# Update on CDC Opiate Prescribing Practices

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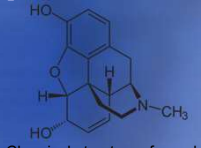
## Clinical Decision Making


&

## What are Opiates

- Opiates are naturally found in the opium poppy plant
- The naturally derived opiates found in the opium plant include morphine and codeine.




Chemical structure of morphine

## What are the short acting prescription opiates

- Codeine ( Tylenol #3 & #4)
- Hydrocodone ( Norco*, Vicoden*, Lortab*)
- Oxycodone (Percocet*, Roxicet, Endocet*,)
- Morphine ( Avinza, Kadian, Oramorph)
- Hydromorphone ( Dilaudid)
- Oxymorphone (Opana)
- Tramadol ( Ultram)

* combination with Tylenol 5 or 7.5 or 10mg/325

## What are the long acting prescription opiates

- MSContin ( morphine)
- Oxycontin ( oxycodone)
- Zohydro ( hydrocodone)
- Methadone*
- Fentanyl patch (3 days)
- Buprenorphine patch (7days)


- * long half-life but short pain relief.
- * It is the way the pill is made that makes them long-acting

## Why are Opioids so Dangerous?

- Opiates can be effective for **pain control in some situations** however they can also get people **addicted** and **lead to death** if used improperly.
- CDC statistics:
- In 2019 49,850 died of opiate use
- In 2020 69,710 died of opiate use
- In 2021 75,673 died of opiate use*
- **Making opiate associated death the leading cause of death for people under the age of 50**

*CDC - National Center for Health Statistics

## How did the opiate epidemic start?

- In the mid 1990s the Joint Commission on the Accreditation of Healthcare Organizations started a national campaign designating Pain as the "5th vital sign"
- There were no guidelines or good studies on how to treat pain, especially chronic pain.
- This led to leniency in opiate prescribing practices.
- Big Pharma sales practices also contributed.
- **Up to 25% of patients who start opiates for pain management develop addiction.**


## Opiates for Acute Pain

- Opiates can be very effective for acute pain
- Post operative Opiate prescriptions with One refill leads to a 50% greater change of opiate addiction.
- There is 20% increase of opiate addiction for each week of opiate medication is used after the first week. *

*BMJ. 2018; 360: j5790.

## Opioids for Chronic Pain

- Studies on opiates for chronic pain, < less than one year, and done by pharmaceutical companies that manufacture these drugs
- Less than one-half of chronic pain patients get 20-30% amount of modest pain relief with the use of opiates in these studies.
- No ceiling doses studied.
  - *Nobel,M et al. Cochran Systematic Reviews 2010

## Some Definitions

- Opiate Dependency
  - When abrupt stopping of chronic use of an opiate medication causes withdrawal.
- Opiate Tolerance
  - Reduced benefit from a drug with long term use
- Opiate Addiction
  - a compulsive need for a habit-forming substance, despite having harmful physical, psychological, and social effects

Substance Use Disorder

- The preferred medical term for addiction.

## Risks With Long Term Opiate Use


- Lowers testosterone levels
- Leads to osteoporosis -2X fracture risk
- Increased falls
- Opiate Induced Hyperalgesia ( more pain)
- Opiate Use Disorder ( Addiction)
- Chemical coping*

*Chemical coping refers to the use of medication in an excessive or inappropriate way to manage psychological distress

## Pain in the 17th century

The Cartesian model of pain (Descartes 1664) is responsible for many misconceptions about pain.

## Pain in the 21st century

2) A branch of the STT projects to the raphe nuclei and loci ceruleus. These nuclei respond by altering the synthesis of serotonin and norepinephrine which mediate mood, emotion, and cognition.

4) Cortical neurons seem to have trouble accurately discriminating C-fiber input. This may impair the cortical capacity to modulate the pain signal thus further leading to the widespread somatic distress of the chronic pain syndrome.

**1) C-fibers enter the Dorsal Horn of the spinal cord and form synaptic contacts with two discrete populations of "second order" spinal afferents.**

**-Nociceptive specific neurons (NS) which function in the spinal cord to localize pain**

**-Wide dynamic range (WDR) neurons evoke sensations of itch, pressure, parasthesias.**

3) STT can also amplify opiate, serotonergic and noradrenergic pain modulation via "desending pathways" in the spinal cord.

2) The C-fibers release **glutamate,** which bind two types of post-synaptic receptors
-AMPA for a fast excitatory response.

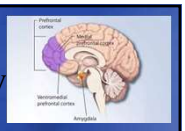
-NMDA that heighten the response of second order neurons to subsequent stimulation (hypersensitivity)

3) The C-fibers also release substance-P that binds to neurokinin -1 (NK-1). Persistent activation of NK-1 remodels the synaptic organization of the dorsal horn.

4) C-fibers can re release substance-P and calcitonin to the tissues they innervate. These potent vasodilators release inflammatory substances from the vasculature.

- 1) The majority of the NS and WDR second order neurons that receive C-fiber input cross-over and ascend the **spinothalamic tracts. (STT)**

## Neuroplasticity




- **Medial Prefrontal Cortex**
- Processes risk and fear –helps with making optimal decisions.
- Chronic pain leads (MPC) to make poor choices such as not exercising, avoiding healthy lifestyle changes – inability to get the body back on the correct course.


* Conquer Chronic Pain –Peter Preekop, DO,PHD 2015 Queens Hospital

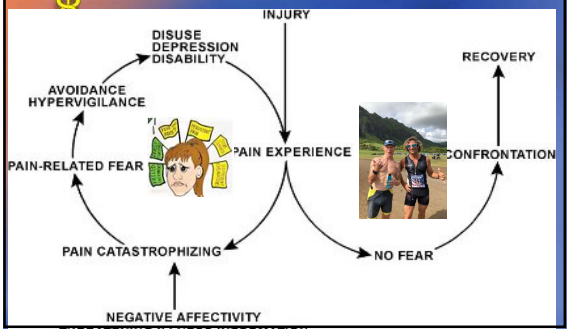
## Perceptions of Pain

As with any medical condition, pain is a continuum and can present as low, moderate, or high risk of poor outcomes.

These outcomes often depend on a patient's mood, behavior, physical abilities, past use of medications, genetics, ACE, and their other medical conditions.

Understand that pain is part of the **story** of the person who suffers from it and not just a clinical diagnosis based on a numeric pain scale.

## Perceptions of Pain




## Hawaii's Opioid Prescribing Laws: Narcotic Enforcement Division

1) Don't let your Hawaii Registration Controlled Substances or DEA Registration expire →
2) The responsibility for proper prescribing and dispensing shall be upon the prescribing practitioner, BUT A ***CORRESPONDING RESPONSIBILITY*** SHALL REST WITH THE PHARMACIST WHO FILLS THE PRESCRIPTION.
3) No schedule II narcotic controlled substance may be prescribed or dispensed for **more than a thirty-day supply**




## Hawaii's Opioid Prescribing Laws: Narcotic Enforcement Division

4) Beginning on July 1, 2018, any provider authorized to prescribe opioids shall adopt and maintain **written policy for your office** that include execution of a **written agreement** to engage in an informed consent process between the prescribing provider and qualifying opioid therapy patient.

*https://health.hawaii.gov/substance-abuse/files/2017/12/opioid_informed_consent_template.pdf*

- *UDS*
- *Check PDMP*
- *Contract*

## Hawaii's Opioid Prescribing Laws: Narcotic Enforcement Division

- **Requires prescribers check the PDMP before prescribing Schedule II-IV controlled substances as necessary.**
- Get your access logons at: *Hawaii.pmpaware.net*
  - VIOLATIONS NOT CRIMINAL—May result in referrals to the Professional Licensing Authority

## Opioids and Benzodiazepines

- The CDC has reported; of all the opioid **overdose deaths** that occur in the U.S. each year, **30% of the time benzodiazepine were used on the same day.**
- It has been determined the combined use of opioids and benzodiazepines leads to an increased risk of cognitive impairment, respiratory decline, and death.
- FDA/CDC recommendations: **Physicians should avoid prescribing opioid medications and benzodiazepines at the same time whenever possible.**

* Have Behavioral Health Experts write for behavioral health medications, that are controlled substances, if you are prescribing chronic opioid therapy.

## Hawaii's Opioid Prescribing Laws: Narcotic Enforcement Division

**Initial concurrent prescriptions** for opioids and benzodiazepines shall **not be for longer than seven consecutive days** unless a supply of longer than seven days is determined to be medically necessary for the treatment of:
1) Post-operative care;
2) Chronic pain and pain management;
3) Substance abuse or opioid or opiate dependence
4) Cancer;
5) Pain experienced while the patient is in palliative care
6) Pain experienced while the patient is in hospice care

## Diversion/Dr. Shopping/Fraud


- Jared K. Redulla
- Narcotics Enforcement Division
- 808-837-8470
- Jared.K.Redulla@Hawaii.gov


## Urine Drug Screen

- A UDS is a data point to start a conversation with your patient.

**Confirmation Testing Details**

| Test | Test Outcome | Measured Result | Cutoff | Consistent (Inconsistent) |
|---|---|---|---|---|
| **Alcohol** | | | | |
| Ethyl Sulfate | Negative | Negative ng/mL | 100 ng/mL | Consistent |
| PEth | Negative | Negative ng/mL | 400.0 ng/mL | Consistent |
| **Benzodiazepines** | | | | |
| Alprazolam | Positive | 647 ng/mL | 50 ng/mL | INCONSISTENT |
| Alpha-hydroxyalprazolam | Positive | >1250 ng/mL | 50 ng/mL | INCONSISTENT |
| Nordiazepam | Negative | Negative ng/mL | 50 ng/mL | Consistent |
| Oxazepam | Negative | Negative ng/mL | 50 ng/mL | Consistent |
| 7-Aminoclonazepam | Negative | Negative ng/mL | 50 ng/mL | Consistent |
| Temazepam | Negative | Negative ng/mL | 50 ng/mL | Consistent |
| Lorazepam | Negative | Negative ng/mL | 50 ng/mL | Consistent |
| Diazepam | Negative | Negative ng/mL | 50 ng/mL | Consistent |
| 7-AminoflunitrazepamNegative | Negative | Negative ng/mL | 50 ng/mL | Consistent |
| 7-hydroxyethylflurazepam | Negative | Negative ng/mL | 50 ng/mL | Consistent |
| Midazolam | Negative | Negative ng/mL | 50 ng/mL | Consistent |
| **Illicit Drugs** | | | | |
| Methamphetamine | Negative | Negative ng/mL | 25 ng/mL | Consistent |
| THC | Positive | >635 ng/mL | 25 ng/mL | INCONSISTENT |
| **Muscle Relaxants** | | | | |
| Hydroxyzine | Negative | Negative ng/mL | 50 ng/mL | Consistent |
| **Others** | | | | |
| Nitrazepam | Negative | Negative ng/mL | 15 ng/mL | Consistent |
| **Semi-synthetic Opiates** | | | | |
| Oxycodone | Positive | 127 ng/mL | 50 ng/mL | INCONSISTENT |
| Noroxycodone | Positive | 476 ng/mL | 50 ng/mL | INCONSISTENT |
| Oxymorphone | Positive | 178 ng/mL | 50 ng/mL | INCONSISTENT |
| **Stimulants** | | | | |
| Amphetamine | Positive | >625 ng/mL | 25 ng/mL | INCONSISTENT |
| **Immunoassay Screening** | | | | |
| Heroin Metabolite | Negative | Negative | 10.00 ng/mL | N/A |
| Amphetamines | Positive | Positive | 500.00 ng/mL | N/A |
| Benzodiazepines | Positive | Positive | 200.00 ng/mL | N/A |

I tell my patients, "I don't want any surprises"

## Weaning Down Opiates – It Works


Tell your patients; "I am lowering your opiate dose for your safety and your health."

## Opiate Risk Tool (ORT)

**OPIOID RISK TOOL PATIENT FORM**

Name:_____

Age:_____

| | | Mark Each Box That Applies | Score If Female | Score If Male |
|---|---|---|---|---|
| 1. Family History of Substance Abuse | • Alcohol<br>• Illegal Drugs<br>• Prescription Drugs | ☐<br>☐<br>☐ | 1<br>2<br>4 | 3<br>3<br>4 |
| 2. Personal History of Substance Abuse | • Alcohol<br>• Illegal Drugs<br>• Prescription Drugs | ☐<br>☐<br>☐ | 3<br>4<br>5 | 3<br>4<br>5 |
| 3. Age (Mark Box if 16-45 years) | | ☐ | 1 | 1 |
| 4. History of Preadolescence Sexual Abuse | | ☐ | 3 | 0 |
| 5. Psychological Disease | • Attention-Deficit/Hyperactivity Disorder, Obsessive Compulsive Disorder, Bipolar Disorder, Schizophrenia<br>• Depression | ☐<br>☐ | 2<br>1 | 2<br>1 |

**Total Score _____Risk Category_____**

**Low Risk 0-3**

**Moderate Risk 4-7**

**High Risk >7**

## Opioid Assessment for Patients with Pain

- Request early refills
- Frequent phone calls
- Opiate focus visits
- Frequent accidents
- Request Brand name
- Polypharmacy
- Self escalation
- Refuse UDS

- *People with Substance Use Disorders are professional manipulators as part of their disease.*

# Tapering Surgical Discharge Prescription

*Rx*

**Oxycodone /Acetaminophen 5/325 mg**

Sig.

1 tab PO 4 times per day for pain for 3 days, then

1 tab PO three times per day for 3 days, then

1 tab PO two times per day for 3 days, then

1 tab PO once per day for 3 days then discontinue

# 30 thirty tabs

*Dr. Jane Smith DO*

USA -Post op opiates 95%  Rest of the world 5%  -Lancet 2022

# How to Taper

1) **Go Slow** – start decrease 10% of dose per week; for long term users slow to q 2-4 weeks **Ok to go slower but don't reverse taper*
2) **Encourage** most patients have improved function without worse pain. * *pain and anxiety might briefly get worse.*
3) Make sure patients receive appropriate psychosocial **support.**

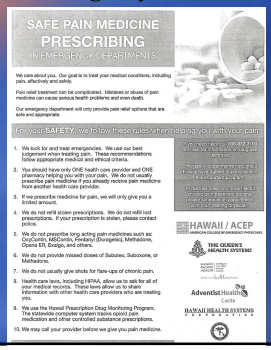
CDC guidelines for prescribing opioids for chronic pain
https://www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf

Opiate withdrawal is NOT lethal

# Withdrawal Medications

| Target Symptoms | Medication | Dosing |
|---|---|---|
| Hypertension, tremors, sweats, anxiety, restlessness | Clonidine<br>Tizanidine | 0.1 mg tid<br>2-4 mg tid |
| Anxiety, Restlessness | Vistaril<br>Benadryl<br>No Benzos!! | 25 mg q 6 hours prn<br>25 mg q 6 hours prn |
| Insomnia | Vistaril / Benadryl<br>Tizanidine | 25-50 mg at HS<br>4-8 mg at hs |
| Nausea | Promethazine<br>Reglan | 25 mg q 6 hours prn<br>10 mg q 6 hours prn |
| Diarrhea | Imodium (OTC) | 2 mg q 6 hours prn |
| Fever | Tylenol ES | 1000 mg tid |
| Pain | Tylenol ES / Gabapentinoids<br>NSAIDs / SNRIs | As directed |

## What is Being Done in Oahu's Emergency Rooms





- No earl refills
- NO "lost Rx" refills
- NO long-acting opiates
- NO standing order IM opiates
- Will call your opiate prescriber

## What's New?

- Suboxone ( Buprenorphine)
- A partial opiate. No risk of overdose or death. Used for Medication Assisted Treatment (MAT) for Opiate Use Disorder.* (MOUD)
- Good for patients with chronic pain **and** Opiate Use Disorder.

*replacing Methadone

** Do NOT need an "X" license to prescribe.


## What's New?

NARCAN® Nasal Spray 4mg

NARCAN® Nasal Spray is a prescription medicine used for the treatment of an opioid emergency such as an **overdose** with signs of breathing problems and severe sleepiness or not being able to respond.

NARCAN® Nasal Spray is to be given right away and does not take the place of emergency medical care. **(Call 911)**


Developed for family, friends, and caregivers.

*can be dispensed by a pharmacist without a prescription

## What's New?

- Vivitrol - naltrexone 95 mg injection
- 380 mg IM q 4 weeks for prevention of relapse following opioid detoxification


## CDC 2022 Clinical Guidelines for prescribing opiates.

- **Updated- (from 2016) clinical practice guideline for prescribing of opioid pain medication for patients aged ≥18 years for pain, excluding pain management related to sickle cell disease, cancer-related pain treatment, palliative care, and end-of-life care.**
- **1) Determining whether or not to initiate opioids for pain;**
- **2) Selecting opioids and determining opioid dosages;**
- **3) Deciding duration of initial opioid prescription and conducting follow-up; and**
- **4) Assessing risk and addressing potential harms of opioid use. In addition,**

## Guiding Principles

- **1) Develop an appropriate treatment of pain. Make a Plan**
- **2) Flexibility to meet the care needs and clinical circumstances of each patient. Be Flexible**
- **3) A multimodal and multidisciplinary approach to pain management. Multi-tiered Approach**
- **4) Avoiding misapplication of the clinical practice guideline beyond its intended use. Don't just say NO**
- **5) Vigilance in attending to health inequities and ensuring access to appropriate, affordable, diversified, coordinated, and effective nonpharmacologic and pharmacologic pain treatment for all persons. Practice Equality**

## Recommendation 1
## Maximize non- opiate therapy

- **Nonopioid therapies are at least as effective as opioids for many common acute pain conditions;**
- low back pain,
- neck pain,
- pain related to other musculoskeletal injuries (e.g., sprains, strains, tendonitis, and bursitis),
- pain related to minor surgeries typically associated with minimal tissue injury and mild postoperative pain
- dental pain,
- kidney stone pain,
- headaches including episodic migraine.

## *JAMA*. 2018;319(9):872-882.

- March 6, 2018
- **Effect of Opioid vs Nonopioid Medications on Pain-Related Function in Patients With Chronic Back Pain or Hip or Knee Osteoarthritis Pain**
  The SPACE Randomized Clinical Trial
- **Conclusions and Relevance** Treatment with opioids was not superior to treatment with nonopioid medications for improving pain-related function over 12 months. Results do not support initiation of opioid therapy for moderate to severe chronic back pain or hip or knee osteoarthritis pain.

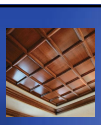
## Recommendation 2

- **Before starting opioid therapy for subacute or chronic pain, clinicians should discuss with patients the realistic benefits and known risks of opioid therapy, establish treatment goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks**
- **For patients with subacute pain who started opioid therapy for acute pain and have been treated with opioid therapy for ≥30 days, clinicians should ensure that potentially reversible causes of chronic pain are addressed and that opioid prescribing for acute pain does not unintentionally become long-term opioid therapy simply because medications are continued without reassessment**

## Recommendation 3

- 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
- Methadone should not be the first choice for an ER/LA opioid
- Because dosing effects of transdermal fentanyl often are misunderstood by both clinicians and patients, only clinicians who are familiar with its dosing and absorption properties of and are prepared to educate their patients about its use should consider prescribing transdermal fentanyl.

## Recommendation 4



- When opioids are initiated for opioid-naïve patients with acute, subacute, or chronic pain, clinicians should prescribe the lowest effective dosage. If opioids are continued for subacute or chronic pain, clinicians should use caution when prescribing opioids at any dosage, should carefully evaluate individual benefits and risks when considering increasing dosage, and should avoid increasing dosage above levels likely to yield diminishing returns in benefits relative to risks to patients
- Watch for breakthrough pain prescribing.
- The lowest starting dose for opioid-naïve patients is often equivalent to a single dose of approximately 5–10 MME or a daily dosage of 20–30 MME/day
- 50 to <100 MME/day associated with 4.73 times the risk for overdose and dosages of ≥100 MME/day associated with 6.64 times the risk, compared with dosages of <20 MME/day

## Recommendation 5

- For patients already receiving opioid therapy, clinicians should carefully weigh benefits and risks and exercise care when changing opioid dosage.
- Clinicians should work closely with patients to optimize nonopioid therapies while continuing opioid therapy. If benefits do not outweigh risks of continued opioid therapy, clinicians should optimize other therapies and work closely with patients to gradually taper to lower dosages
- 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 #5 continued

- Avoiding patient abandonment
- Clinicians should follow up frequently (at least monthly) with patients engaging in opioid tapering
- For patients who have taken opioids long-term (e.g., for ≥1 year), tapers can be completed over several months to years
- At times, tapers might have to be paused and restarted again when the patient is ready and might have to be slowed as patients reach low dosages.
- Tapers of approximately 10% per month or slower are likely to be better tolerated
- Primary care clinicians should collaborate with mental health specialists and with other specialty clinicians as needed to optimize nonopioid pain management and provide psychosocial support for patients who have anxiety related to the taper.

## Recommendation 6

- 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.
- If opioids are used continuously for >3 days but for <1 week, clinicians can consider reducing the daily dosage to 50% for 2 days to ameliorate withdrawal symptoms when discontinuing opioids. When patients have taken opioids continuously for ≥1 week but <1 month, clinicians might consider a slower taper (e.g., reducing the daily dosage by approximately 20% every 2 days
- -One refill has a 20% risk of SUD

## Recommendation 7

- 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. Clinicians should regularly reevaluate benefits and risks of continued opioid therapy with patients
- Patients should be evaluated at least every 2 weeks if they continue to receive opioids for acute pain.
- 47%–56% of post operative opiate pills prescribed remaining unused. ( high risk for diversion)
- Long-term opioid therapy, with a suggested interval of every 3 months or more frequently. And don't forget getting a UDS

## Recommendation 8

- Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk for opioid-related harms and discuss risk with patients.
- Clinicians should offer naloxone when prescribing opioids, particularly to patients at increased risk for overdose.
- Patients at increased risk for overdose, a history of overdose, a history of substance use disorder, sleep-disordered breathing, patients taking higher dosages of opioids (e.g., ≥50 MME/day), patients taking benzodiazepines with opioids.
- 1/3 of people who die of opiate overdose have benzos in their systems!

## Recommendation 9

- 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 OUD.
- Clinicians should not dismiss patients from their practice on the basis of PDMP information.
- Use particular caution when prescribing opioid pain medication and benzodiazepines concurrently, understanding that some patient circumstances warrant prescribing of these medications concomitantly.

## Recommendation 10

- 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
- Toxicology testing should not be used in a punitive manner but should be used in the context of other clinical information to inform and improve patient care. Clinicians should not dismiss patients from care on the basis of a toxicology test result. Dismissal could have adverse consequences for patient safety
- Clinicians should become familiar with the drugs included in toxicology testing panels used in their practice and understand how to interpret results; ensure a laboratorian or toxicologist is available to discuss unexpected results

## Recommendation 11

- 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.
- Polysubstance use
- Clinicians should communicate with other clinicians managing the patient to discuss the patient's needs, prioritize patient goals, weigh risks of concurrent benzodiazepine and opioid exposure, and coordinate care

## Recommendation 12

- Clinicians should offer or arrange treatment with evidence-based medications to treat patients with opioid use disorder. Detoxification on its own, without medications for opioid use disorder, is not recommended for opioid use disorder because of increased risks for resuming drug use, overdose, and overdose death
- M.A.T. ( medication assisted treatment ) is now M.O.U.D. (Medications for Opiate Use Disorder)

## Opiate Use Disorder

- Opioid use disorder is manifested by at least two of 11 defined criteria occurring within a year (*317*):
  - Opioids are often taken in larger amounts than was intended.
  - There is a persistent desire or unsuccessful attempts to cut down opioid use.
  - A great deal of time is spent in activities necessary to obtain the opioid.
  - Craving, or a strong desire or urge to use opioids.
  - Recurrent opioid use resulting in a failure to fulfill majorrole obligations at work, school, or home.
  - Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
  - Important social, occupational, or recreational activities are given up or reduced because of opioid use.
  - Recurrent opioid use in situations in which it is physically hazardous.
  - Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

## Plan for preventing opioid over-prescribing and prevention of SUD

**Supporting judicious prescribing practices Guidelines for Opioid Prescribing Practices:**


**-28 day prescribing/refill cycles**

**-Ceiling dose of Morphine Equivalent dose 100 MED***

**-Maximum quantity dose (i.e. #200) for refills**

**-UDS/PDMP frequently / Patient contracts**

**-Office visits 4 X per year minimum**

**-Pain Consults for daily opiate doses > 100 MED** (get help)!

**-Stop Use of Rx with high rates of SUD: Soma/Zohydro**

**-Attempt Opiate wean for aberrant drug behaviors alon with Chemical Dependency referral** (don't be mean)

PATIENT SUPPORT – step two

## 4-Step Plan for preventing opioid over-prescribing and prevention of SUD

### 2) Focus on Improving patient outcomes

**-Coverage for more non-opiate treatment options: physical therapy, acupuncture, topical Rx, CBT**

**-Improve access to Chemical Dependency programs**

**-Remove barriers for physicians to prescribe buprenorphine for treating addiction and chronic pain**

**-Provide RN Case Managers for high utilizer chronic pain patients**


Support for SUD patients– step three

## 4-Step Plan for preventing opioid over-prescribing and prevention of SUD

### 3) Helping clinicians identify overuse and SUD

-Identify prescribing physician outliers for education and monitoring.

-Identify outlier patients on very high opiate doses to coordinate a treatment and weaning plan with providers.

-Laboratory Hot Lines for interpreting UDS results

-Naloxone promotion

Support for saving lives- step 4

## 4-Step Plan for preventing opioid over-prescribing and prevention of SUD

**4) Multidisciplinary Treatment Approach for Handling the Opiate epidemic**

-Resources need to be allocated to start **Multidisciplinary Pain Management Programs**. This would include Pain physicians, RN case managers, physical therapists, pain psychologists pharmacists.


-Multidisciplinary **Pain rounds** with Primary Care clinicians

-Pain Management **communication between providers**

**-Co-treatment** with primary care physicians ( Phone calls)

## Bottom line for Opioid Prescriptions…


## *Thank You*