Addressing the Opioid Epidemic in Primary Care

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American Medical Student Association

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CDC PRIORITIES: Unintentional Injury Prevention

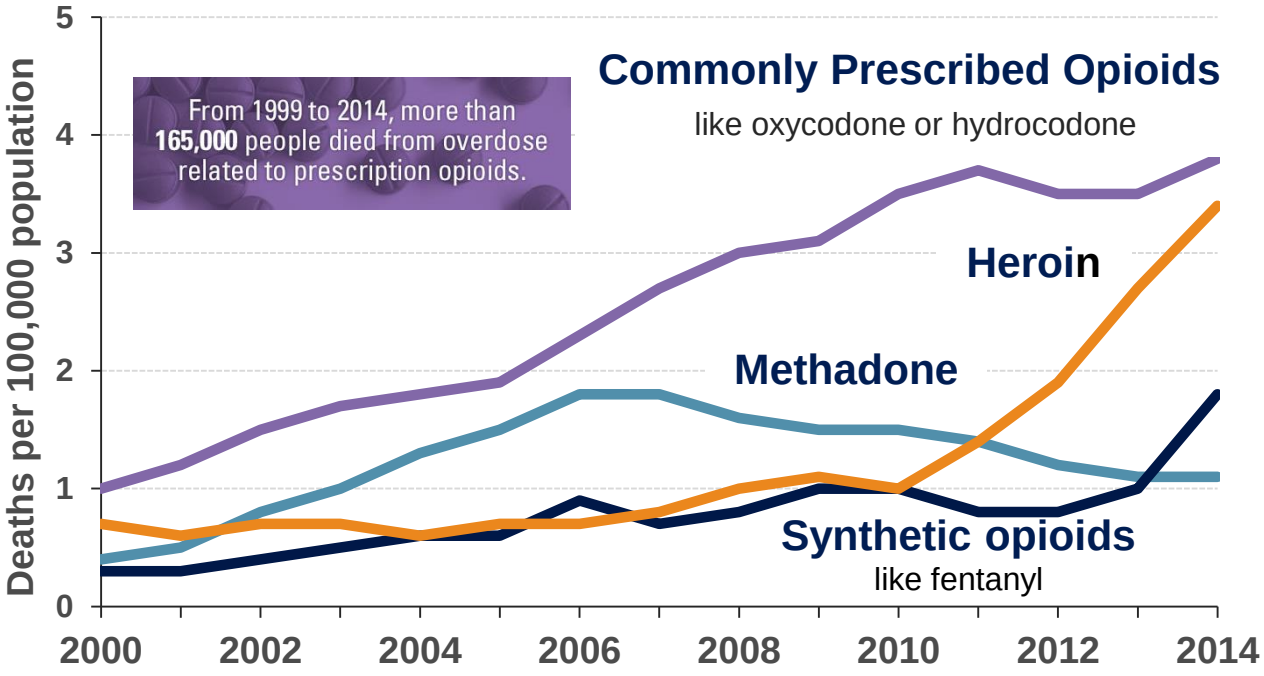
Motor Vehicle Safety

Prescription Drug Overdose

Older Adult Falls

Traumatic Brain Injury

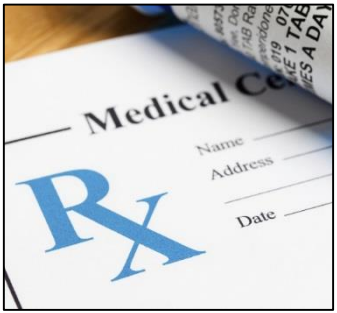
Rise in Rx overdose deaths since 2000 and recent increase in heroin & fentanyl deaths



SOURCE: National Vital Statistics System Mortality File.

Pillars of CDC Activity

- **Improve data** quality and track trends
- **Strengthen state efforts** by scaling up effective public health interventions
- **Supply healthcare providers with resources** to improve patient safety





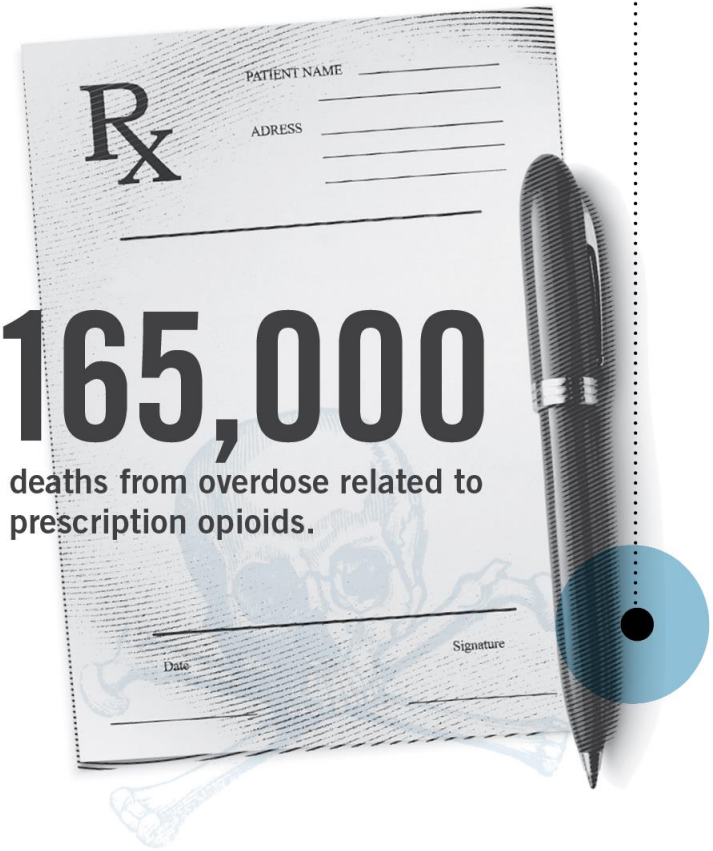
Chronic Pain and Prescription Opioids

- 11% of Americans experience daily (chronic) pain.
- Opioids frequently prescribed for chronic pain.
- Primary care providers commonly treat chronic, non-cancer pain.
  - Account for ~50% of opioid pain medications dispensed.
  - Report concern about opioids and insufficient training.

The amount
of opioids prescribed has
QUADRUPLED
from 1999-2014,

but the pain that
Americans report remains
UNCHANGED

Since 1999, there have been more than



165,000

deaths from overdose related to prescription opioids.

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Recommendations and Reports / Vol. 65 / No. 1
March 18, 2016

CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016

Continuing Education Examination available at http://www.cdc.gov/mmwr/cme/conted.html.

U.S. Department of Health and Human Services
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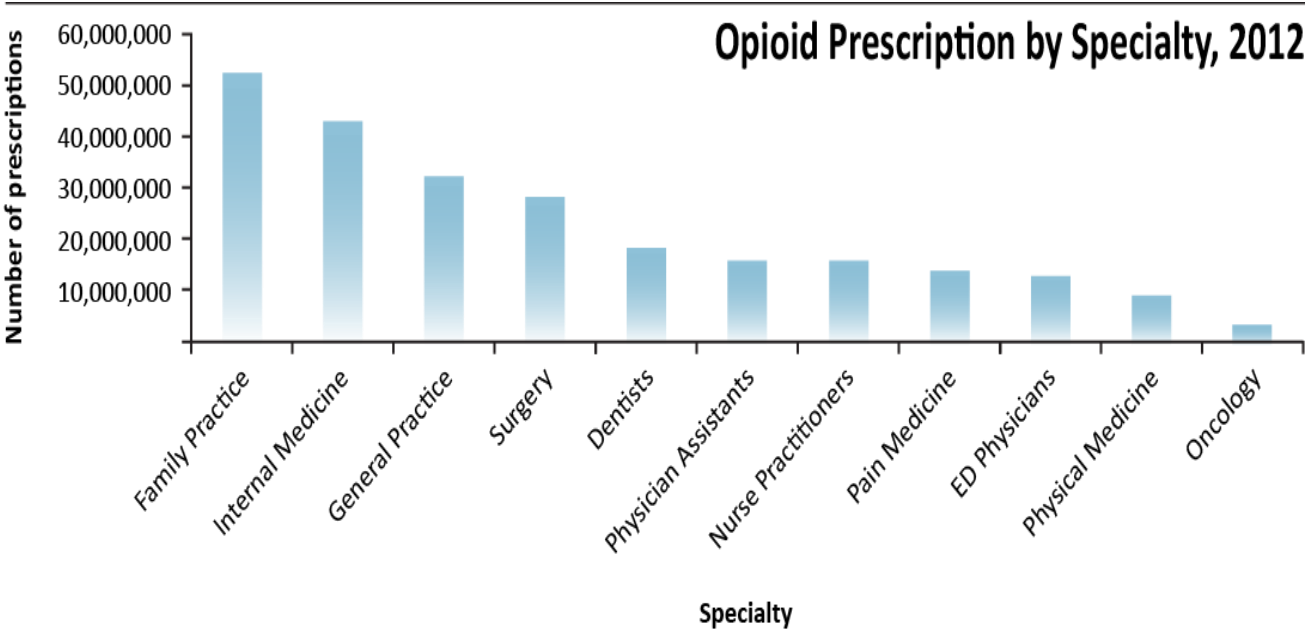
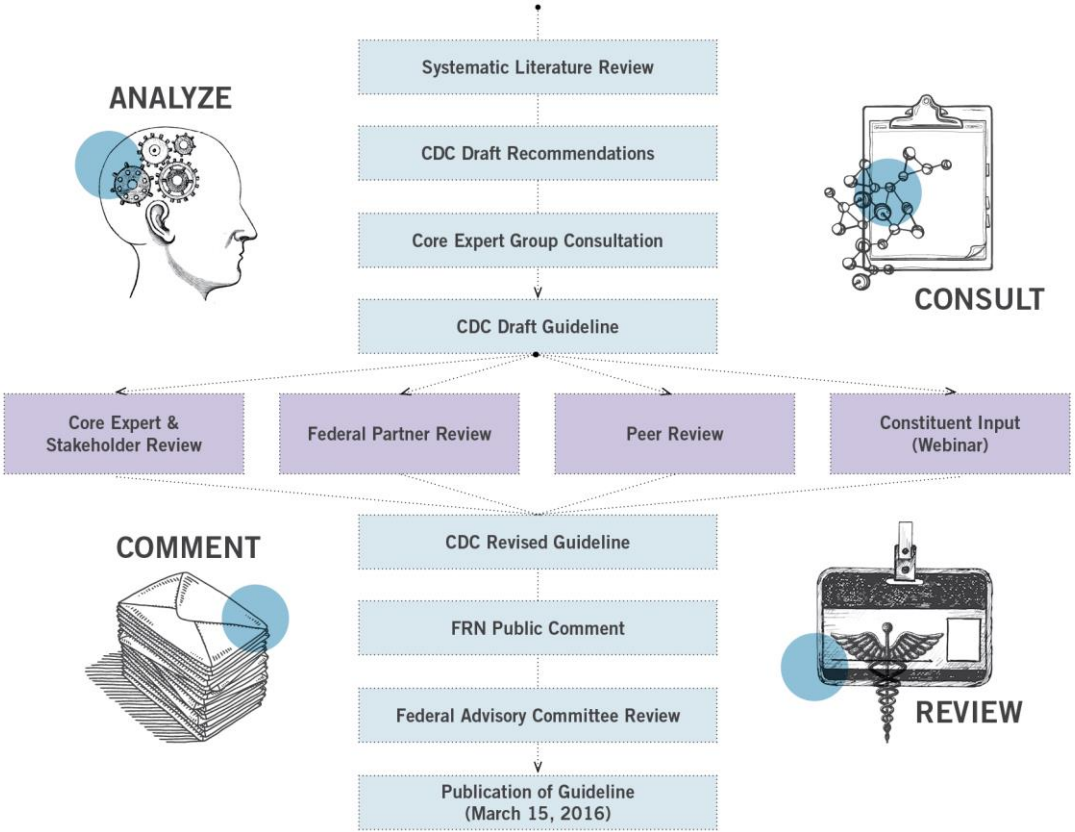
- Primary care
- Outpatient settings
- Outside of active cancer, palliative, and end of life
- Patients > 18 Years with chronic pain

Why Primary Care Providers?



IMS Health, National Prescription Audit, United States, 2012

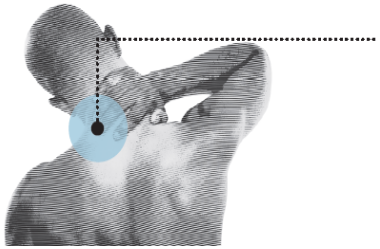
Guideline development process



THE EVIDENCE

1. Lack of evidence that opioids control pain effectively long term.
2. Risk of serious harm increases with opioid dose.
3. Up to a quarter of patients receiving opioids long-term in a primary care setting struggles with addiction.

WHAT CAN PROVIDERS DO?



1. First, **do no harm**. Opioids are not first-line or routine therapy for chronic pain.
2. When opioids are used, prescribe the lowest effective dosage.
3. Exercise caution when prescribing opioids and monitor all patients closely.

Organization of recommendations

- **The 12 recommendations are grouped into three conceptual areas:**
  - 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

Determining when to initiate or continue opioids for chronic pain

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

Opioid selection, dosage, duration, follow-up, and discontinuation

4. Use short-acting opioids when starting

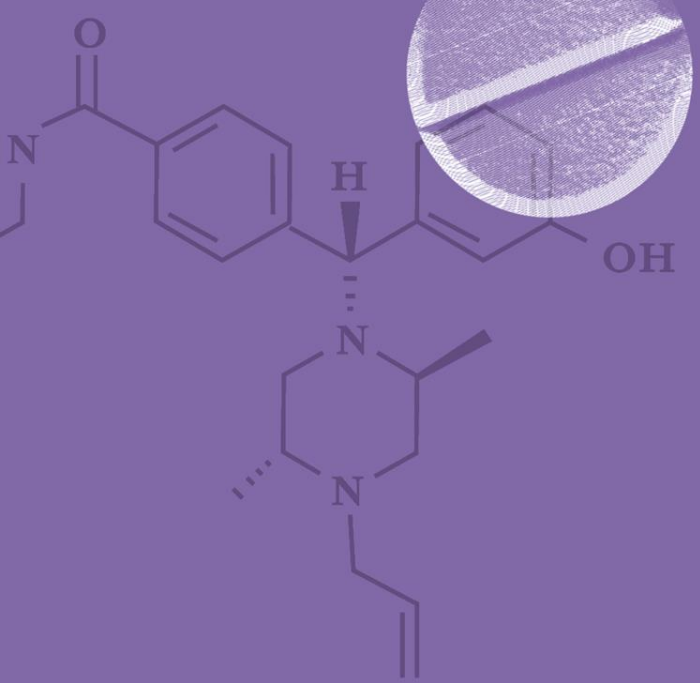
5. Start with the lowest effective dose, carefully reassess before increasing, and avoid or justify high dosages

6. When opioids are needed for acute pain, prescribe no more than needed

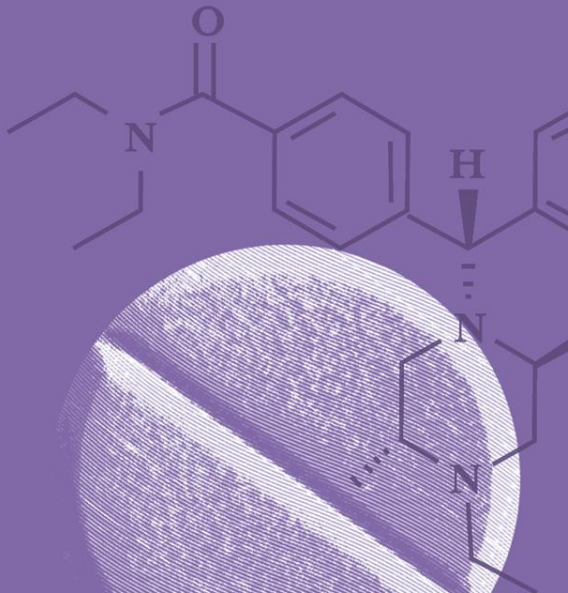
7. Follow up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed

Assessing risk and addressing harms of opioid use

8. Evaluate risk factors for opioid-related harms
9. Check PDMP for high dosages and prescriptions from other providers
10. Use urine drug testing to identify prescribed substances and undisclosed use
11. Avoid concurrent benzodiazepines and opioids
12. Arrange treatment for opioid use disorder if needed



Implementation Activities



CDC Guideline Implementation

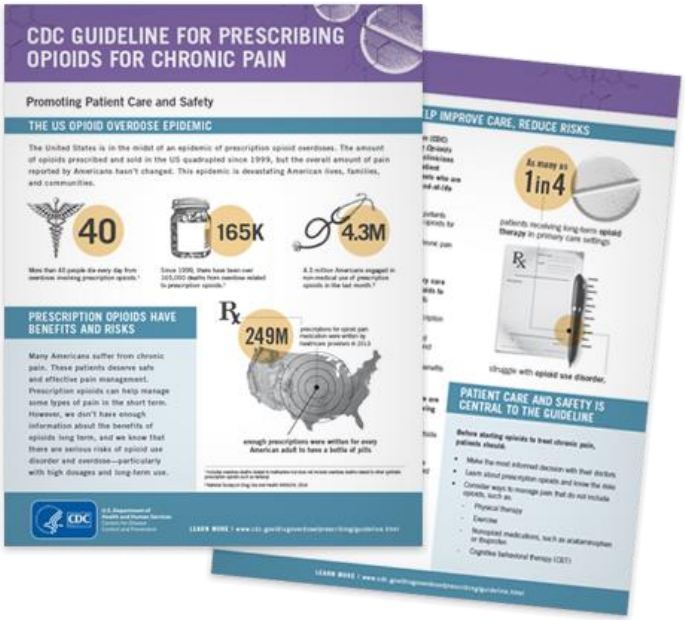
Translation and Communication

Clinical Training

Health System Implementation

Insurer/Pharmacy Benefit Manager Implementation

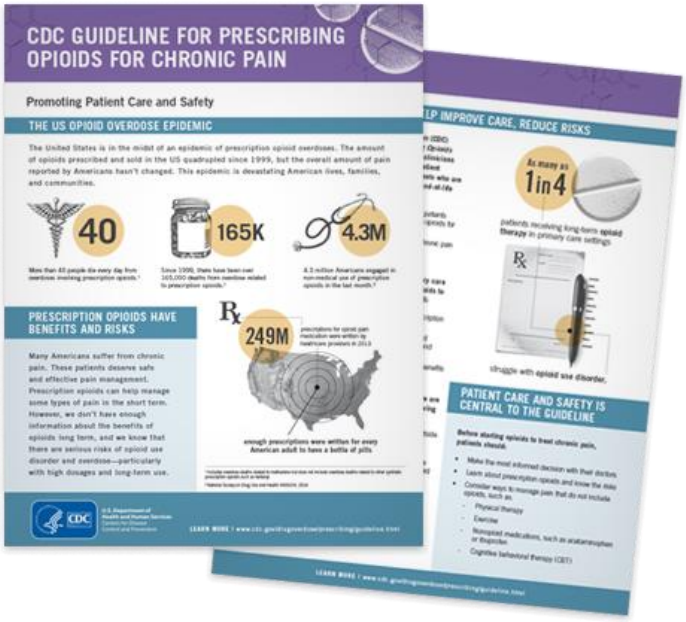
Educational Resources



Patient materials

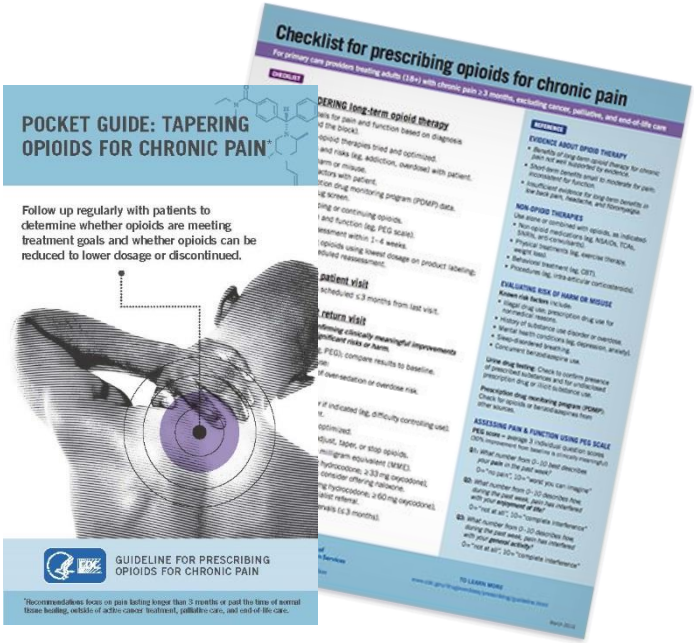
- Graphics and messages
- Fact sheets
- Posters
- Podcasts
- Infographics

Fact Sheets



- New Opioid Prescribing Guideline
- Assessing Benefits and Harms of Opioids
- Prescription Drug Monitoring Programs
- Calculating Total Daily Dose of Opioids
- Pregnancy and Opioid Pain Medications

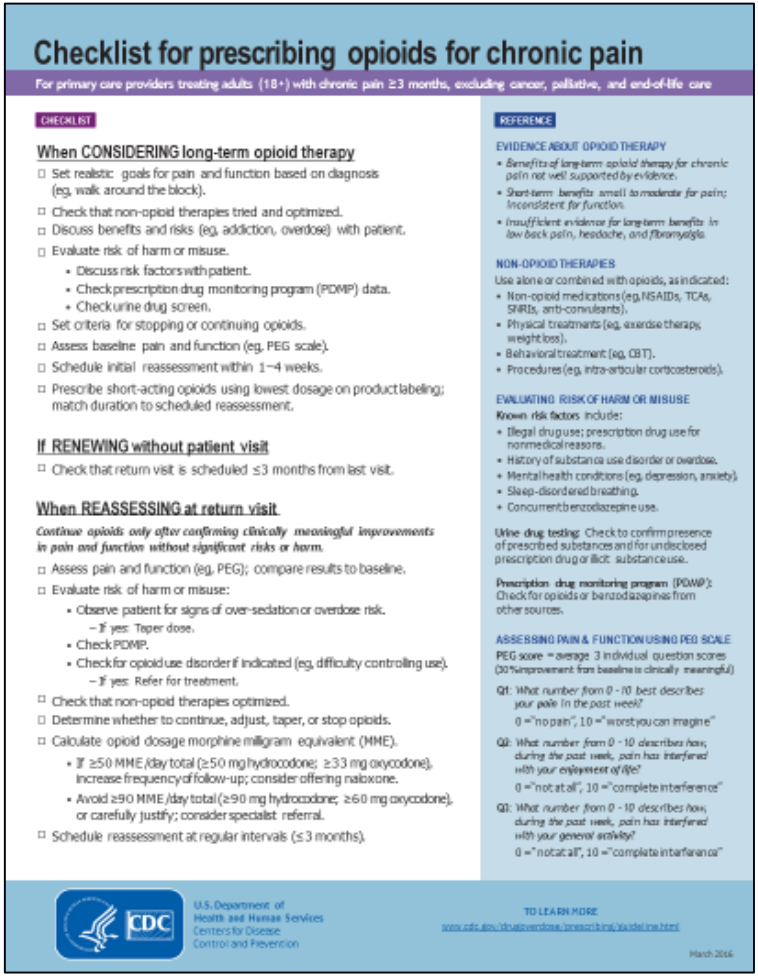
Clinical Tools



Provider materials

- Checklist
- Pocket Guides
  - Tapering
  - Overview
- Fact sheets
  - New Opioid Prescribing Guideline
  - Assessing Benefits and Harms of Opioid Therapy
  - Prescription Drug Monitoring Programs
  - Calculating Total Daily Dose of Opioids for Safer Prescribing

Checklist for prescribing opioids for chronic pain



Checklist for prescribing opioids for chronic pain

For primary care providers treating adults (18+) with chronic pain ≥3 months, excluding cancer, palliative, and end-of-life care

CHECKLIST

When CONSIDERING long-term opioid therapy

- ☐ Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- ☐ Check that non-opioid therapies tried and optimized.
- ☐ Discuss benefits and risks (eg, addiction, overdose) with patient.
- ☐ Evaluate risk of harm or misuse.
  - Discuss risk factors with patient.
  - Check prescription drug monitoring program (PDMP) data.
  - Check urine drug screen.
- ☐ Set criteria for stopping or continuing opioids.
- ☐ Assess baseline pain and function (eg, PEG scale).
- ☐ Schedule initial reassessment within 1–4 weeks.
- ☐ Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

If RENEWING without patient visit

- ☐ Check that return visit is scheduled ≤3 months from last visit.

When REASSESSING at return visit

Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.

- ☐ Assess pain and function (eg, PEG); compare results to baseline.
- ☐ Evaluate risk of harm or misuse:
  - Observe patient for signs of over-sedation or overdose risk.
    - If yes: Taper dose.
  - Check PDMP.
  - Check for opioid use disorder if indicated (eg, difficulty controlling use).
    - If yes: Refer for treatment.
- ☐ Check that non-opioid therapies optimized.
- ☐ Determine whether to continue, adjust, taper, or stop opioids.
- ☐ Calculate opioid dosage morphine milligram equivalent (MME).
  - If ≥50 MME/day total (≥50 mg hydrocodone; ≥33 mg oxycodone), increase frequency of follow-up; consider offering naloxone.
  - Avoid ≥90 MME/day total (≥90 mg hydrocodone; ≥60 mg oxycodone), or carefully justify; consider specialist referral.
- ☐ Schedule reassessment at regular intervals (≤3 months).

REFERENCE

EVIDENCE ABOUT OPIOID THERAPY

- *Benefits of long-term opioid therapy for chronic pain not well supported by evidence.*
- *Short-term benefits small to moderate for pain; inconsistent for function.*
- *Insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.*

NON-OPIOID THERAPIES

Use alone or combined with opioids, as indicated:

- Non-opioid medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants).
- Physical treatments (eg, exercise therapy, weight loss).
- Behavioral treatment (eg, CBT).
- Procedures (eg, intra-articular corticosteroids).

EVALUATING RISK OF HARM OR MISUSE

Known risk factors include:

- Illegal drug use; prescription drug use for nonmedical reasons.
- History of substance use disorder or overdose.
- Mental health conditions (eg, depression, anxiety).
- Sleep-disordered breathing.
- Concurrent benzodiazepine use.

Urine drug testing: Check to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.

Prescription drug monitoring program (PDMP): Check for opioids or benzodiazepines from other sources.

ASSESSING PAIN & FUNCTION USING PEG SCALE

PEG score = average 3 individual question scores (30%improvement from baseline is clinically meaningful)

Q1: *What number from 0 - 10 best describes your pain in the past week?*
0 = "no pain", 10 = "worst you can imagine"

Q2: *What number from 0 - 10 describes how, during the past week, pain has interfered with your enjoyment of life?*
0 = "not at all", 10 = "complete interference"

Q3: *What number from 0 - 10 describes how, during the past week, pain has interfered with your general activity?*
0 = "not at all", 10 = "complete interference"

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TO LEARN MORE
www.cdc.gov/drugoverdose/prescribing/guideline.html

March 2016

Training Resources: Webinars

COCA webinar series

1. Overview
2. Nonopioid Treatments for Chronic Pain
3. Assessing Benefits and Harms of Opioid Therapy
4. Dosing and Titration of Opioids

Additional webinars coming soon!

Training Resources: Online Course

eLearning

- Web-based training
- Modules that can be completed in 30 minutes or less
- Learner-directed content
- Scenario-based interactions
- Mini-lessons on implementing the guideline
- Short videos

Coming Soon

- Mobile “app” with MME calculator
- Videos
- Brochures and pocket guides
- Online training for providers
- Additional materials, such as matte articles, blogs, infographics

Health Systems

- Quality Improvement (QI) Initiative
  - Create QI measures
  - Create QI implementation guide
  - Launch & support Opioid QI Collaborative

- Clinical Decision Supports
  - Create sharable EHR code/artifacts
  - Clinical sites to implement guideline & track outcomes

Health Systems (continued)

- Coordinated Care Plan
  - Create the *Chronic Pain Care Involving Opioids: A Coordinated Care Plan for Safer Practice*
  - Rigorous evaluation (9 clinical intervention sites & 9 clinical comparison sites)
  - Broad dissemination following evaluation period
- State-led efforts through CDC-funded states
  - EHR and PDMP (prescription drug monitoring program) integration
  - Guideline uptake

Insurer Interventions

- Coverage for non-pharmacologic therapies
- Improve ease of prescribing non-opioid pain medications
- Reimbursement for patient counseling, care coordination, & checking PDMP
- Promote more judicious use of high dosages of opioids outside of palliative care, active cancer or end-of-life care, using mechanisms such as drug utilization review
- Remove barriers to evidence-based treatment of opioid use disorder, such as eliminate lifetime limits on buprenorphine

Insurers

- CMS (Medicaid and Medicare)
  - Metric harmonization (MME threshold)
  - Checking PDMP
- Commercial payers
- Pharmacy Benefit Managers
- State-led efforts through CDC-funded states:
  - Medicaid
  - Workers' Compensation
  - National Council for Behavioral Health

Resources

CDC Opioid Overdose Prevention Website
www.cdc.gov/drugoverdose

CDC Media Toolkit
CDC Newsroom

HHS Prescription Drug & Heroin Overdose Epidemic
www.hhs.gov/opioids

Turn the Tide (U.S. Surgeon General's website)
http://turnthetiderx.org/#

For more information, contact CDC
1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 www.cdc.gov

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.