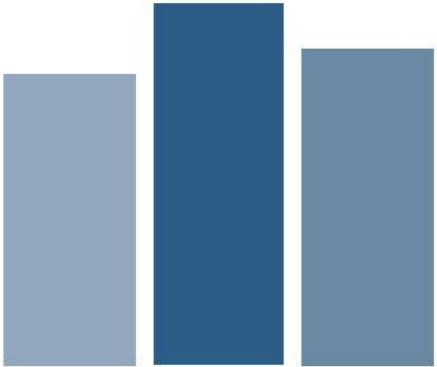


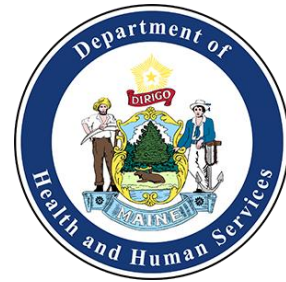
# MICIS



Maine Independent Clinical Information Service

A program of the  
 **Maine Medical Association**

Funded by the Office of MaineCare Services,  
Maine Department of Health and Human Services



# CDC Opioid Prescribing Guideline

*Speaker: Elisabeth Fowlie Mock, 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.

*This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the Hanley Center for Health Leadership and Education and the Maine Independent Clinical Information Service (MICIS). The Hanley Center for Health Leadership and Education is accredited by the Maine Medical Association Committee on Continuing Medical Education and Accreditation to provide continuing medical education for physicians.*



# 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\*

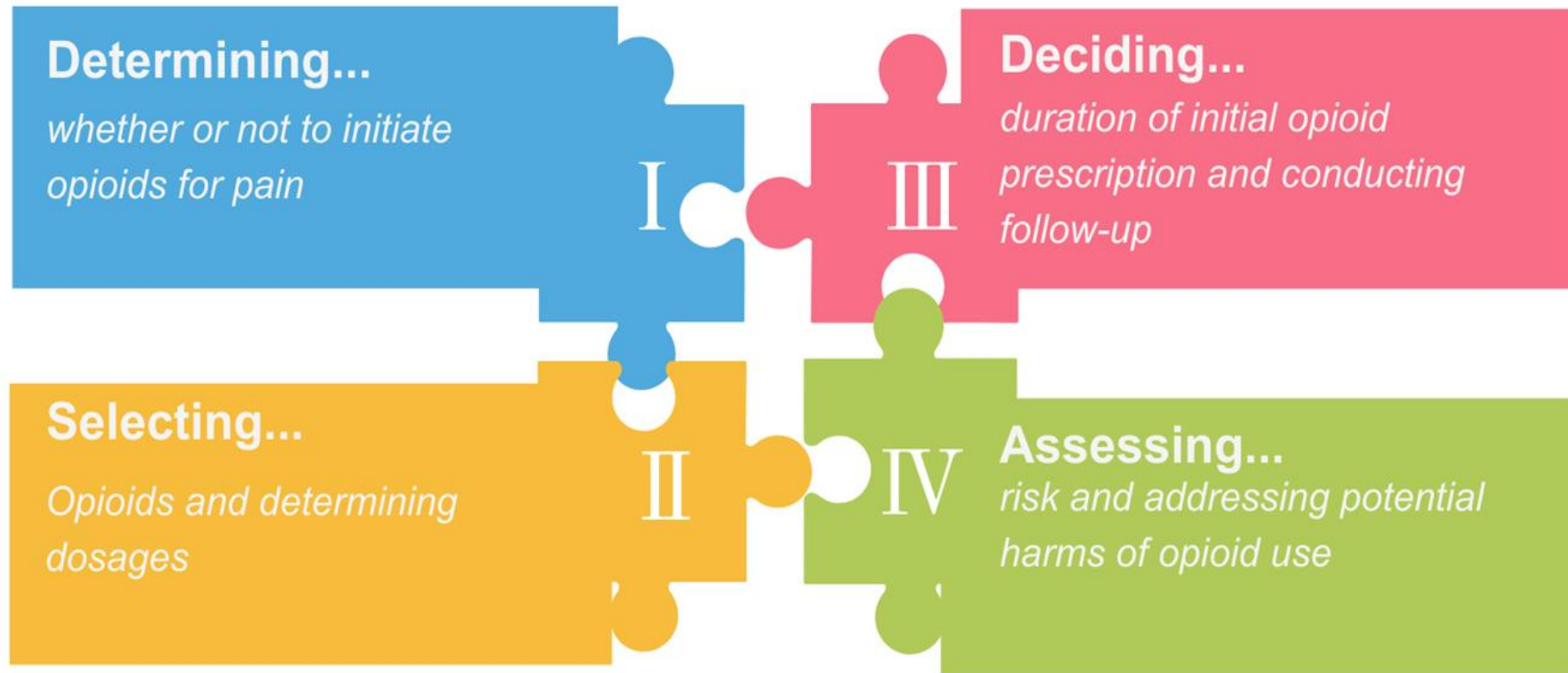
5.

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



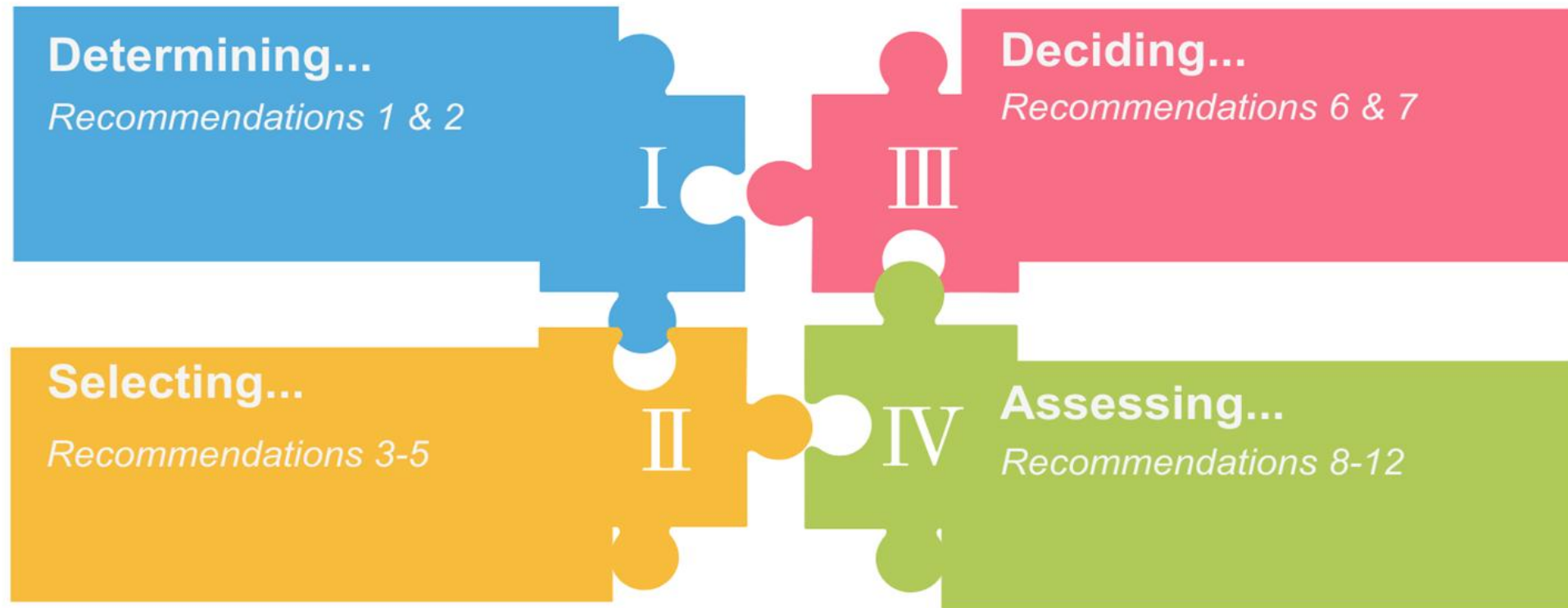
# Putting the Puzzle Together

12 recommendations grouped into 4 categories...



# Putting the Puzzle Together

12 recommendations grouped into 4 categories...



## 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*)



# Poll Everywhere sign on



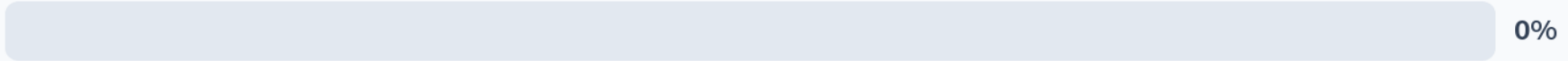
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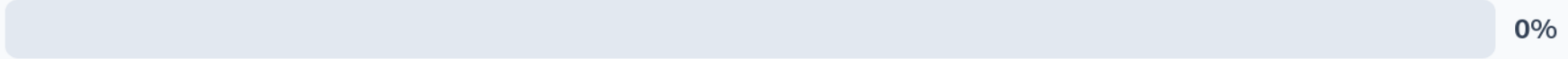
# Poll Everywhere Intro

Which best describes your specialty?

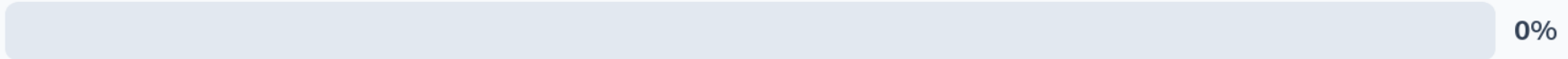
A. Primary Care



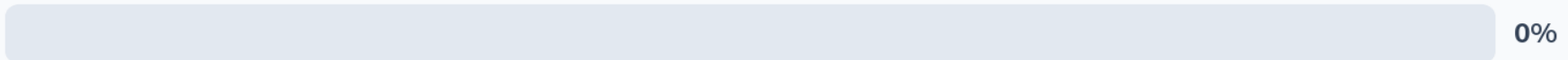
B. Surgery



C. Medical Subspecialty



D. Other



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# 3 Cases to Start Putting the Pieces of the Puzzle Together



# Case #1-Acute pain

## ***Patient discharge medication***

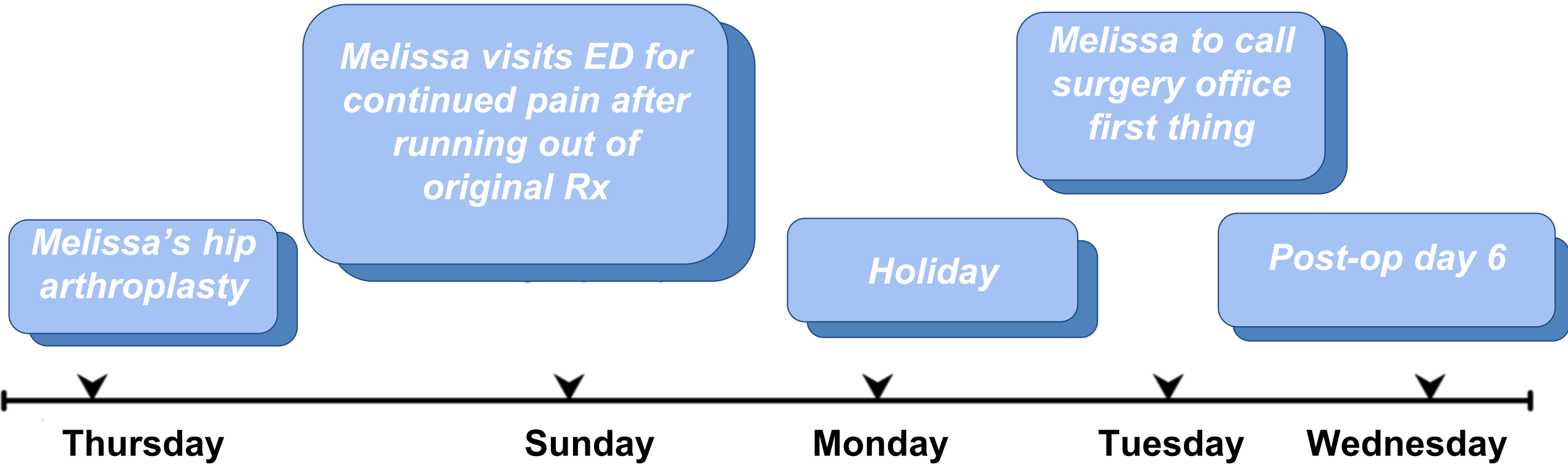
- Oxycodone & acetaminophen 5mg/325mg (every 4-6 hours as needed)
- 12 tablets



## **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%

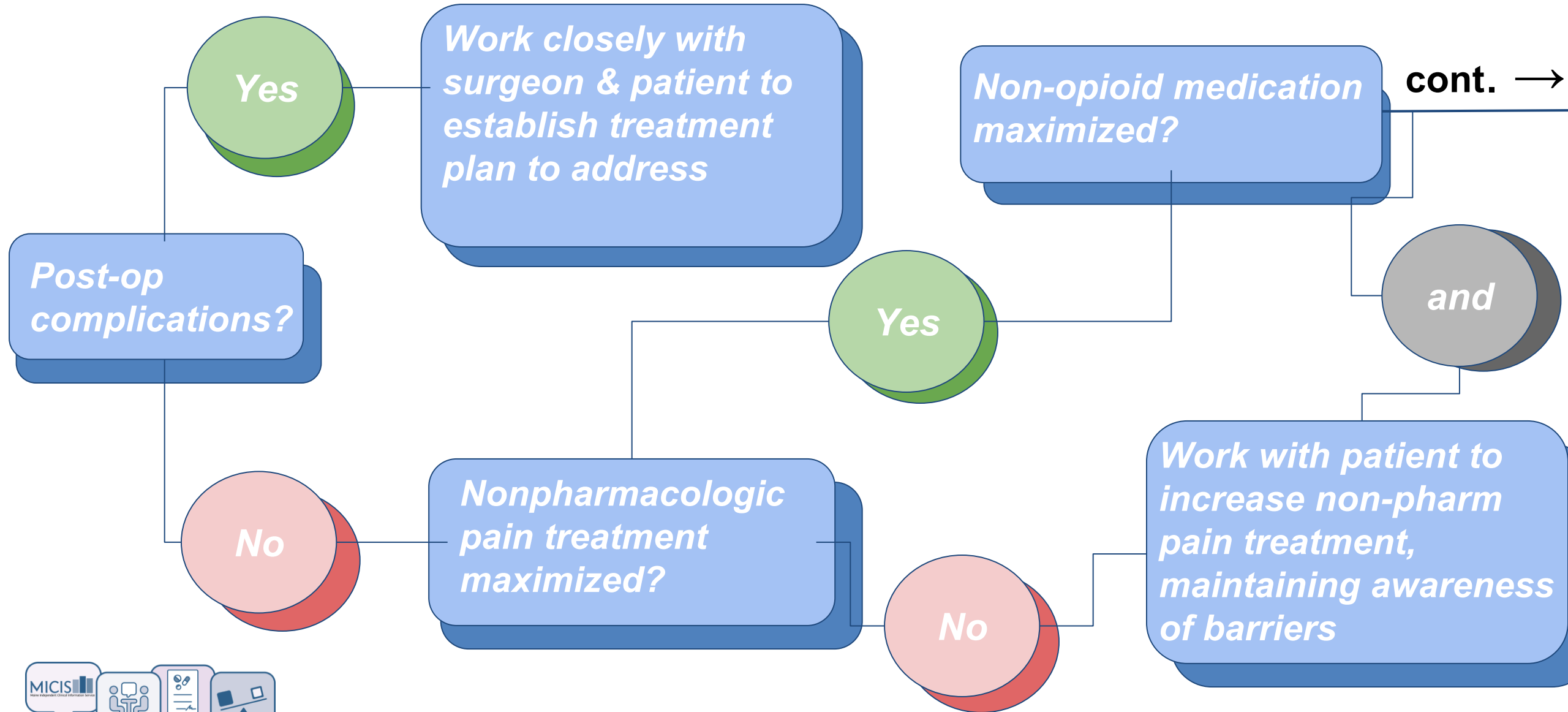
D. Acetaminophen 500 and ibuprofen 400 (unless absolute contraindication) scheduled 3-4x/d

0%

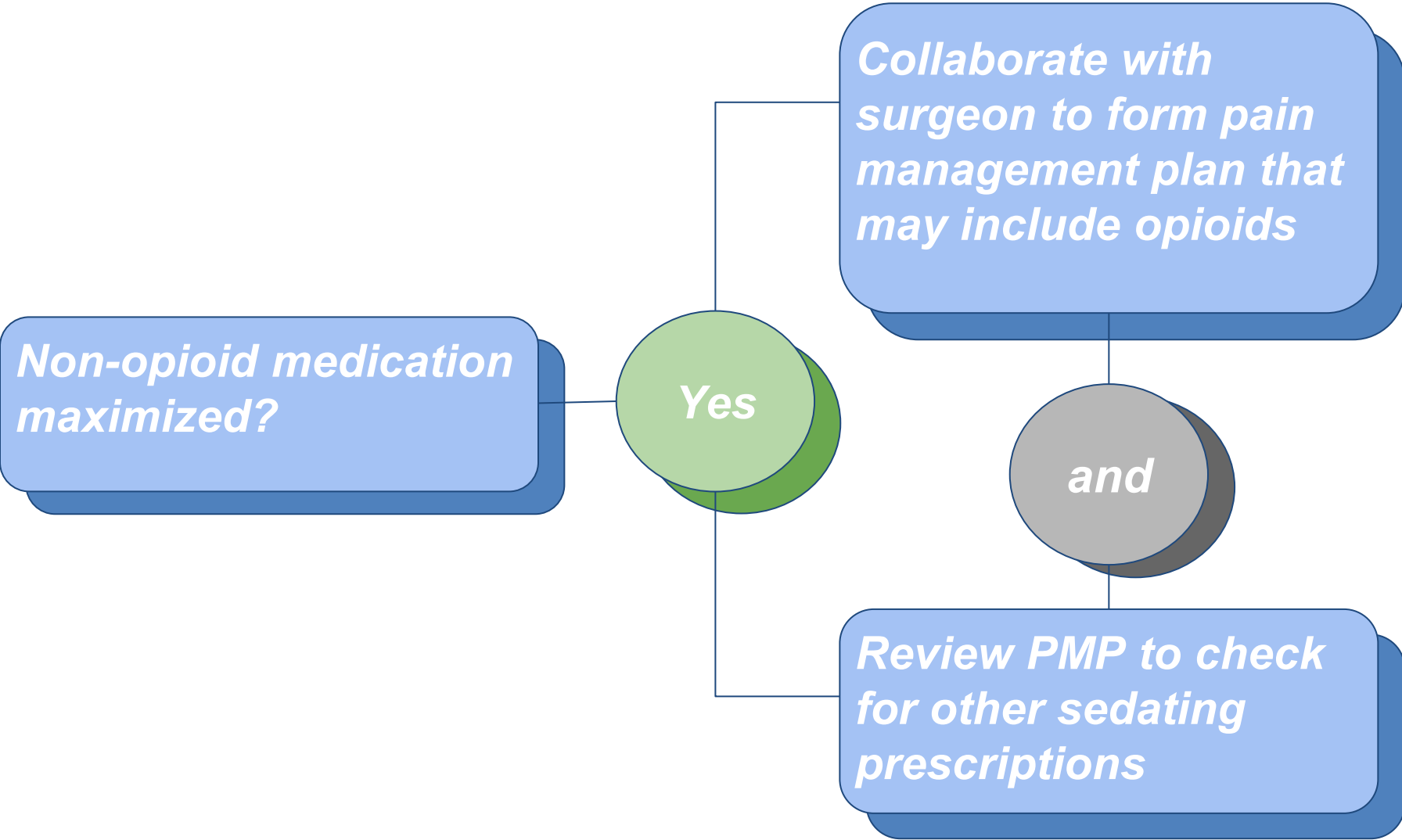
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# Acute Pain Flowchart



# Acute Pain Flowchart Cont.



# 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



Selecting



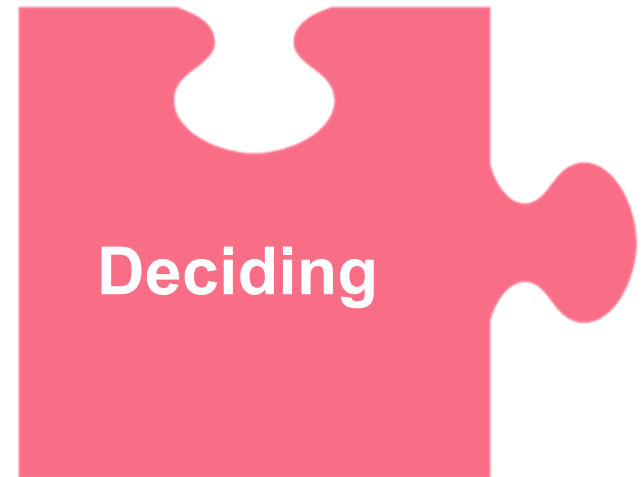
# Recommendation 4

- 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.



# Case #2-Chronic pain

## ***Patient medication***

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

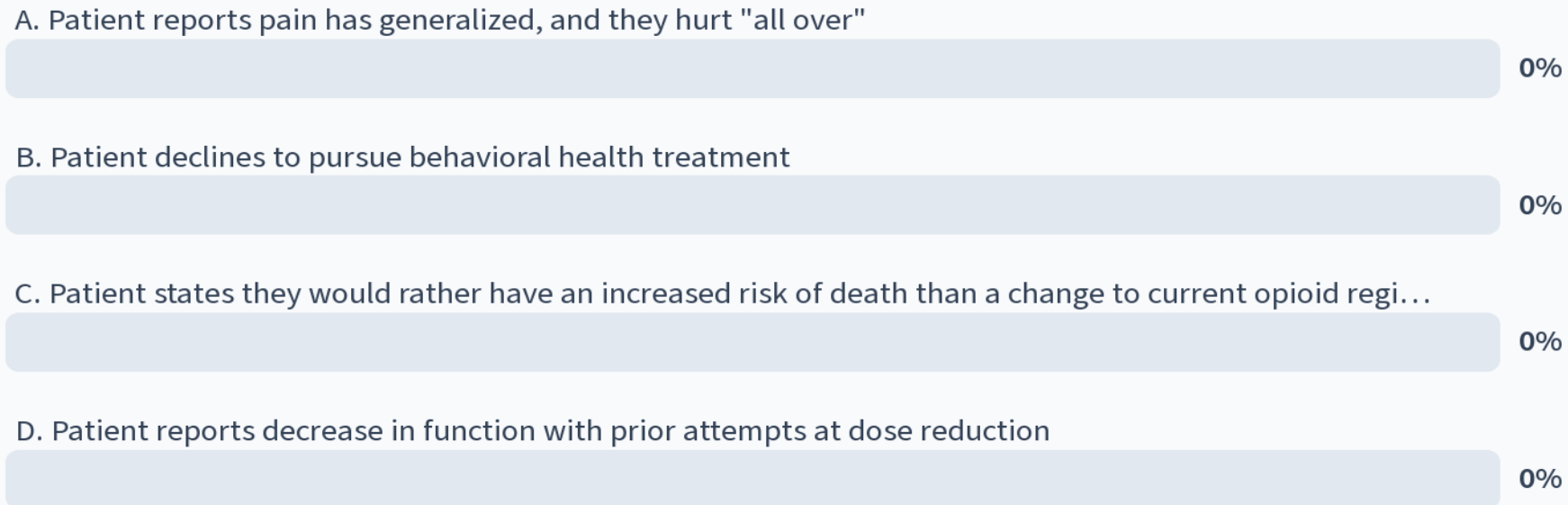


## **Betsy**

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

# Chronic pain challenges poll

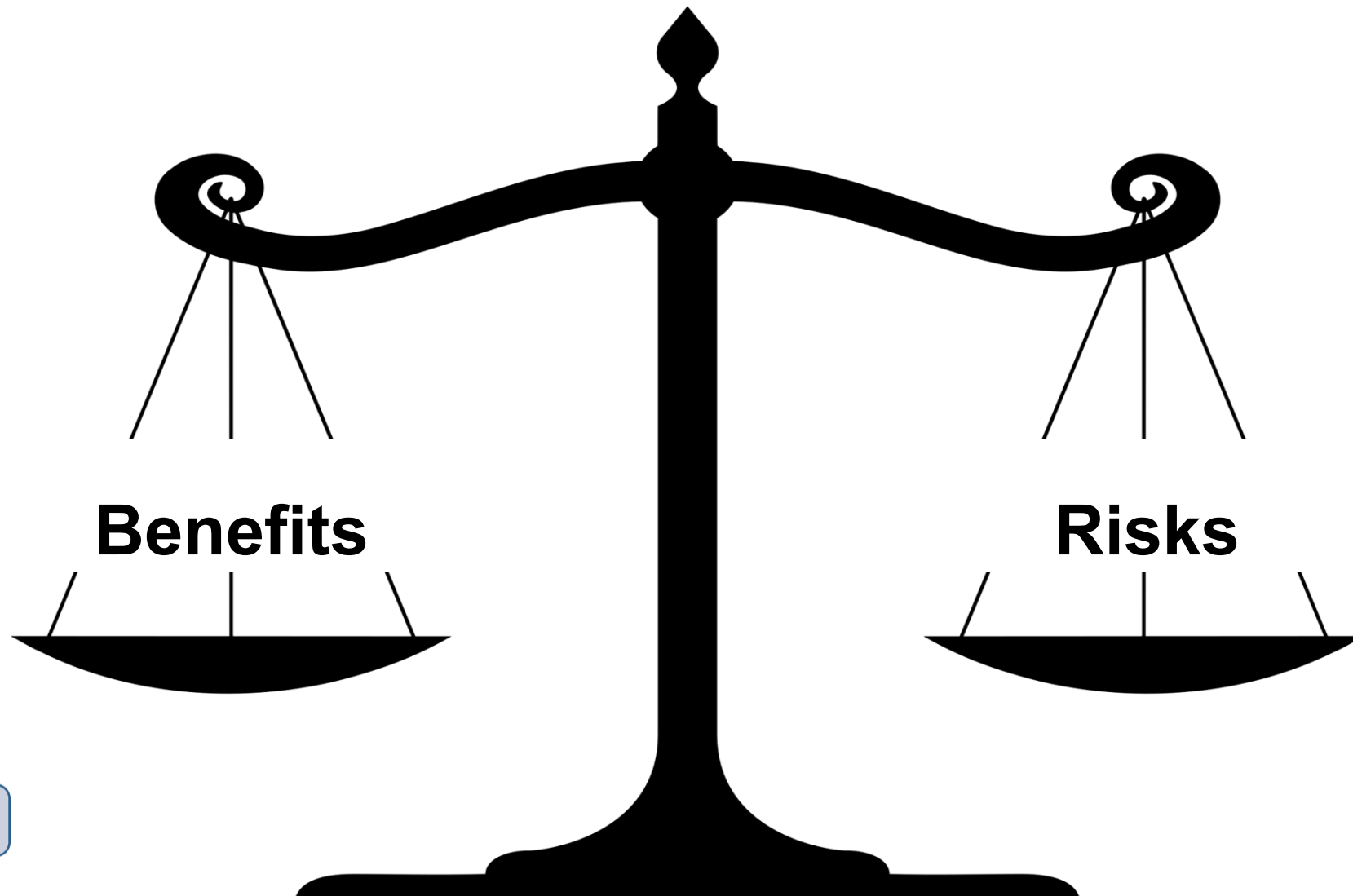
What aspect of chronic pain do you find most challenging?



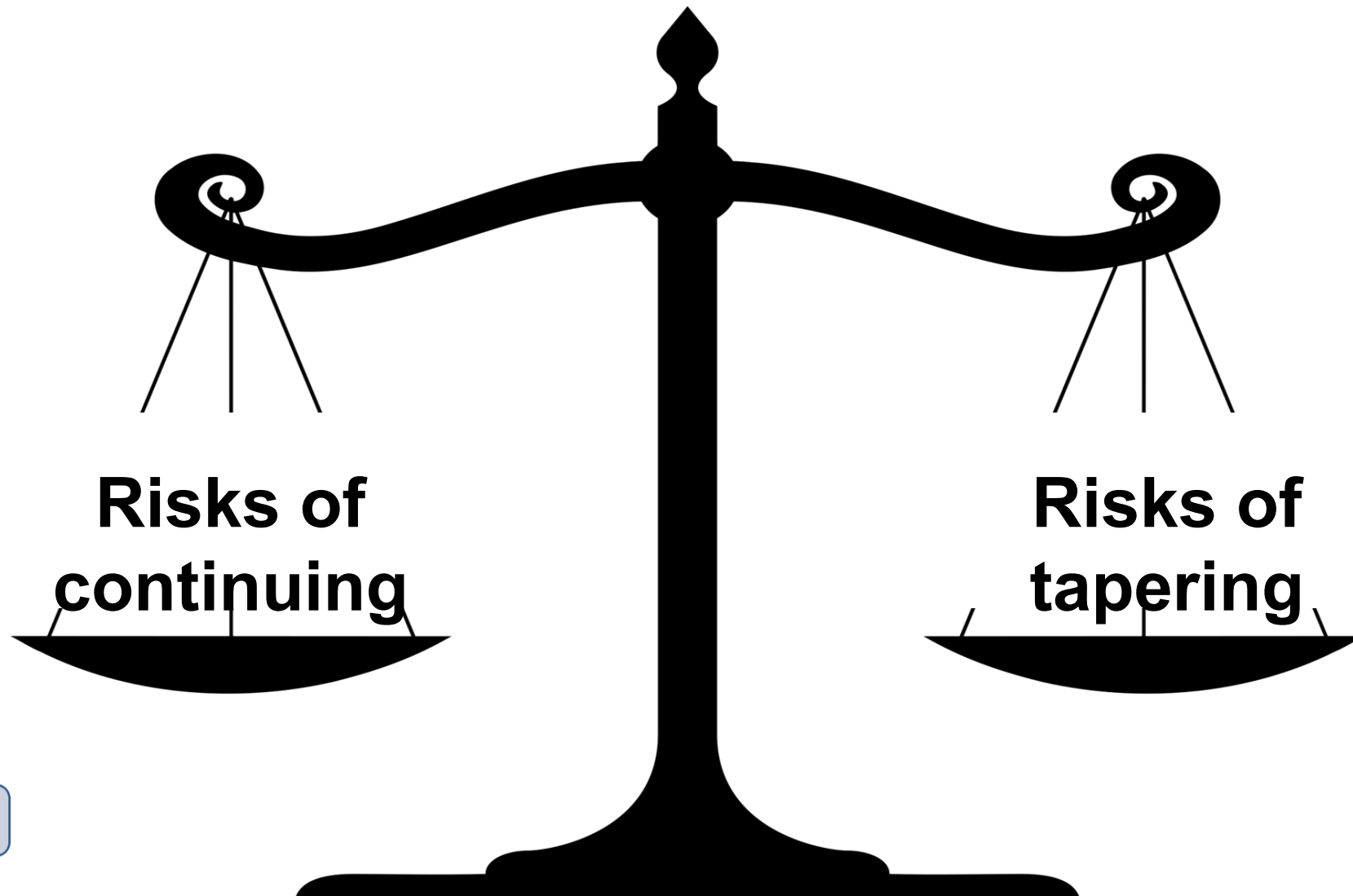
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# Individualizing treatment



# 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



Determining

# Recommendation 5

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

Benefits > Risks	Risks > Benefits
<ul style="list-style-type: none"><li>● Optimize non opioid therapies</li><li>● Continue opioid therapy</li></ul>	<ul style="list-style-type: none"><li>● Optimize non opioid therapies</li><li>● Gradually taper opioids to lower dosages</li></ul>



# 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



Deciding

# Comprehensive Review for Chronic Pain

**Regularly screen  
for OUD using  
validated tool**

**Functional assessment  
with validated tool**

**Complete med. list  
(w/ supplements &  
marijuana)**

**Behavioral health  
assessment &  
treatment history**

**Other elements as  
required by licensing  
boards\***



# 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-ODD 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-OPUD 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**

Assessing



# Maine's OPTIONS Program



Link to Options video:  
<https://youtu.be/W0LhJcncrXPw>

# 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

**Physical therapy**

**Pain management  
specialty clinics**

**Lumbar spinal cord  
stimulator \*\***

\*\* 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



Assessing

# 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



# 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

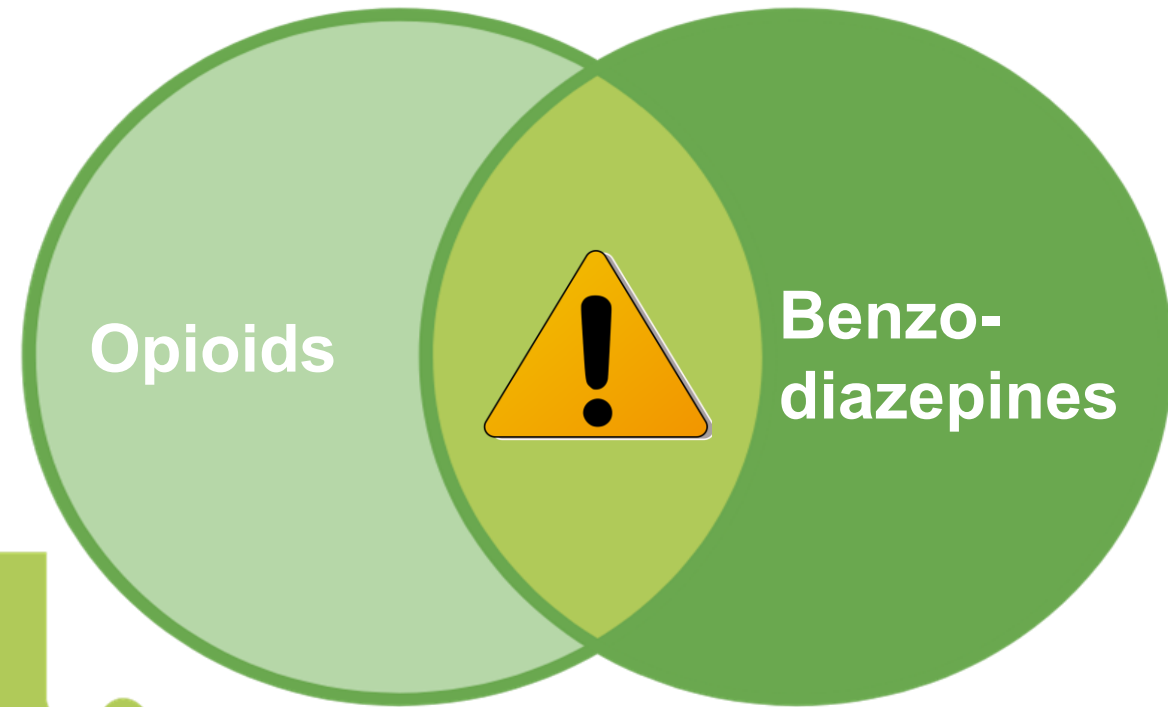
- Using tests that will not impact clinical decision making
- Forgetting the lab resource line
  - One phone call can be very informative
- Forgetting to maintain awareness of cost to patient & insurance requirements/ limitations
  - Usually cannot bill for in office & send out same visit
- Using pill 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?



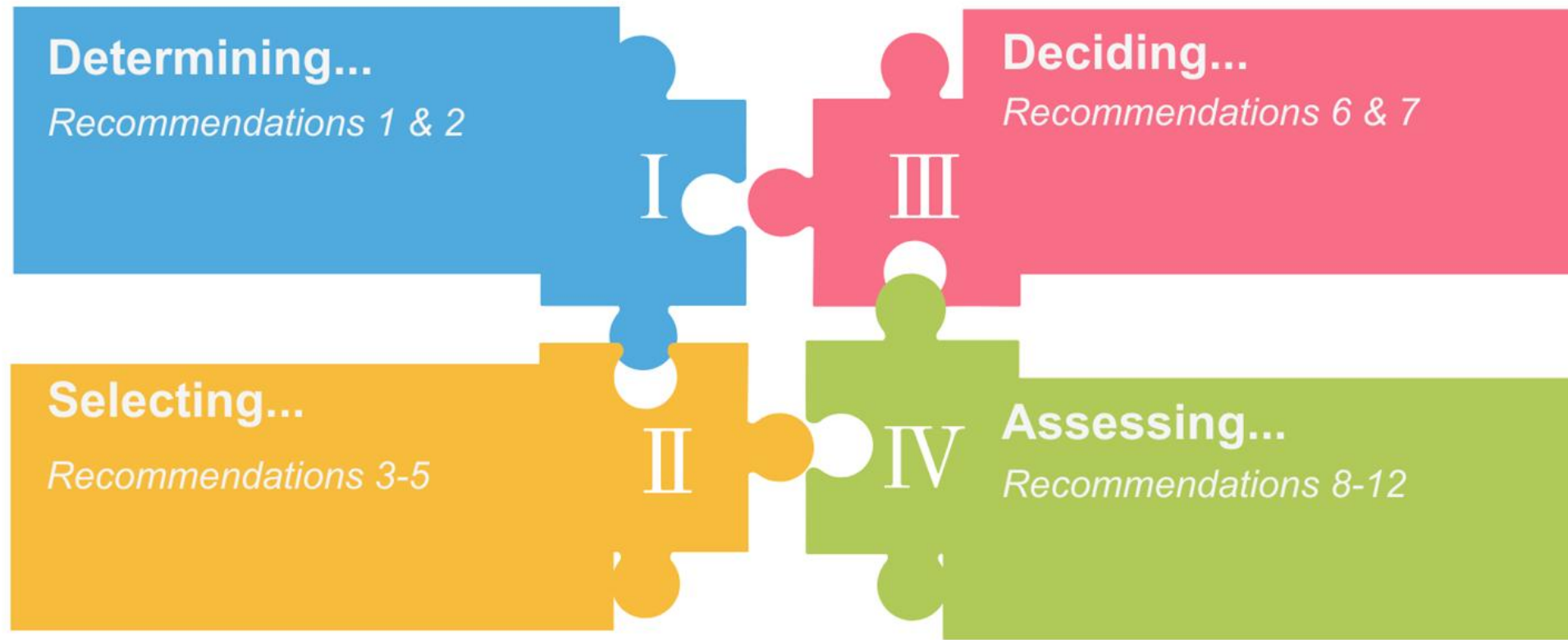
# Case 3-Outcome

- 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

## 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain: Piecing the Puzzle Together

**What is the Goal?**  
 To provide a set of recommendations about how prescribers can best find the balance between managing pain and mitigating risk with opioids

**What is the Structure?**  
 Broken into 4 different categories..

- 1. Determining...**  
whether or not to initiate opioids for pain
- 2. Selecting...**  
opioids and determining dosages
- 3. Deciding...**  
duration of initial opioid prescription and conducting follow-up
- 4. Assessing...**  
risk and addressing potential harms of opioid use



**Determining**

- #1. Nonopioid therapies at least as effective for acute pain
- #2. Nonopioid therapies preferred for subacute and chronic pain

**Selecting**

- #3. Immediate release for starting (not ER/ LA)
- #4. Lowest effective dosage for starting
- #5. Carefully weigh benefits & risks when adjusting dosage

**Deciding**

- #6. Prescribe small quantities for acute pain
- #7. Evaluate patient 1-4 weeks after change in med; regularly reevaluate after

**Assessing**

- #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

Full online version of the 2022 Clinical Practice Guideline!



These are general recommendations only; treatment decisions should be made by a healthcare provider based on an individual patient's clinical condition. Information summarized by the Maine Independent Clinical Information Service (MICIS), a program of the Maine Medical Association funded by Maine DHHS. MICIS does not accept pharmaceutical support. Copyright ©2024 Maine Medical Association - Maine Independent Clinical Information Service. All Rights Reserved.



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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/W0LhJcncrXPw>

