CDC Guidelines for Prescribing Opioids for Chronic Pain

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I DON'T ALWAYS TRY TO REFILL MY HYDROCODONE EARLY

BUT WHEN I DO, IT'S BECAUSE THE PHARMACY SHORTED ME AND I DROPPED THE FEW THAT WEREN'T STOLEN DOWN THE SINK AS I WAS ON MY WAY OUT OF TOWN FOR A FUNERAL AND MY DOCTOR SAID IT WAS OK.
Burden of Chronic Pain in the United States

Affects 100 million Americans
(more than heart disease, cancer and diabetes combined)\(^1\)

Costs society up to $635 billion annually\(^1\)

Associated with 40 million doctor visits annually\(^2\)

Results in 515 million lost workdays annually\(^2\)
40% of all work absences are related to low back pain\(^3\)

Chronic Pain Is Among the Top Costly Conditions in the United States

Changes in Pain Treatment Paradigms

• 1986 Portenoy and Foley published a seminal paper

• 1995 American Pain Society set guidelines for treating pain

• 1997 FDA allows direct-to-consumer marketing

• 1999 the VA Department launched a campaign known as “Pain is the Fifth Vital Sign”

• Joint Commission endorsed the VA campaign
The Dark Side

• Since 1999, 140,000 people have died from an overdose related to opioid pain medication in the US

• More than 16,000 deaths occurred in 2013, four times the number of overdose deaths related to these drugs in 1999
Unintentional Opiate Overdose Deaths Parallel Opioid Sales in United States, 1997–2007

- Overdose deaths
  - 2,901 in 1999
  - 11,499 in 2007

- Distribution by drug companies
  - 96 mg/person in 1997
  - 698 mg/person in 2007

Source: National Vital Statistics multiple cause of death data set and Drug Enforcement Agency ARCOS System
Overdose Deaths

How the Epidemic of Drug Overdose Deaths Ripples Across America

By HAEEYOUN PARK and MATTHEW BLOCH JAN. 19, 2016

Overdose deaths per 100,000

[Map showing overdose deaths across America from 2003 to 2014]
Overdose Deaths, 2014
Overdose Deaths Related to Opiates, Washoe County Residents

Department of Health and Human Services
I've got pills...

They're multiplyin'!
Time for Change

- March of 2016, The CDC published its Guideline for Prescribing Opioids for Chronic Pain
Target Audience

- Opioid prescribing rates have increased more for family practice, general practice, and internal medicine compared to other specialties from 2007 - 2012

- Prescriptions by PCP’s account for nearly half of all dispensed opioid prescriptions
Guideline Goals

• Provide recommendations for primary care providers who are prescribing opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care
Recommendations

- Grouped into 3 areas of consideration:
  1. Determining 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
Determining when to initiate or continue opioids for chronic pain

- Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Providers should only consider adding opioid therapy if expected benefits for both pain and function are anticipated to outweigh risks to the patient.
Determining when to initiate or continue opioids for chronic pain

• Before starting opioid therapy for chronic pain, providers should establish treatment goals with all patients, including realistic goals for pain and function. Providers should not initiate opioid therapy without consideration of how therapy will be discontinued if unsuccessful. Providers should continue opioid therapy only if there is clinical meaningful improvement in pain and function that outweighs risks to patient safety.
Determining when to initiate or continue opioids for chronic pain

• Before starting and periodically during opioid therapy, providers should discuss with patients known risks and realistic benefits of opioid therapy and patient and provider responsibilities for managing therapy.
Opioid selection, dosage, duration, follow up and discontinuation

- When starting opioid therapy for chronic pain, providers should prescribe immediate-release opioids instead of extended-release/long-acting opioids.
Opioid selection, dosage, duration, follow up and discontinuation

• When opioids are started, providers should prescribe the lowest effective dosage. Providers should use caution when prescribing opioids at any dosage, should implement additional precautions when increasing dosage to > 50 MME/day, and should generally avoid increasing dosage to > 90 MME/day.
Opioid selection, dosage, duration, follow up and discontinuation

- Long-acting opioid use often begins with treatment of acute pain. When opioids are used for acute pain, providers 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 or fewer days usually will be sufficient for most nontraumatic pain not related to major surgery.
Opioid selection, dosage, duration, follow up and discontinuation

• Providers should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Providers 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, providers should work with patients to reduce opioid dosage and to discontinue opioids.
Assessing risk and addressing harms of opioid use

• Before starting and periodically during continuation of opioid therapy, providers should evaluate risk factors for opioid-related harms. Providers should incorporate into the pain 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, or high opioid dosages (> 50 MME), are present.
Assessing risk and addressing harms of opioid use

• Providers 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 high opioid dosages or dangerous combinations that put him or her at risk of overdose. Providers 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.
Assessing risk and addressing harms of opioid use

• When prescribing opioids for chronic pain, providers 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.
Assessing risk and addressing harms of opioid use

• Providers should avoid prescribing opioid pain medication for patients receiving benzodiazepines whenever possible.
Assessing risk and addressing harms of opioid use

• Providers should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or Methadone in combinations with behavioral therapies) for patients with opioid use disorder.
Questions
Discussion