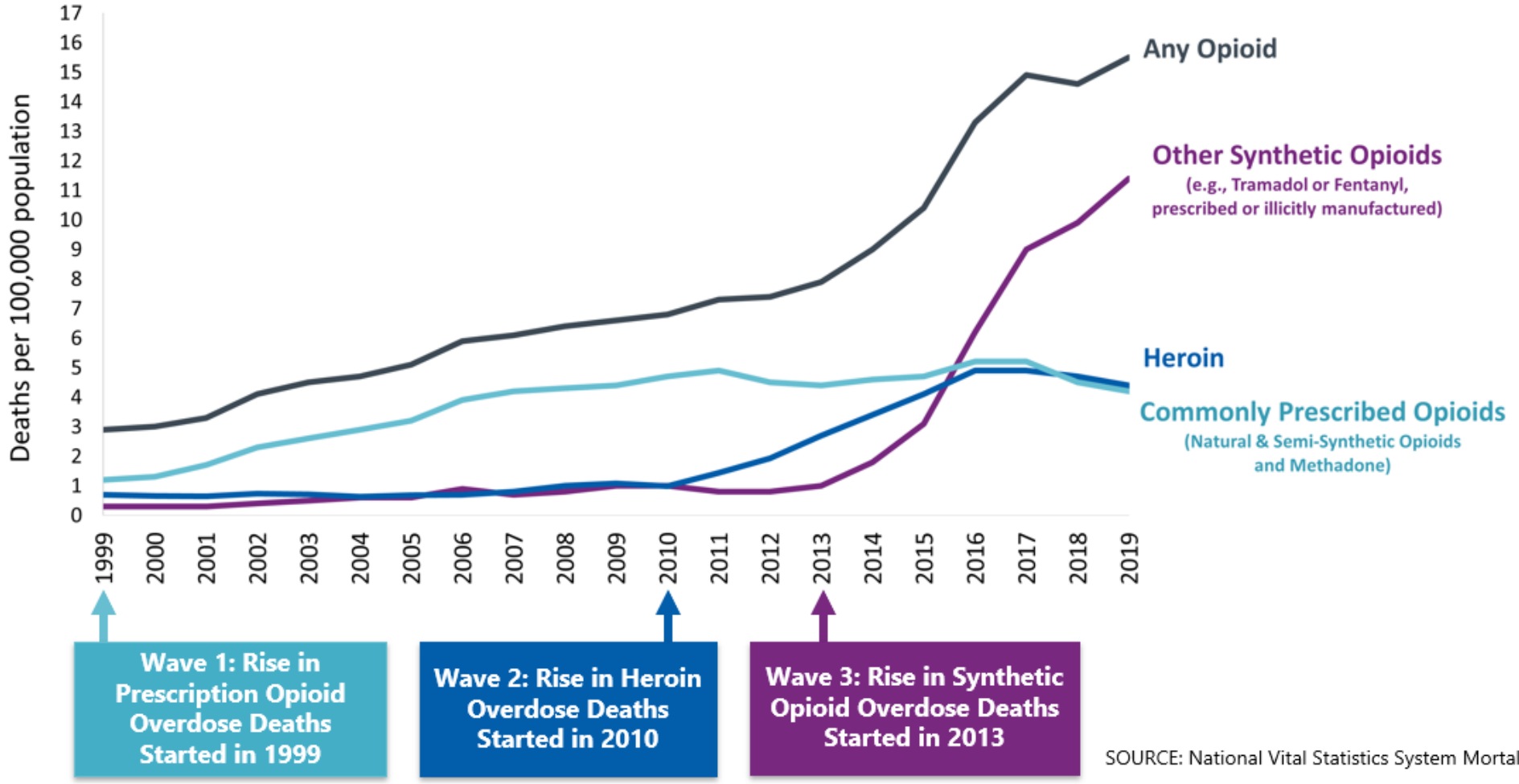
Overview

- CDC Guideline for Opioid Prescribing – 2016
- Update on federal initiatives for pain management
- Be familiar with recent epidemiological data related to opioid tapering, opioid overdose, and illicit drug overdoses
- Understand an evolving appreciation for opioid pharmacology
- Assess affective and motivational factors that may impact ongoing opioid management and tapering of patients
- Review of CDC Draft Guideline
- Patient-Centered Care and Risk Stratification

Three Waves of the Rise in Opioid Overdose Deaths



SOURCE: National Vital Statistics System Mortality File.

NIH National Institute on Drug Abuse

4th Wave: Pharmacovigilance and Pain Management Vacuum

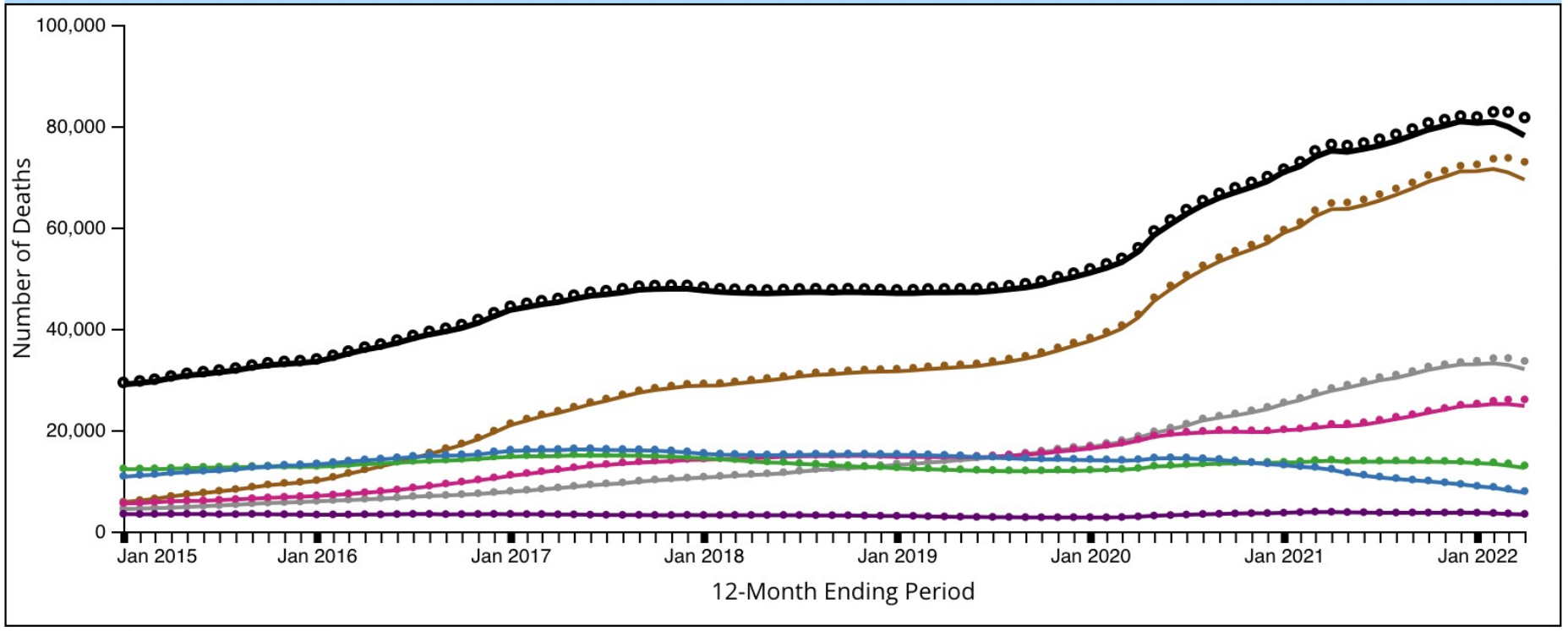
Vital Statistics Rapid Release

Provisional Drug Overdose Death Counts

Select Jurisdiction: United States

Select specific drugs or drug classes: Select drug class

Figure 2. 12 Month-ending Provisional Number of Drug Overdose Deaths by Drug or Drug Class: United States



	US	Colorado
Opioids (T40.0-T40.4,T40.6)	78,000.	1,298
Synthetic opioids, excl. methadone (T40.4)	69,000	1,043
Psychostimulants with abuse potential (T43.6)	32,000	747
Cocaine (T40.5)	25,000	295
Natural & semi-synthetic opioids (T40.2)	12,500.	250
Heroin (T40.1)	7,600	138
Methadone (T40.3)	3,400	60

Legend for Drug or Drug Class

- Cocaine (T40.5)
- Heroin (T40.1)
- Methadone (T40.3)
- Natural & semi-synthetic opioids (T40.2)
- Opioids (T40.0-T40.4,T40.6)
- Psychostimulants with abuse potential (T43.6)
- Synthetic opioids, excl. methadone (T40.4)

---- Reported Value

O Predicted Value

https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

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Drug-involved Overdose Deaths Have Increased Substantially Over the Pandemic*

	ALL DRUGS	HEROIN	NAT & SEMI – SYNTHETIC	METHADONE	SYNTHETIC OPIOIDS	COCAINE	OTHER PSYCHO-STIMULANTS (mainly meth)
3/2020*	75,702	14,136	12,342	2,828	**40,708**	**17,530**	**18,004**
3/2021*	99,559	12,732	14,058	3,893	**63,380**	**20,769**	**27,418**
2/2022*	108,642	8,637	13,442	3,559	**72,758**	**25,436**	**33,683**
Percent Change 3/20-2/22	**43.5%**	**38.9%**	**8.9%**	**25.8%**	**78.7%**	**45.1%**	**87.1%**

*NCHS Provisional drug-involved overdose death counts are PREDICTED VALUES
https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

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CDC
Centers for Disease Control and Prevention

US and Colorado Drug Overdose Deaths: 12-month

Figure 1a. 12 Month-ending Provisional Counts of Drug Overdose Deaths: United States

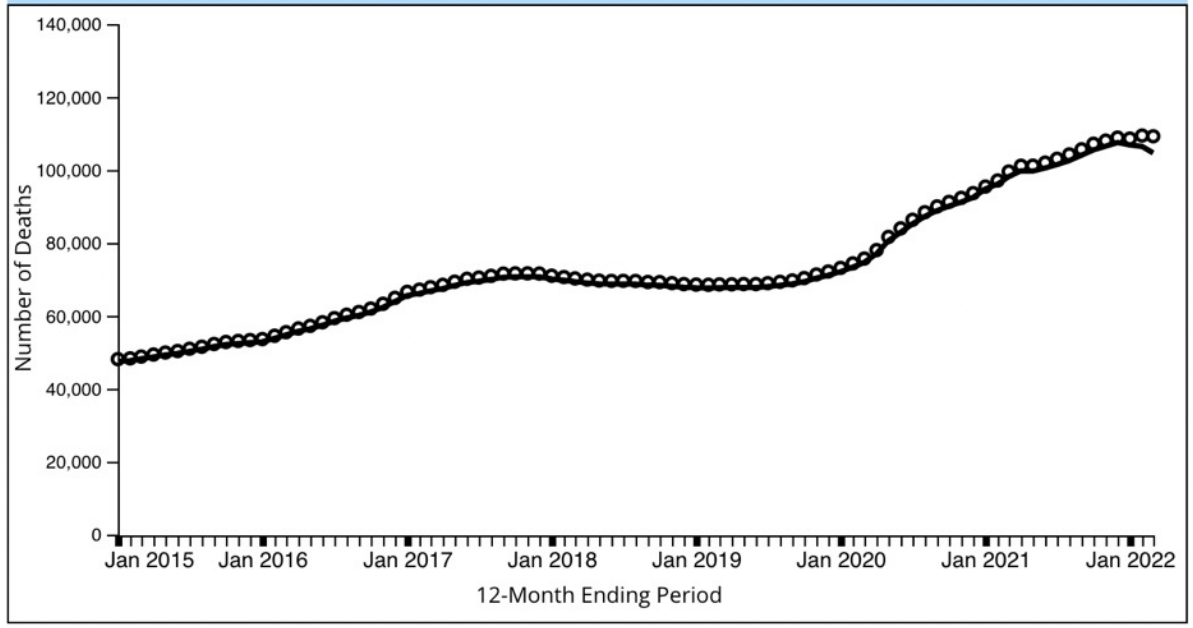
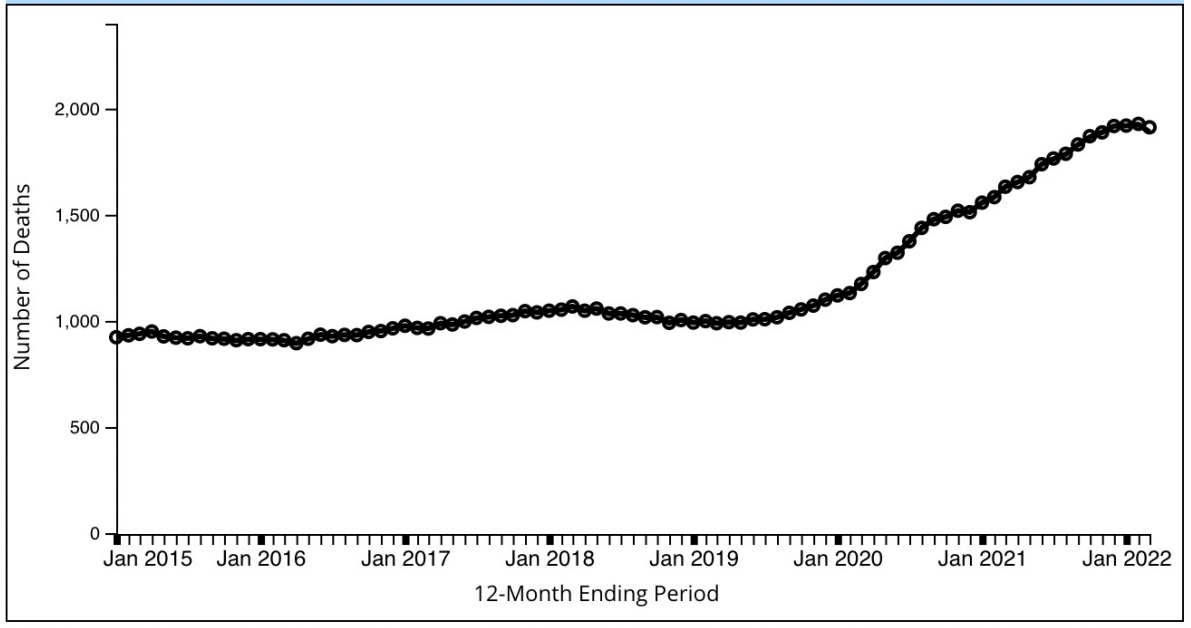
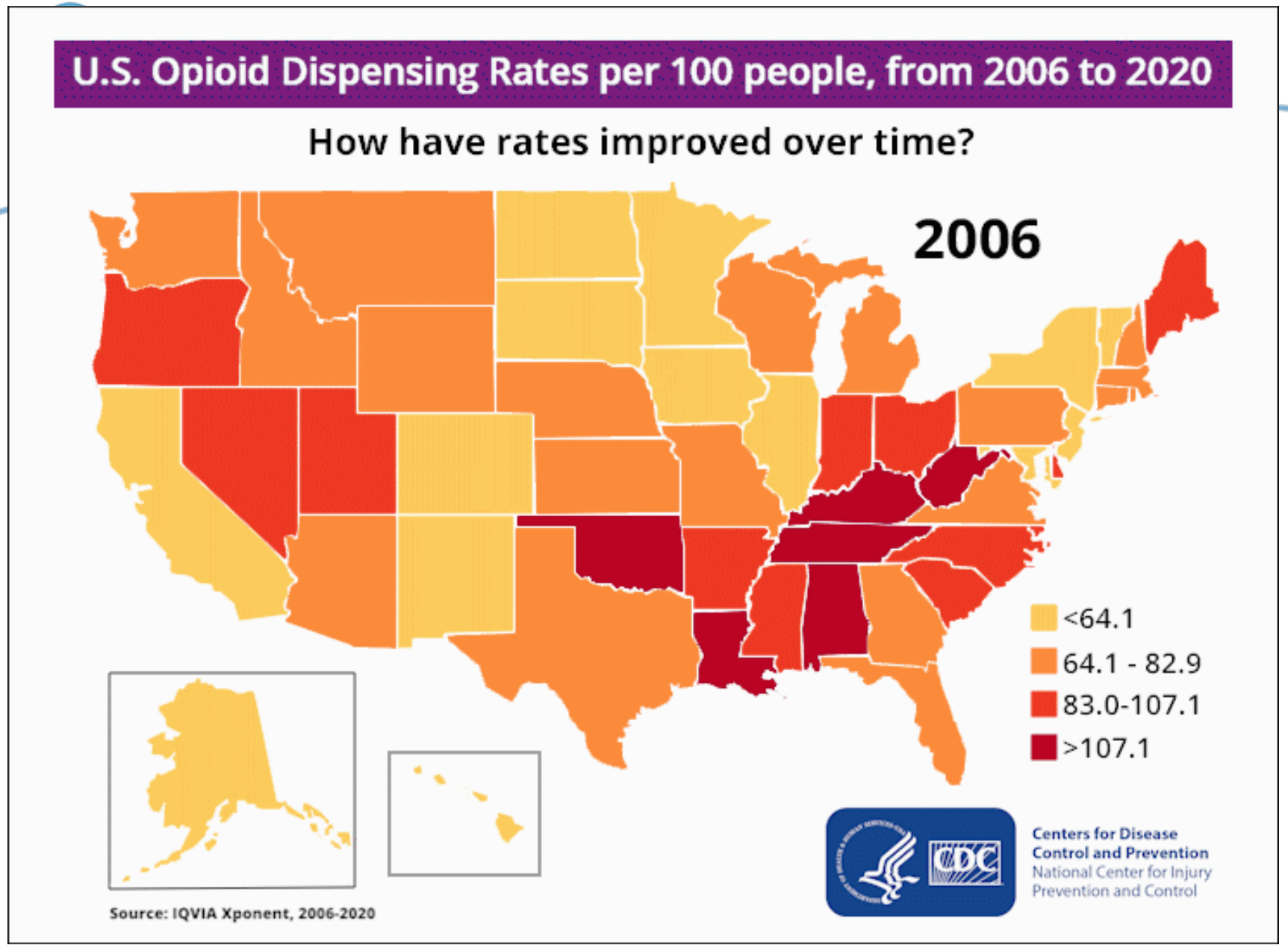


Figure 1a. 12 Month-ending Provisional Counts of Drug Overdose Deaths: Colorado





Colorado (2021) [US]

- ❑ 2.6% reduction opioid prescriptions [2.6%]
- ❑ 47% reduction opioid prescriptions since 2012 [46%]
- ❑ 6.7% reduction MED [6.9]
- ❑ 67% reduction MED since 2012 [57%]

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US Opioid Prescribing

American Medical Association survey of state PDMP queries: 2014-2021

State	Queries 2021	Queries 2020	Queries 2019	Queries 2018	Queries 2017	Queries 2016	Queries 2015	Queries 2014
Alabama	5,563,430	5,394,393	4,473,939	3,550,475*				
Alaska	1,128,794	1,225,673	578,637	599,317	553,917	147,378	69,282	45,145
Arizona	11,156,832	10,133,381	9,839,154	8,883,314	5,136,594	3,975,220	1,548,774	
Arkansas	19,781,120	15,516,746	12,764,550	6,650,191	4,092,529	2,536,448	734,625	555,240
California	6,469,970	3,626,652	31,756,988	13,672,277	9,977,133	9,581,280	6,174,394	3,553,551
Connecticut	7,147,246	2,304,504	2,003,530	1,872,430		974,815	484,736	250,662
Colorado	2,495,696	6,031,272	5,883,754	4,401,923		1,515,839	898,000	682,600

- High dose prescribing decreased by 43%
- 2 million physicians registered for state-based PDMPs

Sources: Xponent, IQIVA

IQVIA Institute for Human Data Science. Parsippany: IQVIA; May 9, 2019.

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Reductions in opioid prescribing have not led to reductions in drug-related mortality

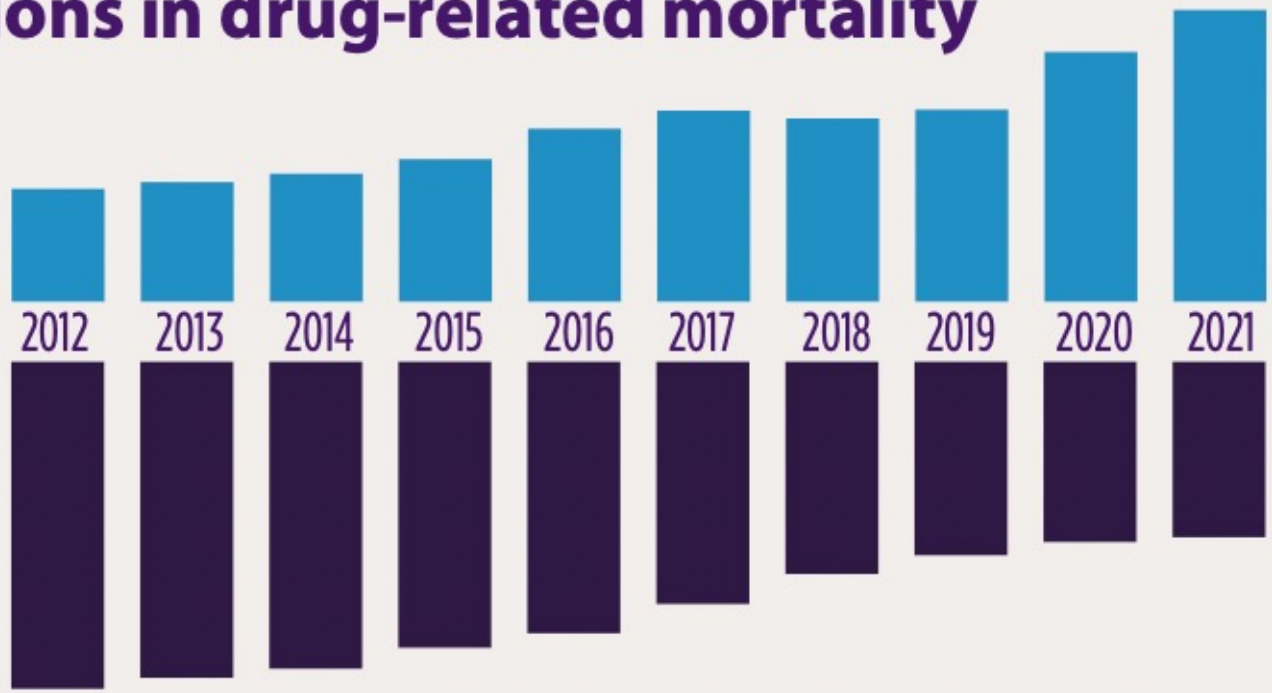
2021 overdose deaths:

107,521*

2021 opioid prescriptions:

139,617,469[1]

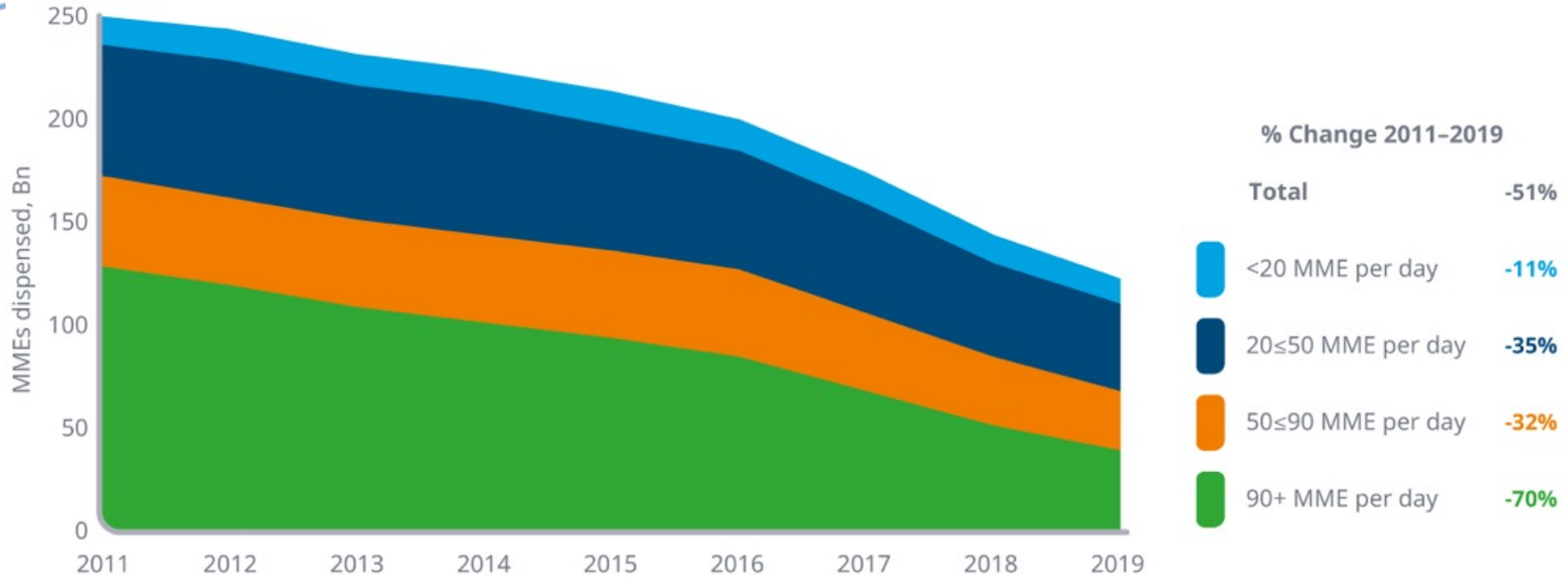
(46.4% decrease since 2012)



*Provisional data for the 12-month period Jan. 2021–Dec. 2021

https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

Opioid Use by MME/Day (2011-2019)



Source: IQVIA Xponent, Mar 2020; IQVIA Institute, Nov 2020
Exhibit Notes: Opioid medicines are categorized and adjusted based on their relative intensity to morphine, called a morphine milligram equivalent (MME), see Methodology. Medicines identified by MME potency at molecule, form and strength level, and divided by days supply at a prescription level to determine MME/day per prescription. Analysis is based on opioid medicines for pain management and excludes those medicines used for medication-assisted opioid use dependency treatment (MAT) or overdose recovery.
Report: Prescription Opioid Trends in the United States. IQVIA Institute for Human Data Science, December 2020.

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Pharmacovigilance & Balanced Care

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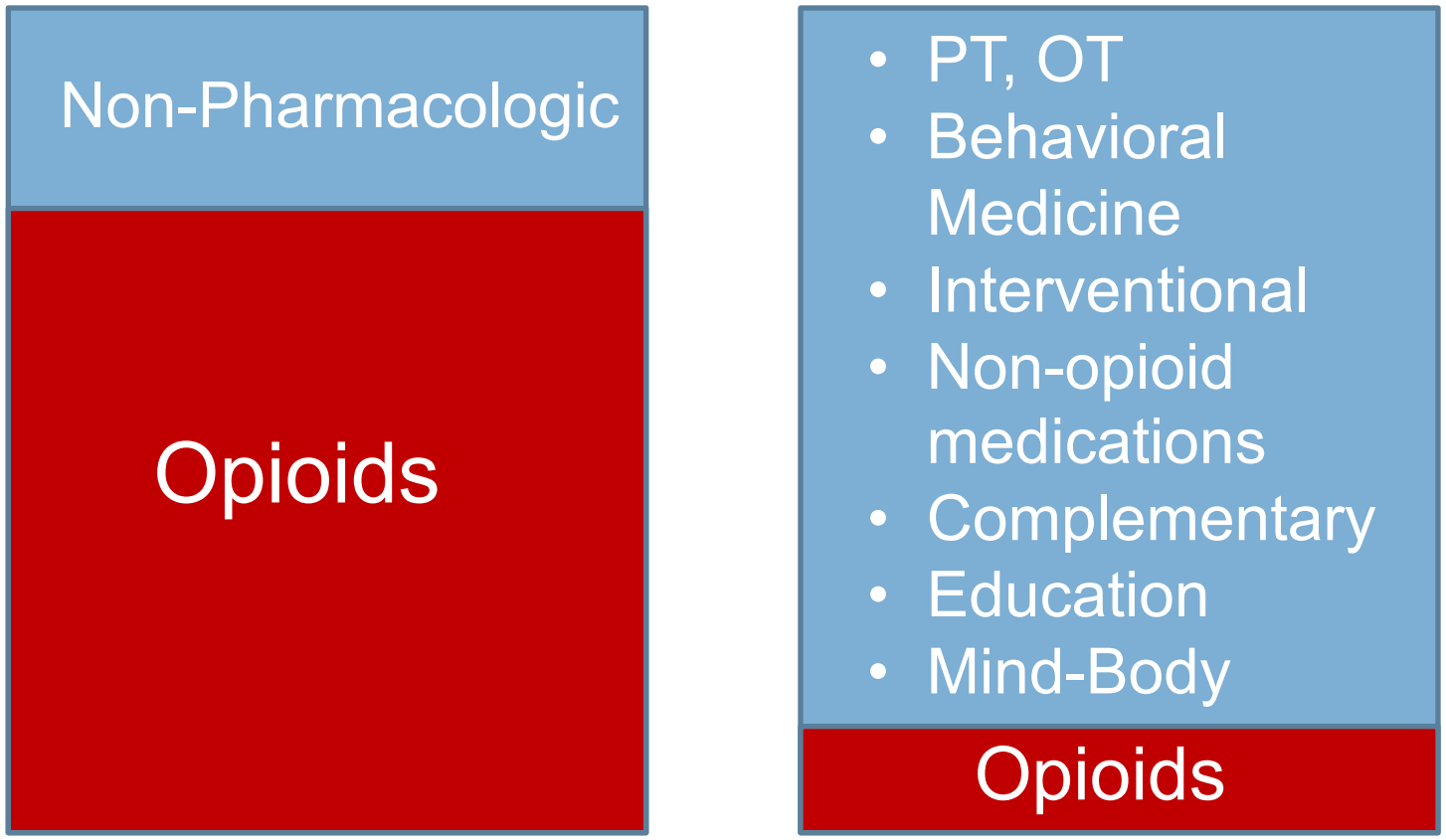
Opioid Therapy: Current & Future State

Therapeutic Options



PAST → PRESENT → FUTURE

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2 Considerations for Pain Management

1. Negative Affect
2. Opioid Receptor: Beyond Analgesia

VAS: Visual Analogue Scale

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1. Negative Affect (NA)

- Pain: aversive physical & emotional state
- Correlates with increased pain intensity and poorer function with LBP patients[1]
- NA as a stronger predictor of opioid misuse vs pain level[2]
- NA psychopathology predicts poor outcome in chronic LBP[3]
- High NA group: higher daily MED vs lower pain relief, greater rate of opioid misuse (39% vs 8%), and greater opioid side effects[4]

1. Dworkin et al 1986
2. Gatchel and Dersh, 2002.
3. Rapp 1996
4. Wasan A, et al Anesthesiology 2015..

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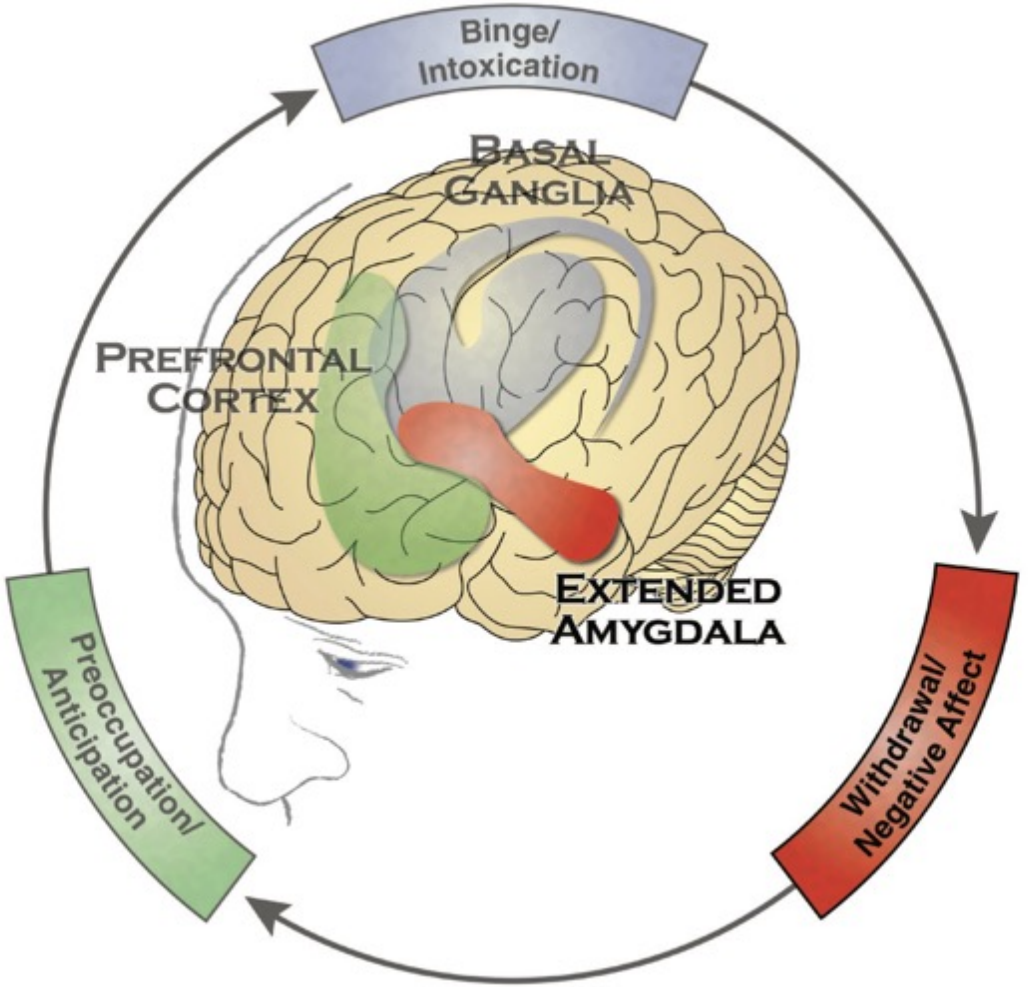
General

Analgesia
Altered mood
Decreased anxiety
Respiratory depression
Inhibition central reflexes
(-) GI motility
Cough suppression
(-) CRF, ACH
Miosis
Pruritus, nausea, vomiting



Reinforcing Effects

Reduce anxiety
Decrease boredom
Decrease aggression
Increase self-esteem

1. Epstein S. In: *Clinical Manual Addiction Psychopharmacology*, 2005.
2. *Facing Addiction In America. Surgeon General's Report*. US Dept. HHS, 2016.

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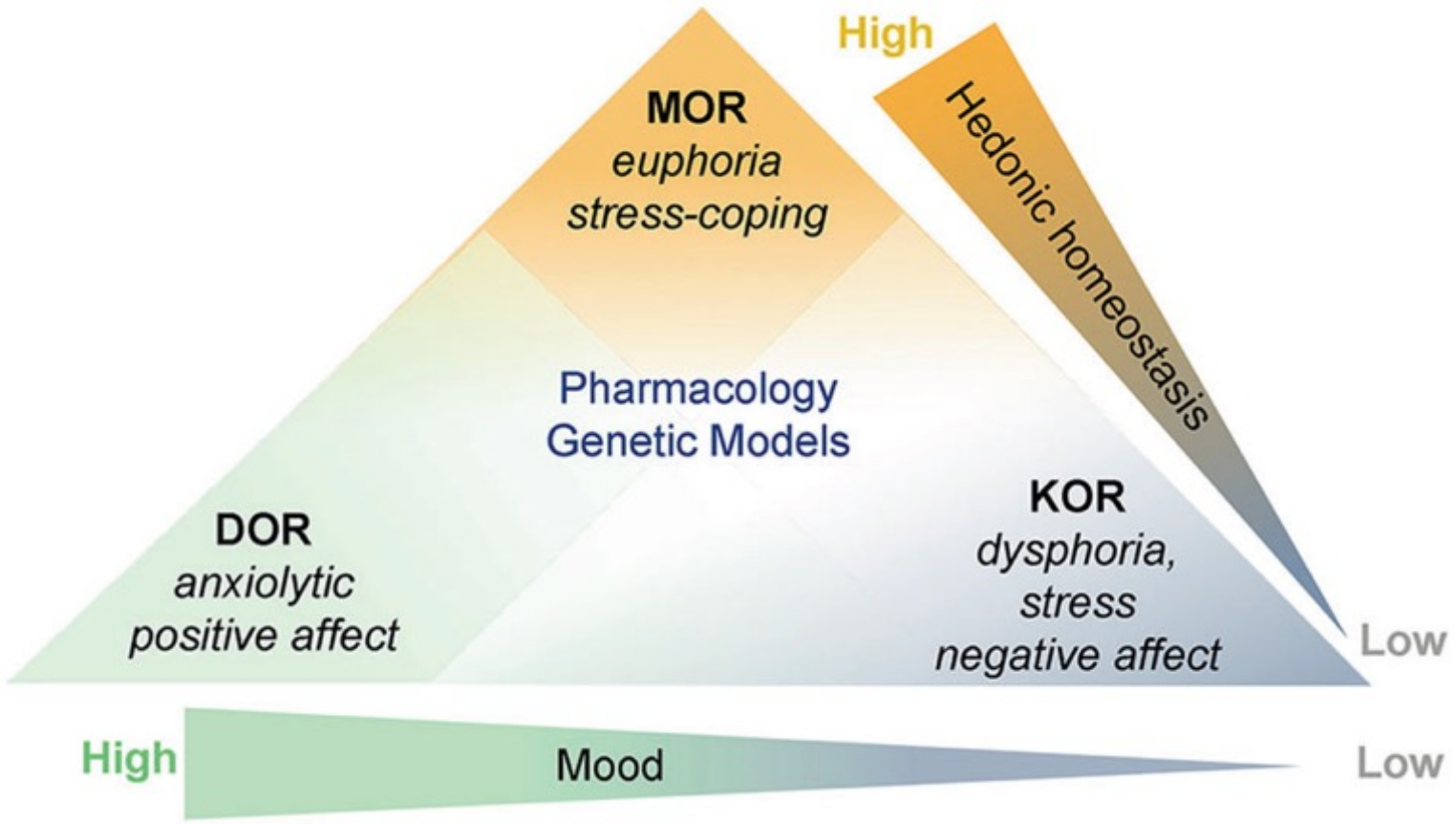
Opioid Receptor Activity
Mood, Euphoria, Reward Continuum



Valentino R Vokow N, *Neuropsychopharmacology* 2018;43:2514-2520.

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Legislative and Regulatory Update: Opioid Prescribing

THE UNITED STATES DEPARTMENT of JUSTICE

Ruan v United States: Supreme Court

- Unanimous decision supporting physicians originally charged and convicted for violating Controlled Substance Act (SCA)

FOR IMMEDIATE RELEASE — Wednesday, March 9, 2022

16 Defendants, Including 12 Physicians, Sentenced to Prison for Distributing 6.6 Million Opioid Pills and Submitting $250 Million in False Billings

as aiming to prevent, cure, or alleviate the symptoms of a disease or injury

"…acting 'as a physician' does not invariably mean acting as a *good* physician […] A doctor who makes negligent or even reckless mistakes in prescribing is still 'acting as a doctor' — he or she is simply acting as a *bad doctor*." - Justice Alito

National Pain Strategy (NPS)

National Pain Strategy
A Comprehensive Population Health Level Strategy for Pain

"The government's first broad-ranging effort to improve how pain is perceived, assessed, and treated: a significant step toward the ideal state of pain care."

HEAL Initiative

Helping to End Addiction Long Term

SUPPORT (HR6):
Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients & Communities

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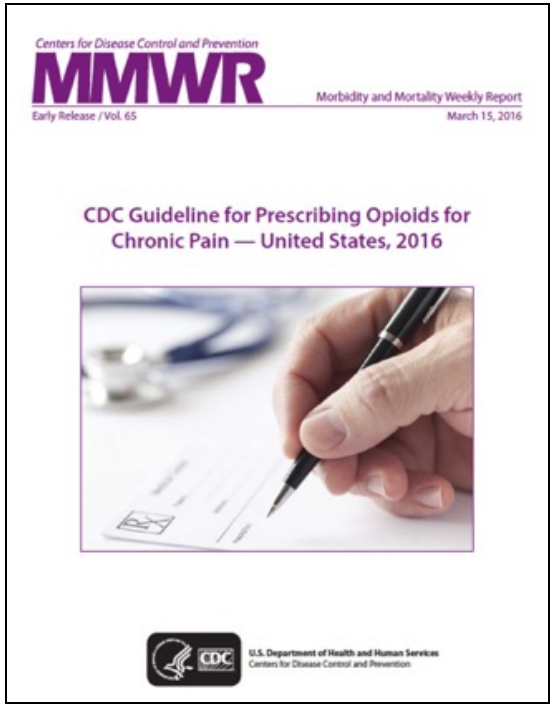
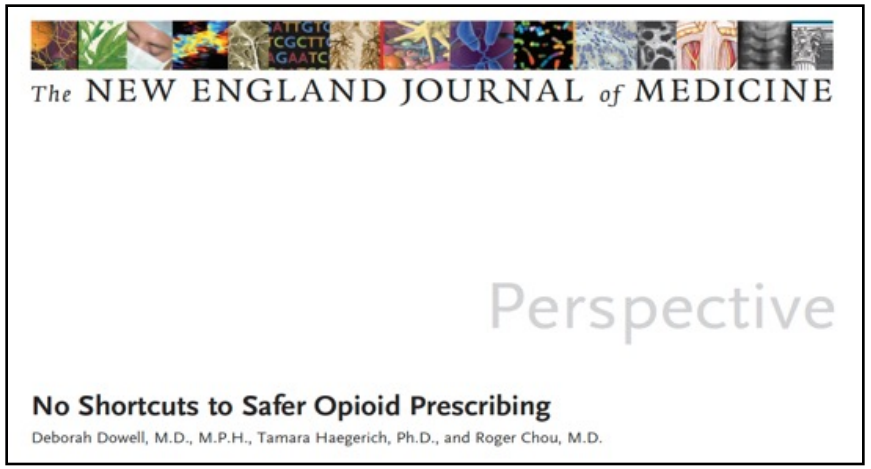
CDC Guideline for Prescribing Opioids



CDC, March 15, 2016



Dowell, Haegerich, Chou. *NEJM* 2019;

CDC, February 2022

Final Update Pending

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Options for Balanced Care

- HHS Pain Management Task Force Report
- Addressing opioid overdose and pain management
- CMS proposals for pain management

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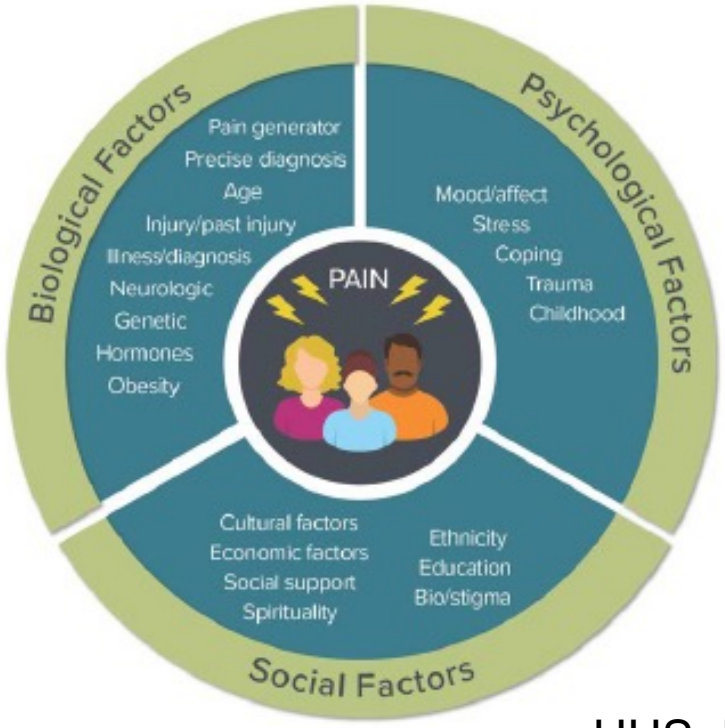
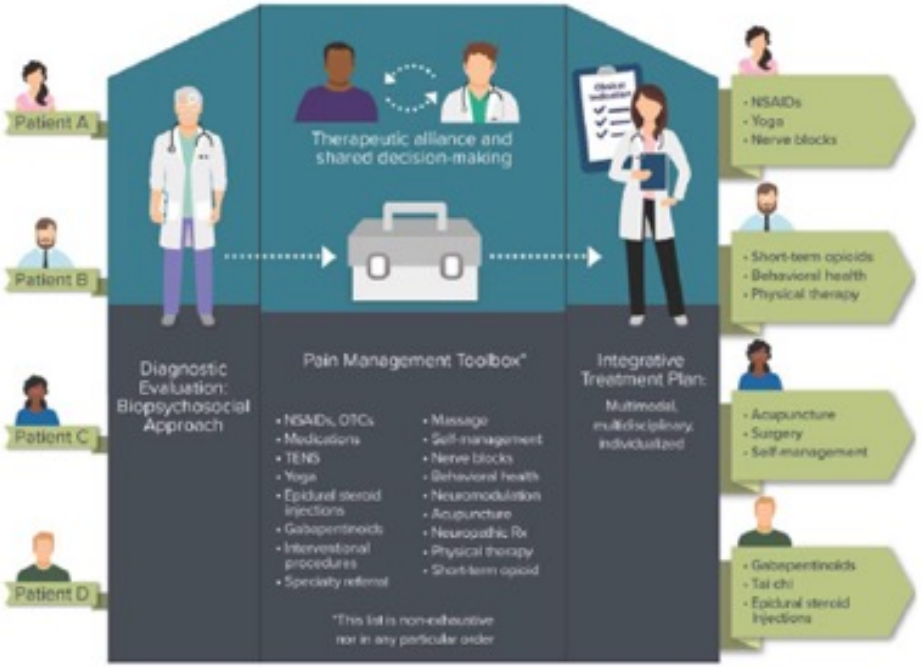
HHS.gov
Office of the Assistant Secretary for Health

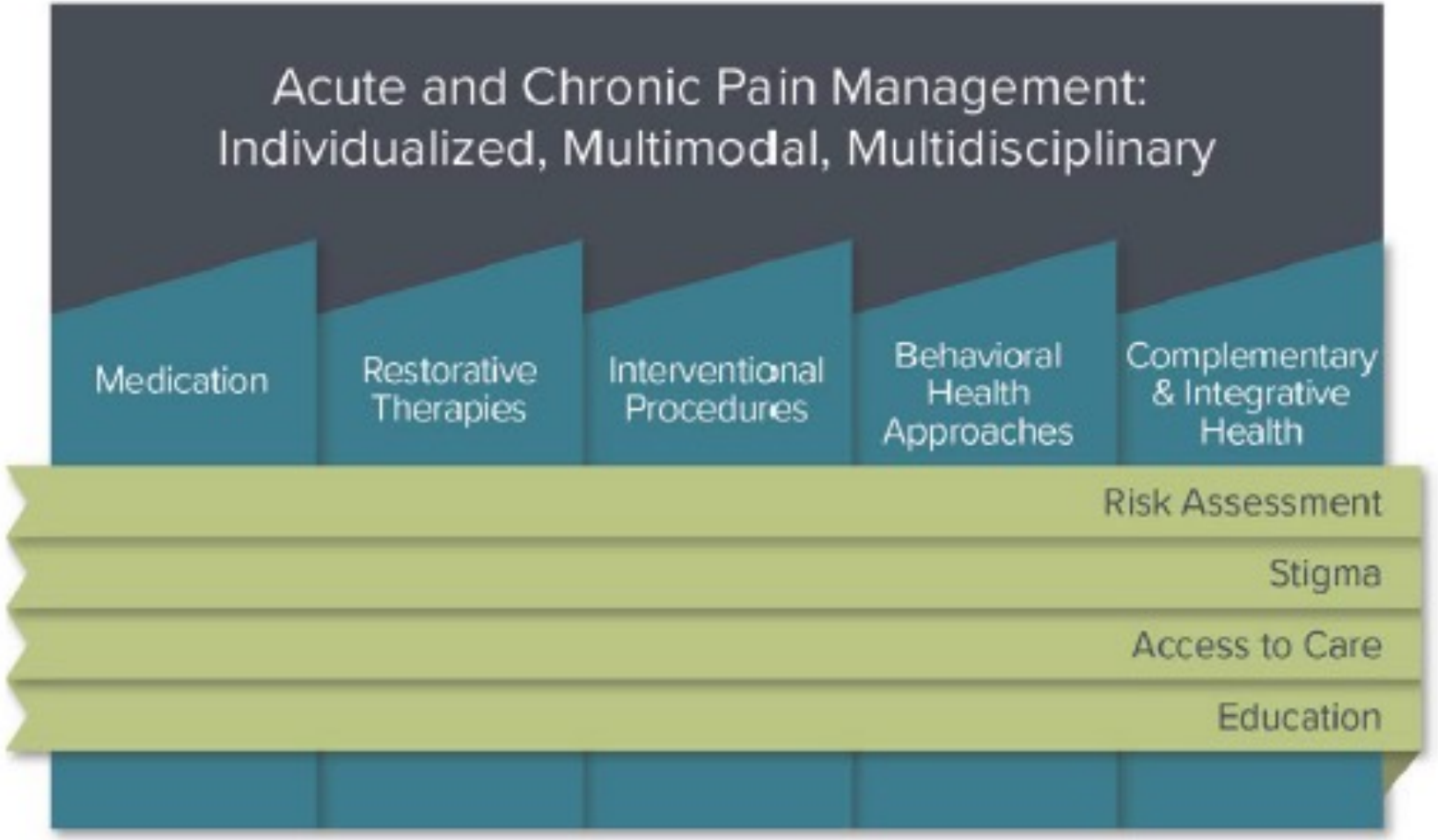
HHS Pain Management Interagency Task Force





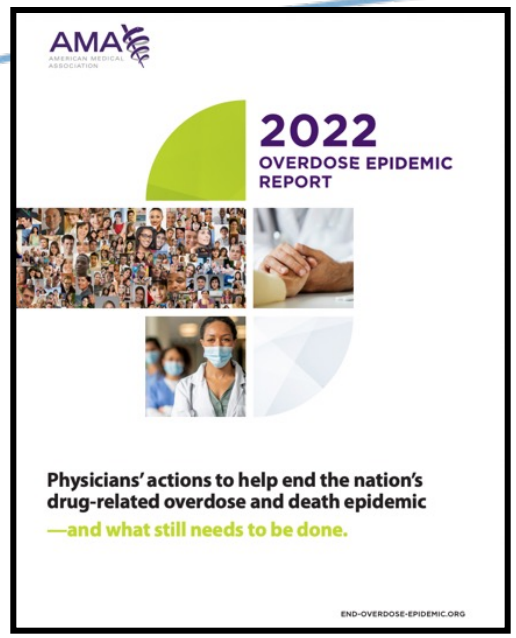
HHS: Interagency Task Force

https://www.hhs.gov/ash/advisory-committees/pain/reports/2018-12-draft-report-on-updates-gaps-inconsistencies-recommendations/index.html. May 6, 2019.



https://www.hhs.gov/ash/advisory-committees/pain/reports/2018-12-draft-report-on-updates-gaps-inconsistencies-recommendations/index.html. May 6, 2019.

END the EPIDEMIC



46.4% decrease in opioid prescriptions
from 260.5M in 2012 to 139.6M in 2021[1]

Increase in PDMP use and nearly **4B queries** since 2014[2]

1.1B

61.5M

- Comprehensive state and community-based solutions by all stakeholders with physicians
- Increase access to MOUD & harm reduction initiatives
- Support syringe services programs
- Remove barriers and increase access to evidence-based pain care

https://end-overdose-epidemic.org

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Current Federal Initiatives: 2022

- CMS Proposed Rule Change (public comment ended Sept 9, 2022)
  - Valuation of codes. Comprehensive pain management
  - Chronic Pain Management (CPM codes) added

1. AHRQ, Draft: Integrated Pain Management Programs, June 2021.
2. CMS. Proposed Rule Change. Federal Register Volume 86, Number 139 (Friday, July 23, 2021)] [Proposed Rules] [Pages 39104-39907

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Strong Opioids or Nonopioid Therapy for Chronic Pain: Systematic Review, Meta-analyses

- 16 PCRC CLPB, 5 CNCP
- Very low to low certainty findings with short or intermediate term opioid therapy may cause relevant reductions in pain, but also GI and nervous system AEs, and no effect on disability
- Long-term opioid therapy in CNCP may not be superior to nonopiods in improving pain or disability, or function, but associated with more AEs, abuse or dependence

Nury E, et al. PAIN. 2022;163(4):610-636.

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Forced Tapering of Opioids

https://www.hrw.org/news/2018/12/18/us-fears-prescribing-hurt-chronic-pain-patients

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Tapering & Overdose Studies

Kaiser Permanente CO study[1]:

- opioid dose fluctuation associated with increased overdose risk
- 228 of 14,998 patients with opioid overdose: high dose variability (>27 MED) associated with overdose vs low dose

Mortality Increased After Discontinuation in PC-Based Clinic[2]

- COT discontinued in 60% of patients; increased risk for overdose (1.3), death (2.9)
- Discontinuation did not reduce risk of death, but increased risk of overdose
- Disruption of continuity of care destabilized patients

1. Glanz J, et al. *JAMA Netw Open*. 2019;2(4):e192613.
2. James J, et al. *J Gen Intern Med. 2019;34(12):2749-2755.*

Tapering and Deprescribing Considerations

- Patient tapered & maintained at lower doses still benefited when used as part of multidisciplinary approach (Turner JA, et al. *PAIN* 2016;157:849-857)
- Potential harm with deprescribing in high-dose, high-risk patients (Halvik et al. *PAIN* 2022;163:83-90.
- Meta-analysis of deprescribing: small number of RPCs, none included low risk patients, limited by heterogeneity, making recommendations challenging (Mathieson S. *Drugs*. 2021;80:1577-1578)

What Patients Want

- Perspective of patients related to deprescribing
- Barriers to opioid deprescribing: fears of pain, withdrawal effects, opioid-related stigma, perceived inadequacies of the HC system
- Success improved by greater communication about expectations of deprescribing and goals of care, provision of greater opportunities for patient engagement in decision making
- Focus on targeting behavioral change

Langford, A. et al. *PAIN* 2021;162(11):2686-2692.

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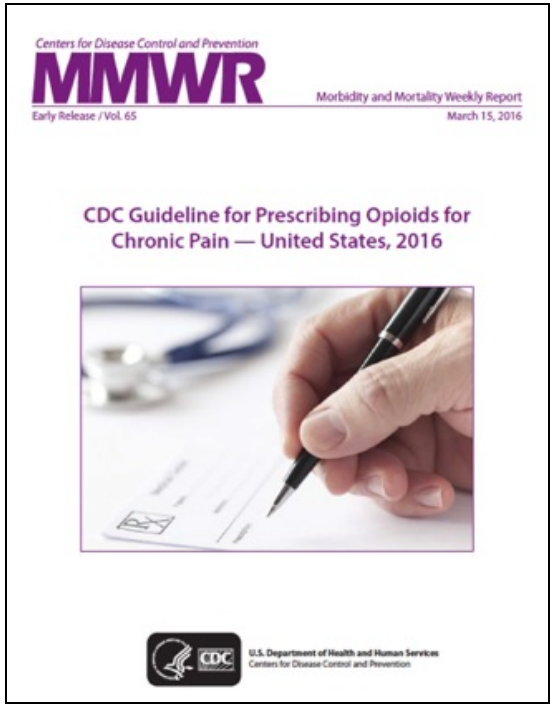
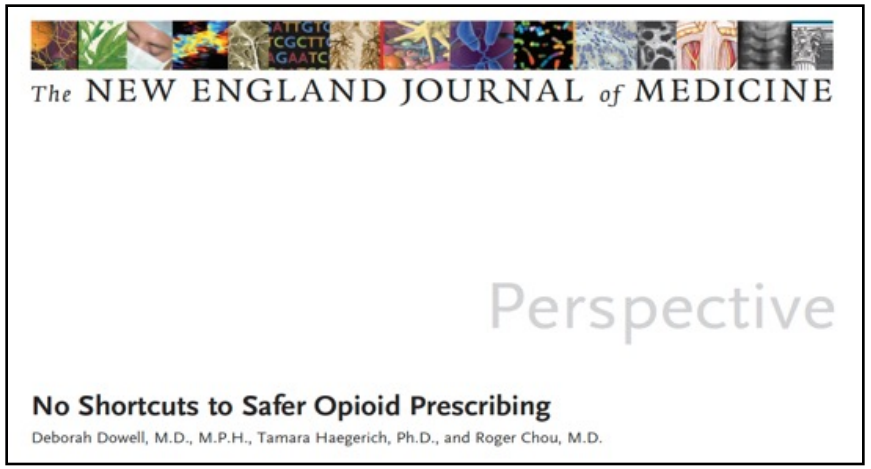
CDC Guideline for Prescribing Opioids



CDC, March 15, 2016



Dowell, Haegerich, Chou. *NEJM* 2019;

CDC, February 2022

Final Guideline Pending

CDC Guideline for Prescribing Opioids for Chronic Pain

Determining need for opioids

- Opioids are not first-line or routine therapy for chronic pain.
- Establish and measure goals for pain and function.
- Discuss benefits and risks of opioid therapy and availability of nonopioid therapies.

Opioid selection, dosage, and duration of therapy

- Use immediate-release opioids when starting.
- Use caution at any dose. Reassess benefits and risk when dose reaches >50 MME and avoid increasing dose to > 90 MME without carefully justifying decision.
- Long-term use begins with treatment of acute pain. 3 days or less is often sufficient.
- Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed.

Assessing risk and addressing harm

- Evaluate risk factors for opioid-related harms.
- Check PDMP for high dosages and prescriptions from other providers.
- Use urine drug testing to identify prescribed substances and undisclosed use.
- Avoid concurrent benzodiazepine and opioid prescribing.
- Arrange treatment for OUD if needed.

Dowell D, et al. *MMWR Recomm Rep* 2016;65(1):1-49.

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CDC
Centers for Disease Control and Prevention

Established patients already taking high dosages of opioids

- "…tapering opioids can be especially challenging after years on high dosages because of physical and psychological dependence."

- Offer in a "nonjudgmental manner"… "the opportunity to re-evaluate their continued use of opioids at high dosages in light of recent evidence regarding the association of opioid dosage and overdose risk."

- Empathically review benefits and risks of continued high-dosage opioid therapy" and "offer to work with the patient to taper opioids to safer dosages"

- "Very slow opioid tapers as well as pauses in the taper to allow gradual accommodation to lower opioid dosages."

- Be aware that anxiety, depression, and opioid use disorder "might be unmasked by an opioid taper"

Centers for Disease Control and Prevention MMWR March 15, 2016; 65:p23

Simple Interventions to Decrease Overdoses and Adverse Events

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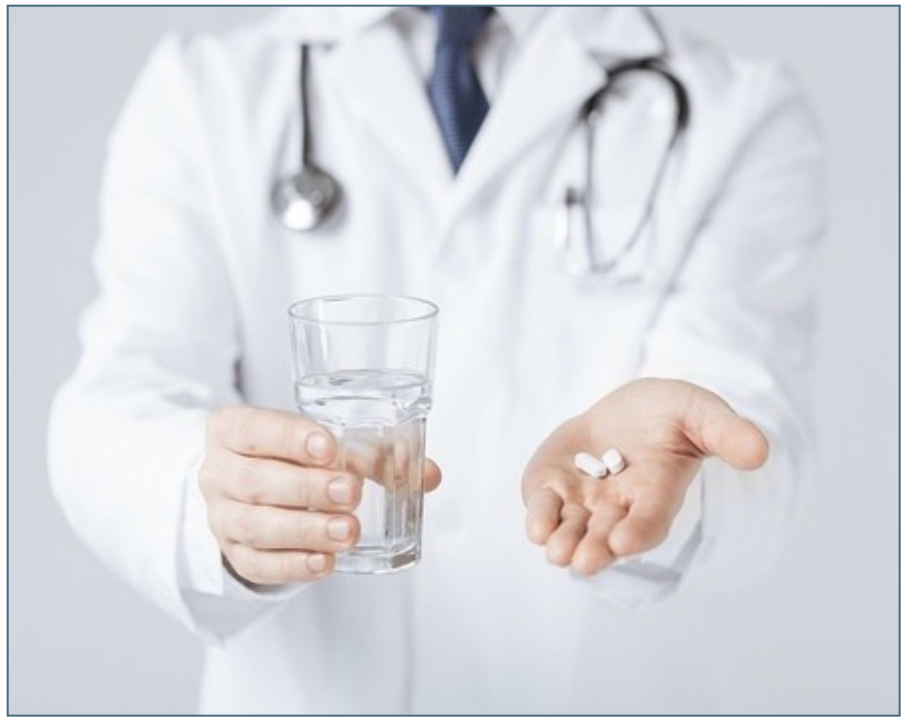
What about unused medications?

ecnmag.com



1. Brummett C, et al. *JAMA Surg* 2017;152(6):e170504.
2. Hill et al. *Ann Surg*, 2016:265:709-714.

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MED-Project
Medication Education & Disposal

Kiosk is open for general public and employee use.
Free, safe, and convenient kiosks for disposing of unwanted medicine from households.

Remove all personal and identifying information from medication labels before disposal.

Kiosk may accept the following:

- Pharmaceutical non-controlled prescriptions
- Pharmaceutical controlled substance prescriptions (Federally Scheduled II through V only)
- Pharmaceutical over-the-counter medications that residents use in their homes, residential settings or long-term care facilities
- Only medications used for residential use may be accepted

Swedish Kiosk Locations

Ballard
ER Waiting Room
Cherry Hill
Main Lobby
Edmonds
Main Lobby
First Hill
3rd Floor Arnold Building
Issaquah
Main Lobby

Search for other locations:
https://med-project.org/

Kiosk may NOT accept the following:

- Medical sharps and needles
- Schedule I illegal substances
  - Marijuana – is a federally scheduled I illegal controlled substance
- Vitamins and supplements
- Herbal-based remedies and homeopathic drugs, products or remedies
- Cosmetics, shampoos, sunscreens, toothpaste, lip balm, antiperspirants
- Personal care products that are regulated as both cosmetics and nonprescription drugs
- Compressed cylinders or aerosols (ie. Inhalers)
- Iodine-containing medications
- Mercury containing thermometers

fda.gov

https://www.fda.gov/drugs/safe-disposal-medicines/disposal-unused-medicines-what-you-should-know

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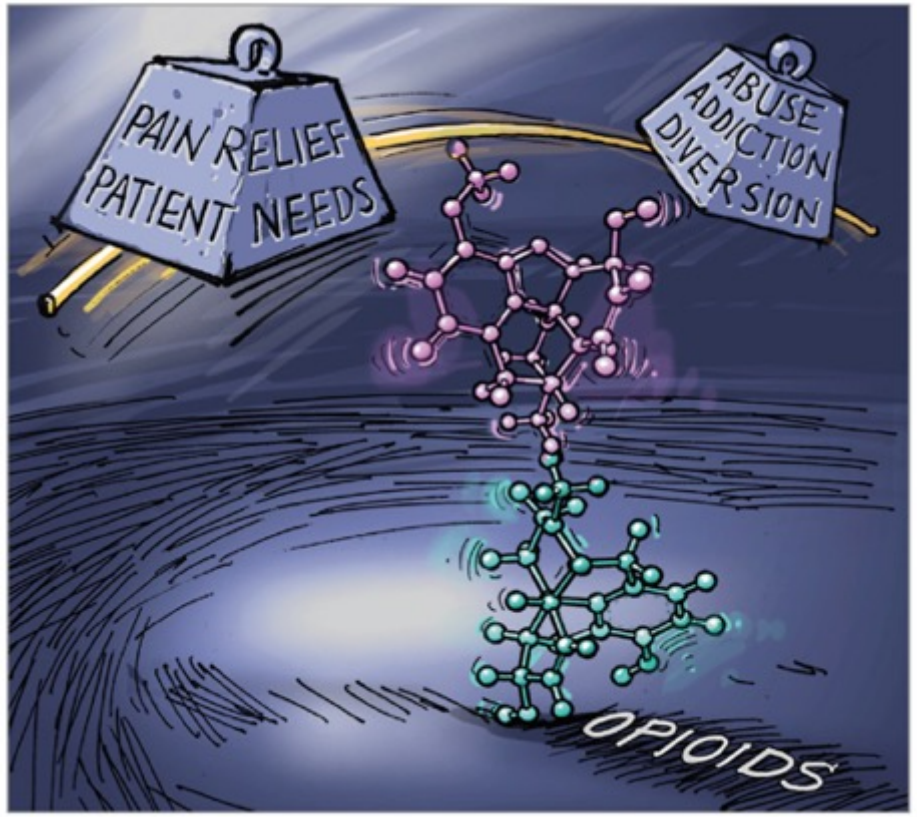
Opioid Tapering, Deprescribing



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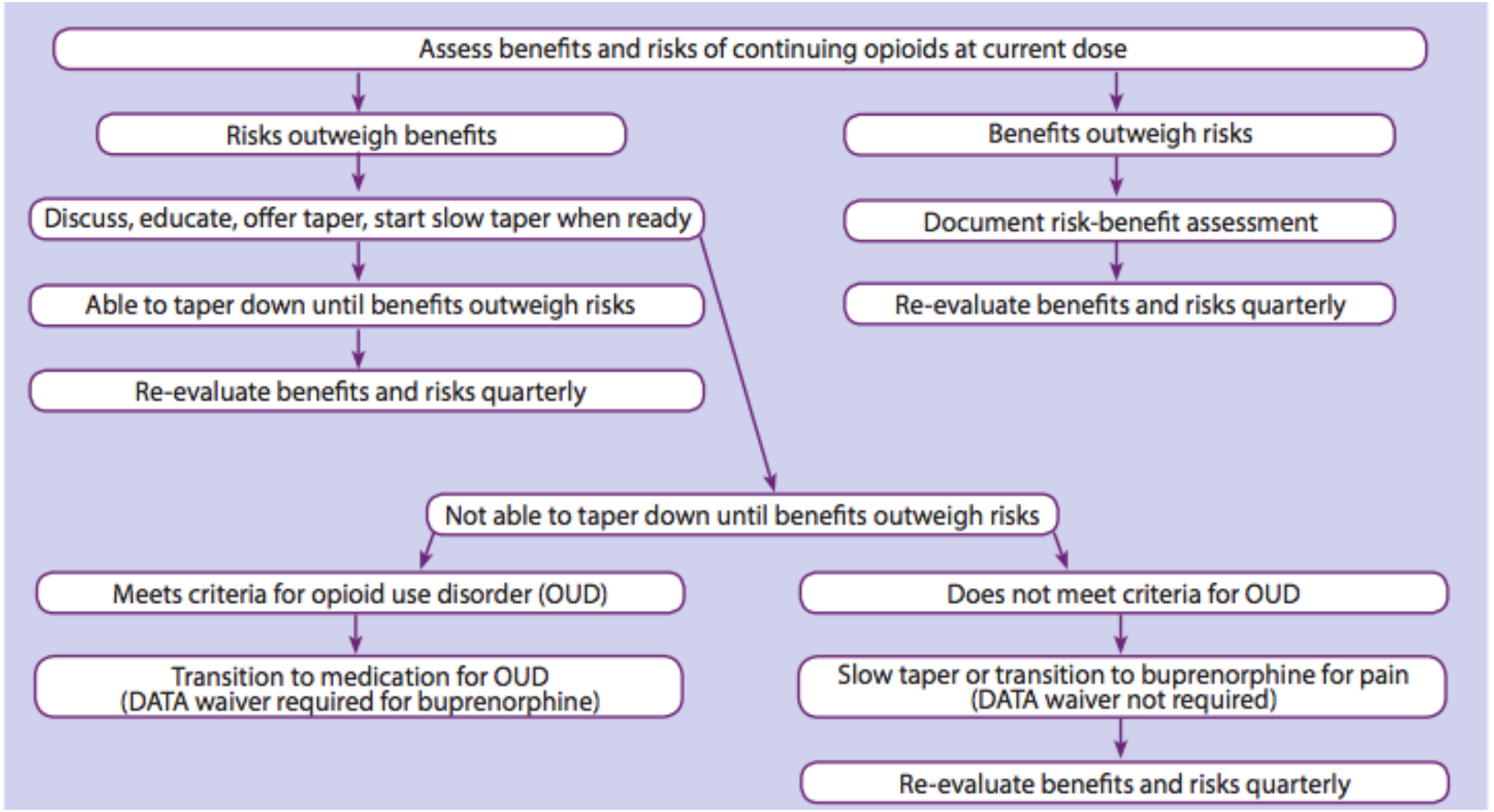
Opioid Tapering: When and How

- Only after thorough assessment of the risk-benefit ratio
- Consider patient-centered compassionate tapering when risks outweigh the benefits
- Assessment should be conducted in collaboration with the patient
- Opioids should not be tapered rapidly or discontinued suddenly
- When tapering, consider underlying comorbidities
- Consider maintaining therapy for patients who are stable on long-term opioid therapy and for who the benefits outweigh the risks

U.S. Department of Health and Human Services. Pain Management Best Practices Inter-Agency Task Force Report: Updates, Gaps, Inconsistencies, and Recommendations. Published May 9, 2019. Available at https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf. Accessed October 2, 2021.

Opioid Tapering Flowchart



Adapted from Oregon Pain Guidance. Tapering – Guidance & Tools. Available at https://www.oregonpainguidance.org/guideline/tapering/. HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics. Published October 2019. Available at https://www.hhs.gov/opioids/sites/default/files/2019-10/Dosage_Reduction_Discontinuation.pdf. Access October 2, 2021.

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Setting Treatment Goals

- CLBP is characterized by a complex interaction between pain, function, and biopsychosocial factors such as patient motivation and confidence[1]
- Putting patients in the principal role of goal setting based on *what is directly important to them* may have a greater likelihood of behavior change[2]
- Pilot study (n = 20) investigated patient-led goal setting to improve disability, pain, quality of life, pain self-efficacy and fear avoidance beliefs in CLBP[2]

1. Hartvigsen J, et al. *Lancet*. 2018;391:2356-2367.; 2. Gardner T, et al. *Br J Sports Med*. 2019;0:1-9.

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Patient-led Goal Setting

Session 1: Wk 1

- Orientation
- SMART goals
- Strategies
- History taken
- Advice about exercise

Sessions 3-4: Wk 5-7

- Review of goals, progress, barriers to achieving goals
- Strategies developed

Postintervention: 3 Mo

- Review of goals, progress, barriers to achieving goals

12 Mon Outcomes Measured

Session 2: Wk 3

- Education and discussion
- Review of goals, progress, barriers
- Strategies developed

Session 5: 2 Mon

- Review of goals, progress, barriers
- Strategies developed
- Outcomes measured
- Review of exercise
- Outcomes measured

Session 5: 2 Mon

- Review of goals, progress, barriers
- Strategies developed
- Outcomes measured
- Review of exercise
- Outcomes measured

Gardner T, et al. *Br J Sports Med*. 2019;0:1-9

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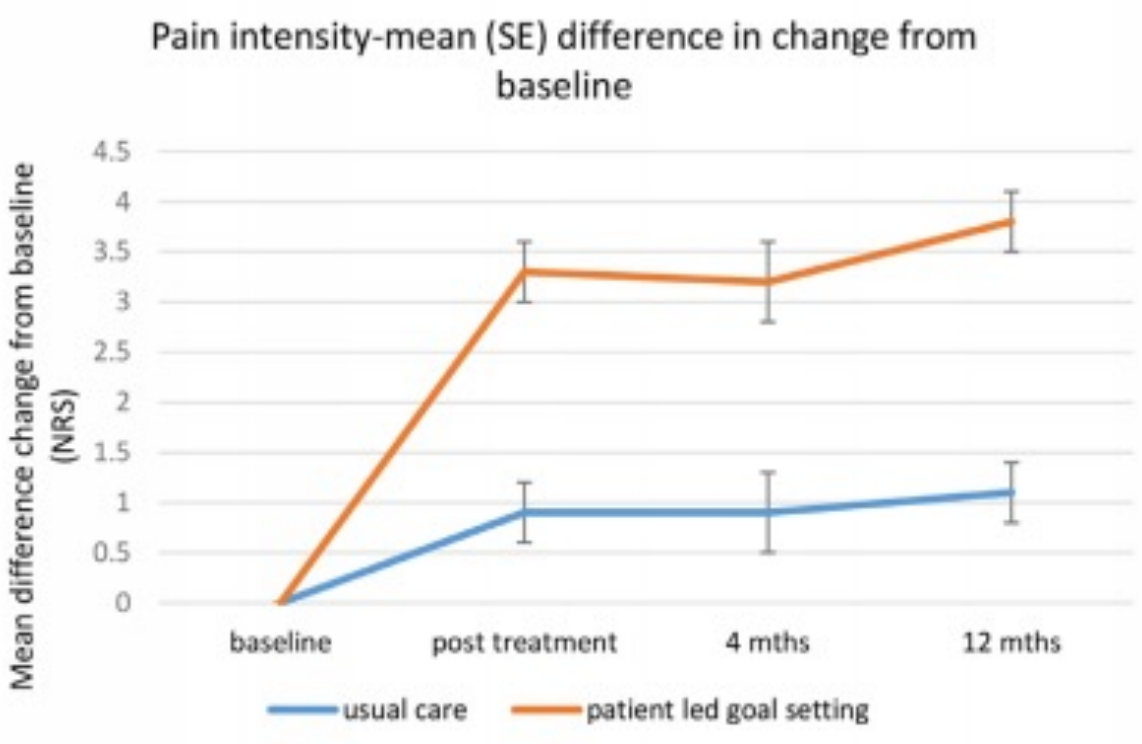

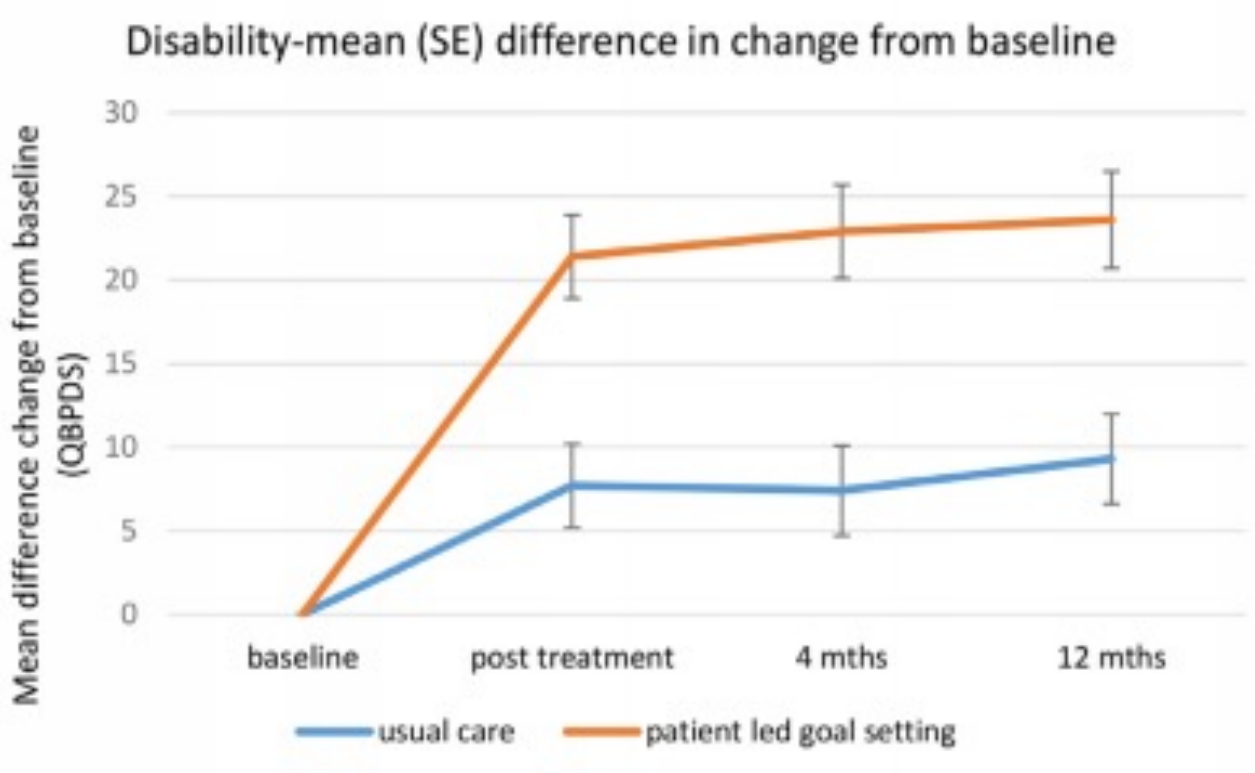

Change From Baseline for Primary Outcomes of Pain and Disability

Gardner T, et al. *Br J Sports Med*. 2019;0:1-9

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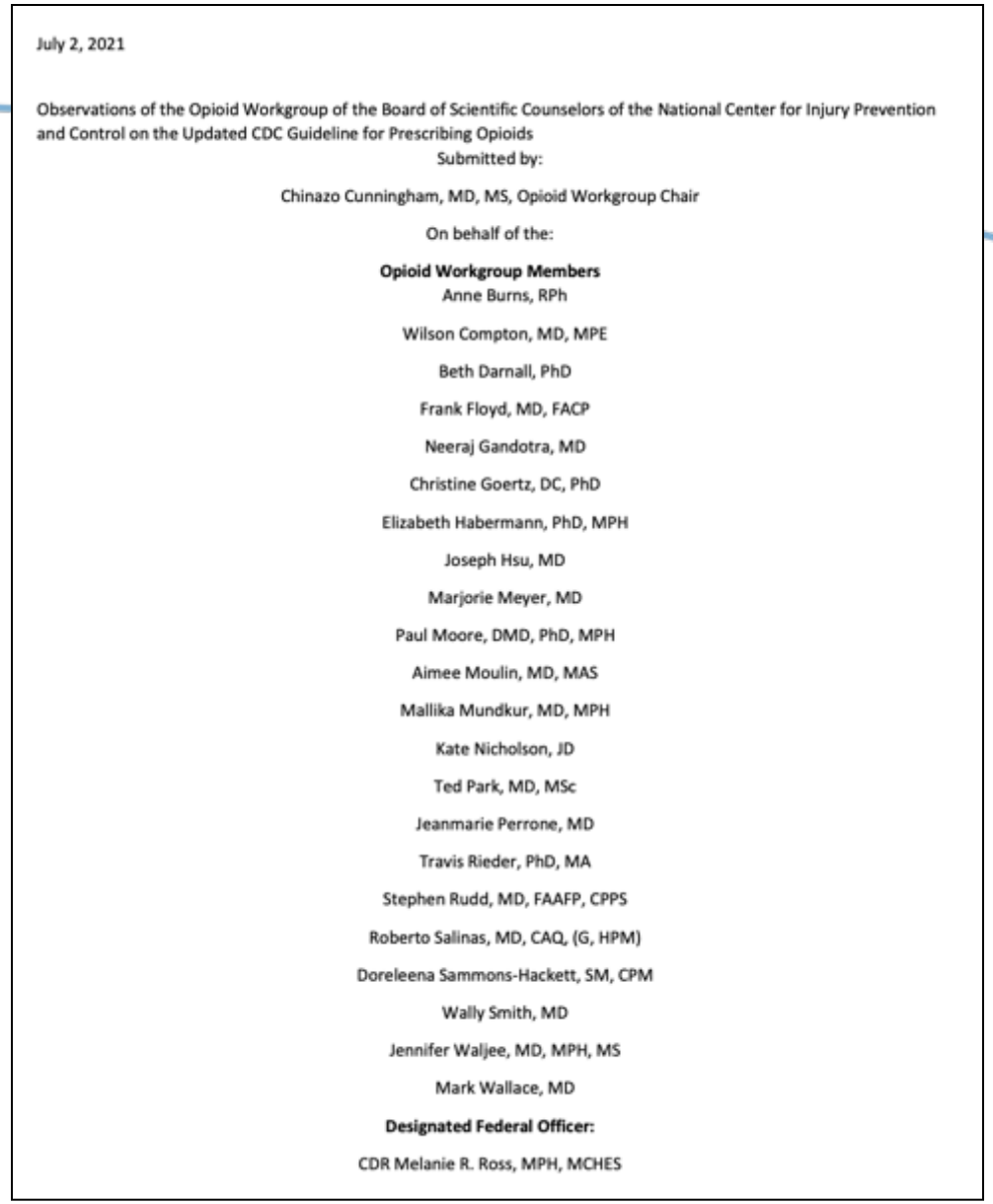
Request to Revise CDC Guideline: Opioid Work Group Report

- Reviewed Draft Revision of 2016
- Endorsed by Board of Scientific Counselors
- Revised guideline to be posted in late 2021



July 2, 2021

Observations of the Opioid Workgroup of the Board of Scientific Counselors of the National Center for Injury Prevention and Control on the Updated CDC Guideline for Prescribing Opioids

Submitted by:

Chinazo Cunningham, MD, MS, Opioid Workgroup Chair

On behalf of the:

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Mark Wallace, MD

Designated Federal Officer:

CDR Melanie R. Ross, MPH, MCHES

https://www.cdc.gov/injury/pdfs/bsc/OWG-Report-of-Recs-1-12-06.30.21-FINAL-508.pdf

	2016 CDC Opioid Prescribing Guideline	2021 Draft CDC Opioid Prescribing Guideline
1	Nonpharmacologic and nonopioid therapy is 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.	Nonopioid therapies are preferred for many common types of acute pain. Clinicians should only consider opioid therapy only for acute pain only if benefits are anticipated to outweigh risks to the patient.
2	Before starting therapy for chronic pain 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.	Nonopioid therapies are preferred for subacute and chronic pian. Discuss with patients known risks and realistic benefits of opioid therapy, establish treatment goals for pain and function, and consider how opioid therapy will be discontinued if benefits do not outweigh risks.

Dowell D, et al. *MMWR Recomm Rep* 2016;65(1):1-49.; U.S. Pain Foundation. https://files.constantcontact.com/2476f49d001/d1ec53d7-4cc4-41a4-960e-8858936ca559.pdf. Accessed October 2, 2021.

CME OUTFITTERS

	2016 CDC Opioid Prescribing Guideline	2021 Draft CDC Opioid Prescribing Guideline
3	Clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.	Clinicians should prescribe immediate-release opioids instead of 1 extended-release/long-acting (ER/LA) opioids.
4	When starting opioids for chronic pain clinician should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.	For opioid-naïve patients with acute, subacute, or chronic pain, clinicians should prescribe the lowest effective dosage. If opioids are continued, carefully reassess evidence of benefits and risks when increasing dosage to ≥50 MME/day, avoid dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to >90 MME/day.

Dowell D, et al. *MMWR Recomm Rep* 2016;65(1):1-49.; U.S. Pain Foundation. https://files.constantcontact.com/2476f49d001/d1ec53d7-4cc4-41a4-960e-8858936ca559.pdf. Accessed October 2, 2021.

CME OUTFITTERS

	2016 CDC Opioid Prescribing Guideline	2021 Draft CDC Opioid Prescribing Guideline
5	When opioids are started . . .Prescribe the lowest effective dosage. Reassess evidence of individual benefits and risks when increasing dosage to ≥50 MME/day, avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.	In patients already receiving higher opioid dosages (>90 MME/day), weigh benefits/risks and exercise care when reducing or continuing opioid dosage. Optimize other therapies and work with patients to taper opioids to lower dosages or discontinue opioids.
6	For acute pain, prescribe the lowest effective dose of IR opioids and no greater quantity than needed for the expected duration of pain. 3 days or less will often be sufficient; > 7 days will rarely be needed.	For acute pain, prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. 1-3 days or less will often be sufficient; > 7 days will rarely be needed.

Dowell D, et al. *MMWR Recomm Rep* 2016;65(1):1-49.; U.S. Pain Foundation. https://files.constantcontact.com/2476f49d001/d1ec53d7-4cc4-41a4-960e-8858936ca559.pdf. Accessed October 2, 2021.

CME OUTFITTERS

	2016 CDC Opioid Prescribing Guideline	2021 Draft CDC Opioid Prescribing Guideline
7	Evaluate benefits and harms within 1-4 wks. Evaluate benefits/harms of continued therapy every 3 mon or more frequently. Optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.	Continue for subacute or chronic pain opioid therapy only if clinically meaningful improvement in pain and function that outweighs risks. Evaluate benefits and harms within 1-4 wks. Evaluate benefits and harms of continued therapy with patients every 3 mon or more frequently.
8	Incorporate strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of SUD, ≥50 MME/day, or concurrent benzodiazepine use are present.	Incorporate strategies to mitigate risk, including (omit "considering") offering naloxone when factors that increase risk for opioid overdose, history of overdose, history of SUD, ≥50 MME/day, or concurrent benzodiazepine use, are present.

Dowell D, et al. *MMWR Recomm Rep* 2016;65(1):1-49.; U.S. Pain Foundation. https://files.constantcontact.com/2476f49d001/d1ec53d7-4cc4-41a4-960e-8858936ca559.pdf. Accessed October 2, 2021.

CME OUTFITTERS

	2016 CDC Opioid Prescribing Guideline	2021 Draft CDC Opioid Prescribing Guideline
9	Review state PDMP data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him/her at high risk for overdose when starting opioid and periodically ranging from every prescription to every 3 mon.	Review history of controlled substance prescriptions using state PDMP data when starting opioid therapy for acute or chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 mon.
10	Use urine drug testing before starting opioid therapy and at least annually to assess for prescribed medications	Use drug testing before starting opioid therapy and at least annually to assess for prescribed medications as well as other controlled and illicit drugs.

Dowell D, et al. *MMWR Recomm Rep* 2016;65(1):1-49.; U.S. Pain Foundation. https://files.constantcontact.com/2476f49d001/d1ec53d7-4cc4-41a4-960e-8858936ca559.pdf. Accessed October 2, 2021.

CME OUTFITTERS

	2016 CDC Opioid Prescribing Guideline	2021 Draft CDC Opioid Prescribing Guideline
11	Avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.	Avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible and consider whether benefits outweigh risks of concurrent opioids and other central nervous system depressants.
12	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.	Clinicians should offer or arrange treatment with medication for patients with opioid use disorder.

Dowell D, et al. *MMWR Recomm Rep* 2016;65(1):1-49.; U.S. Pain Foundation. https://files.constantcontact.com/2476f49d001/d1ec53d7-4cc4-41a4-960e-8858936ca559.pdf. Accessed October 2, 2021.

CME OUTFITTERS

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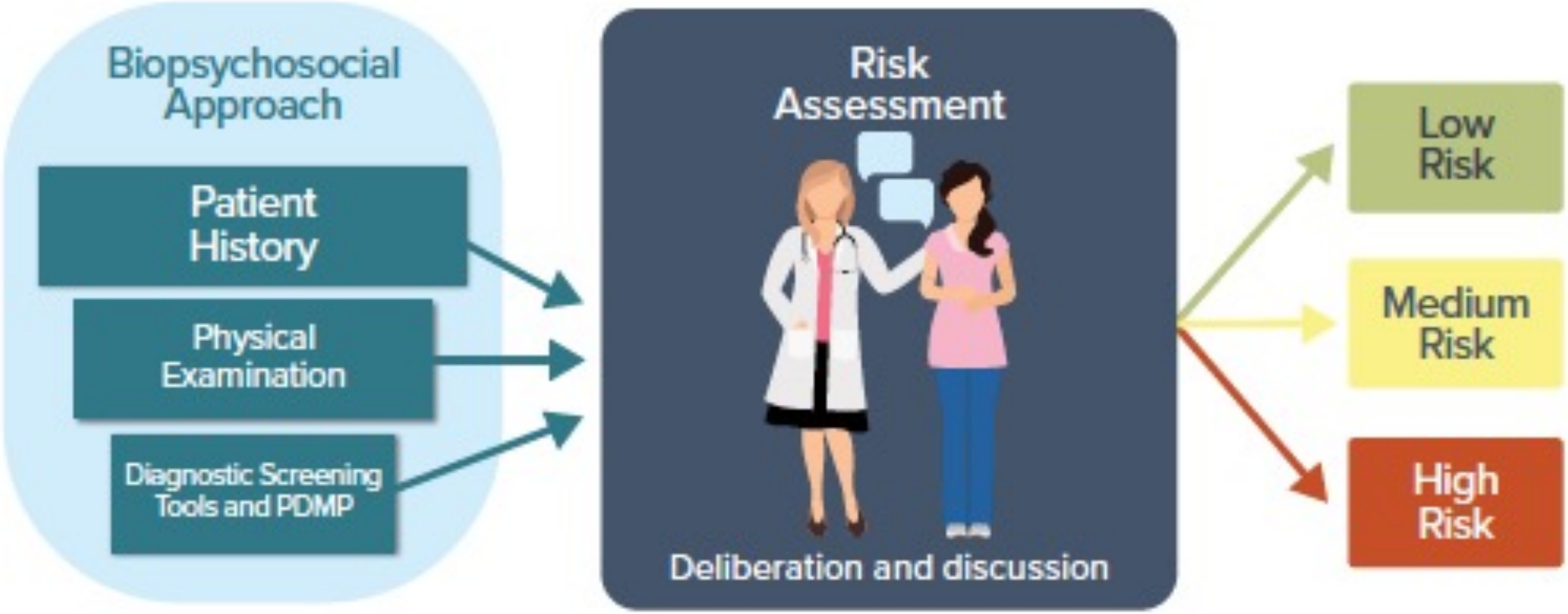
Opioids MAY be part of a treatment plan, but not THE plan.

Putting It All Together



U.S. Department of Health and Human Services. Pain Management Best Practices Inter-Agency Task Force Report: Updates, Gaps, Inconsistencies, and Recommendations. Published May 9, 2019. Available at https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf. Accessed June 1, 2019.

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MAY
Identifying Patient Who Benefit from Chronic Opioid Therapy

- 63 yr. old, rheumatoid arthritis, lumbar spondylosis, s/p L3-sacrum fusion
- Chronic renal disease, COPD, chronic prednisone
- Retired ”lumbar jack”
- Oxycodone 15 mg, 1 TID, MED: 60
- GAD-7, PHQ-9 elevated
- Physical Exam:

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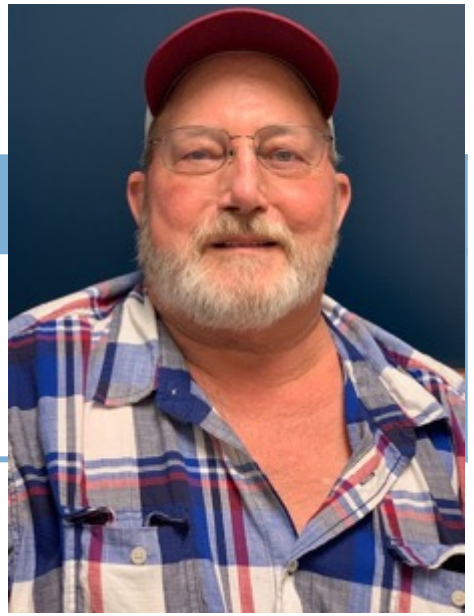
DON'S ASSESSMENT



Determining need for opioids

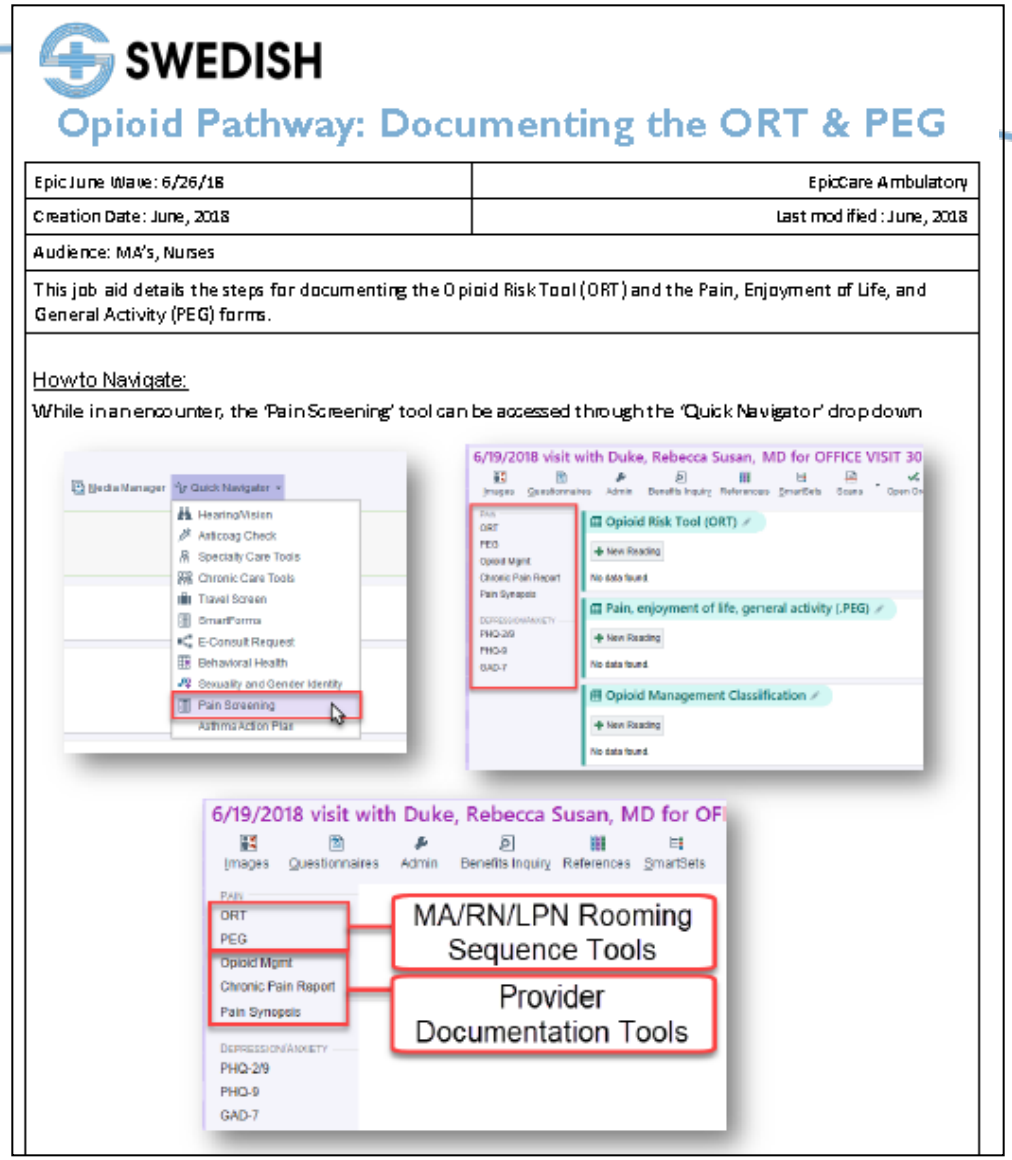
- Opioids are not first-line or routine therapy for chronic pain.
- Establish and measure goals for pain and function.
- Discuss benefits and risks of opioid therapy and availability of nonopioid therapies.

- Patient-centered history
- Functional goals (3)
- Patient expectations
- Risks

Dowell D, et al. *MMWR Recomm Rep* 2016;65(1):1-49.

Pain Navigator

- PEG
- MED
- Opioid Risk Tool (ORT)
- Urine Screen
- Naloxone Plan
- Treatment Agreements
- Risk Stratification Tool
  - MED / ORT
  - Adjust for Medical Comorbidities (1)
  - Adjust for Medications at Greater Risk of Overdose (2)
  - Final “Management Classification”
    - **Low, Medium, High**



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Opioid Pathway: Documenting the ORT & PEG

Epic June Wave: 6/26/18	EpicCare Ambulatory
Creation Date: June, 2018	Last modified: June, 2018
Audience: MA's, Nurses	
This job aid details the steps for documenting the Opioid Risk Tool (ORT) and the Pain, Enjoyment of Life, and General Activity (PEG) forms.	

Howto Navigate:

While in an encounter, the 'Pain Screening' tool can be accessed through the 'Quick Navigator' drop down

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PEG 3

1 What number best describes your pain on average in the past week?

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

2 What number best describes how, during the past week, pain has interferred with your enjoyment of life

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

3 What number best describes how, during past week pain has interferred with you general activity?

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

Krebs E, et al. PEG Scale Development and Validation. *J Gen Intern Med* 2009;24(6):733-8.
Cleeland CS, Ryan K. *Ann Acad Med Singapore*. 1994;231:129-38.

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Don's: Opioid Risk Tool (ORT)

Mark each box that applies		Female	Male
1.	**Family Hx of substance abuse**		
	Alcohol	☐ 1	☒ 3
	Illegal drugs	☐ 2	☐ 3
	Prescription drugs	☐ 4	☐ 4
2.	**Personal Hx of substance abuse**		
	Alcohol	☐ 3	☒ 3
	Illegal drugs	☐ 4	☐ 4
	Prescription drugs	☐ 5	☐ 5
3.	**Age between 16 & 45 yrs**	☐ 1	☐ 1
4.	**Hx of preadolescent sexual abuse**	☐ 3	☐ 0
5.	**Psychologic disease**		
	ADD, OCD, bipolar, schizophrenia	☐ 2	☐ 2
	Depression	☐ 1	☐ 1

Administer

On initial visit

Prior to opioid therapy

Scoring *(RISK)*

0-3: low

4-7: moderate

≥8: high

Webster LR, Webster RM. *Pain Med.* 2005;6:432-42
Link http://www.opioidrisk.com/node/887

Scoring Totals: **6, moderate RISK**

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Assessment and Risk Stratify

MED = 60-80 (Medium)

ORT = 6 (Moderate)

Management Classification

Step #1 Adjustment

MED (Morphine Equiv. Dose)
Low: < 50
Medium: 50-90
High: > 90

Opioid Risk Tool (ORT)
Low risk = neutral risk
Moderate risk = at least "medium" risk
High risk = at least "high" risk

Consider higher of the two categories		
MED	**ORT**	**Step 1 Adjustment**
Low	Medium	Medium
Medium	Low	Medium
High	Low	High

Step #2 Adjustment — Medical comorbidities and concurrent meds (add "A" and "B")

A. Medical comorbidities (1 point per) impaired respiratory function, COPD, CHF, untreated sleep apnea, high fall risk, altered drug metabolism, advanced age/ frail, impaired renal or hepatic dysfunction, unstable psychiatric condition (i.e., depression, anxiety), other

Subtotal A: **2**

B. Concurrent high risk co-prescriptions: (1 point per) Benzodiazepines, barbiturates, carisoprodol, non-benzodiazepine hypnotics, stimulant medications, other

Subtotal B: **0**

Add subtotals "A" and "B" for total adjustment score: _____

If > 2 points = Consider grade **UP**
If 1 point = Maintain classification
If 0 points = Consider grade **DOWN**

2 →

Final "management classification" score

"Low"
"Medium"
"High"

High

- **Use the management classification score for ongoing monitoring.**
- **Risk factors may change over time. Reassess regularly.**
- **Methadone MED classification is limited by unique qualities of the drug.**

Ongoing Patient-Centered (PC) Assessment

PEG

Analgesic Response

Mood

Sleep

Patient Goals & Expectations

Daily Routine

Compliance Monitoring

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Pharmacovigilance & Balanced Care

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Pain Management

Community Education & Support

Inpatient: Transitions of Care

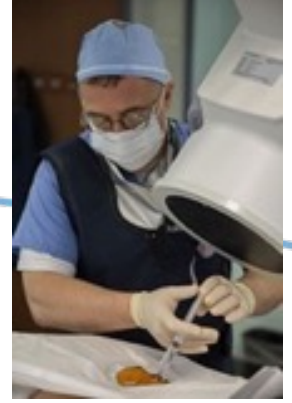
Emergency Department

Primary Care: Patient Centered Medical Home

Integrated Behavioral Health in Primary Care

Addiction Medicine and Behavioral Medicine

Interventional Procedures



Medical Management, Complimentary

Interdisciplinary Care: Functional Restoration

Complimentary and Integrative Care

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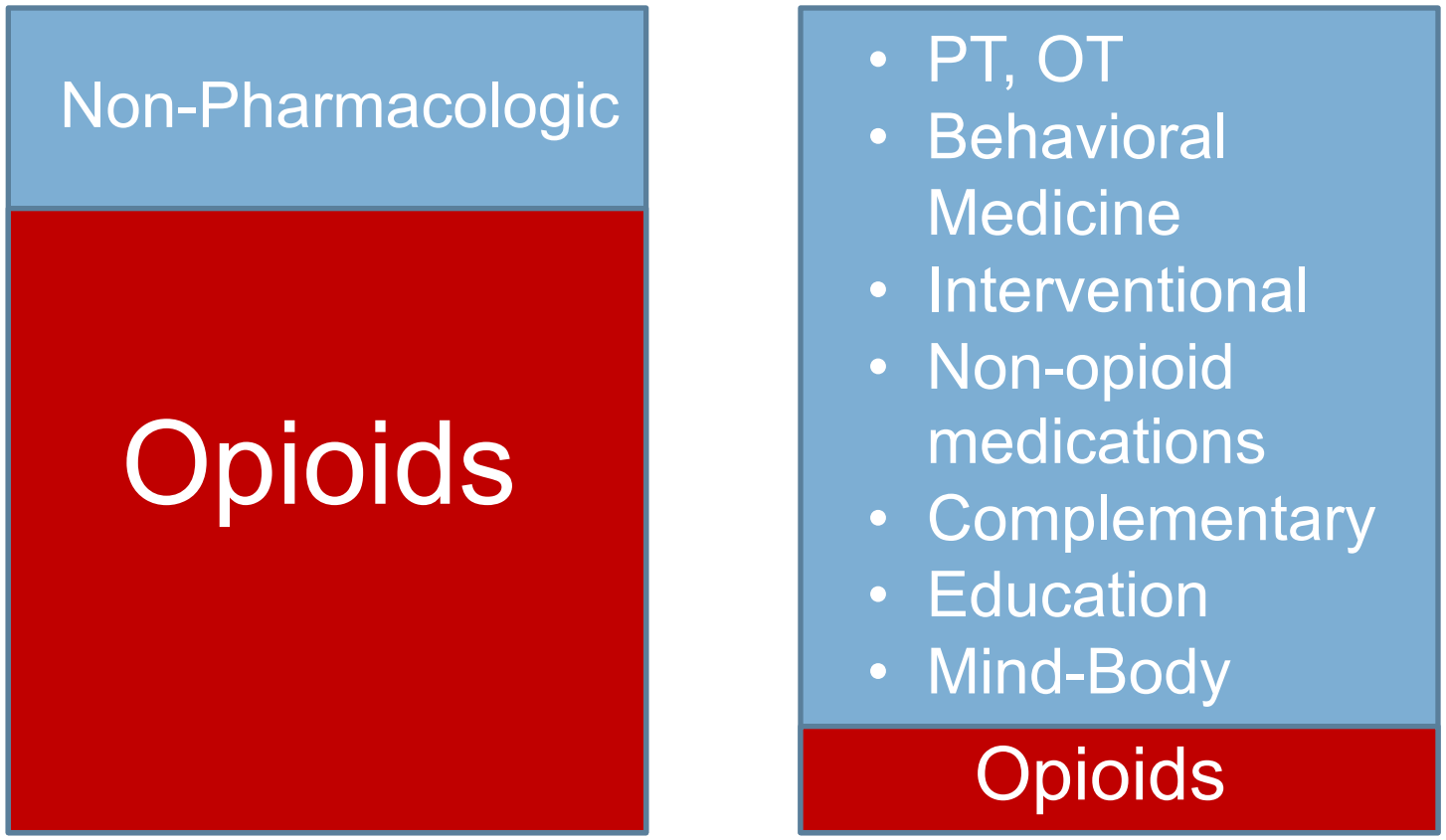
Opioid Therapy: Current & Future State

Therapeutic Options



PAST → PRESENT → FUTURE

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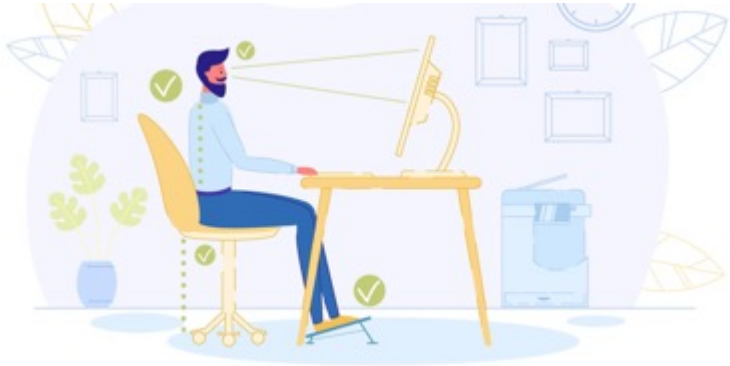
Patient-centered comprehensive care.

Patient- Centered Comprehensive Pain Care

People
(MD/DO, APC, RN, Caregiver surge staffing)

Places
(Hospitals, Beds, OR. Med/Surg, ASCs, etc.)

Products
(PPE, Ventilators, etc.)



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Overview

- Updated CDC Guideline for Opioid Prescribing to be released soon
- Pharmacovigilance and patient-centered care
- Understand an evolving appreciation for opioid pharmacology affective and motivational factors
- Patient-Centered Care and Risk Stratification

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Thank you! steven.stanos@swedish.org