Managing Pain Safely and Effectively: CDC Guideline for Prescribing Opioids

Amy Bohnert, Ph.D.
Disclosures

• No Conflicts of Interest
• No Financial Disclosures
What You Will Learn

• Review the Epidemiology of the Prescription Opioid Epidemic
• Overview of Essential Elements Necessary to Address the Prescription Drug Epidemic
• Discuss the Role of Safer Opioid Prescribing
• Review the 12 CDC Guidelines for Safer Opioid Prescribing for Chronic Pain
• Tools and Resources
• Wrap up and Questions
The Opioid Epidemic...by the numbers

1999-2016
- >350,000 died of an opioid overdose

Three waves of the U.S. Opioid Epidemic
- First wave = Increased Prescription Opioid Overdose due to increased prescribing in early 1990s
- Second wave = Increased Heroin Overdose in the early
- Third wave = Synthetic Opioid Overdoses (e.g., fentanyl)

80% of those who use heroin first misused prescription opioids
The Opioid Epidemic...by the numbers

Michigan Opioid Overdose Deaths by Opioid Type (1999-2016)

- Number of Michigan fatalities resulting from opioid overdoses has increased exponentially since 1999, accounting for 2,357 deaths in 2016.

Kaiser Family Foundation analysis of Centers for Disease Control and Prevention (CDC), National Center for Health Statistics. Multiple Cause of Death 1999-2016 on CDC WONDER Online
The Opioid Epidemic…by the numbers

Opioid Overdose Death Rate (Per 100,000 population, age-adjusted)

In 2016, Michigan ranked 11th out of 51 U.S. States and the District of Columbia in Opioid Overdose Mortality (18.5 deaths per 100,000 people), a 36% increase from 2015.

Kaiser Family Foundation analysis of Centers for Disease Control and Prevention (CDC), National Center for Health Statistics. Multiple Cause of Death 1999-2016 on CDC WONDER Online Database, released 2017. Data are from the Multiple Cause of Death Files, 1999-2016, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.
In 2016,

- 42,249 people died from opioid overdose
- 116 people died every day in 2016 from opioid-related drug overdose
- 2.1 million people had a opioid use disorder
- >900K used heroin; 170K for the first time
- 15,469 deaths due to heroin overdose

11.5 people misused prescription opioids;
2.1 million people for the first time

- 17,087 deaths attributed to opioid overdoses on commonly prescribed medications
- 19,413 deaths due to overdoses on synthetic opioids (other than methadone)

More Prescribing = More Opioid Deaths

The impact of the increase in opioid prescribing observed in the late 1990s and early 2000s was a sharp increase in both opioid pain reliever (OPR) overdose deaths and admissions to hospitals for substance use treatment.
Addressing The Opioid Epidemic

**Prescribing Practices**
- PDMPs (i.e., MAPS)
- Diversion Control/ Safe Disposal

**Harm Reduction Strategies**
- Naloxone availability
- Needle exchange

**Community/ Patient Education**
- Expanded Access to Treatment Services

**Improved Data/ Research and Surveillance**

**Supply/Demand**
- Harm Reduction
- Treatment

**Diversion Control/ Safe Disposal**
With Opioid misuse becoming a national crisis, there was a need for development of clear and consistent guidelines for prescribing.

- Previous guidelines were developed, but inconsistent
- Prior national guidelines were several years old
- Need for clear, consistent guidelines

**Primary Audience:** Primary Care Providers, Nurse Practitioners, Physician Assistants.

**Use:** Treating patients 18 + years of age for chronic pain

*Does not include active cancer treatment, palliative care, and end-of-life care*
Safer Opioid Prescribing Guidelines

Framework: 12 Recommendations; 3 categories

• Determining when to initiate or continue opioid use in the treatment of 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

Focus area #1
What to consider:

**Recommendation 1**

Non-pharmacologic therapies and Non-opioid pharmacologic therapy are preferred for chronic pain to opioid use.
Alternative Tx Options

Recommendation 1

- Opioid Therapy should be considered only if expected benefits for pain and function are anticipated to outweigh the risks to patient.
- If opioids are used for pain control, they should be combined with non-pharmacologic and non-opioid pharmacologic therapy, as appropriate.
- Non-Pharmacologic therapies that have been shown to be effective include:
  - Exercise
  - Exercise + Behavioral Therapies (e.g., CBT)
  - Interdisciplinary rehabilitation
- Non-Opioid Pharmacological Therapies
  - Topical Medications: Lidocaine, Capsaicin
  - First line: Non-steroidal Anti-inflammatory Medications, Acetaminophen
  - Second line: Serotonin/ Norepinephrine reuptake inhibitors (SNRIs); Tricyclic antidepressants (TCAs)
  - Neuropathic pain = Gabapentin; Pregabalin
  - Migraines = Beta Blockers; Calcium Channel Blockers; Tripans (acute); Anti-emetics (acute)
  - Arthrocentesis and Intra-articular injections of glucocorticoids
Recommendation 2:
Establish realistic goals for patients treatment and pain before beginning opioid therapy

Discuss how/when opioid therapy will be discontinued if does not prove beneficial.

Recommendation 3:
Discuss risks and potential benefits of opioid therapy both before beginning treatment and periodically throughout treatment period.
Establishing Treatment Goals

- Acute vs. Chronic Pain Treatment (>3-months = chronic pain treatment)
- Consider that you are probably starting treatment for chronic pain anytime >30-day supply of opioids

Before initiating opioid therapy for chronic pain
- Determine how effectiveness will be evaluated (validated scale)
- Establish treatment goals with patients.
  - Written Treatment Plans - outline plan of course, treatment goals, expectations for monitoring, situations for discontinuing or tapering dosage (e.g., failure to adhere to clinic policies)
  - Treatment goals = Pain relief, functional status (e.g., walking the dog, returning to work)
- Have an Exit Strategy if therapy is unsuccessful
  - Plan for tapering and discontinuing opioids

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

*clinically meaningful improvement defined as 30% improvement in scores for both pain and function
Risks/Benefits of Opioid Treatment

• Patients highlight lack of information regarding opioids and concerns re: safety of medications

• Be explicit/realistic about benefits - Role in short-term pain management, but no evidence for opioids improving pain/function with long-term use and complete relief of pain unlikely

• Emphasize goal of improvement in pain and function.
  • Function can improve even when pain present

• Anticipatory Guidance:
  • Serious (e.g., fatal respiratory depression, opioid use disorder) adverse effects
  • Common adverse effects (e.g., constipation, tolerance, withdrawal symptoms with cessation)
  • Increased risks of overdose
    • Especially at higher dosages
    • Combined with other drugs (e.g., benzos = 10X risk than opioid alone) or alcohol
  • Opioids and driving (initiation, dosage change, combined with CNS depressants)
  • Need for Periodic reassessment to ensure goals are being met, PDMP and urine checks
  • Safe Storage of Medications and Safe Disposal
  • Risks to family members and individuals in the community.
Opioid selection, dosage, duration, follow-up and discontinuation

Focus area #2
Recommendation 4:

When beginning therapy, immediate-release opioids should be prescribed instead of extended-release/long acting opioids.

Recommendation 5:

When beginning opioid treatment, start with the lowest effective dosage.

Use caution with any dose
Start low, go slow - reassess pain and function
Increase frequency of follow-ups
IR vs. ER/LA Opioid Therapy

- Risk of overdose higher in patients initiating therapy with LA opioids as compared to those initiating therapy with IR opioids [HR=2.33], especially during the first two weeks of therapy.
- No evidence that ER/LA is safer or more effective for management of chronic pain.
- Recommendation: ER/LA should be reserved for severe continuous pain in opioid tolerant patients when alternate treatment options are not effective.
- Methadone should be avoided as the first line choice.

Rule of Thumb: Start Low & Go Slow

- Similar to other medications, goal is lowest effective dosage and small dose increases.
  - Begin with lower dosage; Titrate slowly
  - Caution when combining multiple drugs (especially in elderly)
  - Assess for potential drug-drug interactions

- If total opioid dosage >50 MME/ day
  - Reassess pain, function, and treatment; Increase frequency of follow-up
  - Consider offering naloxone teaching/ education and kit for reversal

- Avoid increasing opioid dosages to >90 MME/ day. If patient with escalating dosage requirements,
  - Discuss alternate pain therapies
  - Consider tapering opioids
  - Consider pain specialist consultation

- Patients already taking >90 MME/ day
  - Re-evaluate continued use of high opioid dosages given potential overdose risk
  - Consider tapering plan
**Recommendation 6:**

For *acute pain* treatment with opioids, low dosage with a short duration of time should be considered, if possible.

3-5 days or less will often be sufficient; more than 7 days will rarely be needed.

**Recommendation 7:**

Evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation.

Then re-evaluate continued therapy with patients every 3 months or more frequently.

If benefits do not outweigh harms consider alternatives, lowering dosage and/or discontinuation of opioid treatment.
General Acute Care Opioid Recommendations

- Non-Opioid therapies (NSAIDS, Non-pharmacologic) should be used as first line therapy

- Prescribe the lowest effective dose
  - Prescribe amount to match the expected duration of pain severe enough to require opioids
  - Short acting opioids should be for < 3 days and rarely more than 7 days are needed
  - Do not prescribe additional opioids “just in case”
  - Re-evaluate patients with severe acute pain that continues longer than the expected duration to confirm or revise the initial diagnosis and to adjust management accordingly.

- No replacement of lost or stolen prescriptions (including methadone)
- Do not prescribe ER/ LA opioids for acute pain treatment.
- Consider Naloxone co-prescription for patients with >50 MME/ day
- Avoid co-prescribing with benzodiazepines
- Utilization of PDMPs in accordance with recently passed Michigan laws
Specialty Specific Acute Care Prescribing Recommendations

• Despite CDC guidelines, remains a gap in recommendations for prescribing, especially for acute care – ED, Dental, Surgical
• New acute care prescribing recommendations developed for EM, dental prescribing, and post-surgical prescribing
• Approved by LARA and Prescription Drug and Opioid Abuse Commission
• Handouts available
M-OPEN Post-Surgical Prescribing Recommendations

Data shows that when patients prescribed fewer pills, they consume fewer pills with no evidence for changes in their pain or satisfaction scores.

Recommendations based on patient-reported data around post-operative opioid consumption.

Recommendations are designed for opiate naïve patients.

Meet/Exceed self-reported use of 75% patients.

Opioidprescribing.info (more info on post-surgical prescribing).

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<th>Oxycodone</th>
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<tr>
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<td>Codeine (Tylenol #3)</td>
<td>Hydromorphone</td>
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<td>30 mg tablets</td>
<td>(Dilaudid)</td>
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<td>Tramadol</td>
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<td>50 mg tablets</td>
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<td>Lumpectomy + Sentinel Lymph Node Biopsy</td>
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<td>Wide Local Excision ± Sentinel Lymph Node Biopsy</td>
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Follow-Up with Opioid Therapy

- No good evidence regarding the effectiveness of frequent monitoring intervals
  - 3-months of therapy increases risk for opioid use disorder
  - Risk for overdose with ER/ LA opioids high during first 2 weeks of therapy
  - Patients w/o significant pain relief at 1 month unlikely to experience relief at 6 months

- Re-evaluate patients within 1-4 weeks of starting long-term therapy or of dosage increase
  - Greatest potential to mitigate risk for opioid use disorder if f/u less than 3 months
  - Consider sooner follow-up for ER/ LA opioids and particularly for methadone (3 days)
  - Re-evaluate continued opioid therapy every 3 months

- At follow up, discuss with patients:
  - Opioids continue to meet treatment goals; Benefits continue to be > Risks
  - Common or serious adverse events or early warning signs (e.g., sedation, slurred speech, cravings, difficulty controlling use; greater quantity to control pain, work or family problems)
Tapering Guidelines

When to taper?

- No sustained clinically meaningful improvement in pain and function
- Opioid dosages >50 MME/day without evidence of clinical benefit
- Concurrent use of benzodiazepines that can not be tapered
- Patients requests reduction or discontinuation of opioid therapy
- Patients experience overdose or other serious adverse events/ warning signs.

How to taper?

- No high quality evidence comparing different tapering protocols
- Guidelines in general recommend reducing dosage by 10-50% of original dosage weekly
- 10% dose reduction is a reasonable starting dose and adjust by patient response
  - Taper slowly enough to minimize opioid withdrawal symptoms; consider clonidine for symptoms
  - Slower taper in patients with longer duration of use; may have to pause and restart as tolerated
  - Note – opioid withdrawal in pregnancy associated with spontaneous abortion/ premature labor
- Opiates can be stopped when taking less than once a day
- More rapid tapering may be indicated with adverse events (e.g., overdose)
- Optimize non-opioid pain management and psychosocial support
- Referral patients with opioid use disorder to treatment services
Assessing risk and addressing harms of opioid use

Focus area #3
Recommendation 8:

Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms.
Patients at potential risk for opioid overdose and/or opioid related harms should be considered for co-prescription with naloxone:

- Prior overdose, opioid intoxication/ poisoning
- Substance abuse and/or non-medical opioid use
- Higher dosage opioid use (≥ 50 MME/ day)
- Opioid Pain Med Prescription (and)
  - Are concurrently prescribed methadone/ buprenorphine
  - Moderate or Severe Obstructive Sleep Apnea (OSA)
  - Poorly controlled respiratory disease
  - Renal Dysfunction, hepatic disease, cardiac illness
  - Concurrent alcohol or benzodiazepine use or abuse
  - Poorly controlled depression
  - Special Populations (Elderly; Pregnancy)
- Resumption of opioid use after period of abstinence
- Recent incarceration/ release from prison with history of opioid use
- Remote ability to access EMS services in an emergency (e.g., rural populations)
Overdose Education & Naloxone Distribution

• Naloxone Formulations
• Naloxone Kits
• Good Samaritan Laws
• Standing Naloxone Order
**Recommendation 9:**

Review the patient’s history of controlled substance prescriptions using state PDMP-MICHIGAN AUTOMATED PRESCRIPTION SYSTEM (MAPS)

Review PDMP data before beginning opioid therapy and periodically throughout course of therapy

**Recommendation 10:**

When prescribing opioids for chronic pain, use urine drug testing before starting opioid therapy

Consider UDS at least annually to assess for prescribed medications use and illicit drugs.
What are you looking for when you check PDMP System?

Most fatal overdoses associated with patients receiving opioids from multiple providers and/or from high daily opioid doses.

- **High Dosage**: Talk to your patient about the risks for respiratory depression and overdose. Consider offering to taper opioids as well as prescribing naloxone for patients taking 50 MME/day or more.

- **Multiple Providers**: Counsel your patient and coordinate care with their other prescribers to improve safety and discuss the need to obtain opioids from a single provider. Check the PDMP regularly and consider tapering or discontinuation of opioids if pattern continues.

- **Drug Interactions**: Whenever possible, avoid prescribing opioids and benzodiazepines concurrently. Communicate with other prescribers to prioritize patient goals and weigh risks of concurrent opioid and benzodiazepine use.
Recommendation 11: Avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

Possible alternatives: cognitive behavioral therapy, specific anti-depressants approved for anxiety, other non-benzodiazepine medications

Coordinate care with mental health professionals, when possible

Recommendation 12: Offer or arrange evidence-based treatment (usually MAT with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

Discuss concerns with your patient and provide an opportunity for patient concerns.
Assess for OUD using DSM-5 criteria.
Opioid Use Disorder Treatment

- Counseling and Community Support (without medication)

- **Medication Assisted Treatment (MAT):** a comprehensive method of addressing opioid use disorder by combining medication, behavioral counseling therapy, and case management services
  - **Methadone** (opioid agonist) and **Buprenorphine** (partial agonist) are approved by the FDA for treatment of opioid use disorders
  - Injectable extended release **naltrexone** (antagonist) is approved by the FDA for prevention of relapse after detoxification
Benefit of Medication Assisted Treatment (MAT)

- Treatment Program Retention
- Reduces opioid use/ misuse
- Reduces criminal activity
- Reduces risk of overdose and opioid related overdose deaths
- Reduces risk of HIV, HBV, and HCV infections
- Increases social functioning/ rates of employment

RP Mattick et al. Cochrane Database of Systematic Reviews (2009)
RP Mattick et al. Cochrane Database of Systematic Reviews (2014)
ACOG & ASAM. (2012)
Important Things to Convey

• I hear you and I believe you
• I care and I want to help you
• The brain plays a huge role in pain (interpreting signals of pain, severity of pain)… that does not mean the pain is not real.
  • There is hope for you to have control over your pain.
• Pain plays an important role in telling us there is something wrong (i.e., the goal is not necessarily pain free)
Questions?

Amy Bohnert, Ph.D.
University of Michigan
Associate Professor, Department of Psychiatry
Prescription Drug Overdose Content Lead, Injury Center

www.injurycenter.umich.edu
• Non-medical use of Rx Opioids is the **strongest risk factor for heroin use**
  • Majority (~75-80%) of current heroin users **initiated their opioid use with non-medical prescription opioid use**
  • Only (3-5%) of patients who misuse Rx opioids **transition** to heroin use
• **Rise of heroin overdose deaths** occurred **before** large scale state interventions were instituted, suggesting transition to heroin is **not solely an impact of state policies or changes in prescribing practices**
• Transition to heroin more likely **progression of addiction disease** in a subgroup of non-medical prescription opioid users (i.e., those with frequent non-medical use and/or prescription opioid abuse/dependence)
• Transition also **likely the result of market forces**, including **increased accessibility, reduced prices, and higher purity of heroin**

Compton W, et al. NEJM. 2016; 374; 154-63; Cicero et al. JAMA Psychiatry; 2014; 71-(7): 821-826
Alternative Treatments

• Mindfulness-Based Stress Reduction
• Developed with Chronic Pain Patients
• Benefits Health Overall
• Standardized mindfulness programs contribute positively to pain management
Tai Chi

Gentle on the body

Improves Balance

Beneficial role as an alternative treatment for chronic pain
Alternative Treatments

- Acupuncture
- Evidence that verum AND sham Acupuncture perform better than opioid treatment
- Some insurance companies and the VA now cover acupuncture
Additional resources that are available for providers and patients:

- Posters
- Fact Sheets
- Checklists
- Education on Epidemic

https://www.cdc.gov/drugoverdose/index.html
https://www.cdc.gov/drugoverdose/prescribing/clinical-tools.html

Access the full CDC guideline for prescribing opioids for chronic pain at:

https://www.cdc.gov/mmwr/volumes/65/rr/r6501e1.htm