2022 Updated CDC Clinical Practice Guidelines for Prescribing Opioid

Carrie Ann Matyac, DNP, ARNP, FNP-BC

Objectives

- Define acute, subacute and chronic pain
- Understand scope and rationale for 2016 and 2022 Opioid Prescribing Guidelines
- Review current Washington state prescribing guidelines
- Compare and contrast 2016 and 2022 Opioid Prescribing Guidelines
- Understand and implement key components of 2022 Opioid Prescribing Guidelines

Pain

- "An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage,"[1]

Pain is always a personal experience that is influenced to varying degrees by biological, psychological, and social factors.

Pain and nociception are different phenomena. Pain cannot be inferred solely from activity in sensory neurons.

Through their life experiences, individuals learn the concept of pain.

A person's report of an experience as pain should be respected.

Although pain usually serves an adaptive role, it may have adverse effects on function and social and psychological well-being.

Verbal description is only one of several behaviors to express pain; inability to communicate does not negate the possibility that a human or a nonhuman animal experiences pain.

"High-impact" chronic pain

- Cost >$500 billion annually in direct medical costs, lost productivity and disability
- Pain on most days or every day during the past 3 mos that limits life or work activities
- Affects one in 14 adults
- Common chief complaint

Impaired physical functioning

- Poor mental health
- Reduced quality of life
- Increases morbidity

Co-occurring conditions

- Behavioral health disorders
- Mental and substance use disorders
- Increased for SI/suicidal behaviors
- *9% of successful suicides decedents had diagnosed chronic pain[2]

Pain: Underrecognized and treated

- Marginalized racial and ethnic groups
- Women
- Older individuals
- Individuals with
  - cognitive impairment
  - mental and/or substance use disorders
  - sickle cell disease
  - cancer-related pain and end of life treatment
- Those with social and geographic disparities
- Black and African American individuals are more likely to get lower doses, restricted refills, discontinuation for misuse; yet are less likely to be referred to pain specialists[3-10]

Where did it come from?

Balancing perspectives

- Nominations accepted (255 received)
  - Diversity considered
- 24 members of the workgroup
  - MD
  - PhD
  - PharmD
  - DC
  - DMD
  - SM
  - MSPH
- Open for public comment x 2 mos

Purpose

Guidelines were improved and expanded due to improved science, and increased knowledge regarding individuals living with pain, caregivers and providers

Goal is to provide compassionate, safe, and effective pain control to improve quality of life[11]

Purpose

Improve patient provider communication.

Empower both the patient and provider to make safe and effective decisions for effective pain care, including opioid therapy

Recognize the importance of making informed, individualized decisions about safe and effective pain care[11]

Purpose


Mitigate pain
Improve function
Improve quality of life
Reduce risks of opioid pain therapy including OUD, OD and death[11]

Think outside the box

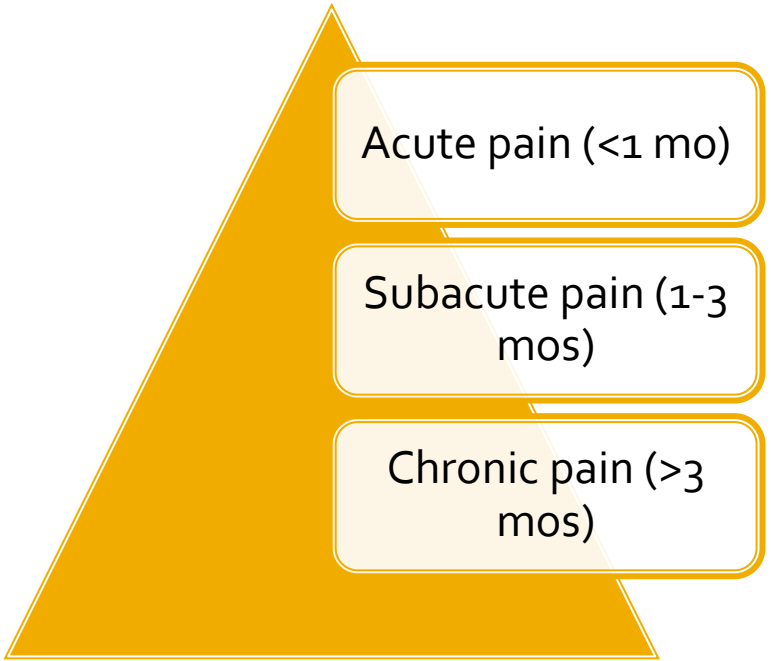
- This clinical practice guideline is not
  - A replacement for clinical judgment or individualized, person-centered care
  - Intended to be applied as inflexible standards of care
  - across patients or patient populations by health care professionals, health systems, pharmacies, third-party payers, or governmental jurisdictions or to lead to the rapid tapering or abrupt discontinuation of opioids for patients
  - A law, regulation, or policy that dictates clinical practice or as a substitute for Food and Drug Administration–approved labeling[11]

Think outside the box

Not applicable to

- Management of pain related to sickle cell disease,
- Management of cancer-related pain, or
- Palliative care or end-of-life care; or
- Focused on opioids prescribed for OUD[11]

2022 Guidelines include recommendations for



Recommendations are considered FLEXIBLE

- Does not apply to sickle cell, cancer, palliative or end of life care[11]

Definitions

- Acute pain “a nearly universal experience, is a physiologic response to noxious stimuli that can become pathologic. Acute pain is usually sudden in onset and time limited (defined in this clinical practice guideline as having a duration of <1 month) and often is caused by injury, trauma, or medical treatments such as surgery.”[13,14]

- Subacute pain: unresolved acute pain

- Chronic pain: can be secondary to underlying medical condition, injury, medical treatment, inflammation, or unknown cause [13]

Guideline Focus

2016

1. When to initiate or continue opioids for chronic pain
2. Opioid selection, dosage, duration, follow-up, and discontinuation
3. Assessing risk and addressing harms of opioid use[12]

2022

1. Determining whether to initiate opioids for pain
2. Selecting opioid medications and determine appropriate dosages
3. Identifying an appropriate duration of initial opioids prescriptions and follow up
4. Assessing risk and addressing potential harms associated with opioid use[11]

Guideline Audience

2016

- Primary care clinicians who are prescribing opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care[12]

2022

Clinicians providing pain care, including those prescribing opioids, for outpatients aged ≥18 years[11]

Guideline Audience

Guideline population focus

- Clinicians prescribing opioids
- Collaborative teams focused on pain management
- Primary care and other outpatient clinicians[11]

Applicable to

- Outpatients
- Patients being discharged from facilities

Not applicable to

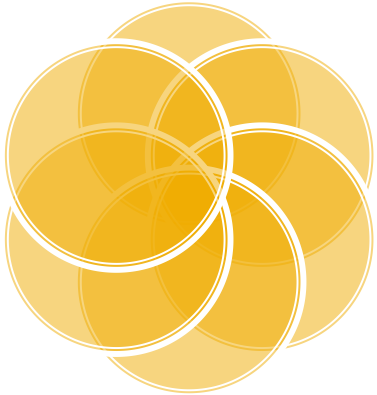
- Hospitalized patients
- Emergency department
- Observational setting
- Hospice and palliative care

Guideline Goals

Goal of 2016 guideline: increase safety

Ineffective pain management d/t undertreatment

Suicidal ideation and attempts



Withdraw

Overdose

Worse pain outcomes

Psychosocial distress[11]

Result with 2016 Guidelines

Medicaid, prescription benefit plans, pharmacies, and other insurers used guidelines to increase nonopioid pain relief options for chronic pain

Approximately 50% of states have legislation limiting initial opioid prescriptions for acute pain

Nearly 20 states required naloxone co-prescription for high risk individuals (based on CDC risk (management classification tool)[11]

Management Classification Tool

- Interpretation
  - Low Risk Level
    - Follow up visits every 3 months
    - PDMP 2x yearly
    - UDM 1x year
  - Medium Risk Level
    - Follow up every 2-3 months
    - PDMP 2x yearly
    - UDM 2x yearly
  - High Risk Level
    - Follow up every 1-2 months
    - PDMP 4x yearly (minimum)
    - UDM 3-4x yearly

Management Classification	
Step 1 (Evaluate)	
MEDD (Morphine Equivalent Daily Dose) Low: < 50 Medium: 50-90 High: >90	**Opioid Risk Tool (ORT)** Low Risk = neutral risk Moderate Risk = at least "medium" risk High Risk = at least "high" risk
Step 2 (Adjustment)	**Medical Comorbidities and Concurrent Medications (Add "A" and "B" below)**
A. Medical comorbidities (1 point per factor if clinically relevant) Impaired respiratory function, COPD, CHF, alternated drug metabolism, advanced age/frail, impaired renal or hepatic dysfunction, unstable psychiatric condition (i.e. depression, anxiety), cigarette smoking, other **Subtotal A: ___**	**B. Concurrent high risk co-prescriptions: (1 point per factor if clinically relevant)** Benzodiazepines, barbiturates, carisoprodol, non-benzodiazepine hypnotics, stimulant medications, others **Subtotal B: ___**
Step 3 (Calculate Score)	
Add subtotals "A" and "B" for **Total adjustment score: ____** If > 2 points = Consider Grade UP If 1 point = Maintain Classification If 0 points = Consider Grade DOWN	**Final "Management Classification" Score** **"LOW"** **"MEDIUM"** **"HIGH"**
• **Use the management classification score for ongoing monitoring** • **Risk factors may change over time. Reassess regularly.** • **Methadone MEDD classification is limited by unique qualities of the drug.**	

Discord between prescribing and recommendations

BUT…

- Notable that prescription opioid misuse and prescription OUD has declined
- OUD decreased by >500,000
- Reports of misuse decreased by 5 million
- However opioid continue to be the most commonly misused prescription drug in the US
- In 2020, misuse was attributed to
  - Relieving physical pain (65%)
  - Feeling good/getting high (11%)
  - Addiction (2%)[11]

2022 Guideline reflects new data

- Patient harm with rapid tapering/discontinuation
- Challenges in patient access to opioids
- Patient abandonment
- Comparison of opioid vs nonopioid pain medication on long term outcomes
- Characteristics of acute opioid use and likelihood of long-term use
- Proportion of opioids used for postoperative pain compared with amount prescribed[11]

Guiding principles for 2022 recommendations

- Acute, subacute, and chronic pain needs to be appropriately assessed and treated independent of whether opioids are part of a treatment regimen.
- Recommendations are voluntary and are intended to support, not supplant, individualized, person-centered care. Flexibility to meet the care needs and the clinical circumstances of a specific patient is paramount.
- A multimodal and multidisciplinary approach to pain management attending to the physical health, behavioral health, long-term services and supports, and expected health outcomes and well-being of each person is critical.[11]

Guiding principles for 2022 recommendations

- Special attention should be given to avoid misapplying this clinical practice guideline beyond its intended use or implementing policies purportedly derived from it that might lead to unintended and potentially harmful consequences for patients.
- Clinicians, practices, health systems, and payers should vigilantly attend to health inequities; provide culturally and linguistically appropriate communication, including communication that is accessible to persons with disabilities; and ensure access to an appropriate, affordable, diversified, coordinated, and effective nonpharm and pharm pain management regimen for all persons.[11]

Recommendation Categories

Based on evidence type, balance between desirable and undesirable effects, values and preferences, and resource allocation (cost).

- Category A recommendation: Applies to all persons; most patients should receive the recommended course of action.
- Category B recommendation: Individual decision making needed; different choices will be appropriate for different patients. Clinicians help patients arrive at a decision consistent with patient values and preferences and specific clinical situations.

Evidence Type

Based on study design as well as a function of limitations in study design or implementation, imprecision of estimates, variability in findings, indirectness of evidence, publication bias, magnitude of treatment effects, dose-response gradient, and constellation of plausible biases that could change effects.

- Type 1 evidence: Randomized clinical trials or overwhelming evidence from observational studies.
- Type 2 evidence: Randomized clinical trials with important limitations, or exceptionally strong evidence from observational studies.
- Type 3 evidence: Observational studies or randomized clinical trials with notable limitations.
- Type 4 evidence: Clinical experience and observations, observational studies with important limitations, or randomized clinical trials with several major limitations.

12 Recommendations

- Recommendations 1 & 2: Determining Whether or Not to Initiate or continue Opioids for chronic Pain
- Recommendations 3-5: Selecting Opioids and Determining Opioid Dosages
- Recommendations 6 & 7: Deciding Duration of Initial Opioid Prescription and Conducting Follow-Up and discontinuation
- Recommendations 8-12 : Assessing Risk and Addressing Potential Harms of Opioid Use

Determining Whether or Not to Initiate Opioids for Pain

2016 Recommendation 1

- Nonpharm therapy and nonopioid pharm 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 nonpharm therapy and nonopioid pharm therapy, as appropriate (recommendation category: A, evidence type: 3).

2022 Recommendation 1

- Stronger recommendation with new evidence
- Nonopioid therapies are at least as effective as opioids for many common types of acute pain.
- Maximize use of nonpharm and nonopioid pharm therapies
- Only consider opioid therapy for acute pain if benefits are anticipated to outweigh risks to the patient
- Before prescribing opioids for acute pain, clinicians should discuss realistic benefits and known risks of opioid therapy
- Recommendation category: B; evidence type: 3

2016 Recommendation 2 & 3

- 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 (recommendation category: A, evidence type: 4).
- 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 (recommendation category: A, evidence type: 3).

2022 Recommendation 2

- Loses focus on risk and benefit changes focus to subacute and chronic pain
- Nonopioid therapies are preferred for subacute and chronic pain
- Clinicians should maximize use of nonpharm and nonopioid pharm therapies
- Only consider initiating opioid therapy if expected benefits for pain and function are anticipated to outweigh risks to the patient
- Before starting opioid therapy for subacute or chronic pain, discuss with patients the realistic benefits and known risks of opioid therap
- Work to establish treatment goals for pain and function, and consider how opioid therapy will be discontinued if benefits do not outweigh risks
- Recommendation category: A; evidence type: 2)

Selecting Opioids and Determining Opioid Dosages

2016 Recommendation 4

- When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids (recommendation category: A, evidence type: 4).

2022 Recommendation 3

- Addition of acute and subacute
- When starting opioid therapy for acute, subacute, or chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release and long-acting (ER/LA) opioids (recommendation category: A; evidence type: 4).

Pain
Acute v Chronic

- Acute pain (< 1 month)
  - Sudden and time limited
- Subacute pain (1-3 months)
  - Unresolved acute pain
- Chronic pain (>3 months)
  - Can be secondary to underlying medical condition, injury, inflammation, etc.
  - Can result in:
    - Impaired physical functioning
    - Poor mental health
    - Increased morbidity
    - Reduced quality of life

2016 Recommendation 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 (recommendation category: A, evidence type: 3).

2022 Recommendation 4

- IR to lowest effective dose and refers to decreased efficacy with high dose opioids, no definitive max
- When opioids are initiated for opioid-naïve patients with acute, subacute, or chronic pain, prescribe the lowest effective dosage
- If opioids are continued use caution when prescribing opioids at any dosage
  - Carefully evaluate individual benefits and risks when considering increasing dosage
  - Avoid increasing dosage above levels likely to yield diminishing returns in benefits relative to risks to patients (recommendation category: A; evidence type: 3).

2022 Recommendation 5

- Recommendation for COT and tapering
- For patients on opioid therapy, weigh benefits and risks and exercise care when changing opioid dosage
- If benefits outweigh risks of continued opioid therapy, work closely with patients to optimize nonopioid therapies while continuing opioid therapy
- If benefits do not outweigh risks of continued opioid therapy, optimize other therapies and work closely with patients to gradually taper to lower dosages or appropriately taper and discontinue opioids.
  - Unless there are indications of a life-threatening issue such as warning signs of impending overdose (e.g., confusion, sedation, or slurred speech), opioid therapy should not be discontinued abruptly, and clinicians should not rapidly reduce opioid dosages from higher dosages
- Recommendation category: B; evidence type: 4)

Management of Opioid Misuse Not OUD Meet Criteria

- For patients with opioid misuse that does not meet criteria for OUD (ie, taking opioids in larger amounts than intended without meeting other criteria for OUD)
  - Reassess the patient's pain
  - Ensure that therapies for pain management have been optimized (see Recommendation 2)
  - Discuss carefully weighing benefits and risks of continuing opioids at the current dosage (see Recommendation 5)
  - For patients who choose to but are unable to taper, clinicians can reassess for OUD and offer buprenorphine treatment or refer
- Even without a diagnosis of OUD, transitioning to buprenorphine for pain also can be considered because of reduced risk for overdose with buprenorphine compared with risk associated with full agonist opioids (see Recommendation 5).

Pain Management for Patients with OUD

- OUD can alter the expected benefits and risks of opioid therapy for pain, patients with co-occurring pain and substance
- These patients require ongoing pain management to maximizes benefits relative to risks.
- Clinicians should use nonpharm and nonopioid pharm pain treatments as appropriate but provides optimal pain management
- Consider buprenorphine or methadone for patients with pain with n active OUD not in treatment
- Patients taking buprenorphine for OUD with acute pain,
  - Consider temporarily increasing the buprenorphine dosing frequency (e.g., to twice per day because the duration of effects of buprenorphine is shorter for pain than for suppression of withdrawal (242).
  - For severe acute pain (ie, trauma or unplanned major surgery) consider additional as-needed doses of buprenorphine

Pain Management for Patients with OUD

- In supervised settings, adding a short-acting full agonist opioid to the patient's regular dosage of buprenorphine can be considered without discontinuing the patient's regular buprenorphine dosage; however, if a decision is made to discontinue buprenorphine to allow for more μ-opioid receptor availability,
  - Patients should be monitored closely because high doses of a full agonist opioid causing oversedation and respiratory depression
- Patients receiving naltrexone for OUD, short-term use of higher-potency nonopioid analgesics
- Patients receiving methadone for OUD who require additional opioids as treatment for severe acute pain management should be monitored carefully, and when feasible, should optimally be treated by a clinician experienced in the treatment of pain in consultation with their opioid treatment program (96). The Refer to ASAM National Practice Guideline

Deciding Duration of Initial Opioid Prescription and Conducting Follow-Up

2016 Recommendation 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 (recommendation category: A, evidence type: 4).

2022 Recommendation 6

- Omission of definitive language (3 days)
- When opioids are needed for acute pain, clinicians should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids (recommendation category: A; evidence type: 4).

2016 Recommendation 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 (recommendation category: A, evidence type: 4).

2022 Recommendation 7

- Omission of definitive language (every 3 mos) and need to taper/discontinue
- Clinicians should evaluate benefits and risks with patients within 1–4 weeks of starting opioid therapy for subacute or chronic pain or of dosage escalation
- Regularly reevaluate benefits and risks of continued opioid therapy with patients
- Recommendation category: A; evidence type: 4)

Assessing Risk and Addressing Potential Harms of Opioid Use

2016 Recommendation 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 (recommendation category: A, evidence type: 4).

2022 Recommendation 8

- Collaboration with patient and omission of definitive language
- Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk for opioid-related harms and discuss risk with patients. Clinicians should work with patients to incorporate into the management plan strategies to mitigate risk, including offering naloxone (recommendation category: A; evidence type: 4).

2016 Recommendation 9

- Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) 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 (recommendation category: A, evidence type: 4).

2022 Recommendation 9

- Omission of definitive language
- When prescribing initial opioid therapy for acute, subacute, or chronic pain, and periodically during opioid therapy for chronic pain, clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or combinations that put the patient at high risk for overdose (recommendation category: B; evidence type: 4).

2016 Recommendation 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 (recommendation category: B, evidence type: 4).

2022 Recommendation 10

- Omission of definitive language
- When prescribing opioids for subacute or chronic pain, clinicians should consider the benefits and risks of toxicology testing to assess for prescribed medications as well as other prescribed and nonprescribed controlled substances
- Recommendation category: B; evidence type: 4).

2016 Recommendation 11

- Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible (recommendation category: A, evidence type: 3).

2022 Recommendation 11

- Omission of definitive language
- Clinicians should use particular caution when prescribing opioid pain medication and benzodiazepines concurrently and consider whether benefits outweigh risks of concurrent prescribing of opioids and other central nervous system depressants
- Recommendation category: B; evidence type: 3).

2016 Recommendation 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 OUD (recommendation category: A, evidence type: 2).

2022 Recommendation 12

- No indication for abrupt discontinuation
- Clinicians should offer or arrange treatment with evidence-based medications to treat patients with OUD. Detoxification on its own, without medications for OUD, is not recommended for OUD because of increased risks for resuming drug use, overdose, and overdose death
- Recommendation category: A; evidence type: 1).

2019 Washington State Opioid Prescribing Requirements

Provider Requirements	Board of Osteopathic Medicine and Surgery	Dental Commission	Medical Commission	Nursing Commission
Acute Pain Prescribing Limits (0-6 weeks)	✓ Seven-day limit for acute non-operative and fourteen-day limit for acute perioperative unless clinically documented	✓ Seven-day limit for acute non-operative and acute perioperative pain unless clinically documented	✓ Seven-day limit for acute non-operative and fourteen-day limit for acute perioperative unless clinically documented	✓ Seven-day limit for acute non-operative and fourteen-day limit for acute perioperative unless clinically documented
Subacute Pain Prescribing Limits (6-12 weeks)	✓ Fourteen-day limit unless clinically documented	✓ Fourteen-day limit unless clinically documented	✓ Fourteen-day limit unless clinically documented	✓ Fourteen-day limit unless clinically documented

2019 Washington State Opioid Prescribing Requirements

	Board of Osteopathic Medicine and Surgery	Dental Commission
Chronic Pain Requirements (Applies to All Five)	• Mandatory consultation when prescribing over 120 MED • Complete a written agreement for treatment • Confirm or provide naloxone when prescribing opioids to a high risk patient or as clinically indicated (ARNP requirement for naloxone when 50 MED or above)	
PMP Requirements	PMP check prior to every opioid or Benzodiazepine prescription	PMP check prior to first refill or renewal for all acute pain and when transitioning to another pain phase
ICD Code, Diagnosis, or Indication for Use Included on Prescription	Not required	Diagnosis, indication, or ICD Code must be included on all opioid prescriptions

2019 Washington State Opioid Prescribing Requirements

- Periodical review of the treatment plan and query the PMP: Quarterly for high-risk, semiannually for moderate-risk, and annually for low-risk patients
- Mandatory co-prescribing provider requirements for prescribing opioids in combination with benzodiazepines, barbiturates, sedatives, Carisoprodol, and z-drugs

Medical Commission	Nursing Commission	Podiatric Medical Board
PMP check prior to first refill or renewal for all acute pain and when transitioning to another pain phase	First prescription, or first refill or renewal for all acute pain if clinical exception documented and when transitioning to another pain phase	PMP check prior to second refill or renewal for all acute pain and when transitioning to another pain phase
Not required	ICD Code or diagnosis must be included on all opioid prescriptions	Not required

Previous Guidelines (2016)

- Before the visit
- During the visit
- At conclusion of the visit

Before the Visit

Overall goal:

- Complete necessary screenings to set visit up for success

Step one:

- Schedule an appointment and assign pre-visit work
- Assess a baseline
  - i.e.) medical history, previous treatment, psychiatric history, etc.

Step two:

- Pre-visit mental health screenings
  - i.e.) PEG, PHQ-9, GAD-7, ORT, drug or alcohol screening, etc.

Step three:

- Asses the risk for the patient
  - i.e.) PDMP, UDS, and MEDD

During the Visit

Overall goal:

- Provide education for the patient, ensure collaboration, create a complete and mutually accepted treatment plan with the patient.

Step one:

- Review pre-visit data
  - Look for co-morbidities that need treatment

Step two:

- Assess UDS or PDMP to look for substance use disorders along with efficacy of opioid therapy for patient
  - Taper in a supportive manner as needed
- Review chronic pain agreement at least yearly

During the Visit

Step three:

- Use a shared discission making to determine a c
  - Pain agreement, state-required documentatio
  - Benefits vs. Harm or risks
- Pain management opportunities
  - i.e.) PT, OT, exercise, chiropractic, sleep, etc.

Step four:

- Determine score using Management Classificati

Step five

Conclusion of the Visit

Overall goal:

- Set the patient up for successful adherence to treatment plan

Step one:

- Review goals of therapy and plan
- Plan to reassess progress

Step two:

- Provide educational material for the patient
- Consider referral to alternative pain management as appropriate

Washington State Opioid Prescribing Requirements (2019)

- Acute pain prescribing limits (0-6 weeks)
  - 7-day limit non-operative
  - 14-day limit for acute perioperative pain
- Subacute pain prescribing limits (6-12 weeks)
  - 14-day limit
- Chronic pain requirements
  - Mandatory consultation when prescribing over 120 MED
  - Complete written agreement for treatment
  - Confirm or provide naloxone to high-risk patients or as indicated (50 MED or above ARNP requirement)

Case Study

- 46 year old female with post herpetic neuralgia
- h/o opioid addiction with pelvic fx

References

- 1. Raja SN, Carr DB, Cohen M, et al. The revised International Association for the Study of Pain definition of pain: concepts, challenges, and compromises. *Pain*. 2020;161(9):1976-1982. doi:10.1097/j.pain.0000000000001939
- 2. Zelaya CE, Dahlhamer JM, Lucas JW, Connor EM. Chronic Pain and High-impact Chronic Pain Among U.S. Adults, 2019. *NCHS Data Brief*. 2020;(390):1-8.
- 3. Hardt J, Jacobsen C, Goldberg J, Nickel R, Buchwald D. Prevalence of Chronic Pain in a Representative Sample in the United States. *Pain Med*. 2008;9(7):803-812. doi:10.1111/j.1526-4637.2008.00425.x
- 4. Centers for Disease Control and Prevention (CDC). Vital signs: overdoses of prescription opioid pain relievers---United States, 1999--2008. *MMWR Morb Mortal Wkly Rep*. 2011;60(43):1487-1492.
- 5. *Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings*. US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration; 2014.
- 6. Edlund MJ, Martin BC, Russo JE, DeVries A, Braden JB, Sullivan MD. The Role of Opioid Prescription in Incident Opioid Abuse and Dependence Among Individuals With Chronic Noncancer Pain: The Role of Opioid Prescription. *Clin J Pain*. 2014;30(7):557-564. doi:10.1097/AJP.0000000000000021
- 7. Zedler B, Xie L, Wang L, et al. Risk Factors for Serious Prescription Opioid-Related Toxicity or Overdose among Veterans Health Administration Patients. *Pain Med*. 2014;15(11):1911-1929. doi:10.1111/pme.12480
- 8. Bohnert ASB. Association Between Opioid Prescribing Patterns and Opioid Overdose-Related Deaths. *JAMA*. 2011;305(13):1315. doi:10.1001/jama.2011.370
- 9. Agency Medical Directors' Group. *Interagency Guideline on Prescribing Opioids for Pain 3rd Ed*. Agency Medical Directors' Group; 2016.
- 10. *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life*. National Academies Press; 2015:18748. doi:10.17226/18748
- 11. Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022. *MMWR Recomm Rep*. 2022;71(3):1-95. doi:10.15585/mmwr.rr7103a1
- 12. Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. *MMWR Recomm Rep*. 2016;65(1):1-49. doi:10.15585/mmwr.rr6501e1
- 13. Paulozzi LJ, Mack KA, Hockenberry JM, Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, CDC. Vital signs: variation among States in prescribing of opioid pain relievers and benzodiazepines - United States, 2012. *MMWR Morb Mortal Wkly Rep*. 2014;63(26):563-568.
- 14. Levy B, Paulozzi L, Mack KA, Jones CM. Trends in Opioid Analgesic–Prescribing Rates by Specialty, U.S., 2007–2012. *Am J Prev Med*. 2015;49(3):409-413. doi:10.1016/j.amepre.2015.02.020