MICIS

Maine Independent Clinical Information Service

Maine Medical Association

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives

2022 CDC Opioid Prescribing Guideline

Speaker: Diane Zavotsky, MD

Disclosures

- MICIS does not accept any money from pharmaceutical companies nor ineligible companies.
- None of the individuals in control of content for this activity have relevant financial relationships to disclose.
- Speaker has no conflicts of interest.

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Learning Objectives

At the end of this presentation, learners should be able to:

- Recall at least four of the Guideline's 12 Recommendations
- List two strategies for managing acute pain
- Implement one recommendation for patients on long-term opioid therapy (LTOT)

Guiding Principles for Implementation

1.

Pain needs to be appropriately assessed and treated

2.

Recommendations are voluntary, flexibility to meet patient needs is paramount

3.

Pain management should be multimodal and multidisciplinary

4.

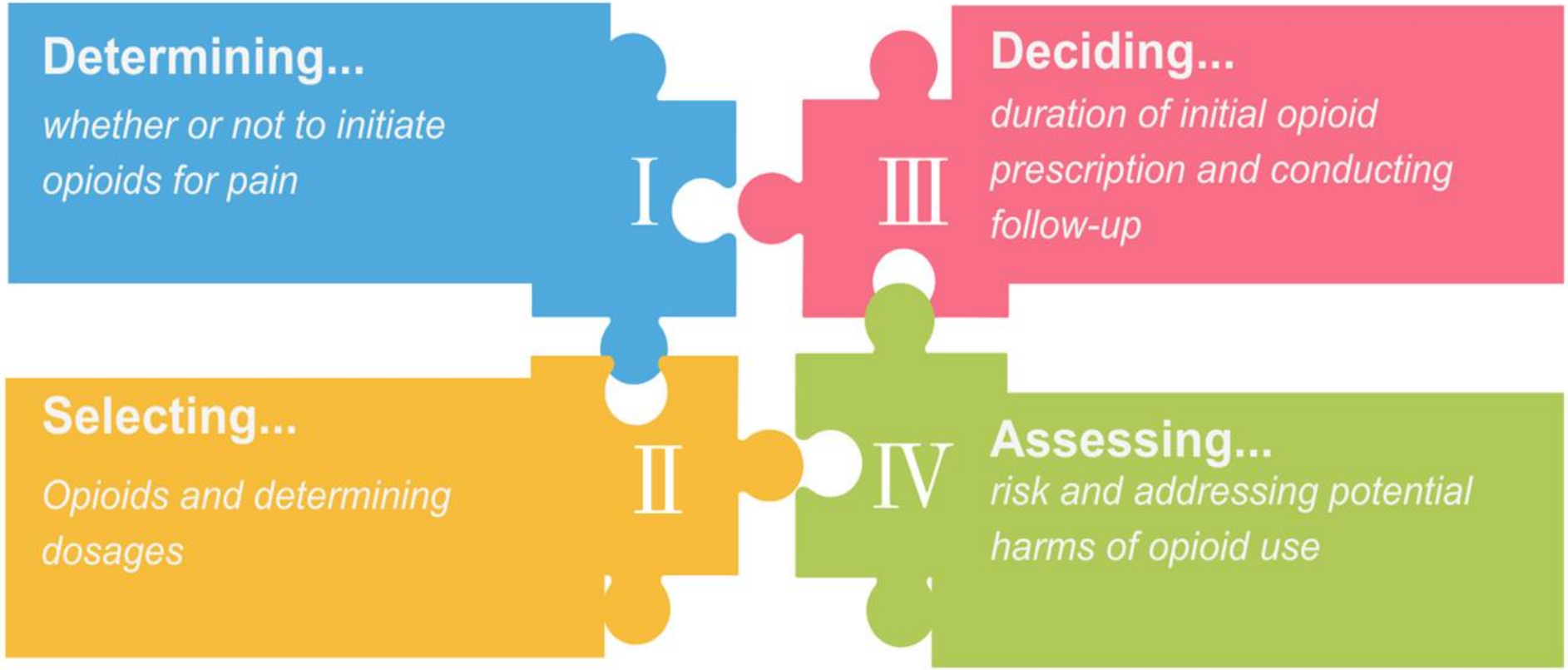
Avoid misapplying clinical practice guidelines beyond their intended use*

5.

Ensure equitable access to & communication of pharmacological and non-pharmacological pain management

Putting the Puzzle Together

12 recommendations grouped into 4 categories…



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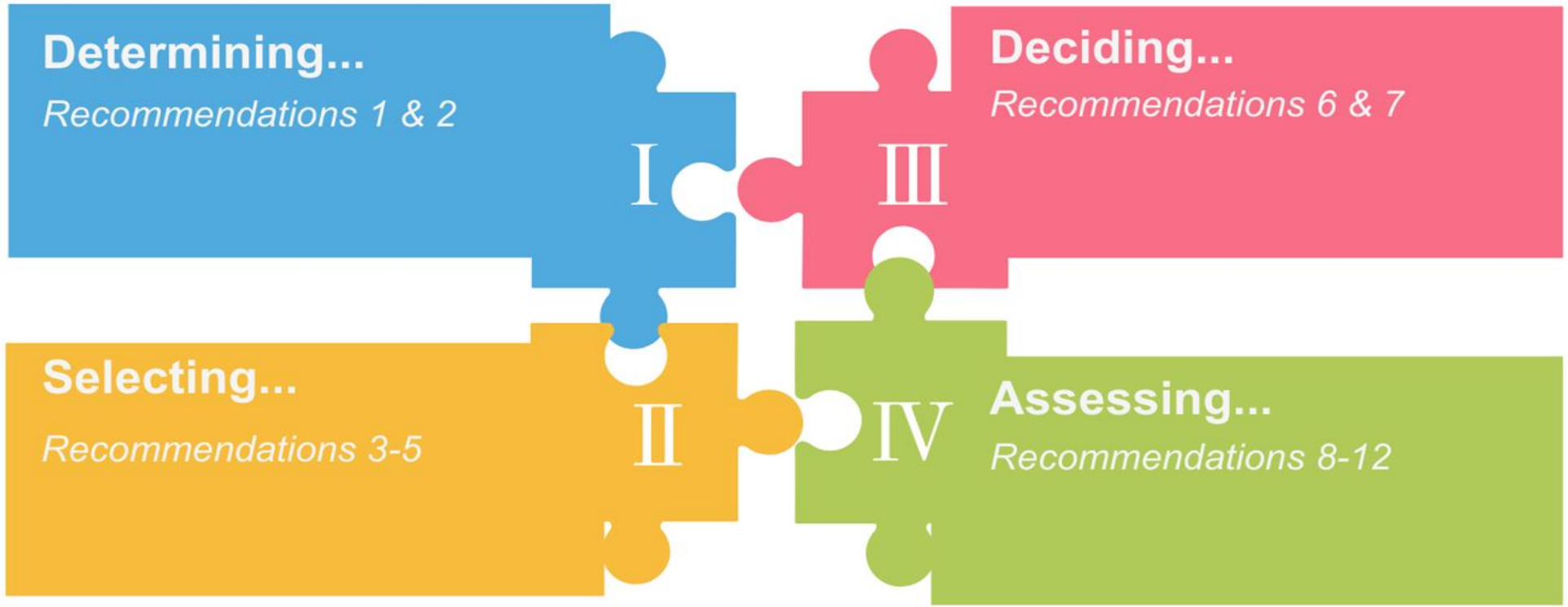

Recommendations

#1. Nonopioid therapies at least as effective for acute pain

#2. Nonopioid therapies preferred for subacute and chronic pain

Determining whether or not to initiate opioids for pain *(Recs.1 & 2)*

Recommendations

#3. Immediate release for starting (not ER/LA)

#4. Use lowest effective dosage if starting

#5. Carefully weigh benefits & risks when adjusting dosage

Selecting opioids and determining dosages (*Recs 3-5*)

Recommendations

#6. Prescribe small quantities for acute pain

#7. Evaluate patient 1- 4 weeks after change in med; regularly reevaluate after

Deciding duration of initial opioid prescription and conducting follow-up *(Recs 6 & 7)*

Recommendations

#8. Evaluate and discuss opioid risks; offer naloxone

#9. Review PDMP to assess patient risk

#10. Consider benefits & risks of toxicology testing for opioid therapy

#11. Caution with concurrent opioid & benzodiazepine use

#12. Facilitate access to MOUD for patients with OUD

Assessing Risk and Addressing Potential Harms of Opioid Use *(Recs 8-12)*

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Poll Everywhere Intro

3 Cases to Start Putting the Pieces of the Puzzle Together

Case #1-Acute pain

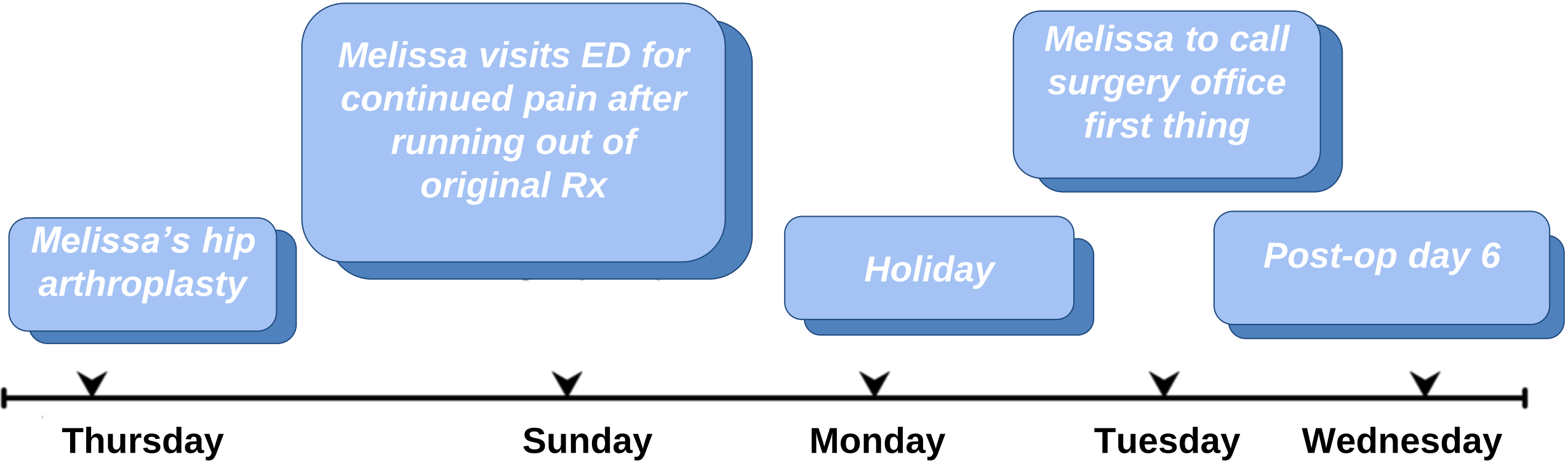
Patient discharge medication

- Oxycodone & acetaminophen 5mg/325mg (every 4-6 hours as needed)
- 12 tablets

Melissa

- 40 y/o
- Hip dysplasia → total hip arthroplasty
- Continued moderately severe pain 3 days post-op

Case Timeline



Acute pain poll

What do you prescribe/recommend for moderate post-operative pain?

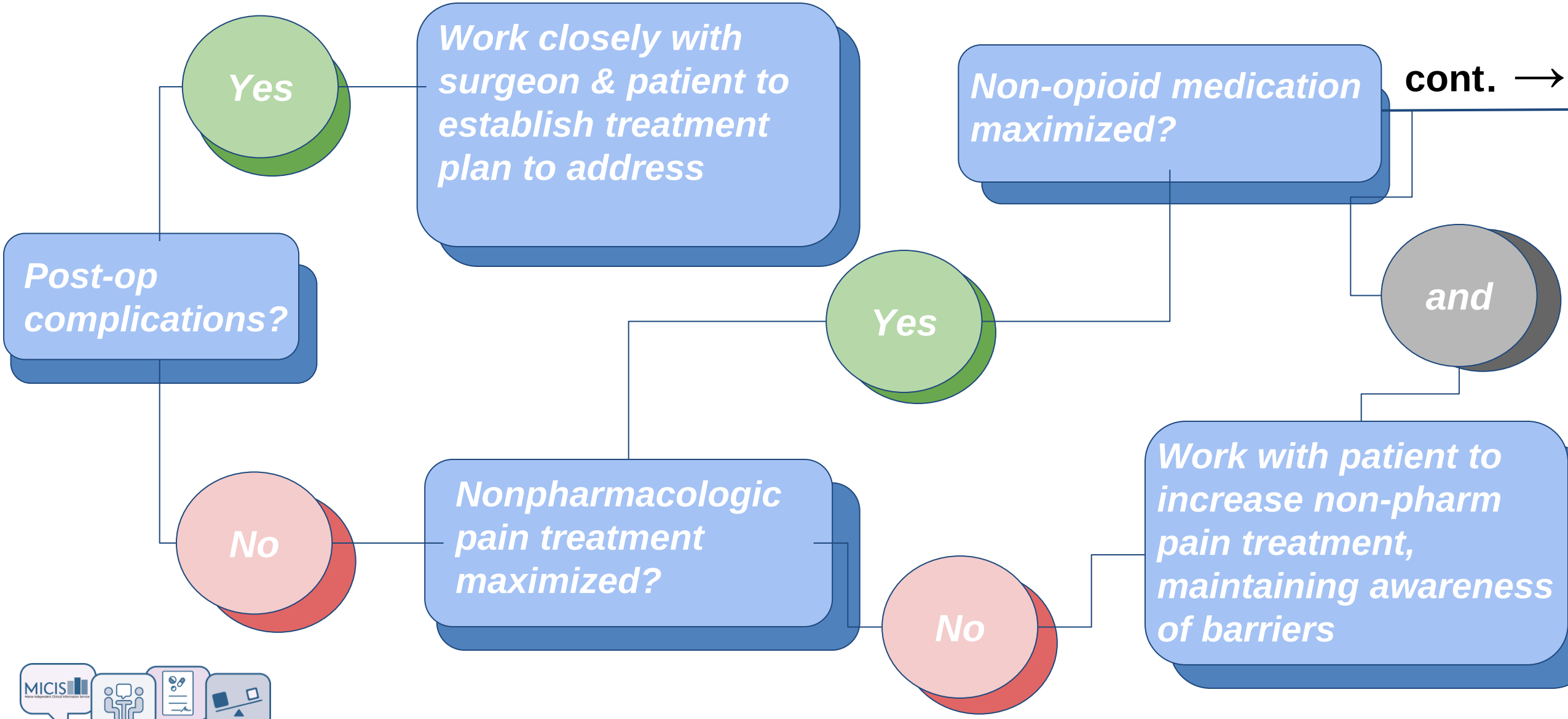
A. Gabapentin 300 mg, 3x/d — 0%

B. Hydrocodone-acetaminophen every 4h prn — 0%

C. Oxycodone-acetaminophen every 4h prn — 0%

D. Acetaminophen 500 and ibuprofen 400 (unless absolute contraindication) scheduled 3-4x/d — 0%

Acute Pain Flowchart



Acute Pain Flowchart Cont.

Non-opioid medication maximized?

Yes

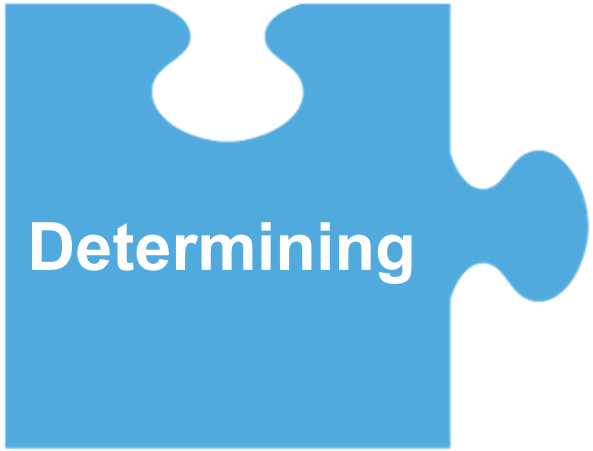
Collaborate with surgeon to form pain management plan that may include opioids

and

Review PMP to check for other sedating prescriptions

Recommendation 1

- Non-opioid therapies are at least as effective as opioids for many types of acute pain
- Only consider initiating opioid therapy if benefits to pain and function > risks
- Discuss benefits and risks with patient



Recommendation 3

- Prescribe immediate-release opioids instead of extended-release or long-acting opioids when starting opioid therapy, regardless of pain duration

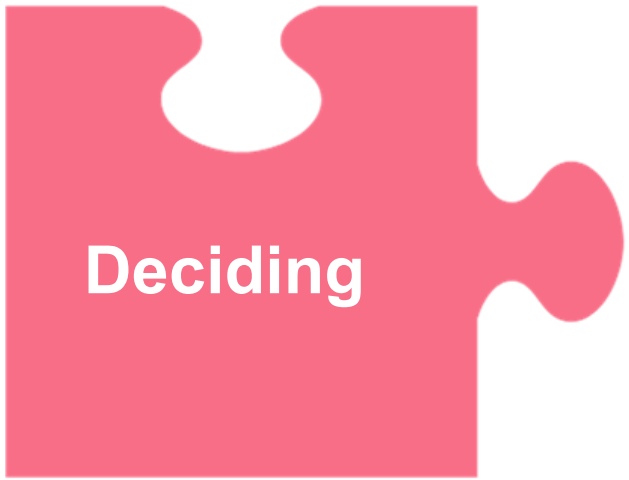
Recommendation 4

- Prescribe the lowest effective dosage when initiating opioids for opioid-naïve patients, regardless of pain duration

- Evaluate benefits and risks when considering increasing dosage for subacute and chronic pain

Recommendation 6

- For acute pain, prescribe no more opioids than needed for the expected duration of pain severe enough to require them



Case 1-Outcome

Melissa increases her use of non-pharm and non-opioid treatments and only takes two of the six additional opioid tablets prescribed in the ED. She disposes of the left-over opioids as directed, in the green drop box at her pharmacy.

*Patients who receive an opioid prescription after a short-stay surgery have a 44% increased risk of long-term opioid use.

Alam A, Gomes T, Zheng H, et al. Long-term analgesic use after low-risk surgery: a retrospective cohort study. *Arch Intern Med* March 12 2012;172(5):425–430.

Case #2-Chronic pain

Patient medication

- *Oxycodone 30 mg 4x/day*
- *Oxycodone 5 mg 3x/day as needed*
- *Ibuprofen 600 mg 3x/day*

Betsy

- 54 y/o
- rheumatoid arthritis (RA)
- new pt due to retirement of prior provider

Chronic pain challenges poll

What aspect of chronic pain do you find most challenging?

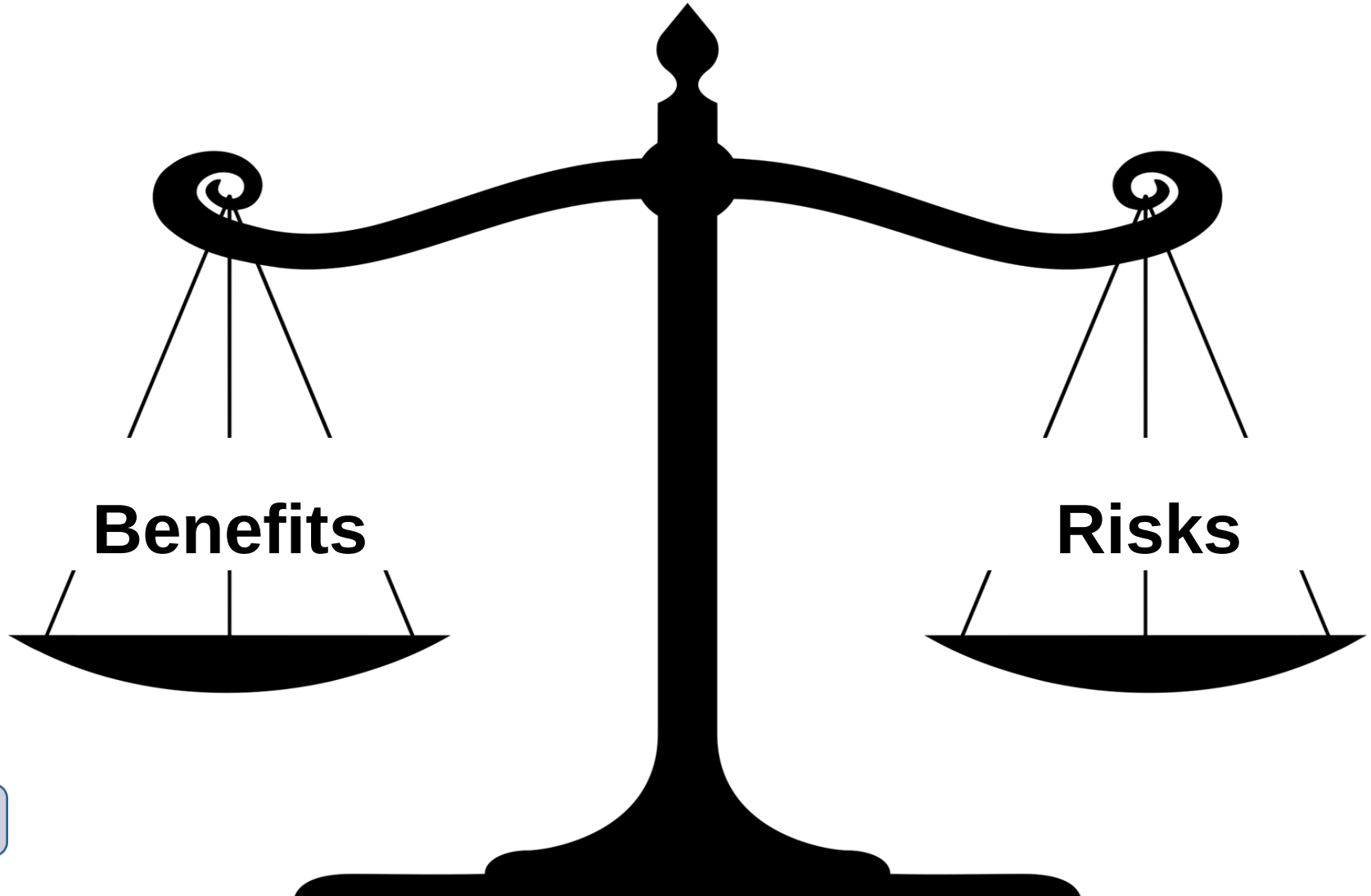
A. Patient reports pain has generalized, and they hurt "all over" 0%

B. Patient declines to pursue behavioral health treatment 0%

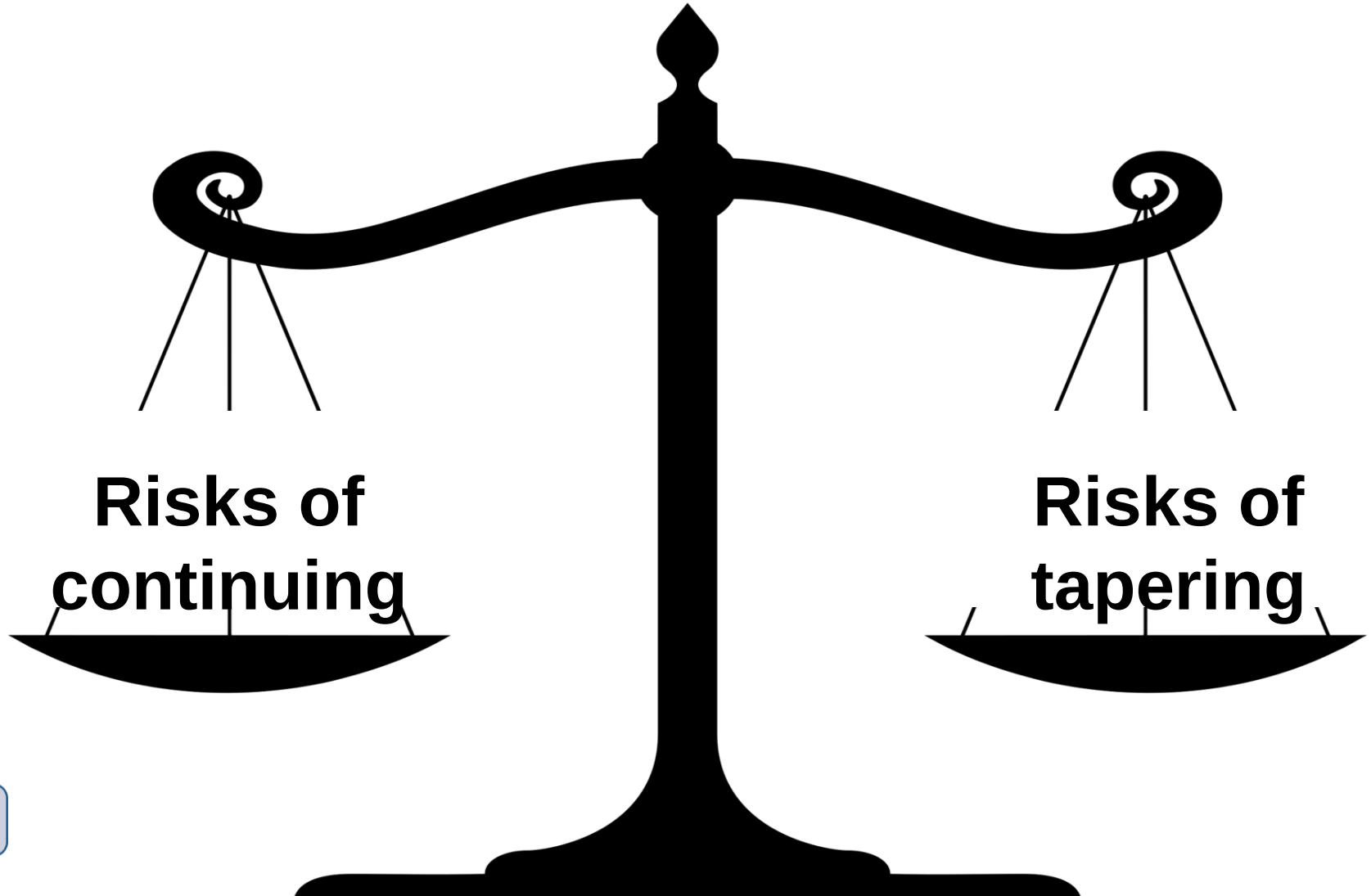
C. Patient states they would rather have an increased risk of death than a change to current opioid regi… 0%

D. Patient reports decrease in function with prior attempts at dose reduction 0%

Individualizing treatment



An Alternative Analysis



Recommendation 2

- Nonopioid therapies preferred for subacute and chronic pain

- Only consider initiating opioid therapy if benefits to pain and function > risks
  - Discuss benefits and risks with patient

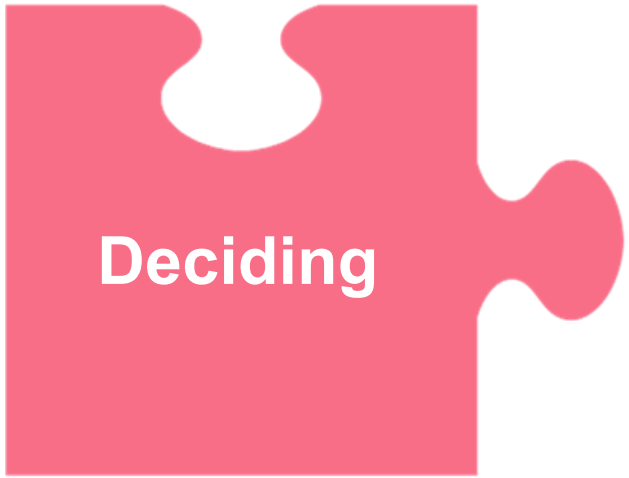
Recommendation 5

- Carefully weigh benefits and risks when changing opioid dosage for legacy patients

Benefits > Risks	Risks > Benefits
• Optimize non opioid therapies • Continue opioid therapy	• Optimize non opioid therapies • Gradually taper opioids to lower dosages

Recommendation 7

- Evaluate benefits & risks with patients within 1-4 weeks of…
  - Starting opioid therapy for subacute/ chronic pain
  - Dosage escalation
- Regularly reevaluate benefits & risks of continued therapy with patients



Comprehensive Review for Chronic Pain

Regularly screen for OUD using validated tool

Complete med. list (w/ supplements & marijuana)

Functional assessment with validated tool

Behavioral health assessment & treatment history

Other elements as required by licensing boards*

*Chapter 21, https://www.maine.gov/boardofnursing/laws-rules/Chapter%2021%2005.27.20.pdf

After discussion including brief MI with patient…

Betsy…

a. Is interested in tapering
b. Is reluctant to taper
c. Meets diagnostic criteria for OUD

A ‘choose your own ending’ case!

A-Motivated to taper

- Concerned about risks of long-term use
- Plan to decrease dose by 5 mg daily every 2-4 weeks
- Pt to control pace (advise quicker at first, then more slowly)
- Referred to rheumatology for possible disease modulating tx
- Re-engaging with behavioral health counseling
- Tapers off opioids after 24 months
- Reports some increase in pain during tapering stages but remains at baseline pain & function level at month 24

B-Reluctant to taper

- Safer options discussed
- Pt agreeable to change to buprenorphine formulation for pain (via low dose cross initiation method over 10 days)
- Agreeable to in-office behavioral health counseling
- Referred to Rheumatology (4-6 month wait) to investigate disease modulating tx

C-OUD in the Context of Prescription Opioids

- Screening reveals history of alcohol use disorder in both parents
- After standardized OUD screening questions at four visits in a row, at the fourth she states she crushes and snorts oxycodone “due to uncontrolled pain”
- Sometimes borrows or buys additional prescription opioids
- Admittedly, it's usually more of a gray area

C-OUD in the Context of Prescription Opioids

- Take-home naloxone given to patient from your in-office state supply
- Be frank and nonjudgemental while delivering the diagnosis
- Normalize the phenomenon of developing an addiction after LTOT (i.e. up to 1/3 of people have the "switch" turned on)
- Discuss MOUD options and initiate the plan
- Discharging the patient is no longer recommended
- *For an in-depth discussion of buprenorphine, sign up for MICIS One on One Academic Detailing

Recommendation 12

- Offer/ arrange MOUD treatments
- Detoxification without MOUD **NOT** recommended because of increased risk for
  - Resuming drug use
  - Overdose
  - Overdose death

OPTIONS SAVE LIVES

Maine's OPTIONS Program

Link to Options video:
https://youtu.be/W0LhJcnrXPw

Case #3

Patient medication & history

- 5 mg immediate release oxycodone four times daily
- 15 mg meloxicam daily
- 1 mg lorazepam daily
- 10 mg escitalopram daily

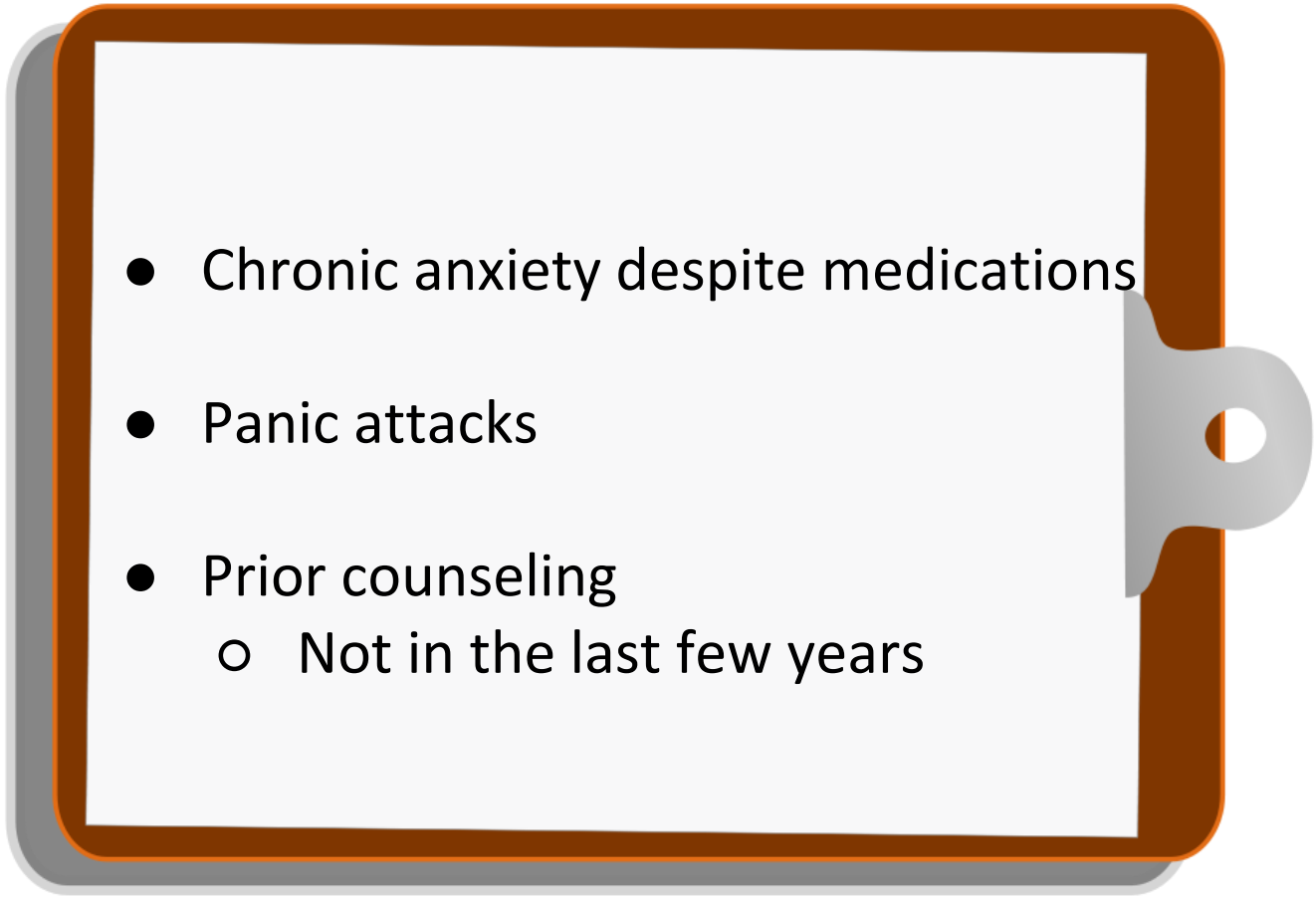
Sandy

- 66 y/o
- Chronic back pain
- DJD of cervical spine
- Multilevel lumbar spine surgery
- Rotator cuff repair

Sandy's Story

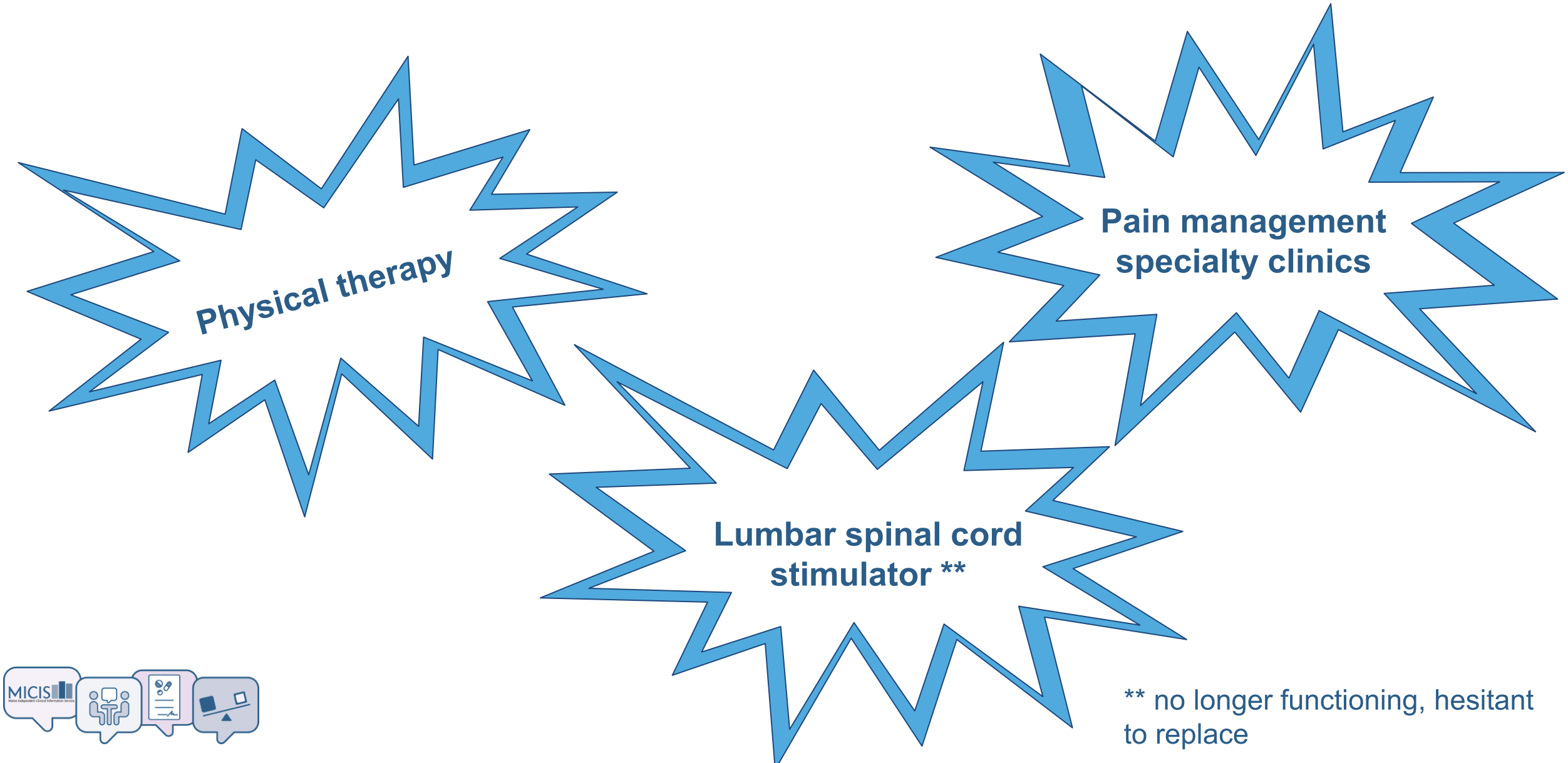
- Logging accident
- Modifications over the years with different providers
- Prior trials of long-acting opioids

Sandy's Psychiatric History



- Chronic anxiety despite medications
- Panic attacks
- Prior counseling
  - Not in the last few years

Prior treatment modalities



** no longer functioning, hesitant to replace

Functional Assessment

- Pain limits daily activity
- Asks about dose increase
- Continues to serve as primary caregiver for elderly parent

Recommendation 8

- Evaluate for opioid related harms and discuss risks with patients….
  - Before starting & periodically during opioid therapy

- Work with patients to incorporate risk mitigation strategies into the management plan
  - Offer naloxone

Harm Reduction Strategies

- Offer & encourage naloxone in the home & training for family
- Be mindful of cost/ co-pays (Rx vs OTC)
- Offer free naloxone or direct to state-supported program https://getmainenaloxone.org/

Assess Side Effects/ Risks

- Constipation assessment, other side effects
- Monitor renal & hepatic function
- Assess for alcohol use (i.e. Please tell me about your use of alcohol)

Recommendation 9

- Review PDMP data to determine if patient is receiving dosages or combinations that put them at risk for OD…
  - When initiating opioid therapy for any pain duration
  - Periodically during opioid therapy for chronic pain

PDMP/ PMP Usage

- Required to check before an initial opioid or benzodiazepine prescription & every 90 days
  - Delegate must select the correct prescriber before checking
  - Covering partners/ delegates must check under their own name when "refilling"

PDMP/ PMP Usage

- Develop a standard office protocol
- Sandy did not have any unexpected findings or early refills

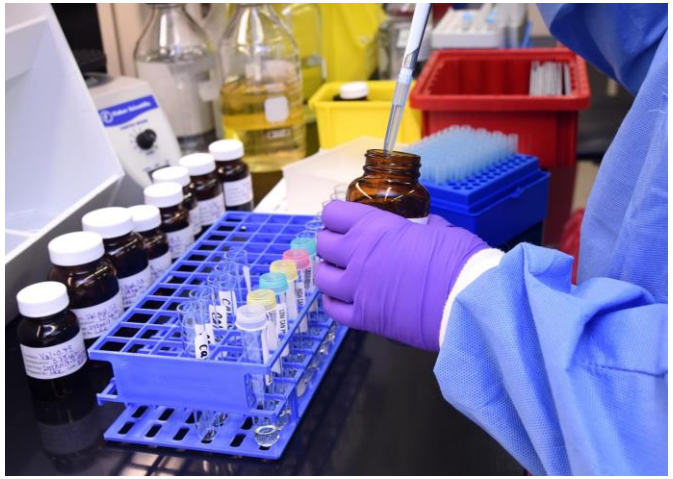
https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/PMP%20check%20workflow.pdf

Assessing for Non-reassuring behaviors

- Regular assessments for OUD/misuse
- ? Increasing dose, running out, early refills
- Show PMP report to pt; ask open-ended questions if unexpected findings
- PMP data is just one piece of data in the opioid prescribing assessment
- Do not abruptly discontinue or rapidly taper

Recommendation 10

- Consider the benefits and risks of toxicology testing to assess for prescribed medications as well as other prescribed & non prescribed controlled substances



Urine or saliva toxicology testing (1)

Do's

- Know your office & send out options & limitations
  - Synthetic opioids need special tests (buprenorphine, fentanyl, methadone)
- Follow office policy & procedure; DOCUMENT
- Annual toxicology at a minimum
  - Required by ME licensing boards
- Adjust frequency to risk/ concern
- Consider regular collections & send out at random intervals

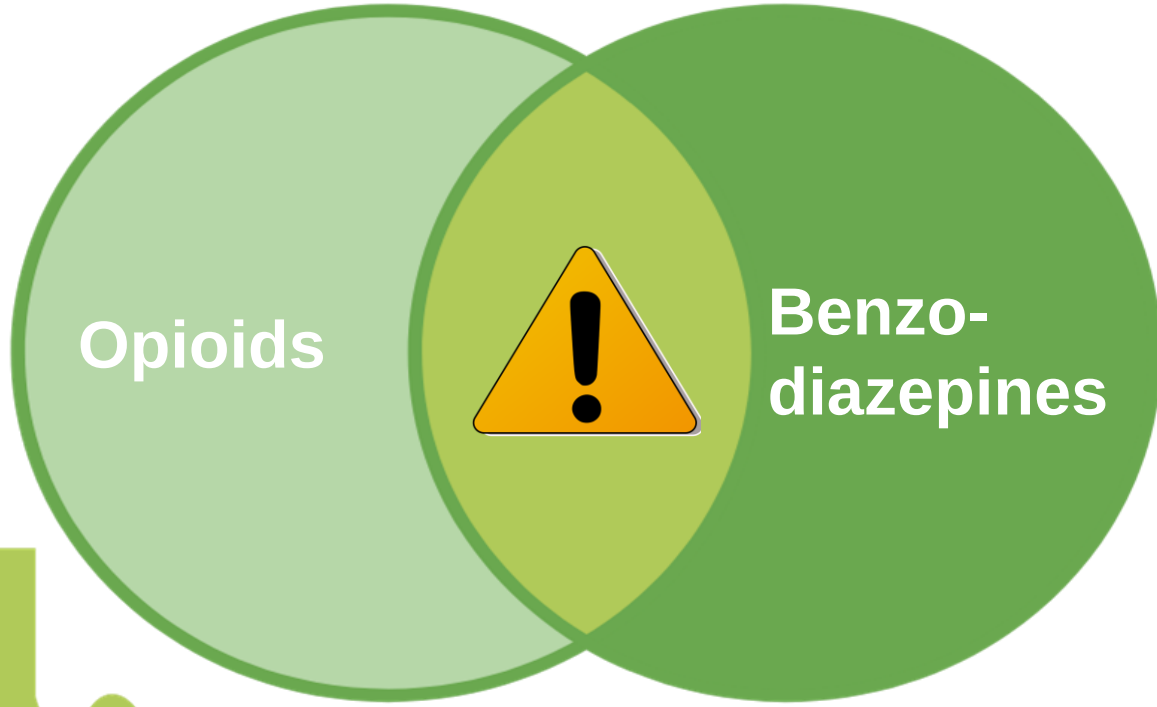
Urine or saliva toxicology testing (2)

AVOID

- Using tests that will not impact clinical decision making
- Forgetting the lab resource line
  - One phone call can be very informative
- Forgetting to maintain awareness of cost to patient & insurance requirements/ limitations
  - Usually cannot bill for in office & send out same visit
- Using pill counts unnecessarily
  - Not a primary CDC recommendation nor required by ME licensing boards (optional)

Recommendation 11

- Use particular caution when prescribing opioid pain medication and benzodiazepines concurrently:
  - Benefits > Risks?
  - Can one be tapered?

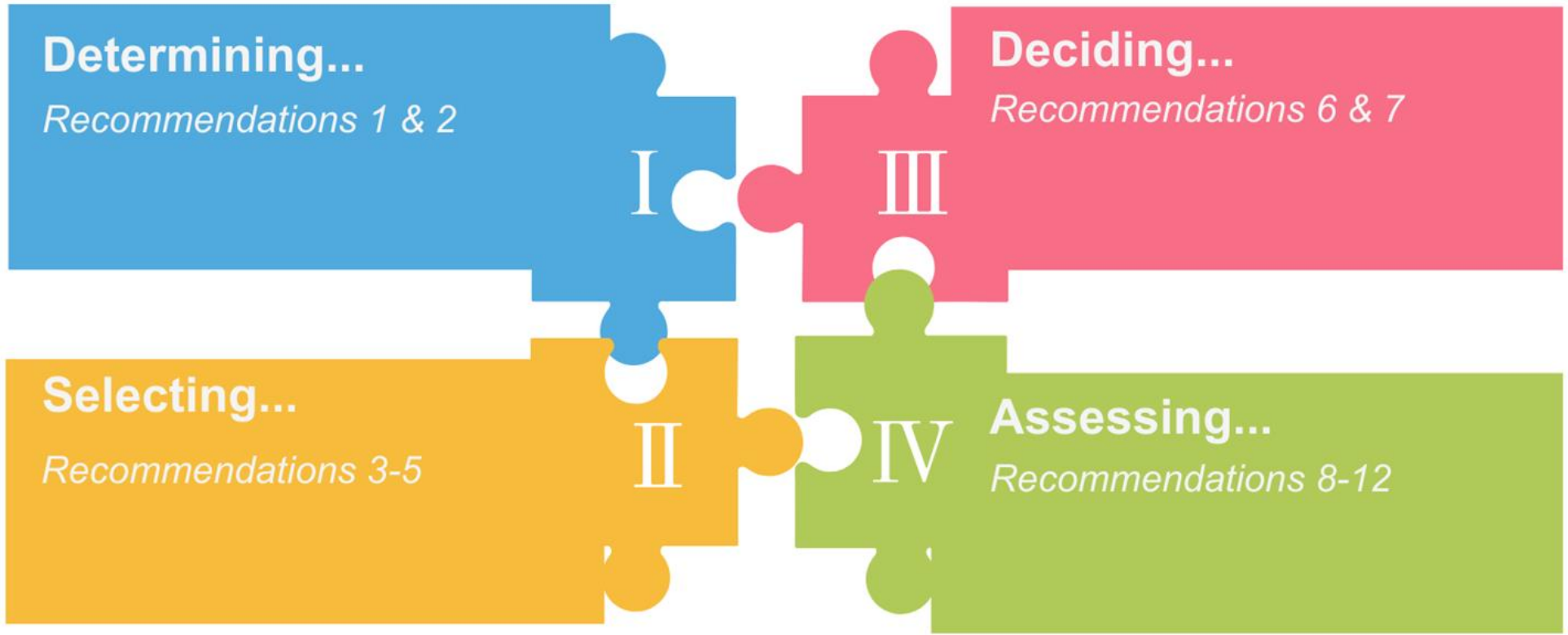


Case 3-Outcome

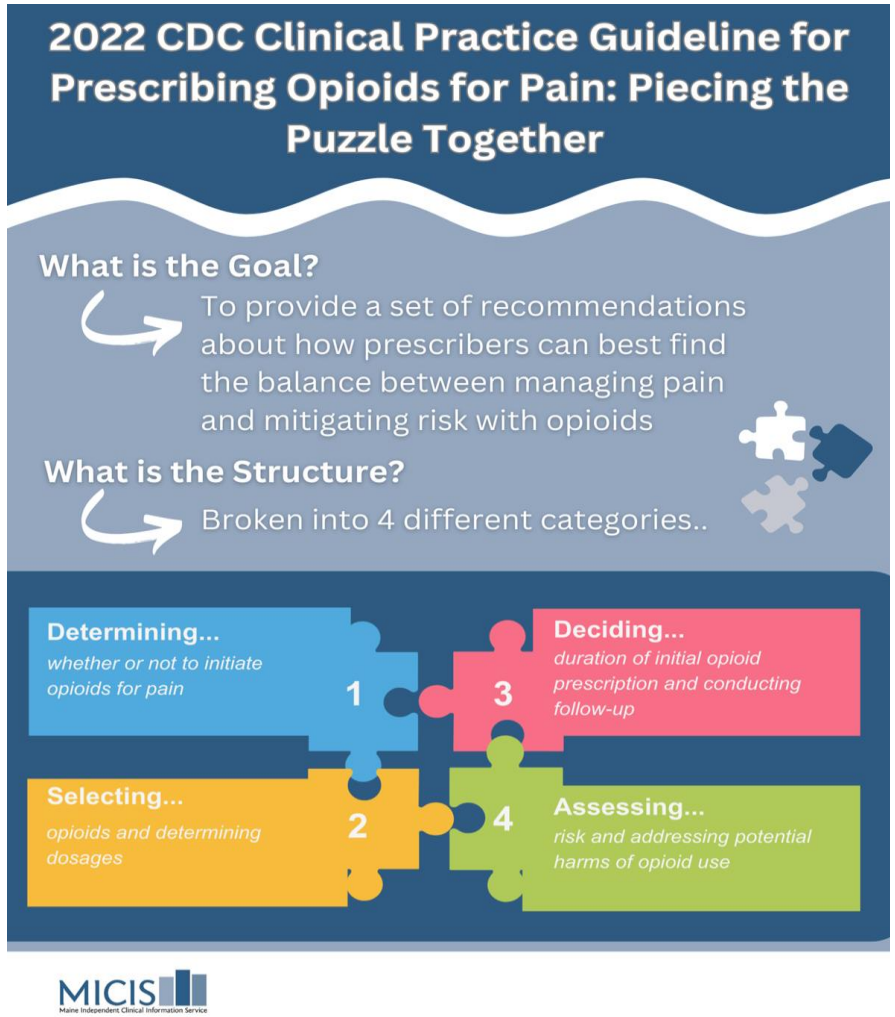
- Previously unable to tolerate benzodiazepine alternatives and anxiety had become disabling without it
- Patient was able to slowly decrease and discontinue opioid
- Patient was seen every month due to high-risk combination and for tapering support
- Patient has maintained his caregiver responsibilities for elderly parent
- Written informed consent, patient-provider agreement and documentation template completed in chart (*avoid cut and paste/carry forward)

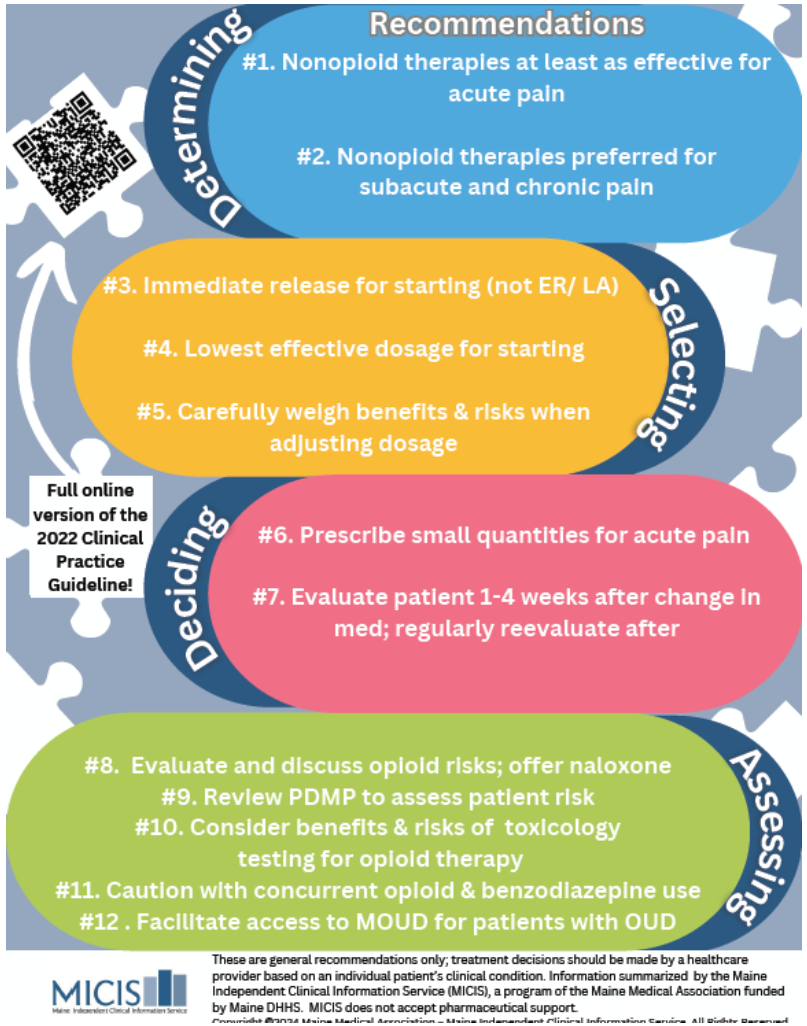
Recommendation Review

12 recommendations grouped into 4 categories…



MICIS Opioid Prescribing Handout





https://micismaine.org/education-topics/clinical-toolkit/

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- If MICIS is providing credit, please fill out the survey within 2 weeks and a credit document will be emailed from the Maine Medical Association.
- This content satisfies one hour of the Maine licensing board requirement as well as the DEA MATE act.

micismaine.org

Link to Options video: https://youtu.be/W0LhJcnrXPw

Reserve poll questions

Acute care visit poll

Which of the following is NOT a recommended action for the ED provider?

A. Check the PMP — 0%

B. Discuss risks of continued opioid use with patient — 0%

C. Confirm that non-opioid medications are maximized — 0%

D. Provide a 7 day supply of opioids — 0%

Approaches to Chronic Pain Discussion

Which aspects of chronic pain do you discuss with patients? (choose all that apply)

A. Opioid induced hyperalgesia — 0%

B. Risk for opioid use disorder — 0%

C. Relationship to psychological trauma history — 0%

D. Evolving understanding of pain & opioids — 0%

E. Laws that restrict opioid prescribing — 0%

Benzodiazepine alternative poll

Which are recommended non-benzodiazepine evidence-based treatments for anxiety? (choose all that apply)

A. SSRI/SNRI 0%

B. TCA 0%

C. Atypical antipsychotics 0%

D. Buspirone 0%

E. Mirtazepine 0%