



Chronic Pain Management and the Use of Opiate Medications: The CDC Guideline and Beyond

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Disclosures

- None



Overview

- Scope of the opiate problem
- Brief history of pain and opiate prescribing
- CDC Guideline review
- CPG Guideline and policy highlights
- Barriers to safe and effective practice
- Call to action

Scope of the Opiate Problem

- Nationally
 - 1999-2014: >165,000 deaths from prescription opiates alone¹
 - 2015: 33,000 deaths from all opiates
- Utah²
 - 2013: #8 in US for prescription opiate deaths; 2014 #7
 - 24 Utahns die every day from prescription opiates

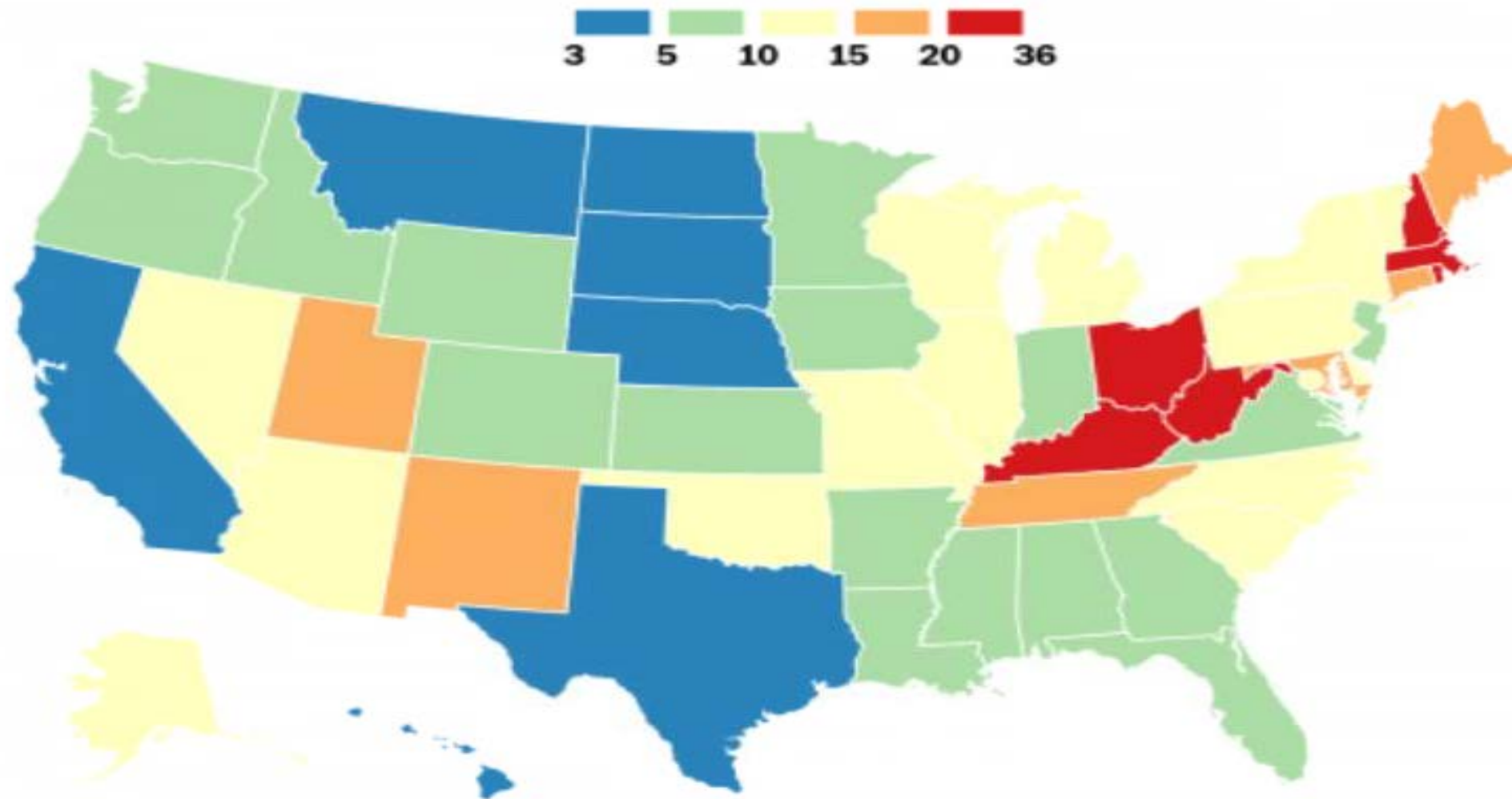
1. CDC. Multiple cause of death data on CDC WONDER. Atlanta, GA: US Dept of Health and Human Services, CDC; 2016

2. Utah Department of Health website



Opioid deaths in 2015

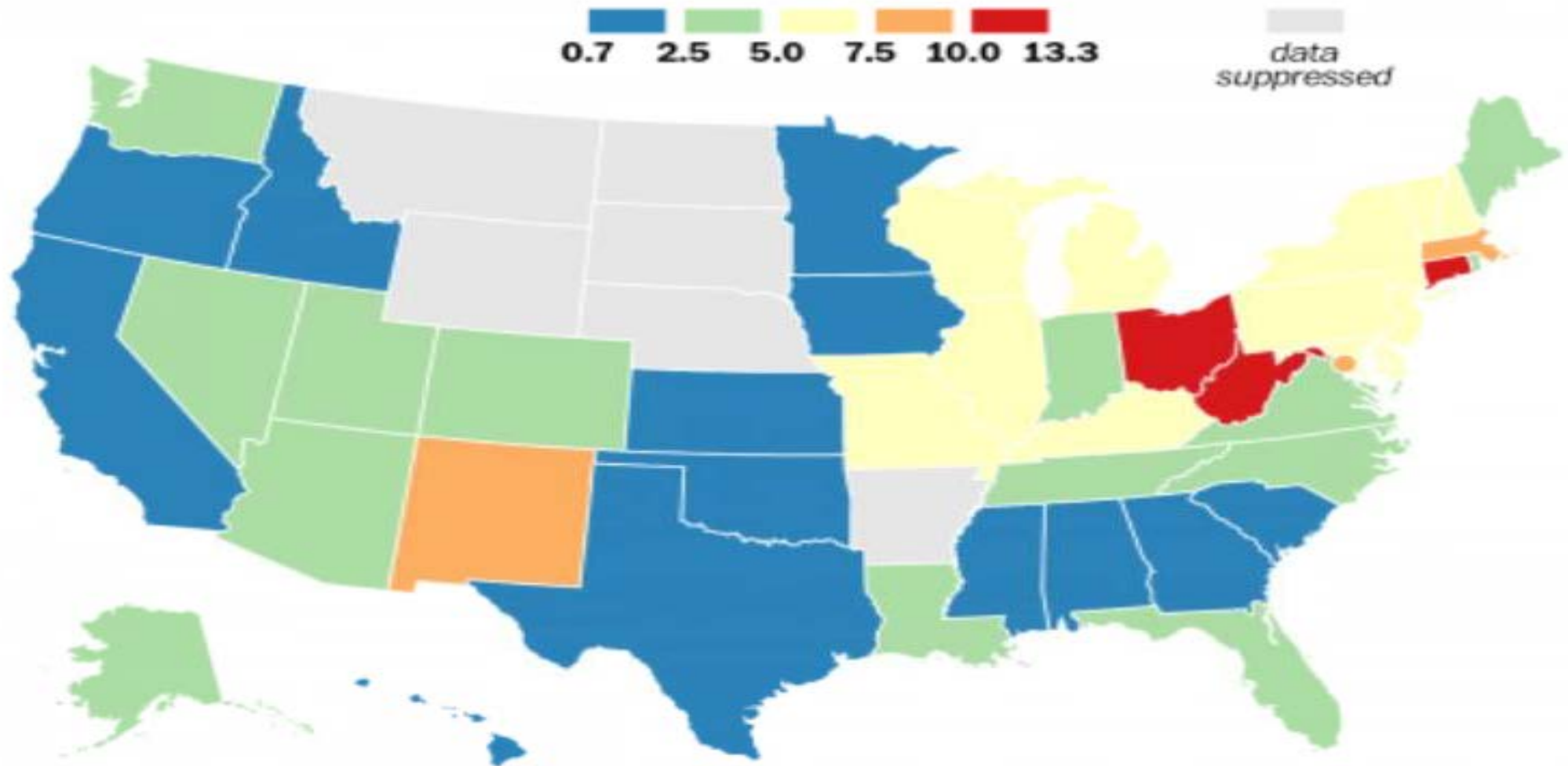
Age-adjusted death rates (per 100,000) for overdose deaths from all opioid drugs





Heroin deaths in 2015

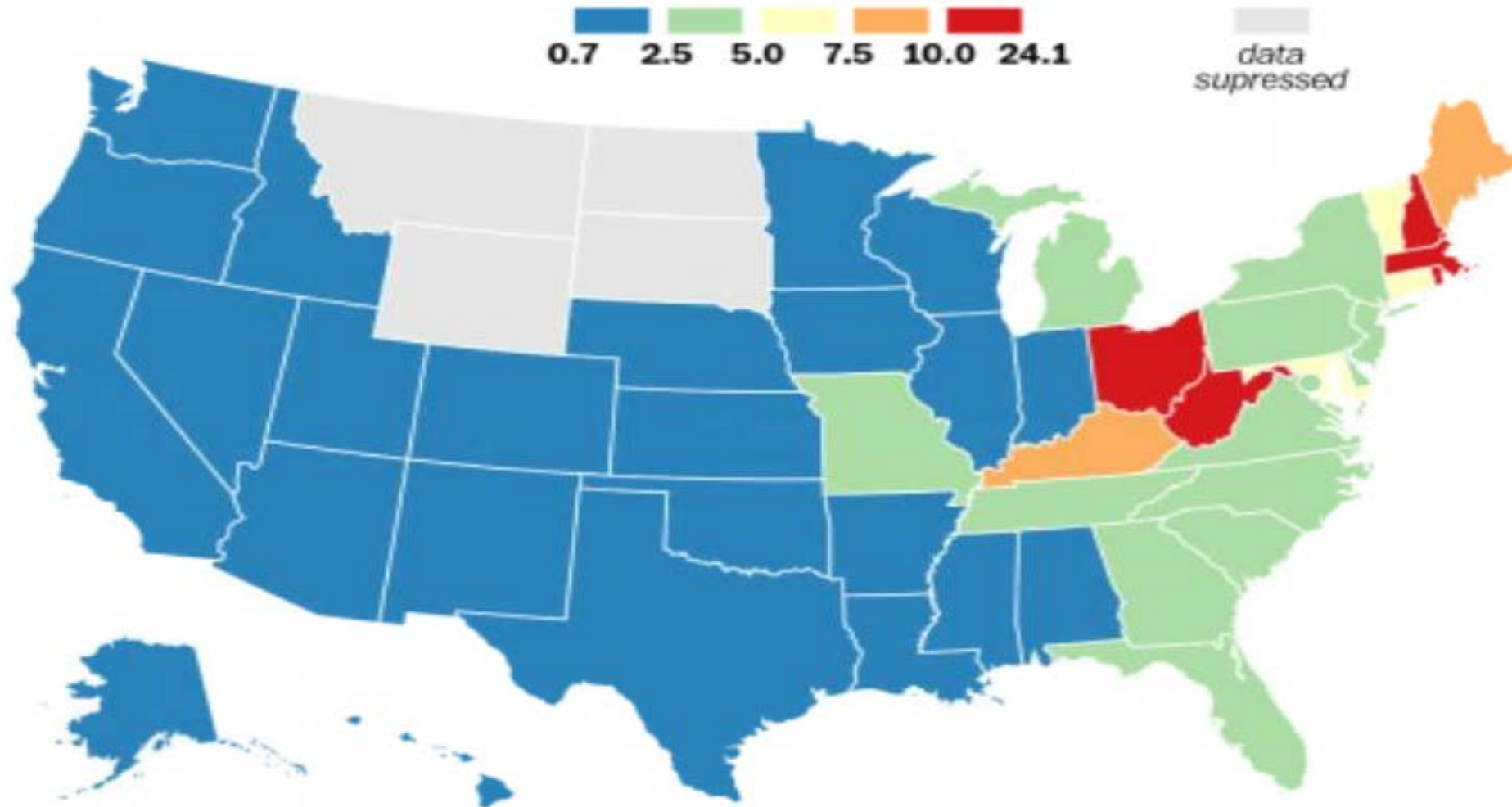
Age-adjusted heroin overdose death rate (per 100,000)





Synthetic opioid deaths in 2015

Age-adjusted synthetic opioid overdose death rate (per 100,000)



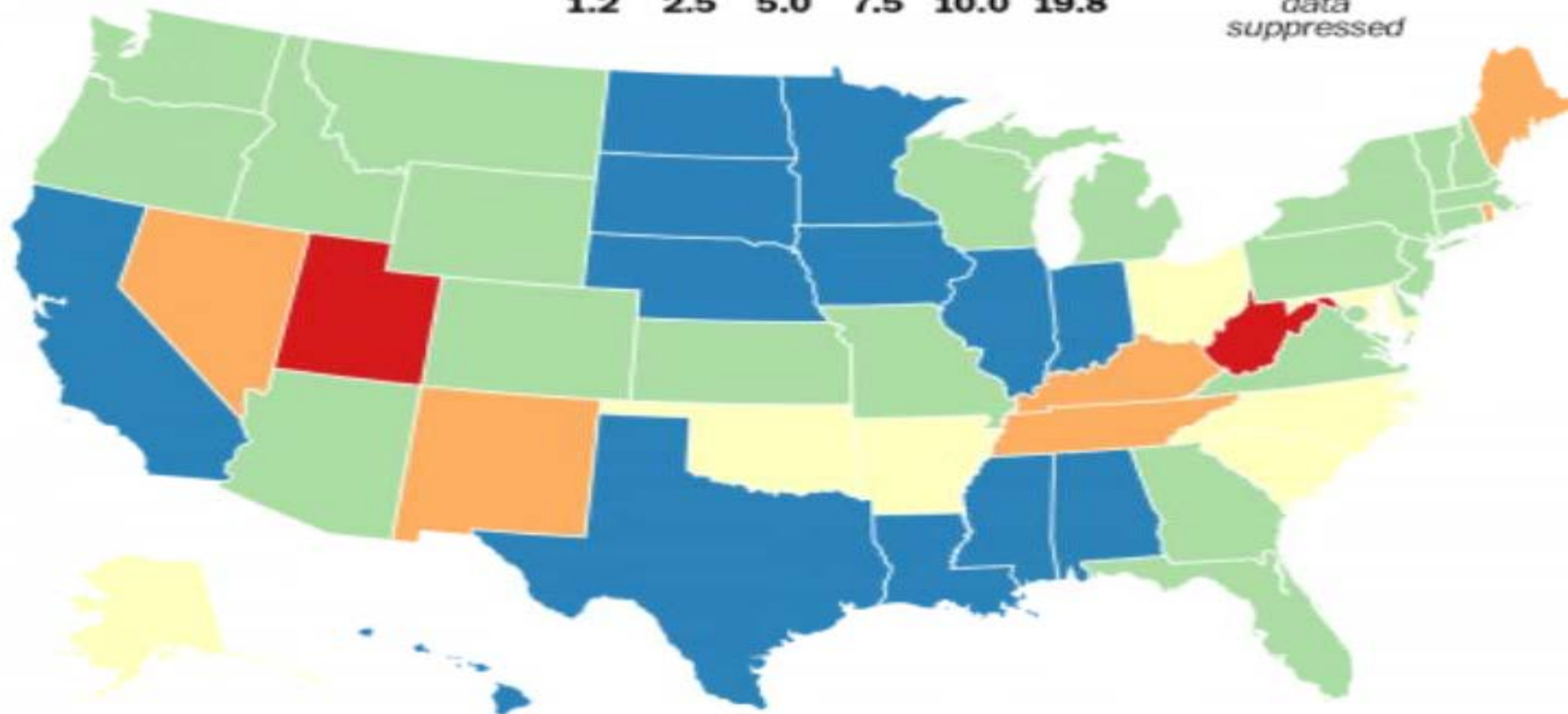


Natural opioid deaths in 2015

Age-adjusted natural opioid overdose death rate (per 100,000)



data
suppressed





Scope of the Problem: The Key Actors

- Payers (Regence BCBS in Massachusetts)
- State Legislatures
 - Washington State
 - Focus: limiting amount prescribed
- Federation of State Medical Boards (recommendations, CME requirements)



Scope of the Problem: The Key Actors

- Medical Community
 - Largely silent
 - Professional Societies: CME requirements for MOC
 - CDC Guideline
- Primary Care Providers
 - Inadequate training¹
 - Account for nearly 50% of opiates dispensed²

1. Jamison et al. Beliefs and attitudes about opioid prescribing and chronic pain management: survey of primary care providers. J Opioid Management 2014; 10:375.

2. Levy B et al. Trends in opioid analgesic prescribing rates by specialty, US, 2007-12. AM J Prev Med, 2015: 49:409.



Opiate Prescribing: a brief history

- Prescribing trends follow several developments
 - Development of meds and delivery systems
 - Rise of Pharma as driver of prescribing practices
 - Progress of neuroscience
- Early 19th Century: “pain is good”
 - Improved healing via stimulation of CV and immune function
- 1850s: “pain should be eliminated”
 - Development of new meds
 - Development of hollow bore needle



Opiate Prescribing: a brief history

- Today: “Pain is bad for health”
 - Belief that any pain can lead to organic (CNS) and psychiatric changes (PTSD) that can decrease pain perception threshold
 - Directly responsible for increases in opiate prescribing
- 1980s: 3 Opiate Myths
 - “Effective for long-term pain control”
 - “No dose is too high”
 - “Not addictive if given for pain”



Opiate Prescribing: a brief history

- State regulations prevented Pharma from incentivizing providers directly
 - Pharma turned focus on academic medicine and regulatory agencies
 - Ex: Purdue Pharma and JCAHO
 - JCAHO used Purdue's videos as training materials
 - Tied pain control to Quality measures
 - Created analog pain scale ("5th VS")



Opiate Prescribing: a brief history

- Current understanding of chronic pain: theories
 - Acute pain pathways dependent on peripheral NS
 - Development of central pathways that sustain pain perception without input from the peripheral NS.
 - Exact mechanism not clear.
 - Psychiatric: untreated, severe pain can lead to PTSD (or PTSD-like conditions)
 - Lower threshold for perception of both psychic and physical pain.



CDC Guideline: Data

- Good data on opiate effectiveness for acute pain¹ and cancer pain
- Few studies on long term benefits of opiates for chronic pain
- What evidence there is suggests “serious harms that appear to be dose-dependent”²

1. Chou R, et al. The effectiveness and risks of long-term opioid treatment of chronic pain. AHRQ Pub #14-E005-EF, 2014.

2. CDC Guideline for Prescribing Opioids for Chronic Pain - United States, 2016, p9.



CDC Guideline: Data

Odds Ratio of Overdose by Opiate Dosage (relative to 1-19 MME/day)		
Opiate Dosage Ranges (MME/day)	OR of Any OD Event	OR of OD Death
20-49	1.44	1.32
50-99	3.73	1.92
100-199	8.87	2.04
>200		2.88



CDC Guideline: When to Initiate or Continue

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are 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. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate



CDC Guideline: When to Initiate or Continue

2. Before starting opioid therapy for chronic pain, clinicians should establish ***treatment goals*** with all patients, including realistic goals for pain ***and function***, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should **continue opioid therapy only** if there is clinically meaningful improvement in pain ***and function*** that outweighs risks to patient safety



CDC Guideline: When to Initiate or Continue

3. Before starting and periodically during opioid therapy, clinicians should ***discuss with patients known risks and realistic benefits*** of opioid therapy and patient and clinician responsibilities for managing therapy



CDC Guideline: Opioid Selection, Dosage, Duration, etc.

4. When starting opioid therapy for chronic pain, clinicians should ***prescribe immediate-release*** opioids instead of extended-release/long-acting (ER/LA) opioids



CDC Guideline: Opioid Selection, Dosage, Duration, etc.

5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to **≥ 50 morphine milligram equivalents (MME)/day**, and should avoid increasing dosage to **≥ 90 MME/day** or ***carefully justify*** a decision to titrate dosage to ≥ 90 MME/day



CDC Guideline:

Opioid Selection, Dosage, Duration, etc.

6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. **Three days or less** will often be sufficient; more than seven days will rarely be needed



CDC Guideline: Opioid Selection, Dosage, Duration, etc.

7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients **every 3 months or more frequently**. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids



CDC Guideline: Assessing Risk and Addressing Harms

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate **risk factors** for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering **naloxone** when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (**≥ 50 MME/day**), or concurrent benzodiazepine use, are present



CDC Guideline: Assessing Risk and Addressing Harms

9. Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP; ***DOPL-CSDB in UT***) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months



CDC Guideline: Assessing Risk and Addressing Harms

10. When prescribing opioids for chronic pain, clinicians should use ***urine drug testing*** before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs



CDC Guideline: Assessing Risk and Addressing Harms

11. Clinicians should avoid prescribing opioid pain medication and ***benzodiazepines*** concurrently whenever possible



CDC Guideline: Assessing Risk and Addressing Harms

12. Clinicians should 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***



CPG Guideline & Policy

- Rationale
 - PCPs can no more be excused from addressing their patients' chronic pain than they can be expected to prescribe opiates in every case or in an unlimited manner.
 - Assist PCPs in deciding when to treat with opiates and when not to
 - Provide institutionally-endorsed limits for opiate dosages
 - Provide workflow options to facilitate safe and appropriate opiate management
 - Reduce both the risk to the provider as well as conflict with patients



CPG Guideline & Policy

- Proper assessment: thorough Hx (pain and PMH)
 - Effective and ineffective treatments
 - Impact on function (2 Item Graded or PEG)
 - Screen for mood disorders (PHQ-9 & GAD)
 - Opiate Risk Tool (ORT)
 - CAGE-AID
 - UDS
 - CSDB review
- No opiates at the first visit!



2 Item Graded Pain Scale

Pain intensity and interference

In the last month, on average, how would you rate your pain? Use a scale from 0 to 10, where 0 is "no pain" and 10 is "pain as bad as could be"? [*That is, your usual pain at times you were in pain.*]

No pain											Pain as bad as could be
0	1	2	3	4	5	6	7	8	9	10	

In the last month, how much has pain interfered with your daily activities? Use a scale from 0 to 10, where 0 is "no interference" and 10 is "unable to carry on any activities"?

No interference											Unable to carry on any activities
0	1	2	3	4	5	6	7	8	9	10	

Interpretation of the Two Item Graded Chronic Pain Scale – This two item version of the Graded Chronic Pain Scale is intended for brief and simple assessment of pain severity in primary care settings. Based on prior research, the interpretation of scores on these items is as follows:

Pain Rating Item	Mild	Moderate	Severe
Average/Usual Pain Intensity	1–4	5–6	7–10
Pain-related interference with activities	1–3	4–6	7–10



PEG

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”



CPG Guideline & Policy: Who to Treat, Who Not to Treat

- Reasonable
 - Cancer pain
 - Moderate-severe arthritis & DDD
 - Spinal stenosis
 - Some neuropathic pain
 - RLS



CPG Guideline & Policy: Who to Treat, Who Not to Treat

- Caution Advised
 - Psychiatric co-morbidities
 - Renal & hepatic disease
 - Pulmonary disease
 - Lack of engagement in full treatment plan
 - Unclear Diagnosis
 - History of treatment by multiple providers



CPG Guideline & Policy: Who to Treat, Who Not to Treat

- Discouraged
 - Migraine (and most headache)
 - Fibromyalgia (and most myofascial conditions)
 - Mechanical low back pain
 - Sciatica
 - History of substance abuse (tobacco?)



CPG Guideline & Policy

- Medication Specifics
 - Dosage limits
 - Re-evaluate at 50 MME/day
 - 90 MME/day requires referral to pain specialist
 - Sleep testing for >90 MME/day (lower if pulm dis)
 - Start with short-acting
 - Avoid dangerous combos (benzos ~~discouraged~~ prohibited; SOMA prohibited)



CPG Guideline & Policy

- Medication Specifics
 - Methadone only if provider experienced
 - No meperidine (Demerol)
 - Transmucosal fentanyl rarely, if at all
 - Naloxone > 50 MME/day
 - Tapering protocol



CPG Guideline & Policy

- Workflow Expectations
 - Controlled Substance Agreements
 - No refills without a clinic appointment
 - One provider, one pharmacy
 - UDS at least annually
 - Schedule follow-up at each refill appointment
 - Continually monitor function, not just pain
 - Document treatment goals and progress
 - 5As
 - Patient Education

1. Activity

What progress has been made in the patient's functional goals?

- Sitting tolerance
- Standing tolerance
- Walking ability
- Ability to perform activities of daily living

2. Analgesia

How does the patient rate the following over the last 24 hours?

Eg) on a scale from 0 to 10, where 0 = no pain, 10 = worst pain imaginable

- Average pain ?
- Worst pain ?
- How much relief have pain medications provided? e.g. 10%, 20%, 30% or more?

3. Adverse effects

Has the patient experienced any adverse effects from medication?

Eg) constipation, nausea, dizziness, drowsiness

4. Aberrant behaviours

Has the patient been taking medication/s as prescribed?

Has the patient exhibited any signs of problematic behaviours or medication abuse/misuse?

- Signs of drug and alcohol use
- Unsanctioned dose escalations
- Has the patient reported lost prescriptions or requested early repeats?

5. Affect

Have there been any changes to the way the patient has been feeling?

- Is pain impacting on the patient's mood?
- Is the patient depressed or anxious?

Patient Instructions



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The opiate/narcotic medication you have been prescribed is dangerous. Please read and follow these instructions without exception!

See <http://useonlyasdirected.org> for more information to include the proper way to take, store and dispose of your medication.

DO:

- Read and follow your Controlled Substance Agreement
- Take your medicine exactly as prescribed
- Store your medicine away from children and in a safe place, preferably in a locked container to which only you have access.
- Dispose of unused medication appropriately. Options include taking the medication to an approved disposal site in your community; mix the medication with kitty litter or coffee grounds, place in a sealable container (zip-lock bag) and mix with water, then place in the trash on the day of collection.

DON'T:

- Do not give your medicine to others
- Do not take medicine unless it was prescribed for you
- Do not take a higher dose of this medication unless directed to do so by your healthcare provider
- Do not stop taking your medicine without talking to your healthcare provider
- Do not break, chew, crush, dissolve, or inject your medicine. If you cannot swallow your medicine whole, talk to your healthcare provider
- Do not drink alcohol while taking this medicine
- Do not take this medicine with other sedating medications (Benadryl/diphenhydramine and other cold medicines, sleeping medications, anti-anxiety medications)

Patient Instructions



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HEALTH CARE

Side effects of opiate medications include the following; please report these your healthcare provider right away:

- Drowsiness or confusion
- Constipation, abdominal pain, nausea or vomiting
- Shortness of breath or any difficulty breathing
- Fatigue
- Agitation
- Depression
- Dizziness
- Itching
- Hiccups
- Sexual dysfunction
- Overdose is a real risk with this medication and can be fatal. Signs of overdose include:
 - Heavy snoring
 - Excessive drowsiness or difficulty awakening
 - Shallow or troubled breathing
 - Increased or decreased heart rate, palpitations
 - Dizziness
 - Confusion
- If you experience any of these:
 - Use the naloxone (autoinjector or nasal spray) if prescribed
 - Do not induce vomiting
 - Do not take anything by mouth
 - Call 911 or get someone to take you to the emergency room immediately



CPG Guideline & Policy

- Mandatory use of formatted pain note in EMR
- Mandatory documentation of treatment goals, ineffective treatments
- Must have a specific, legitimate diagnosis

Note Template: New



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@CHIEF COMPLAINT@

S- @NAME@ is a @AGE@ @SEX@ presenting to address the following issue(s):

@REVIEW OF SYSTEMS BY AGE@

[MA: complete the following in Doc Flowsheets, save and then refresh below: PHQ-9, GAD-7, CAGE-AID (type in CAGE), ORT Female or Male as appropriate, Graded]

@PHQ9LINK@

@GAD7QUESTIONNAIRE@

@CAGEAID@

@ORTMALE@

@ORTFEMALE@

@GRADED@

@DA5A@

@PROB@

@PSH@

@SOC@

@FAMHX@

@ACTMEDWITHNOTE@

@ALLERGY@

- All the above reviewed by me at this visit.

O-

@VITALSALL@

@PHYEXAMBYAGE@

@PROVIDERSCORE@

A/P-

Note Template: Established



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HEALTH CARE

@CHIEFCOMPLAINT@

S- @NAME@ is a @AGE@ @SEX@ presenting to address the following issue(s):

[MA: complete the following in Doc Flowsheets, save and then refresh below: Graded; Order & collect UDS - if not done within past year - Lab Code 3366]

@GRADED@

@DA5A@

@REVIEWOFSYSTEMSBYAGE@

@PROB@

@SOC@

@ACTMEDWITHNOTE@

@ALLERGY@

- All the above reviewed by me at this visit.

O-

@VITALSALL@

@PHYEXAMBYAGE@

@PROVIDERSCORE@

A/P-



Treatment Goals

Ineffective Therapies: ***

Goals for opiate treatment: ***

Next UDS: ***

Violations:



Barriers to Policy Implementation

- Provider discomfort with opiate prescribing & managing chronic pain
 - Unethical to refuse to address & manage pain
 - No obligation to treat unsafely (think: antibiotics)
- Takes time
- Patient expectations & impact on satisfaction
- Learning to say “no” and set boundaries with kindness and empathy



A Call To Action!

Create Your Own Policy

- Recommendations vs Mandatory Limits
- Dosage limits (# pills vs MME/d)
- Documentation requirements
- No refills without an appointment
- Dedicated refill appointments
- Use of CSDB every time
- UDS
- Medication specifics
- Provide support resources as much as possible



Visit the CDC Website!

- www.cdc.gov
 - search by alphabet: O; pick “Opioids”
 - Guideline Resources: Clinical Tools



Questions?

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- Within the UofU: SmartWeb