Break

Agenda

The First 30 Hour:

Why We Are here

The current situation

Assessment of Risk

Assessment of Need

BOP

Contracts

The Hour After That:

Prescribing Opioids

Opioid equivalents

Testing:
Urine
Pill counts

The Last Hour:

The New CDC Guidelines

The WV Opioid Reduction Act

2022 CDC Guidelines

The 2016 guidelines,

"..were essentially taken out of context beyond (their) intent and applied as rigid laws, regulations and policies."

-**Christopher Jones**, PharmD, MPH and acting director of the CDC's National Center for Injury Prevention and Control

https://www.narcotics.com/prescription-opioids-cdc guidance/#:~:text=The%20CDC%20stepped%20in%20with%20official%20prescribing%20guidelines%2C,the%20CDC%20guidelines%2C%20opioid%20laws%20began%20to%20change.

2022 CDC Guidelines

Like the previous guideline the new guideline addresses :

(1) When to initiate or continue opioids for chronic pain, (not first line);
(2) Opioid selection, dosage, duration, follow-up, and discontinuation, and;
(3) Assessing risk and addressing harms of opioid use.

It differs in that it:

1. No longer includes specific dosage ceilings, (often misinterpreted and harmful);
2. No longer suggests that opioids for acute pain be limited to three days;
3. Advises starting patients off on low doses of immediate-release pills;
4. Stresses that the guideline are voluntary, rather than prescriptive standards,
5. Clarifies that clinicians should consider the circumstances and unique needs of each patient when providing care.

https://www.aamc.org/advocacy-policy/washington-highlights/cdc-issues-updated-guideline-prescribing-opioids

2022 CDC Guidelines

The new guideline specifically:

- Removes the suggestion to limit opioid treatment for acute pain to three days.
- No longer recommends avoiding increasing dosage to 90 MME a day.
- Removes the suggestion to have patients undergo urine testing *annually*.
- Urges doctors to avoid abruptly halting treatment unless the situation appears life threatening.
- Offers suggestions for tapering patients off of opioids.

2022 CDC Guidelines

The updated guideline provides recommendations for primary care physicians, AS WELL AS, other specialty clinicians who are treating **three** categories of patients:

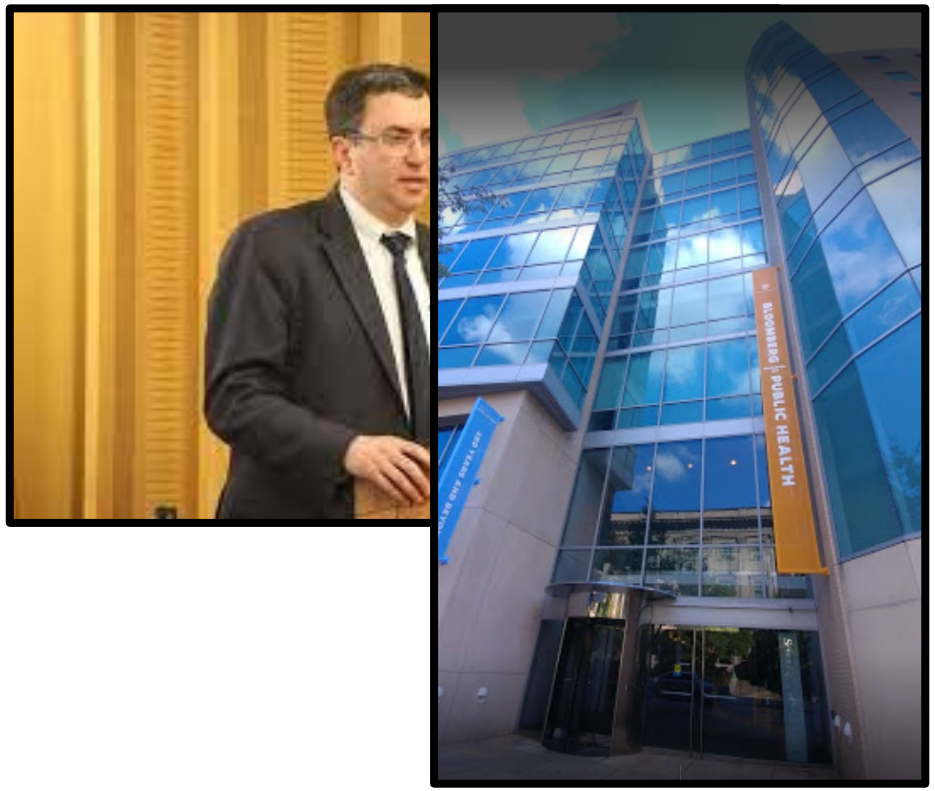
- Adults with **acute pain** (lasting less than one month)
- Adults with **subacute pain** (lasting one to three months)
- Adults with **chronic pain** (lasting three months or longer)

The guidelines **do not apply** to patients being treated for **cancer or sickle cell disease or receiving palliative or end-of-life care**.

2022 CDC Guidelines

"They are trying to thread the needle here. They're trying to balance, on the one hand, the importance of clear guidance to clinicians, and on the other, the danger it could turn into a rigid policy that undermines patient care. The general intent is to foster individualized patient care."

-Dr. Joshua Sharfstein, vice dean for public health practice and community engagement at Johns Hopkins Bloomberg School of Public Health.



https://www.google.com/url?sa=i&url=https%3A%2F%2Fen.wikipedia.org%2Fwiki%2FJoshua_Sharfstein&psig=AOvVaw1PeGJnBAwreg1c5yJpSaFP&ust=1648764574756000&source=images&cd=vfe&ved=2ahUKEwi2ntLn7O72AhULBs0KHbw4AEoQr4kDegUIARCxAQ

2022 CDC Opioid Prescribing Guideline

"The 2022 guideline aims to promote equitable access to effective, informed, individualized, and safe pain management that improves patients' function and quality of life, while clarifying and reducing the risks associated with opioid use. Ideally, new recommendations should result in greater and more equitable access to the full range of evidence-based treatments for pain, more judicious initial use of opioids, and more careful consideration and management of benefits and risks associated with continuing, tapering, or discontinuing opioids in patients who are already receiving them long term."

"..there are persistent barriers to access to pain care and evidence-based treatment; shared decision making by patients and clinicians is critical; discontinuing opioids after extended use can be very challenging and potentially harmful, especially if doses are tapered rapidly or patients do not receive effective support; and the new recommendations need to be communicated and implemented carefully"

Deborah Dowell, M.D., M.P.H., Kathleen R. Ragan, M.S.P.H., Christopher M. Jones, Pharm.D., Dr.P.H., Grant T. Baldwin, Ph.D., M.P.H., and Roger Chou, M.D.
Prescribing Opioids for Pain — The New CDC Clinical Practice Guideline November 3, 2022 DOI: 10.1056/NEJMp2211040

2022 CDC Opioid Prescribing Guideline

Pain is one of the most common reasons adults seek medical care in the United States.

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 guideline as <1 month) and often is caused by injury, trauma, or medical treatments such as surgery.

Unresolved acute pain or **subacute pain** (defined as pain present for 1–3 months) can evolve into chronic pain.

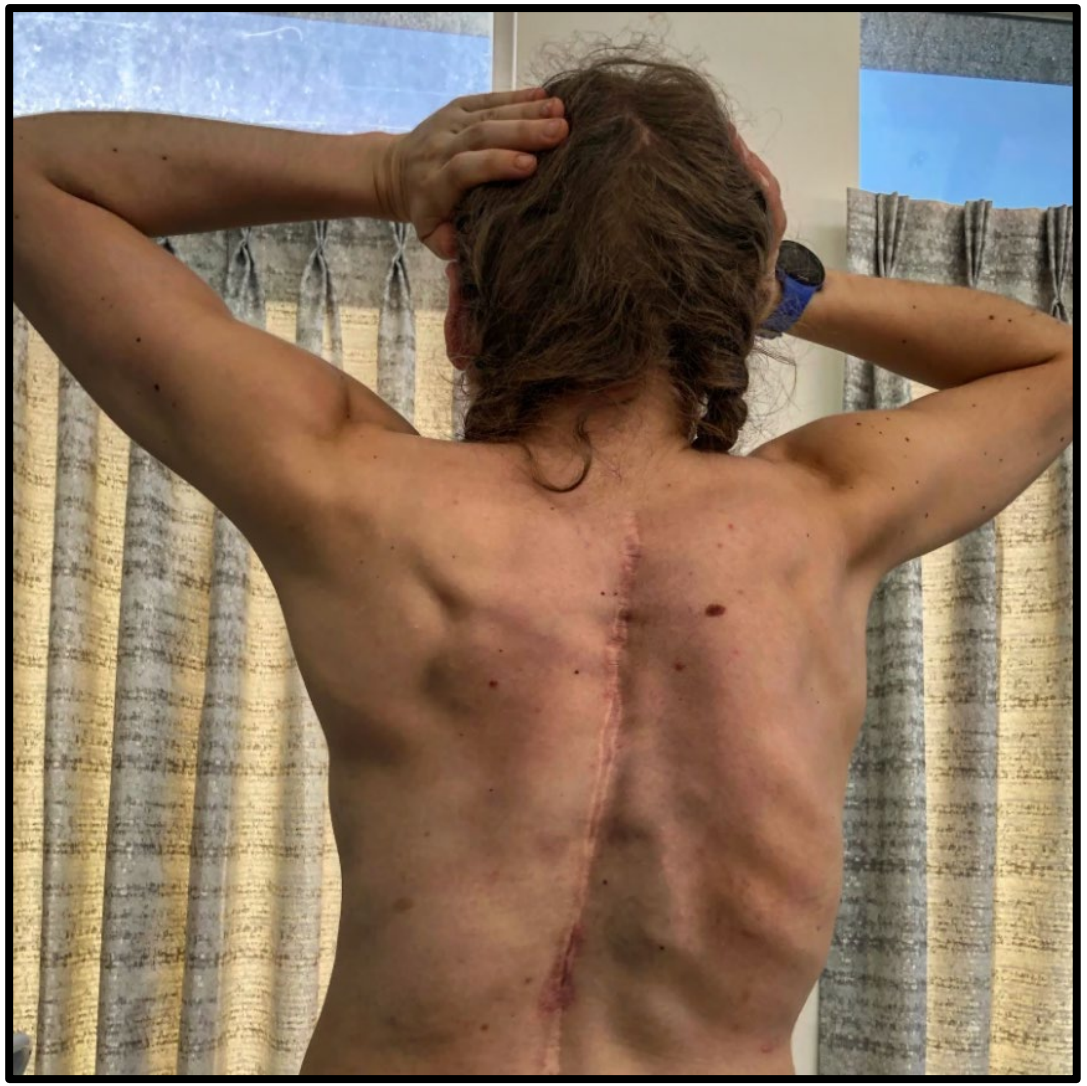
https://www.google.com/search?q=compound+shin+fracture&sxsrf=ALiCzsbNz3dJowOKaaIM4wa5Z_RyOoLmIg:1667774995922&source=lnms&tbm=isch&sa=X&ved=2ahUKEwjns8mB0pr7AhXNlIkEHZzzAdoQ_AUoAXoECAEQAw&biw=745&bih=607&dpr=1.2#imgrc=3QXnl-ERvR5nnM

2022 CDC Opioid Prescribing Guideline

Chronic pain typically lasts >3 months and can be the result of an underlying medical disease or condition, injury, medical treatment, inflammation, or unknown cause.

Approximately 1:5 U.S. adults had chronic pain in 2019.

Approximately 1:14 adults experienced "**high-impact**" chronic pain, defined as having **pain on most days or every day during the past 3 months that limited life or work activities.**



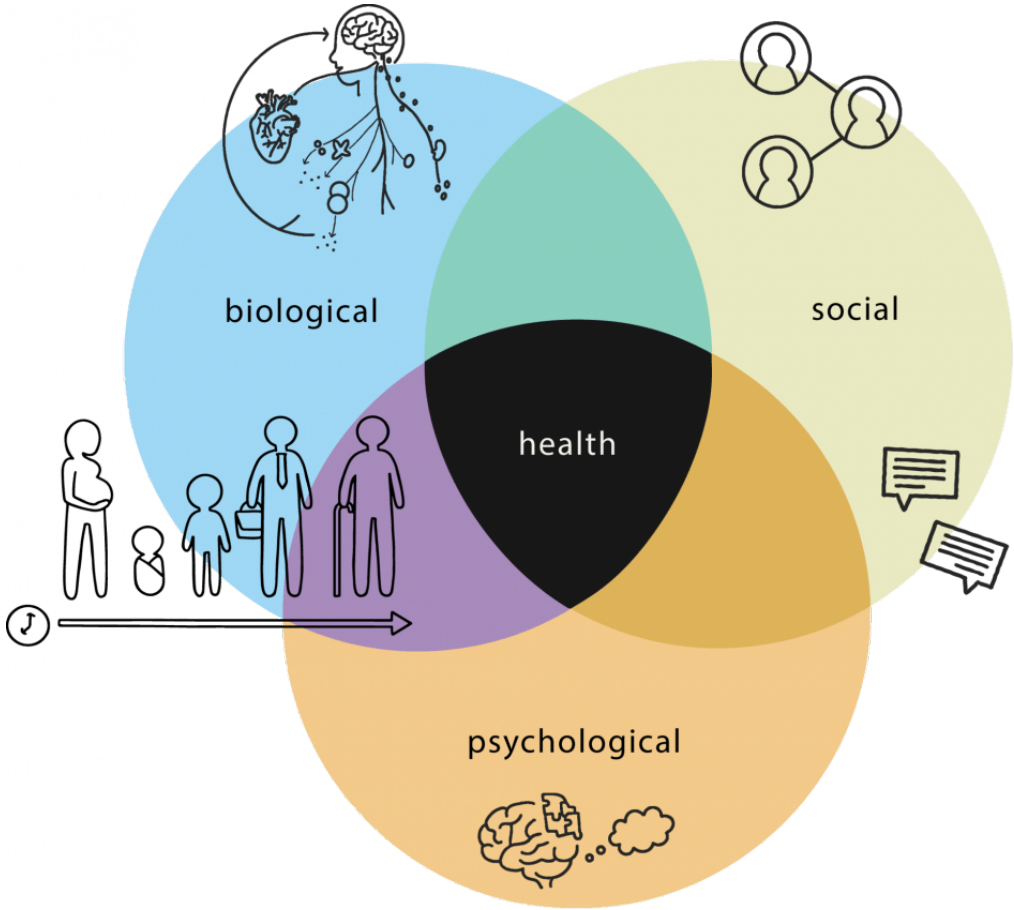
https://www.thesun.ie/news/7598951/personal-trainer-severe-scoliosis-ultra-running-marathons/

2022 CDC Opioid Prescribing Guideline

Pain is **a complex phenomenon influenced by multiple factors**, including biologic, psychological, and social factors.

This complexity means **substantial heterogeneity exists in the effectiveness of various pain treatments**, depending on the type of underlying pain or condition being treated.

Chronic pain often co-occurs with behavioral health conditions, including mental and substance use disorders. Patients with chronic pain also are at increased risk for suicidal ideation and behaviors.



(Rice Social Sciences, 2022) https://psychology.rice.edu/what-health-psychology

2022 CDC Opioid Prescribing Guideline

Data from death investigations in 18 states during 2003–2014 indicate that:

Approximately **9% of suicide decedents had evidence of chronic pain at the time of death;** ..this is likely an underestimate..

These factors and potentially harmful outcomes associated with chronic pain for some persons add to the clinical complexity and **underscore the importance of adequately treating and providing care to persons with pain.**

https://www.wvnstv.com/archives/update-names-released-in-mcdowell-county-murder-suicide/amp/

2022 CDC Opioid Prescribing Guideline

Pain might go unrecognized, and some persons :

- members of marginalized racial and ethnic groups;
- women;
- older persons;
- persons with cognitive impairment;
- persons with mental and substance use disorders,
- sickle cell disease,
- cancer-related pain; and
- persons at the end of life

can be at risk for **inadequate pain treatment**.

2022 CDC Opioid Prescribing Guideline

Although opportunity exists for improved pain management across the United States, data underscore opportunities for addressing specific, long-standing health disparities in the treatment of pain.

For example:

- Patients who identify as Black or African American (Black), Hispanic or Latino, and Asian receive fewer postpartum pain assessments relative to White patients.
- Black and Hispanic patients are less likely than White patients to receive analgesia for acute pain.
-
- Among opioid patients receiving opioids, Black patients are less likely to be referred to a pain specialist, and
- Black patients receive prescription opioids at lower dosages than White patients.

https://www.nia.nih.gov/health/providing-care-diverse-population

https://www.google.com/search?q=blck+patient&tbm=isch&ved=2ahUKEwitk7Sp2pr7AhXRmmoFHRbDAiwQ2cCegQIABAA&oq=blck+patient&gs_lcp=CgNpbWcQAzIGCAAQCBAeOgQIABBDOgcIABCABBAYOggIABCABBCxAzoFCAAQgAQ6CAgAELEDEIMBOgkIABCABBAKEBhQhQdYsBpg5RtoAXAAeACAAdkBiAHkD5IBBjAuMTIuMZgBAKABAaoBC2d3cy13aXotaW1nsAEAwAEB&sclient=img&ei=ykJoY62GOdG1qtsPloaL4AI&bih=810&biw=1542#imgrc=2ZDv5JVr2p54gM

2022 CDC Opioid Prescribing Guideline

Racial/ethnic differences remain after adjusting for factors.

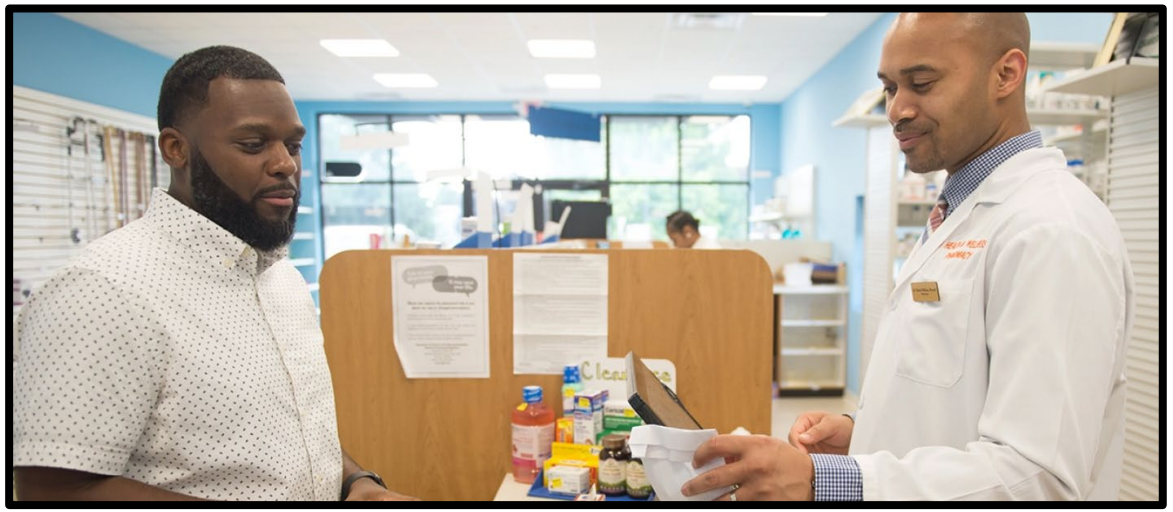
- They appear to be magnified for Black and Hispanic patients in **socioeconomically disadvantaged neighborhoods.**
- Women might be at higher risk for inadequate pain management, although they have higher opioid prescription fill rates than men at a population level.
- Geographic disparities contribute to increased use of opioids for conditions for which non-opioid treatment options might be preferred but are less available.

https://www.bing.com/images/search?view=detailV2&ccid=ksYIfecS&id=BE8B856E10F3490181F8EC9A1015BBDC27846938&thid=OIP.ksYIfecS9D1I2Ma5Tu-6MAHaFH&mediaurl=https%3a%2f%2frentpath-res.cloudinary.com%2fw_558%2ch_386%2ct_rp%2ccs_tinysrgb%2cfl_force_strip%2cc_fill%2ce_improve%2cf_auto%2fe_unsharp_mask%3a50%2cq_auto%2fbd70ef1e477775c4065a0ab899a1dc23&cdnurl=https%3a%2f%2fth.bing.com%2fth%2fid%2fR.92c6087de712f43d48d8c6b94eefba30%3frik%3dOGmEJ9y7FRCa7A%26pid%3dImgRaw%26r%3d0&exph=386&expw=558&q=homecrest+appartments+parkersburg+WV&simid=608031597135212794&FORM=IRPRST&ck=4A9812866FFA88FE32279041EF91B3FF&selectedIndex=5&ajaxhist=0&ajaxserp=0

2022 CDC Opioid Prescribing Guideline

For example,

- Adults living in rural areas are more likely to be prescribed opioids for chronic nonmalignant pain than adults living in non-rural areas.
- Although some ethnic/racial populations have experienced much higher rates of prescription opioid–related overdose deaths than others.
- **Application of safeguards in opioid prescribing are disproportionately applied to Black patients.**



https://khn.org/news/black-pharmacists-culturally-competent-health-care-diversity/

2022 CDC Opioid Prescribing Guideline

In 2020, prescription **opioids remained the most commonly misused prescription drug in the United States.**

Also in 2020, among those reporting misuse during the past year, **64.6% reported the main reason for their most recent misuse was to "relieve physical pain"** compared with 11.3% to "feel good or get high" and 2.3% "because I am hooked or have to have it."

Taken together, these factors underscore the need for an updated clinical practice guideline on appropriate opioid prescribing for pain and pain management.

the CDC's Deborah Dowell, MD, MPH

https://ldi.upenn.edu/wp-content/uploads/2021/08/cherish17-15-x1200.jpg

2022 CDC Opioid Prescribing Guideline

The guideline **is intended for clinicians who are treating outpatients aged ≥18 years with**:

- acute (duration of <1 month),
- subacute (duration of 1–3 months),
- or chronic (duration of >3 months) pain,

and excludes pain management related to

- sickle cell disease,
- cancer-related pain treatment,
- palliative care, and
- end-of-life care.

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2022 CDC Opioid Prescribing Guideline

The recommendations are most relevant to clinicians whose scope of practice includes prescribing opioids :

- physicians,
- nurse practitioners and other advanced-practice registered nurses,
- physician assistants, and
- oral health practitioners.

Because clinicians might work within team-based care, the guideline also refers to and promotes integrated pain management and collaborative working relationships among clinicians (e.g., behavioral health specialists such as social workers or psychologists, pharmacists, and registered nurses).

2022 CDC Opioid Prescribing Guideline

This guideline update includes recommendations for:

- **primary care clinicians** - internists and family physicians,

and other clinicians managing pain in **outpatient settings**:

- surgeons,
- emergency medicine clinicians,
- occupational medicine clinicians,
- physical medicine and rehabilitation clinicians, and
- neurologists.

Applicable **settings include clinician offices, clinics, and urgent care centers**.

https://www.hcchospital.org/medical_clinics/hcch_medical_clinic.aspx

2022 CDC Opioid Prescribing Guideline

The recommendations **do not apply** to care provided to patients who are:

- Hospitalized,
- In an emergency department,
- Other observational setting from which they might be admitted to inpatient care.

These recommendations **do apply to prescribing for pain management** for patients when they are:

- discharged from hospitals,
- emergency departments,
- or other facilities.

https://www.theclio.com/entry/19224

2022 CDC Opioid Prescribing Guideline

This clinical practice guideline includes **12 recommendations** for clinicians..

The recommendations are not intended to be implemented as absolute limits of policy or practice across populations by organizations, health care systems, or government entities.

In accordance with the ACIP adapted GRADE method, CDC based the recommendations on consideration of clinical evidence, contextual evidence (e.g., benefits and harms, values and preferences, and resource allocation), and expert opinion. Expert input is reflected within the recommendation rationales.

For each recommendation statement, CDC notes the recommendation category (A or B) and the type of evidence (1, 2, 3, or 4) supporting the statement .

https://www.etsy.com/listing/1308270315/12-rules-for-life-motivational-poster?gpla=1&gao=1&&utm_source=google&utm_medium=cpc&utm_campaign=shopping_us_c-home_and_living-home_decor-wall_decor other&utm_custom1=_k_CjwKCAjwtp2bBhAGEiwAOZZTuPQ0H3r0FwJwlohyQD1OiBBZ8FDN4LbpIY_LvKkSW8jiGk_E1laQVRoCnWIQAvD_BwE_k_&utm_content=go_1843970815_73688737670_346429619168_pla-307501513391_c__1308270315_12768591&utm_custom2=1843970815&gclid=CjwKCAjwtp2bBhAGEiwAOZZTuPQ0H3r0FwJwlohyQD1OiBBZ8FDN4LbpIY_LvKkSW8jiGk_E1laQVRoCnWIQAvD_BwE

2022 CDC Opioid Prescribing Guideline

The recommendations are grouped into four areas:

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

https://www.darksky.org/in-search-of-the-stars/

2022 CDC Opioid Prescribing Guideline

Guiding principles for implementation of the CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022 recommendations

1. **Pain needs to be assessed and treated** independent of whether opioids are part of a treatment regimen.

2. **Recommendations are voluntary** and are intended to support, not supplant, individualized, person-centered care. Flexibility is paramount.

3. A multimodal approach to 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.

4. Special attention should be given to **avoid misapplying this clinical practice guideline**.

5. Clinicians, practices, health systems, and payers should vigilantly **attend to health inequities**;

Determining Whether to Initiate Opioids

Recommendation 1

Non-opioid therapies are at least as effective as opioids for many common types of acute pain. Clinicians should **maximize use of non-pharmacologic and non-opioid pharmacologic therapies** as appropriate for the specific condition and patient and only consider opioid therapy for acute pain if benefits are anticipated to outweigh risks to the patient. Before prescribing opioid therapy for acute pain, **clinicians should discuss with patients the realistic benefits** and known risks of opioid therapy

(recommendation category: B; evidence type: 3).

Determining Whether to Initiate Opioids

Recommendation 1
Maximize non-opioid therapies for the specific condition and consider opioid therapy for acute pain if benefits outweigh risks.

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

- **Maximize use of non-opioid pharmacologic** (e.g., topical or oral NSAIDs, acetaminophen) and **non-pharmacologic** (e.g., ice, heat, elevation, rest, immobilization, or exercise) therapies as appropriate for the specific condition.

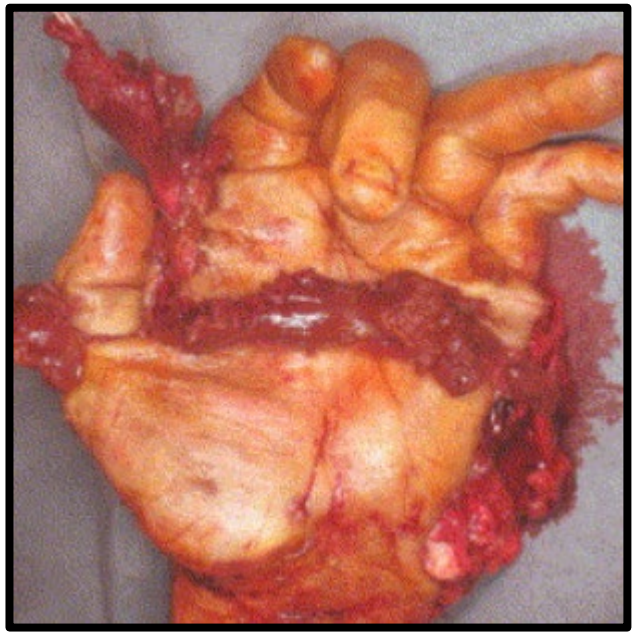
https://www.vivehealth.com/blogs/resources/best-ice-pack-for-knee

Determining Whether to Initiate Opioids

Recommendation 1
Maximize non-opioid therapies for the specific condition and consider opioid therapy for acute pain if benefits outweigh risks.

- **Opioid therapy has an important role for acute pain** related to severe traumatic injuries (including crush injuries and burns), invasive surgeries typically associated with moderate to severe postoperative pain, and other severe acute pain when NSAIDs and other therapies are contraindicated or likely to be ineffective.

- When diagnosis and severity of **acute pain warrant the use of opioids, clinicians should prescribe immediate-release opioids** (see Recommendation 3) at the lowest effective dose (see Recommendation 4) and for no longer than the expected duration of pain severe enough to require opioids (see Recommendation 6).



https://www.sciencedirect.com/science/article/abs/pii/S0266768106003652

Determining Whether to Initiate Opioids

Recommendation 1
Maximize non-opioid therapies for the specific condition and consider opioid therapy for acute pain if benefits outweigh risks.

- Prescribe and advise opioid use **only as needed** , i.e.:

  "hydrocodone 5 mg/acetaminophen 325 mg, one tablet every 4 hours PRN for moderate to severe pain "

- Rather than scheduled (e.g., one tablet every 4 hours) and

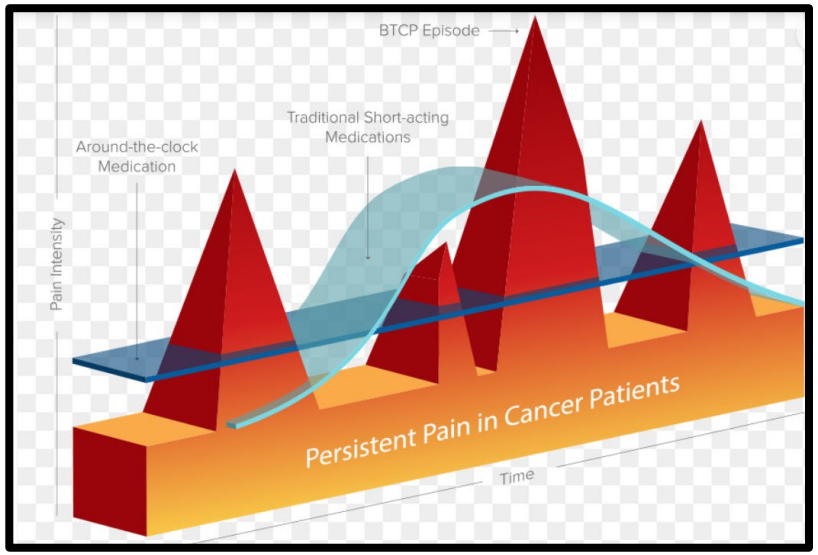
- Encourage and recommend an opioid taper if opioids are taken around the clock for more than a few days (see Recommendation 6).

Determining Whether to Initiate Opioids

Recommendation 1
Maximize non-opioid therapies for the specific condition and consider opioid therapy for acute pain if benefits outweigh risks.

- If patients already receiving opioids long term require **additional medication for acute pain**, non-opioid medications should be used when possible and, if additional opioids are required (e.g., for superimposed severe acute pain), they should be continued only for the duration of pain severe enough to require additional opioids, returning to the patient's baseline opioid dosage as soon as possible, **including a taper to baseline dosage if additional opioids were used** around the clock for more than a few days (see Recommendation 6).

- Ensure that patients are aware of expected benefits and common risks of opioids before starting or continuing opioid therapy and involve patients meaningfully in decisions.



https://www.pngdownload.id/png-09jyrn/

Determining Whether to Initiate Opioids

Recommendation 2

Non-opioid therapies are preferred for subacute and chronic pain. Maximize use of non-pharmacologic and non-opioid pharmacologic therapies as appropriate for the specific condition and patient and 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 therapy, work with patients to establish treatment goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks

(recommendation category: A; evidence type: 2).

Determining Whether to Initiate Opioids

Recommendation 2

Maximize use of non-opioid therapies for the subacute and chronic pain patient and start opioids only if benefits outweigh risks.

- To guide patient-specific selection of therapy, evaluate patients and establish or confirm the diagnosis.

- Recommend appropriate noninvasive non-pharmacologic approaches to manage chronic pain, such as exercise for back pain, fibromyalgia, and hip or knee osteoarthritis;
- weight loss for knee osteoarthritis;
- manual therapies for hip osteoarthritis;

https://www.completetherapies.com/services/aquatic-therapy/

Determining Whether to Initiate Opioids

Recommendation 2
Maximize use of non-opioid therapies for the subacute and chronic pain patient and start opioids only if benefits outweigh risks.

- psychological therapy, spinal manipulation, low-level laser therapy, massage, mindfulness-based stress reduction, yoga, acupuncture, and multidisciplinary rehabilitation **for low back pain**;
- mind-body practices (e.g., yoga, tai chi, or qigong), massage, and acupuncture for neck pain; cognitive behavioral therapy, myofascial release massage, mindfulness practices, tai chi, qigong, acupuncture, and multidisciplinary rehabilitation **for fibromyalgia**; and
- spinal manipulation for **tension headache**.

https://www.prochiromt.com https://blog.mindvalley.com/qigong-exercises/

Determining Whether to Initiate Opioids

Recommendation 2
Maximize use of non-opioid therapies for the subacute and chronic pain patient and start opioids only if benefits outweigh risks.

- Low-cost options to integrate exercise include **walking in public spaces**, or
- Use of **public recreation facilities for group exercise**.
- Physical therapy can be helpful for patients who have limited access to safe public spaces
- Health insurers and health systems can improve pain management and reduce medication use by **increasing reimbursement of non-pharmacologic therapies**.
- **Review FDA-approved labeling**, including boxed warnings, and weigh benefits and risks before initiating treatment with any pharmacologic therapy.

Determining Whether to Initiate Opioids

Recommendation 2
Maximize use of non-opioid therapies for the subacute and chronic pain patient and start opioids only if benefits outweigh risks.

When patients affected by osteoarthritis have an insufficient response to non-pharmacologic interventions:

- Use **topical NSAIDs** for pain in joints near the surface of the skin (e.g., knee).
- For pain in multiple joints or poorly controlled with topical NSAIDs, **duloxetine or systemic NSAIDs** can be considered.
- **NSAIDs should be used at the lowest dose and shortest duration needed**, Use with caution in older adults and those with CV comorbidities, CKD, or previous GI bleed.

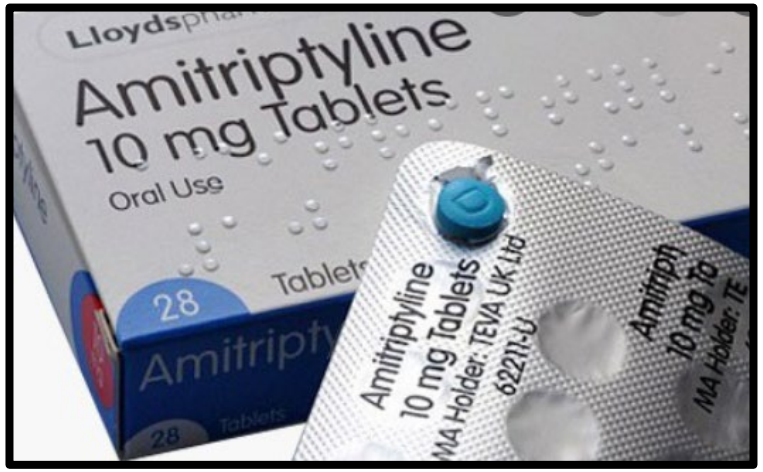
https://epmonthly.com/article/topical-nsaids/

Determining Whether to Initiate Opioids

Recommendation 2
Maximize use of non-opioid therapies for the subacute and chronic pain patient and start opioids only if benefits outweigh risks.

•Tricyclic, tetracyclic, and SNRI antidepressants; selected anticonvulsants (e.g., pregabalin, gabapentin enacarbil, oxcarbazepine); and capsaicin and lidocaine patches can be considered for **neuropathic pain**. In older adults, tricyclic antidepressants should be used on a case-by-case basis because of risks for confusion and falls.

•Duloxetine and pregabalin are FDA-approved for the treatment of diabetic peripheral neuropathy, and pregabalin and gabapentin are FDA-approved for treatment of **post-herpetic neuralgia.**



Amitriptyline | Elavil Prescribing Information - MedWorks Media

Determining Whether to Initiate Opioids

Recommendation 2
Maximize use of non-opioid therapies for the subacute and chronic pain patient and start opioids only if benefits outweigh risks.

In patients with **fibromyalgia,**
- tricyclic (e.g., amitriptyline) and
- SNRI antidepressants (e.g., duloxetine, milnacipran),
- NSAIDs (e.g., topical diclofenac), and
- specific anticonvulsants (i.e., pregabalin and gabapentin) are used to improve pain, function, and quality of life.

Patients with **co-occurring pain and depression** might be especially likely to benefit from antidepressant medication (see Recommendation 8).

Determining Whether to Initiate Opioids

Recommendation 2
Maximize use of non-opioid therapies for the subacute and chronic pain patient and start opioids only if benefits outweigh risks.

Opioids should not be considered first-line or routine therapy for subacute or chronic pain.

•However, patients are not required to sequentially fail non-pharmacologic and non-opioid pharmacologic therapy or be required to use any specific treatment before proceeding to opioid therapy.

•Rather, benefits specific to the clinical context should be weighed against risks before initiating therapy. In some clinical contexts opioids might be appropriate regardless of previous therapies used.

•In other situations (e.g., headache or fibromyalgia), expected benefits of initiating opioids are unlikely to outweigh risks.

http://www.kmzu.com/sodomy-case-proceeds-pettis-county/istock_generic-scales-of-justice/

Determining Whether to Initiate Opioids

Measure risk using one of several partially validated measures:

The **Screener and Opioid Assessment for Patients with Pain** (SOAPP),

The **Diagnosis, Intractability, Risk, and Efficacy inventory** (DIRE),

The **Opioid Risk Tool** (ORT).

One small study predicting discontinuance for aberrant drug-related behavior found **the highest sensitivity for the clinical interview** (0.77) and the SOAPP (0.72), followed by the **ORT** (0.45) and the **DIRE** (0.17). Combining the clinical interview with the SOAPP increased sensitivity to 0.90.

Moore TM, Jones T, Browder JH, Daffron S, Passik SD. A comparison of common screening methods for predicting aberrant drug-related behavior among patients receiving opioids for chronic pain management. Pain Med. 2009 Nov;10(8):1426-33.

Determining Whether to Initiate Opioids

Recommendation 2
Maximize use of non-opioid therapies for the subacute and chronic pain patient and start opioids only if benefits outweigh risks.

- Opioid therapy should not be initiated without consideration of an **exit strategy** to be used if opioid therapy is unsuccessful.
- Before opioid therapy is initiated for subacute or chronic pain, determine jointly with patients **how functional benefit will be evaluated and establish specific, measurable treatment goals**.

https://www.huffingtonpost.co.uk/2013/09/17/nasa-road-signs-moon-iss_n_3939445.html

Determining Whether to Initiate Opioids

Baseline Functional Tool

PEG score = average 3 individual question scores

What number, from 0 – 10 best:

Q1: Describes your

Pain in the past week?

Q2: Describes how, during the past week, pain has interfered with your **Enjoyment** of life?

Q3: Describes how, during the past week, pain has interfered with your **General activity**?

Determining Whether to Initiate Opioids

Recommendation 2
Maximize use of non-opioid therapies for the subacute and chronic pain patient and start opioids only if benefits outweigh risks.

For patients with subacute pain who started opioid therapy for acute pain and have been treated with opioid therapy for ≥30 days

- Ensure that potentially reversible causes of pain are addressed.
- Ensure prescribing for acute pain does not **unintentionally become long-term opioid therapy** simply because of lack of reassessment.
- This should occur only **as an intentional decision** that benefits outweigh risks after informed discussion and as part of a comprehensive pain management approach.

Determining Whether to Initiate Opioids

Recommendation 2
Maximize use of non-opioid therapies for the subacute and chronic pain patient and start opioids only if benefits outweigh risks.

- Clinicians **seeing new patients already receiving opioids should establish treatment goals**, including functional goals, for continued opioid therapy. Avoid rapid tapering or abrupt discontinuation of opioids (see Recommendation 5).

- Patient education and **discussion before starting opioid therapy** are critical so that patient preferences and values can be understood and used to inform clinical decisions.

https://www.mgeonline.com/2018/3-ways-improve-new-patient-conversion/

Determining Whether to Initiate Opioids

Recommendation 2
Maximize use of non-opioid therapies for the subacute and chronic pain patient and start opioids only if benefits outweigh risks.

Review available low-cost options for pain management for all patients and particularly for patients who have low incomes, do not have health insurance, or have inadequate insurance.

Black Panther Party's Free Medical Clinics (1969-1975) • (blackpast.org)

Selecting and Determining Opioid Dosages

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

(recommendation category: A; evidence type: 4).

Selecting and Determining Opioid Dosages

Recommendation 3
When starting opioid therapy prescribe immediate-release opioids

- **Do not treat acute pain with ER/LA opioids** or initiate opioid treatment for subacute or chronic pain with ER/LA opioids,
- Do not prescribe ER/LA opioids for intermittent or as-needed use.
- **ER/LA opioids should be reserved for severe, continuous pain**.
- FDA has noted that some ER/LA opioids should be considered only for patients who have received certain dosages of opioids of immediate-release opioids daily for at least 1 week.

NEW!!

Selecting and Determining Opioid Dosages

Recommendation 3
When starting opioid therapy prescribe immediate-release opioids

- When changing to an ER/LA opioid for a patient previously receiving a different immediate-release opioid, consult product labeling and **reduce total daily dosage to account for incomplete opioid cross-tolerance**.

- Use additional caution with ER/LA opioids and **consider a longer dosing interval when prescribing to patients with renal or hepatic dysfunction because decreased clearance** of medications among these patients can lead to accumulation of drugs to toxic levels and persistence in the body for longer durations.

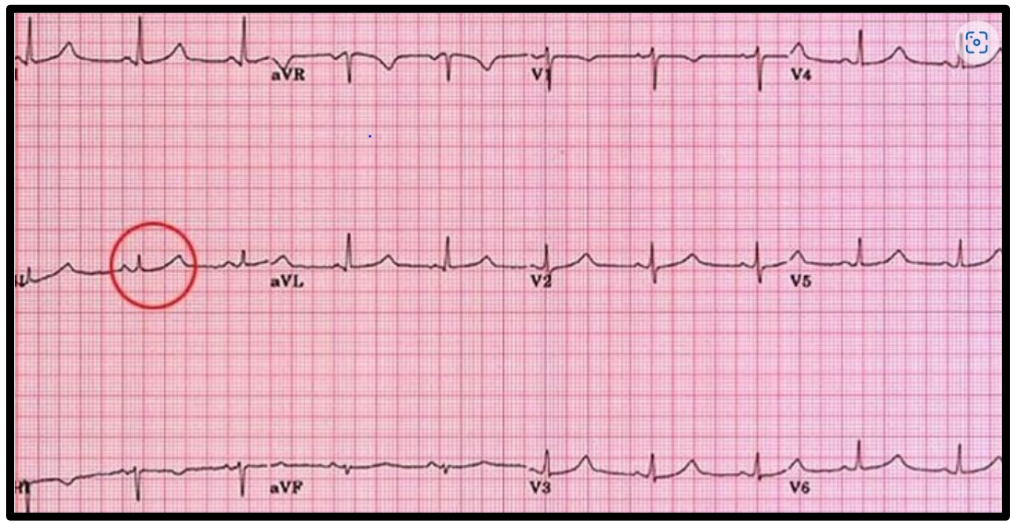
https://www.drugs.com/pro/kadian.html

Selecting and Determining Opioid Dosages

Recommendation 3
When starting opioid therapy prescribe immediate-release opioids

- Methadone should not be the first choice for an ER/LA opioid. Only clinicians who are familiar with methadone's unique risk profile and who are prepared to educate and closely monitor their patients, including assessing risk for QT prolongation and considering electrocardiographic monitoring, should consider prescribing methadone for pain.

- Only clinicians who are familiar with the **dosing and absorption properties of the ER/LA opioid transdermal fentanyl** and are prepared to educate their patients about its use should consider prescribing it.



https://elentra.healthsci.queensu.ca/assets/modules/ts-ecg/prolonged_qt_interval.html

Selecting and Determining Opioid Dosages

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

(recommendation category: A; evidence type: 3).

Selecting and Determining Opioid Dosages

Recommendation 4
When initiating opioids to naïve patients use the lowest effective dosage

- The recommendations related to opioid dosages are not intended to be used as an inflexible, rigid standard of care; rather, they are **intended to be guideposts to help inform clinician-patient decision-making**.
- **Risks of opioid use, including risk for overdose and overdose death, increase continuously with dosage**, and there is no single dosage threshold below which risks are eliminated.
- **Avoid increasing dosage above levels likely to yield diminishing returns in benefits** relative to risks to patients rather than emphasizing a single specific numeric threshold.
- Further, **these recommendations apply specifically to starting opioids or to increasing opioid dosages**, and a different set of benefits and risks applies to reducing opioid dosages (see Recommendation 5).

Selecting and Determining Opioid Dosages

Recommendation 4
When initiating opioids to naïve patients use the lowest effective dosage

•When opioids are initiated for opioid-naïve patients with acute, subacute, or chronic pain, **prescribe the lowest effective dosage.**

•For patients not already taking opioids, **the lowest effective dose can be determined using product labeling** as a starting point with calibration as needed based on the severity of pain and other clinical factors such as renal or hepatic insufficiency (see Recommendation 8).

•**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.** A listing of common opioid medications and their doses in MME equivalents is provided.

•If opioids are continued for subacute or chronic pain, use caution when prescribing at any dosage and **avoid dosage increases when possible.**

Selecting and Determining Opioid Dosages

Recommendation 4
When initiating opioids to naïve patients use the lowest effective dosage

- Many patients do not experience benefit in pain or function from increasing opioid dosages to ≥50 MME/day but are exposed to increases in risk as dosage increases.

- Therefore, **before increasing total opioid dosage to ≥50 MME/day, pause** and carefully reassess evidence of individual benefits and risks.

- If a decision is made to increase dosage, **increase dosage by the smallest practical amount**.

- The recommendations related to dosages are not intended to be used as an inflexible standard of care; rather, they are intended to help inform clinician-patient decision-making.

https://www.lollydaskal.com/leadership/pausebutton-before-it-hits-you/

Selecting and Determining Opioid Dosages

Recommendation 5

For patients already receiving opioid therapy, clinicians should carefully weigh benefits and risks and exercise care when changing opioid dosage. If benefits outweigh risks of continued opioid therapy, clinicians should work closely with patients to optimize non-opioid 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 or, if warranted based on the individual circumstances of the patient, 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).

Selecting and Determining Opioid Dosages

Recommendation 5
Carefully weigh benefits and risks and exercise care when changing opioid dosage..
work to optimize non-opioid therapies, do not rapidly reduce opioid dosages from higher dosages

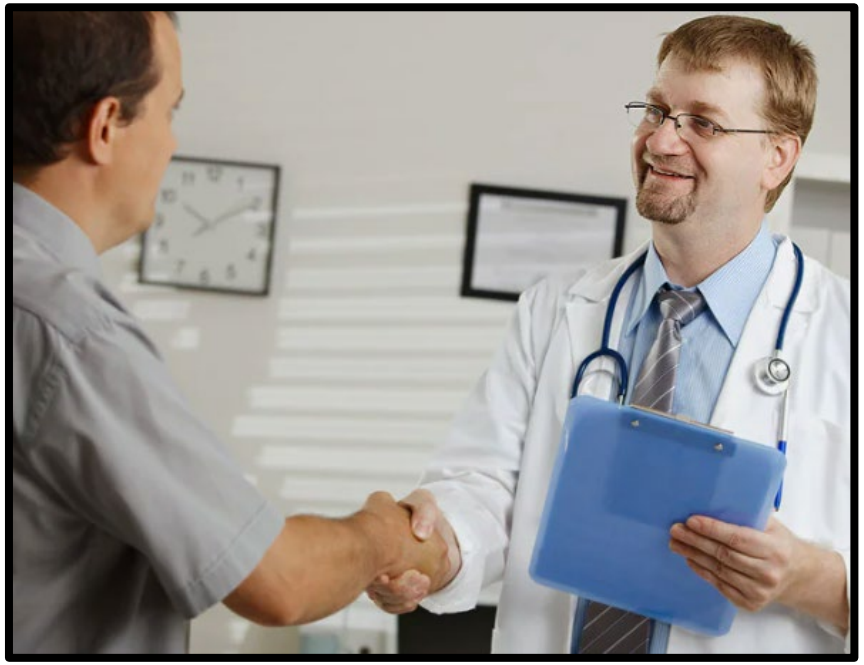
- Weigh the benefits and risks of continuing opioids and the benefits and risks of tapering opioids.
- If benefits outweigh risks work closely with patients to optimize non-opioid therapies while continuing opioid therapy.
- When benefits (including avoiding risks of tapering) do not outweigh risks of continued opioid therapy, **optimize other therapies and work with patients to gradually taper to a reduced dosage** or, if warranted based on the individual clinical circumstances of the patient, appropriately taper and discontinue opioid therapy.

https://www.pinterest.com/pin/197665871136650120/

Selecting and Determining Opioid Dosages

Recommendation 5
Carefully weigh benefits and risks and exercise care when changing opioid dosage..
work to optimize non-opioid therapies, do not rapidly reduce opioid dosages from higher dosages

- When benefits and risks are considered to be close or unclear, shared decision-making with patients is important.
- At times, clinicians and patients might disagree on whether tapering is necessary. When unable to arrive at a consensus on the assessment of benefits and risks, clinicians should acknowledge this discordance, express empathy, and seek to implement treatment changes in a patient-centered manner while avoiding patient abandonment.
- Patient agreement and interest is likely to be a key component of successful tapers.



https://www.medscape.com/viewarticle/825288

Selecting and Determining Opioid Dosages

Recommendation 5
Carefully weigh benefits and risks and exercise care when changing opioid dosage..
work to optimize non-opioid therapies, do not rapidly reduce opioid dosages from higher dosages

- **Establish goals** with patients agreeing to taper to lower dosages and for those remaining on higher dosages (see Recommendations 2 and 7).
- Maximize pain treatment with non-pharmacologic and non-opioid pharmacologic treatments as appropriate (see Recommendation 2).
- Collaborate with the patient on the tapering plan, **including patients in decisions such as how quickly tapering will occur and when pauses in the taper might be warranted**.

https://bshockey.com/hockey-goal-size/

Selecting and Determining Opioid Dosages

Recommendation 5
Carefully weigh benefits and risks and exercise care when changing opioid dosage..
work to optimize non-opioid therapies, do not rapidly reduce opioid dosages from higher dosages

Follow up at least monthly with patients engaging in tapering.

Team members (e.g., nurses, pharmacists, and behavioral health professionals) can support the clinician and patient during the ongoing taper process through telephone contact, telehealth visits, or face-to-face visits.

A taper slow enough to minimize symptoms and signs of opioid withdrawal should be used.

https://blog.drupa.com/de/print-calendar/

Selecting and Determining Opioid Dosages

Recommendation 5
Carefully weigh benefits and risks and exercise care when changing opioid dosage..
work to optimize non-opioid therapies, do not rapidly reduce opioid dosages from higher dosages

- Longer duration of therapy might require a longer taper.
- For patients who have taken opioids for ≥1 year, tapers can over months to years depending on the opioid dosage and should be individualized based on patient goals and concerns.
- When patients have been taking opioids for ≥1 year, **tapers of 10% per month or slower are likely to be better tolerated** than more rapid tapers.
- For patients struggling to tolerate a taper, clinicians should maximize non-opioid treatments for pain and should address behavioral distress.

https://www.pinterest.com/pin/459789443188967598/

Selecting and Determining Opioid Dosages

Recommendation 5
Carefully weigh benefits and risks and exercise care when changing opioid dosage..
work to optimize non-opioid therapies, do not rapidly reduce opioid dosages from higher dosages

- Clinically significant opioid withdrawal symptoms can signal the need to **further slow the taper rate**.
- 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.
- Before reversing a taper, clinicians should carefully assess and discuss with the patient the benefits and risks of increasing opioid dosage.

https://cartreatments.com/car-wont-go-in-reverse/

Selecting and Determining Opioid Dosages

Recommendation 5
Carefully weigh benefits and risks and exercise care when changing opioid dosage..
work to optimize non-opioid therapies, do not rapidly reduce opioid dosages from higher dosages

- Goals of the taper might vary (e.g., discontinuation or reduced dosage at which functional benefits outweigh risks).
- If the ultimate goal of tapering is discontinuing opioids, after the smallest available dose is reached the interval between doses can be extended and opioids can be **stopped when taken less frequently than once a day.**
- Access appropriate expertise if considering tapering opioids during pregnancy because of possible risks to the pregnant patient and the fetus if the patient goes into withdrawal.

https://timesofindia.indiatimes.com/life-style/parenting/pregnancy/common-mistakes-most-women-make-during-pregnancy/photostory/91918385.cms

Selecting and Determining Opioid Dosages

Recommendation 5
Carefully weigh benefits and risks and exercise care when changing opioid dosage..
work to optimize non-opioid therapies, do not rapidly reduce opioid dosages from higher dosages

- Advise patients of an increased risk for overdose on abrupt return to a previously prescribed higher dose because of loss of tolerance, provide overdose education, and offer naloxone.
- Remain alert and screen for anxiety, depression, and opioid misuse or OUD (see Recommendations 8 and 12) that might be revealed by a taper and provide treatment or arrange for management of these comorbidities.
- Monitor patients who are unable to taper and who continue on high-dose or otherwise high-risk opioid regimens (e.g., opioids prescribed concurrently with benzodiazepines) and work with patients to mitigate overdose risk (e.g., by **providing overdose education and naloxone**) (see Recommendation 8).
- Use periodic and strategic **motivational questions and statements** to encourage movement toward appropriate therapeutic changes and functional goals.

Selecting and Determining Opioid Dosages

Recommendation 5
Carefully weigh benefits and risks and exercise care when changing opioid dosage..
work to optimize non-opioid therapies, do not rapidly reduce opioid dosages from higher dosages

- Clinicians have a responsibility to provide or **arrange for coordinated management** of patients' pain and opioid-related problems, including opioid use disorder.

- Payers, health systems, and state medical boards **should not use this clinical practice guideline to set rigid standards or performance incentives related to dose or duration of opioid therapy**; should ensure that policies based on cautionary dosage thresholds do not result in rapid tapers or abrupt discontinuation of opioids; and should ensure that policies do not penalize clinicians for accepting new patients who are using prescribed opioids for chronic pain, including those receiving high dosages of opioids, or for refraining from rapidly tapering patients prescribed long-term opioid medications.

Selecting and Determining Opioid Dosages

Recommendation 5
Carefully weigh benefits and risks and exercise care when changing opioid dosage..
work to optimize non-opioid therapies, do not rapidly reduce opioid dosages from higher dosages

Although Recommendation 5 specifically refers to patients using long-term opioid therapy for subacute or chronic pain, many of the principles also are relevant when discontinuing opioids in patients who have received them for shorter durations (see Recommendations 6 and 7).

https://www.writingthoughts.com/of-note-punctuality-rules/

Selecting and Determining Opioid Dosages

Recommendation 5
Carefully weigh benefits and risks and exercise care when changing opioid dosage..
work to optimize non-opioid therapies, do not rapidly reduce opioid dosages from higher dosages

Management of Opioid Withdrawal During Tapering

- The first approach to withdrawal should generally be consideration of slowing or pausing the taper.

- If needed, short-term oral medications **might help** manage withdrawal symptoms.

https://www.dmlawfirm.com/zofran-birth-defect-risks/

Selecting and Determining Opioid Dosages

Recommendation 5
Carefully weigh benefits and risks and exercise care when changing opioid dosage..
work to optimize non-opioid therapies, do not rapidly reduce opioid dosages from higher dosages

medications addressing specific symptoms:

Sweating and tachycardia: clonidine and lofexidine, tizanidine

Muscle Aches: NSAIDs, acetaminophen, or topical menthol or methyl salicylate

Sleep Disturbance: trazodone

Nausea: prochlorperazine, promethazine, or ondansetron

Abdominal cramping: dicyclomine

Diarrhea: loperamide or bismuth subsalicylate

https://www.amazon.com/Pepto-Bismol-Including-Diarrhea-Original-Chewable/dp/B004AZZDW6

Selecting and Determining Opioid Dosages

Recommendation 5
Carefully weigh benefits and risks and exercise care when changing opioid dosage..
work to optimize non-opioid therapies, do not rapidly reduce opioid dosages from higher dosages

Evidence suggests that patients for whom risks outweigh benefits but who are unable to taper and who do not meet criteria for OUD might benefit from **transition to buprenorphine**.

Buprenorphine is a partial agonist opioid that can treat pain and OUD and has less respiratory depression and overdose risk than other opioids.

However, overdose is still possible, particularly if taken concurrently with other respiratory depressants (e.g., full agonist opioids, benzodiazepines, or alcohol).

https://morningsidepharm.com/product/generic-medicines/buprenorphine-tablets/

Break

Deciding Duration of Initial Rx and Follow-Up

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

(recommendation category: A; evidence type: 4).

Deciding Duration of Initial Rx and Follow-Up

Recommendation 6
Clinicians should prescribe no greater quantity than needed

- Non-traumatic, nonsurgical **acute pain can often be managed without opioids** (see Recommendation 1).
- When the severity of acute pain warrant use of opioids, prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids.
- For many causes a few days are often sufficient. Shorter courses can minimize the need to taper opioids.
- Individualize durations to the patient's circumstances.
- Avoid prescribing additional opioids just in case pain continues longer than expected.

"Lowest dose, shortest time."

Deciding Duration of Initial Rx and Follow-Up

Recommendation 6
Clinicians should prescribe no greater quantity than needed

- **For postoperative pain related to major surgery**, procedure-specific opioid prescribing recommendations are available with ranges for amounts of opioids needed (on the basis of actual use and refills and on consensus).

- To minimize unintended effects on patients **health systems should have mechanisms in place for the subset of patients who experience severe acute pain that continues longer than the expected duration.** These mechanisms should allow for timely reevaluation to confirm or revise the initial diagnosis and adjust pain management accordingly. Health systems can help minimize disparities in access to and affordability of care and refills by ensuring all patients can obtain and afford additional evaluation and treatment, as needed.

https://www.rmch.org/getpage.php?name=Rapid_Care

Deciding Duration of Initial Rx and Follow-Up

Recommendation 6
Clinicians should prescribe no greater quantity than needed

- Longer durations of opioid therapy are more likely when the injury is expected to result in prolonged severe pain (e.g., severe traumatic injuries).
- **Evaluate patients at least every 2 weeks** if they continue to receive opioids for acute pain.
- If continued for ≥1 month, ensure that reversible causes of chronic pain are addressed and that prescribing for acute pain does not unintentionally become long-term therapy simply because medications are continued without reassessment.
- Continuation of therapy should occur only as an intentional decision that benefits are likely to outweigh risks and as part of a comprehensive management approach.

(WV allows only for 7 days on first dose..)

Deciding Duration of Initial Rx and Follow-Up

Recommendation 6
Clinicians should prescribe no greater quantity than needed

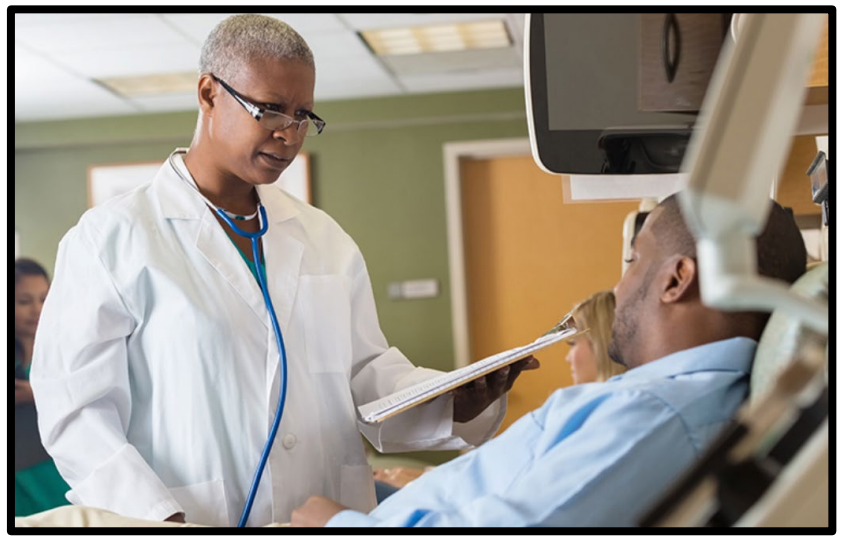
- If patients already receiving long-term opioid therapy require additional opioids for superimposed severe acute pain (e.g., major surgery), opioids should be continued only for the duration of pain severe enough to require additional opioids, returning to the patient's baseline opioid dosage as soon as possible, including a taper to baseline dosage if additional opioids were used around the clock for more than a few days.

- If used continuously (around the clock) for more than a few days for acute pain, prescribe a brief taper to minimize withdrawal symptoms on discontinuation of opioids.

https://www.ibji.com/services/orthopedic-surgery/

Deciding Duration of Initial Rx and Follow-Up

Recommendation 6
Clinicians should prescribe no greater quantity than needed



- If a taper is needed, durations might need to be adjusted depending on the duration of the initial opioid prescription
- Tapering plans should be discussed with the patient before hospital discharge and with clinicians coordinating the patient's care as an outpatient. (See Recommendation 5 for tapering considerations when patients have taken opioids continuously for >1 month.)

https://www.teamhealth.com/blog/patient-experience-week-2019/?r=1

Deciding Duration of Initial Rx and Follow-Up

Recommendation 7

Evaluate benefits and risks with patients within 1–4 weeks of starting opioid therapy for subacute or chronic pain or of dosage escalation. Regularly re-evaluate benefits and risks of continued opioid therapy with patients

(recommendation category: A; evidence type: 4).

Deciding Duration of Initial Rx and Follow-Up

Recommendation 7
Evaluate patients within 1–4 weeks of starting opioid therapy

- In addition to evaluating benefits and risks before starting opioid therapy (see Recommendation 2), **evaluate patients to assess benefits and risks within 1–4 weeks of starting long-term opioid therapy or of dosage escalation**.

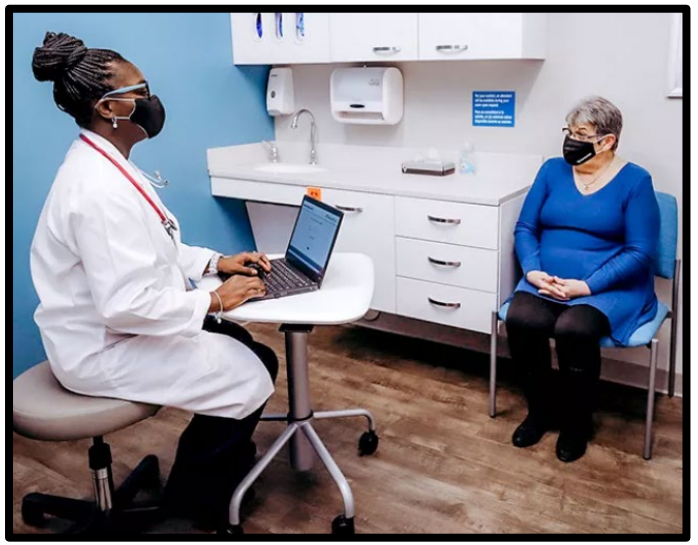
- Consider follow-up intervals within the lower end of this range when ER/LA opioids are started or increased, because of the increased risk for overdose within the first 2 weeks of treatment, or when total daily dosage is ≥50 MME/day. (Overdose risk is doubled for dosages of 50 to <100 MME/day relative to <20 MME/day.) (See Recommendation 4.)

1 week FU!

Deciding Duration of Initial Rx and Follow-Up

Recommendation 7
Evaluate patients within 1–4 weeks of starting opioid therapy

- Shorter follow-up intervals (every 2–3 days for the first week) should be considered when starting or increasing the dosage of methadone, because of the variable half-life of this drug (see Recommendation 3)
- An initial follow-up interval closer to 4 weeks can be considered when starting immediate-release opioids at a dosage of <50 MME/day.
- Follow up and evaluate patients with subacute pain who started opioid therapy for 30 days to reassess the patient's pain, function, and treatment course.



https://www.centerwellprimarycare.com/

Deciding Duration of Initial Rx and Follow-Up

Recommendation 7
Evaluate patients within 1–4 weeks of starting opioid therapy

- Regularly reassess all patients receiving long-term therapy with a suggested interval of every 3 months or more frequently for most patients.
- Clinicians seeing new patients already receiving opioids should establish treatment goals, including functional goals, for continued opioid therapy (see Recommendation 2).
- Reevaluate patients who are at higher risk for opioid use disorder or overdose more frequently than every 3 months. Regularly screen all patients for these conditions, which can change during the course of treatment (see Recommendation 8).

https://bendycomputers.com/product/3-months-of-support-for-a-business

Deciding Duration of Initial Rx and Follow-Up

Recommendation 7
Evaluate patients within 1–4 weeks of starting opioid therapy

- Health systems can help minimize unintended effects on patients by ensuring all patients can access and afford follow-up evaluation.
- Where virtual visits are part of standard care, or for patients for whom in-person follow-up visits are challenging (e.g., frail patients), follow-up through telehealth modalities might be conducted.
- At follow-up, review patient perspectives and goals, determine whether opioids continue to meet treatment goals, determine whether the patient has experienced common or serious adverse events or has signs of opioid use disorder.
- Ensure that treatment for depression, anxiety, or other psychological comorbidities is optimized.

https://www.cdc.gov/chronicdisease/resources/publications/factsheets/telehealth-in-rural-communities.htm

Deciding Duration of Initial Rx and Follow-Up

Recommendation 7
Evaluate patients within 1–4 weeks of starting opioid therapy

- **Ask patients about their preferences for continuing opioids,** considering their effects on pain and function relative to any adverse effects experienced. If risks outweigh benefits of continued opioid therapy (e.g.,

  if no improvements in pain and function;
  if taking ≥50 MME/day or opioids combined with benzodiazepines without evidence of benefit;
  if patients believe benefits no longer outweigh risks; or
  if patient request dosage reduction or discontinuation; or
  if patients experience overdose or other serious adverse events),

Then **work with patients to taper and discontinue opioids when possible** (see from Recommendation 5).

- Clinicians should maximize pain treatment with non-pharmacologic and non-opioid pharmacologic

Assessing Risk and Potential Harms

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 work with patients to incorporate into the management plan strategies to mitigate risk, including offering naloxone

(recommendation category: A; evidence type: 4).

Assessing Risk and Potential Harms

Recommendation 8
When prescribing opioids, evaluate and discuss risk with patients

- Ask patients about their drug and alcohol use and **use validated tools** or consult with behavioral specialists to screen for and assess mental health and substance use disorders.
- Ensure that treatment for mental health conditions are optimized.
- **Offer naloxone when prescribing opioids**

https://willcountyhealth.org/extended-shelf-life-approved-for-narcan-nasal-spray/

Assessing Risk and Potential Harms

Recommendation 8
When prescribing opioids, evaluate and discuss risk with patients

Educate patients on overdose prevention and naloxone use and offer to provide education to members of their households.

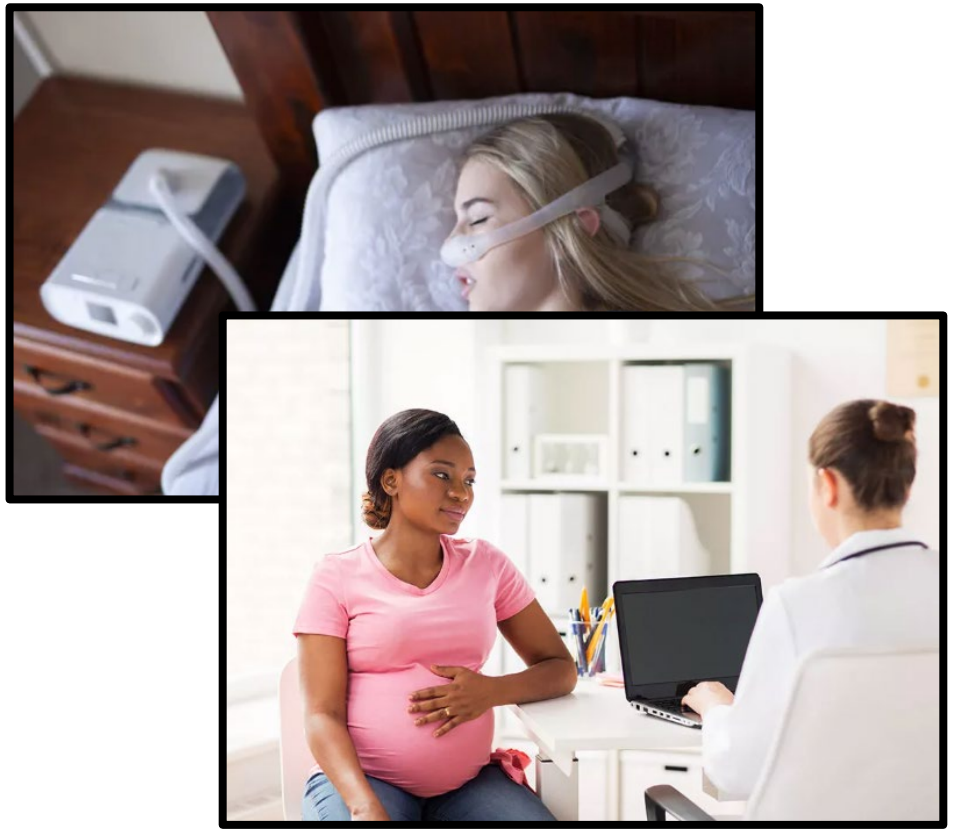
•Naloxone co-prescribing can be facilitated by clinics or practices with resources to provide naloxone training, by collaborative practice models with pharmacists, or through statewide protocols or standing orders for naloxone at pharmacies.

https://www.pharmacy.umn.edu/degrees-and-programs/continuing-pharmacy-education/continuing-education-courses/naloxone

Assessing Risk and Potential Harms

Recommendation 8
When prescribing opioids, evaluate and discuss risk with patients

- Avoid prescribing to patients with moderate or severe sleep-disordered breathing when possible to minimize risk for respiratory depression.
- For pain during pregnancy, carefully weigh benefits and risks. For pregnant persons already receiving opioids, access appropriate expertise if tapering is being considered because of possible risks if the patient goes into withdrawal (see Recommendation 5).
- For pregnant persons with opioid use disorder, **buprenorphine or methadone** is the recommended therapy and should be offered as early as possible in pregnancy to prevent harms to both the patient and the fetus (see Recommendation 12).



https://cpapsupplies.com/blog/cpap-masks-quieter-others

https://www.eleanorhealth.com/blog/suboxone-while-pregnant

Assessing Risk and Potential Harms

Recommendation 8
When prescribing opioids, evaluate and discuss risk with patients

- Use caution and increased monitoring (see Recommendation 7) to minimize risks of opioids prescribed for patients with renal or hepatic insufficiency and for patients aged ≥65 years.
- Clinicians should implement interventions to mitigate common risks of opioid therapy among older adults, such as exercise or bowel regimens to prevent constipation, risk assessment for falls, and patient monitoring for cognitive impairment.
- For patients with jobs that involve potentially hazardous tasks and who are receiving opioids that can negatively affect sleep, cognition, balance, or coordination, assess patients' abilities to safely perform the hazardous tasks

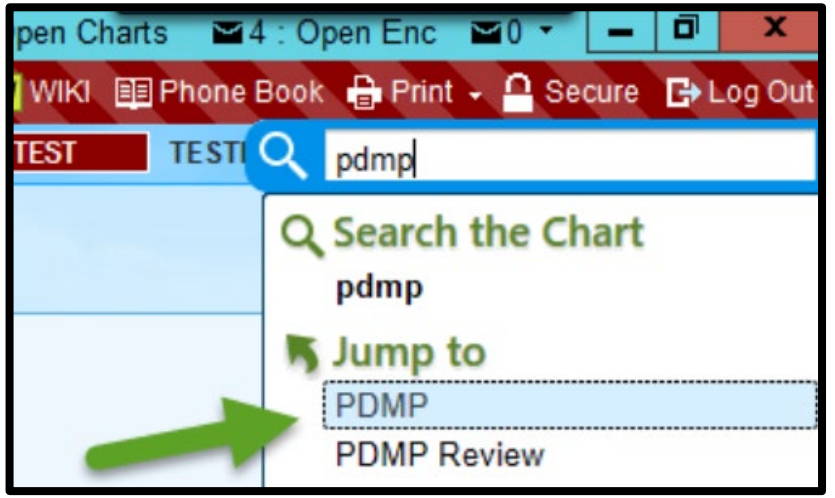
https://talkbusiness.net/2021/10/truck-driver-shortage-increases-to-80000-nearly-1-million-new-drivers-needed-over-next-decade/

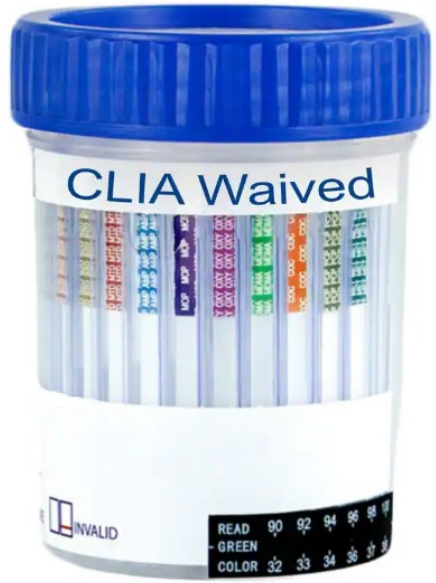
https://www.practicalpainmanagement.com/treatments/pharmacological/opioids/dialysis-opioids-pain-management-where-evidence

Assessing Risk and Potential Harms

Recommendation 8
When prescribing opioids, evaluate and discuss risk with patients

Use PDMP data (see Recommendation 9) and toxicology screening (see Recommendation 10) as appropriate to assess for concurrent substance use that might place patients at higher risk for opioid use disorder and overdose.





https://www.fishersci.com/shop/products/safecup-iii-urine-test-cup-6/p-7139276

https://clientaccess.suttercommunityconnect.org/files/2020/11/CURES-PDMP-Review-Activity-Providers-APC-Prescribers-FINAL-11_10.pdf

Assessing Risk and Potential Harms

Recommendation 8
When prescribing opioids, evaluate and discuss risk with patients

Provide specific counseling on increased risks for overdose when opioids are combined with other drugs. Ensure patients receive effective treatment for SUD when needed.

Although SUD can alter the expected benefits and risks of opioid therapy, **patients with co-occurring pain and SUD require ongoing pain management that maximizes benefits relative to risks**.

If considering opioid therapy for chronic pain for patients with SUD, discuss increased risks for OUD and overdose with patients and incorporate strategies to mitigate risk (e.g., offering naloxone and increasing frequency of monitoring).

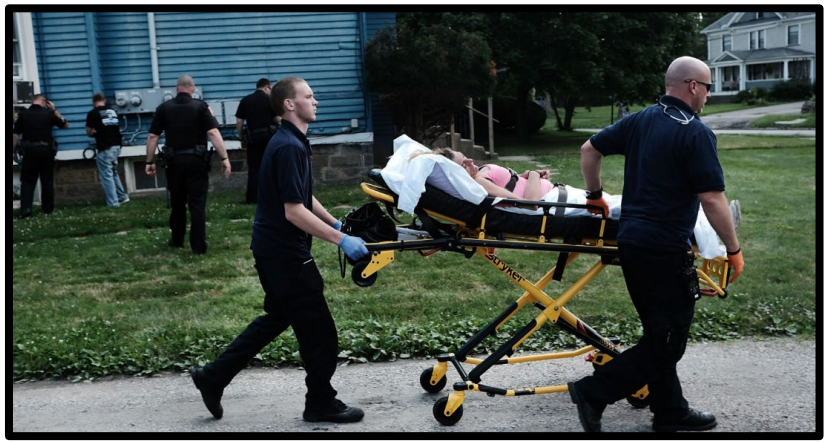
https://busybeingjennifer.com/101-handmade-days-diy-change-jar/

Assessing Risk and Potential Harms

Recommendation 8
When prescribing opioids, evaluate and discuss risk with patients

- If patients experience nonfatal opioid overdose, clinicians should evaluate for OUD and arrange treatment if needed. Work with patients to reduce opioid dosage and to discontinue opioids when indicated (see Recommendation 5) and ensure continued close monitoring and support for patients prescribed or not prescribed opioids.

- If continuing opioid therapy in patients with previous opioid overdose, then discuss increased risks for overdose with patients, incorporate strategies to mitigate risk into the management plan (e.g., offering naloxone and increasing frequency of monitoring [see Recommendation 7]).



https://www.statnews.com/2019/07/12/opioid-overdose-emergency-hold/

Assessing Risk and Potential Harms

Recommendation 8
When prescribing opioids, evaluate and discuss risk with patients

Patients with Previous Overdose

Previous opioid overdose is associated with substantially increased risk for future nonfatal or fatal opioid overdose.

A recent study found that opioids were dispensed to 91% of patients who had a previous overdose; a substantial percentage experienced a repeated opioid overdose, with a cumulative incidence at 2 years of:

17% among patients receiving ≥100 MME/day,
15% among those prescribed 50–100 MME/day,
9% among those prescribed <50 MME/day, and
8% among those prescribed no opioids.

If patients experience nonfatal opioid overdose, clinicians should evaluate them for opioid use disorder and provide or arrange treatment if needed. Treatment with buprenorphine or methadone for opioid use

Assessing Risk and Potential Harms

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

(recommendation category: B; evidence type: 4).

Assessing Risk and Potential Harms

Recommendation 9
When prescribing initial opioid therapy, review the PDMP

EVERYTIME!!

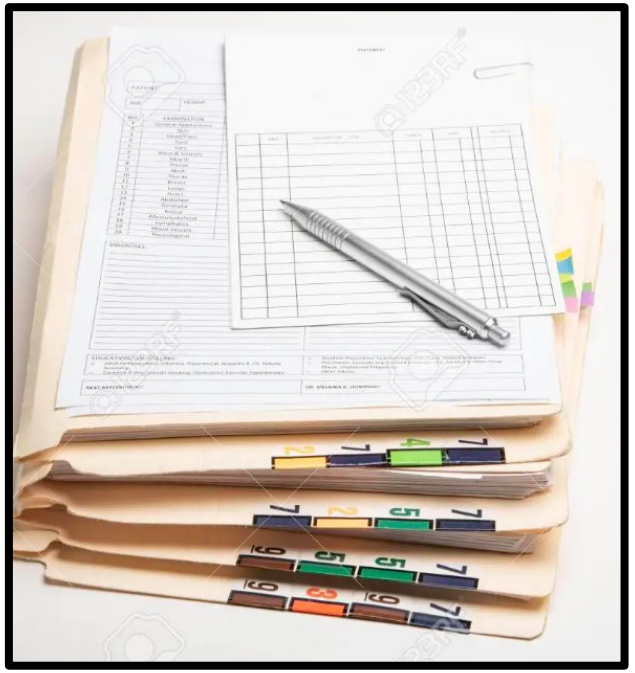
- PDMP data should be reviewed before every opioid prescription for acute, subacute, or chronic pain. This practice is recommended where PDMP availability make it practicable
- At a minimum, during long-term opioid therapy, PDMP data should be reviewed before an initial opioid prescription and then every 3 months or more frequently.
- PDMP information can be most helpful when results are unexpected and, to minimize bias in application, clinicians should apply this recommendation when feasible to all patients.

Assessing Risk and Potential Harms

Recommendation 9
When prescribing initial opioid therapy, review the PDMP

- Use specific PDMP information about medications prescribed to patient **in the context of other clinical information**, including patient history, physical findings, and other testing, to help them communicate with and protect their patient

- Review PDMP data specifically for prescription opioids and other controlled medications from additional prescribers to determine whether a patient is receiving total opioid dosages or combinations that put the patient at risk for overdose.

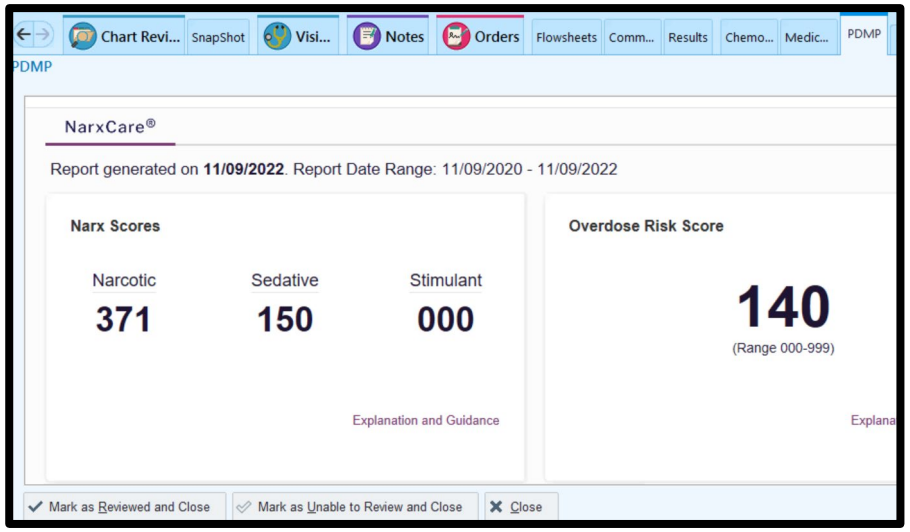


https://www.123rf.com/photo_124559004_a-stack-of-colorcoded-and-numbered-folders-with-patients-medical-records-with-a-patients-chart-and-l.html

Assessing Risk and Potential Harms

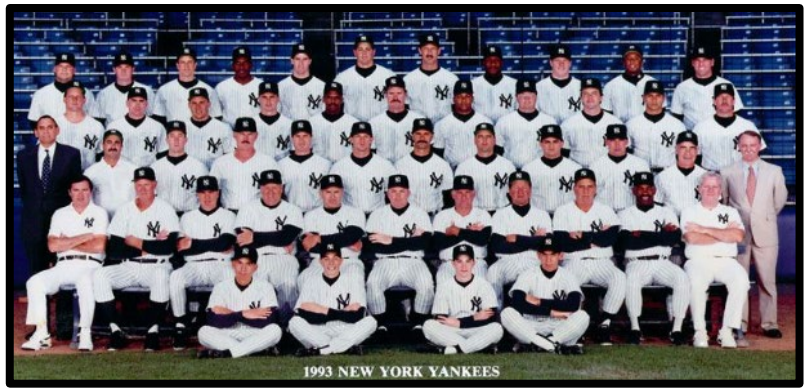
Recommendation 9
When prescribing initial opioid therapy, review the PDMP

- PDMP-generated risk scores have not been validated against clinical outcomes such as overdose and should not take the place of clinical judgment.
- **Clinicians should not dismiss patients from their practice on the basis of PDMP information.** Doing so can adversely affect patient safety and could result in missed opportunities to provide potentially lifesaving information and interventions



Assessing Risk and Potential Harms

Recommendation 9
When prescribing initial opioid therapy, review the PDMP



Take actions to improve patient safety:

- Discuss information from the PDMP with the patient. Because clinicians often work as part of teams, prescriptions might appropriately be written by more than one clinician coordinating the patient's care. Occasionally, PDMP information can be incorrect.
- Discuss safety concerns, including increased risk for respiratory depression and overdose, with patients found to be receiving overlapping prescription opioids from multiple clinicians who are not coordinating the patient's care or patients who are receiving medications that increase risk when combined with opioids and offer naloxone

https://www.pinterest.com/pin/480548222718027903/

Assessing Risk and Potential Harms

Recommendation 9
When prescribing initial opioid therapy, review the PDMP

Use particular caution when prescribing opioid pain medication and benzodiazepines concurrently, understanding that some patient circumstances warrant prescribing of these medications concomitantly. Communicate with others managing the patient to discuss the patient's needs, prioritize patient goals, weigh risks of concurrent benzodiazepine and opioid exposure, and coordinate care (see Recommendation 11).

https://www.freepik.com/free-photos-vectors/doctor-phone-call

Assessing Risk and Potential Harms

Recommendation 9
When prescribing initial opioid therapy, review the PDMP

Consider the total MME/day for concurrent opioid prescriptions to help assess the patient's overdose risk (see Recommendation 4).

Buprenorphine should not be counted in the total MME/day in calculations because of its partial agonist properties at opioid receptors that confer a ceiling effect on respiratory depression.

If a patient is found to be receiving total daily dosages of opioids that put them at risk for overdose, discuss safety concerns with the patient, consider in collaboration with the patient whether or not benefits of tapering outweigh risks of tapering, and offer naloxone.

Calculating morphine milligram equivalents (MME)

OPIOID (doses in mg/day except where noted)	CONVERSION FACTOR
Codeine	0.15
Fentanyl transdermal (in mcg/hr)	2.4
Hydrocodone	1
Hydromorphone	4
Methadone	
1-20 mg/day	4
21-40 mg/day	8
41-60 mg/day	10
≥ 61-80 mg/day	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3

CDC Calculating MME Conversion Factor chart

https://www.researchgate.net/figure/CDC-Calculating-MME-Conversion-Factor-chart_fig2_319874294

Assessing Risk and Potential Harms

Recommendation 9
When prescribing initial opioid therapy, review the PDMP

- Discuss safety concerns with other clinicians who are prescribing controlled substances for the patient. First, discuss concerns with the patient and inform them of the plan to coordinate care.
- **Screen for substance use and discuss concerns with the patient in a nonjudgmental manner** (see Recommendations 8 and 12).
- When diverting might be likely, consider toxicology testing to assist in determining whether prescription opioids can be discontinued without causing withdrawal. A negative toxicology test for prescribed opioids might indicate the patient is not taking prescribed opioids. Consider other possible reasons for this test result (e.g., false-negative results).

https://www.google.com/search?q=exit+over+door&tbm=isch&ved=2ahUKEwjqw9zCmaH7AhXcmmoFHWT_C7gQ2cCegQIABAA&oq=exit+over+door&gs_lcp=CgNpbWcQAzIGCAAQCBAeOgQIABBDOgUIABCABDoHCAAQgAQQGDoICAAQgAQQsQM6CwgAEIAEELEDEIMBOgcIABCxAxBDOggIABCxAxCDAToECAAQHjoGCAAQBRAeUNYLWLsnYLwoaAFwAHgAgAHzAYgB2BCSAQYwLjEzLjGYAQCgAQGqAQtnd3Mtd2l6LWltZ7ABAMABAQ&sclient=img&ei=XaprY6qhNty1qtsP5P6vwAs&bih=810&biw=1542#imgrc=VOVWOI8ZPYGxRM

Assessing Risk and Potential Harms

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 non-prescribed controlled substances

(recommendation category: B; evidence type: 4).

Assessing Risk and Potential Harms

Recommendation 10
Consider the benefits and risks of toxicology testing

- 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. Do not dismiss patients from care on the basis of a toxicology test. Dismissal could have adverse consequences for patient safety, potentially including the patient obtaining opioids or other drugs from alternative sources and the clinician missing opportunities to facilitate treatment for substance use disorder.

- Before starting opioids and at least annually during therapy, clinicians should consider the benefits and risks of toxicology testing to assess for prescribed opioids and other prescription and non-prescription controlled substances that increase risk for overdose when combined with opioids.

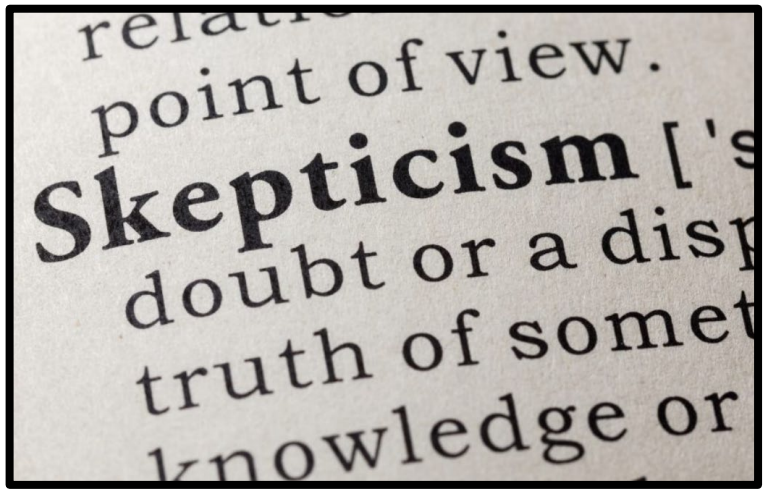
- Health systems should aim to minimize bias in testing and should not apply this recommendation differentially on the basis of assumptions about patients.

Assessing Risk and Potential Harms

Recommendation 10
Consider the benefits and risks of toxicology testing

- Predicting risk is challenging, and available tools do not allow clinicians to reliably identify patients who are at low risk for substance use or SUD. **Clinicians should consider toxicology screening results as potentially useful data,** in the context of other clinical information, for all patients and consider toxicology screening whenever its potential limitations can be addressed.

- Clinicians should explain to patients that toxicology testing will **not** be used to dismiss patients from care and is intended to improve their safety.



https://namas.co/the-importance-of-skepticism/

Assessing Risk and Potential Harms

Recommendation 10
Consider the benefits and risks of toxicology testing

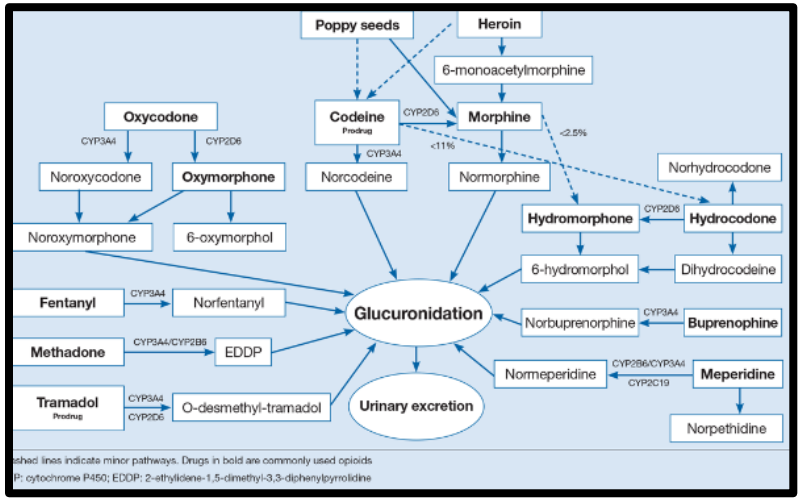
- Clinicians should **explain expected results** (e.g., presence of prescribed medication and absence of drugs, and ask patients in a nonjudgmental manner about use of prescribed and other drugs and whether there might be unexpected results.

- Limited toxicology screening can be performed with a relatively inexpensive presumptive immunoassay panel that tests for opiates as a class, benzodiazepines as a class, and several non-prescribed substances. Toxicology screening for a class of drugs might not detect all drugs in that class. For example, fentanyl testing is not included in widely used toxicology assays that screen for opiates as a class.

Assessing Risk and Potential Harms

Recommendation 10
Consider the benefits and risks of toxicology testing

- Be familiar with the drugs included in toxicology screening panels used in their practice and understand how to interpret results for these drugs.
- For example, a positive opiates immunoassay detects morphine, which might reflect patient use of morphine, codeine, or heroin, but does not detect synthetic opioids and might not detect semisynthetic opioids.
- In some cases, positive results for specific opioids might reflect metabolites from opioids the patient is taking and might not mean the patient is taking the specific opioid that resulted in the positive test.



https://www.mdedge.com/psychiatry/article/205524/addiction-medicine/urine-drug-tests-how-make-most-them/page/0/1

Assessing Risk and Potential Harms

Recommendation 10
Consider the benefits and risks of toxicology testing

- Confirmatory testing should be used when
  - toxicology results will inform decisions with major clinical or nonclinical implications for the patient;
  - a need exists to detect specific opioids or other drugs within a class, such as those that are being prescribed, or those that cannot be identified on standard immunoassays; or
  - a need exists to confirm unexpected screening toxicology test results.
- Restricting confirmatory testing to situations and substances for which results can reasonably be expected to affect patient management **can reduce costs of toxicology testing.**
- Clinicians might want to discuss unexpected results with the local laboratory or toxicologist and should discuss unexpected results with the patient.

Assessing Risk and Potential Harms

Recommendation 10
Consider the benefits and risks of toxicology testing

- Clinicians should **discuss unexpected results with patients in a nonjudgmental manner,** avoiding use of potentially stigmatizing language (e.g., avoid describing a specimen as testing "clean" or "dirty").

- Discussion with patients before specific confirmatory testing can sometimes yield a candid explanation of why a particular substance is present or absent and remove the need for confirmatory testing during that visit. For example, a patient might explain that the test is negative for prescribed opioids because they felt opioids were no longer helping and discontinued them. If unexpected results from toxicology screening are not explained, a confirmatory test on the same sample using a method selective enough to differentiate specific opioids and metabolites (e.g., gas or liquid chromatography–mass spectrometry) might be warranted.

https://www.elephango.com/index.cfm/pg/k12learning/lcid/13037/Let%27s_Be_Honest!

Assessing Risk and Potential Harms

Recommendation 10
Consider the benefits and risks of toxicology testing

Clinicians should use unexpected results to improve patient safety (e.g., optimize pain management strategy [see Recommendation 2], carefully weigh benefits and risks of reducing or continuing opioid dosage [see Recommendation 5], reevaluate more frequently [see Recommendation 7], offer naloxone [see Recommendation 8], and offer treatment or refer the patient for treatment with medications for opioid use disorder [see Recommendation 12], all as appropriate).

https://www.riverhouseinc.org/safety-first/

Assessing Risk and Potential Harms

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

(recommendation category: B; evidence type: 3).

Assessing Risk and Potential Harms

Recommendation 11
Use caution when prescribing opioids and benzodiazepines concurrently

- Although in some circumstances it might be appropriate to prescribe opioids to a patient who is also prescribed benzodiazepines (e.g., severe acute pain in a patient taking long-term, stable low-dose benzodiazepine therapy), use particular caution when prescribing opioid pain medication and benzodiazepines concurrently. In addition, consider whether benefits outweigh risks for concurrent use of opioids with other central nervous system depressants (e.g., muscle relaxants, non-benzodiazepine sedative hypnotics, and potentially sedating anticonvulsant medications such as gabapentin and pregabalin).

- **Buprenorphine or methadone for opioid use disorder should not be withheld from patients taking benzodiazepines** or other medications that depress the central nervous system.

https://oxfordtreatment.com/prescription-drug-abuse/xanax/

https://www.hameln-pharma.com/product/uk-oxycodone-50-mg-ml-50-mg-in-1-ml-3466/

Assessing Risk and Potential Harms

Recommendation 11
Use caution when prescribing opioids and benzodiazepines concurrently

- Check the PDMP for concurrent controlled medications prescribed by other clinicians (see Recommendation 9) and consider involving pharmacists as part of the management team when opioids are co-prescribed with other central nervous system depressants.

- In patients receiving opioids and benzodiazepines long term, clinicians should carefully weigh the benefits and risks of continuing therapy with opioids and benzodiazepines and discuss with patients and other members of the patient's care team.

https://blog.ochsner.org/articles/little-known-ways-pharmacists-can-help-you-stay-healthy

Assessing Risk and Potential Harms

Recommendation 11
Use caution when prescribing opioids and benzodiazepines concurrently

- Risks of concurrent opioid and benzodiazepine use are likely to be greater with unpredictable use of either medication, with use of higher-dosage opioids and higher-dosage benzodiazepines in combination, or with use with other substances including alcohol (compared with long-term, stable use of lower-dosage opioids and lower-dosage benzodiazepines without other substances).

- In specific situations, benzodiazepines can be beneficial, and stopping benzodiazepines can be destabilizing.

- Clinicians should taper benzodiazepines gradually before discontinuation because abrupt withdrawal can be associated with rebound anxiety, hallucinations, seizures, delirium tremens, and, rarely, death. **The rate of tapering should be individualized.**

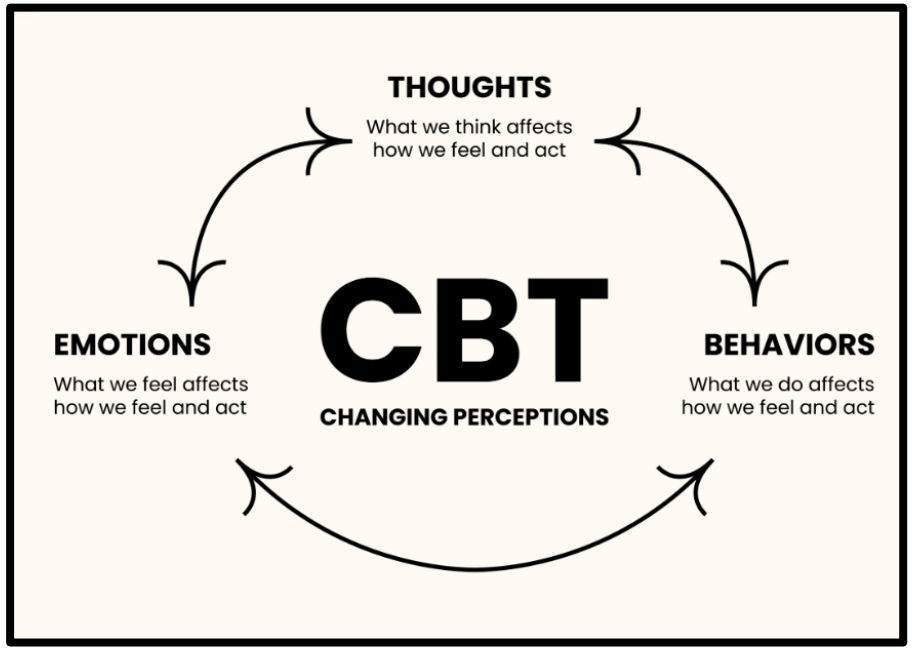
https://blog.knotstandard.com/black-suit-combinations-that-will-make-you-stand-out/

Assessing Risk and Potential Harms

Recommendation 11
Use caution when prescribing opioids and benzodiazepines concurrently

- If benzodiazepines prescribed for anxiety are tapered or discontinued, or if patients receiving opioids require treatment for anxiety, evidence-based psychotherapies (e.g., cognitive behavioral therapy), specific antidepressants or other non-benzodiazepine medications approved for anxiety, or both, should be offered.

- 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.



https://www.inspiremalibu.com/cognitive-behavioral-therapy-cbt/

Assessing Risk and Potential Harms

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

(recommendation category: A; evidence type: 1).

Assessing Risk and Potential Harms

Recommendation 12
Offer treatment with evidence-based medications to treat OUD.

- Although stigma can reduce the willingness of persons with opioid use disorder to seek treatment**, OUD** is a chronic, treatable disease from which persons can recover and continue to lead healthy lives.
- If clinicians suspect OUD, they **should discuss their concern with their patient in a nonjudgmental manner** and provide an opportunity for the patient to disclose related concerns or problems.
- Assess for the presence of OUD using DSM-5 criteria.
- For patients meeting criteria for OUD, clinicians should arrange for patients to receive evidence-based treatment with medications for OUD.

Assessing Risk and Potential Harms

Recommendation 12
Offer treatment with evidence-based medications to treat OUD.

- For patient safety do not dismiss patients from their practice because of opioid use disorder.

- Medication treatment of OUD has been associated with reduced risk for overdose and overall deaths. Identification of opioid use disorder represents an opportunity for a clinician to initiate potentially life-saving interventions, and the clinician should collaborate with the patient regarding their safety to increase the likelihood of successful treatment.

Assessing Risk and Potential Harms

Recommendation 12
Offer treatment with evidence-based medications to treat OUD.

- For pregnant persons with OUD, medication for OUD (buprenorphine or methadone) is the recommended therapy and should be offered as early as possible in pregnancy to prevent harms to both the patient and the fetus.

- Clinicians unable to provide treatment themselves should arrange for patients with OUD to receive care from a SUD treatment specialist (e.g., an office-based buprenorphine or naltrexone treatment provider), or from an opioid treatment program certified by SAMHSA to provide methadone or buprenorphine for patients with OUD.

Assessing Risk and Potential Harms

Recommendation 12
Offer treatment with evidence-based medications to treat OUD.

- **All clinicians should obtain a waiver to prescribe buprenorphine for OUD**

- Clinicians prescribing opioids should **identify treatment resources for OUD** in the community, establish a network of referral options that span the levels of care that patients might need to enable rapid collaboration and referral, when needed, and work together to ensure sufficient treatment capacity for OUD at the practice level.

- Although identification of an OUD can alter the expected benefits and risks of opioid therapy for pain, patients with co-occurring pain and opioid use disorder require ongoing pain management that maximizes benefits relative to risks.

https://www.samhsa.gov/medication-assisted-treatment/become-buprenorphine-waivered-practitioner/buprenorphine-waiver-faqs

Assessing Risk and Potential Harms

Recommendation 12
Offer treatment with evidence-based medications to treat OUD.

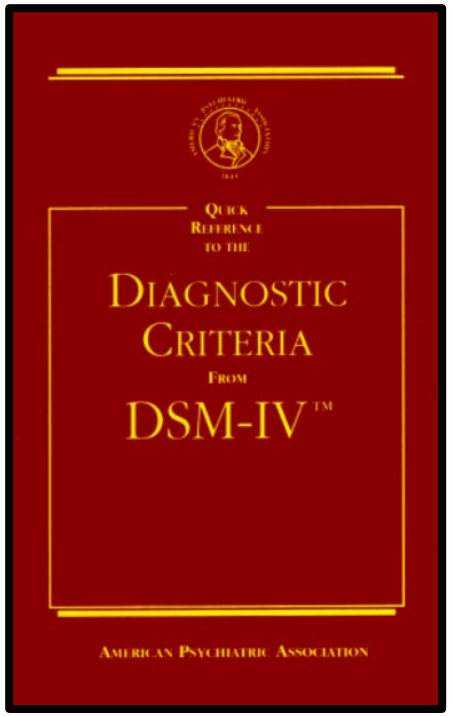
OUD is defined in the DSM-5 as a..

"problematic pattern of opioid use leading to clinically significant impairment or distress"

Risk for OUD, increases particularly if opioids are prescribed for >90 days.

The rate of addiction among chronic pain patients averaged 8%–12% in studies from 2000–2013.

Recent studies found estimates of 23.9%–26.5% for any prescription OUD, but 5.2%–9.0% for moderate to severe OUD among adults receiving long-term opioid therapy for pain, with **slightly lower prevalence in clinics with more consistent use of risk reduction**



https://www.abebooks.com/9780890420638/Quick-Reference-Diagnostic-Criteria-DSM-IV-0890420637/plp

Assessing Risk and Potential Harms

Recommendation 12
Offer treatment with evidence-based medications to treat OUD.

Opioid use disorder is manifested by at least two of 11 defined criteria occurring within a year:

1.Opioids taken in larger amounts or over a longer period than was intended.

2.There is a persistent desire or unsuccessful attempts to cut down opioid use.

3. Significant time is spent trying to obtain opioids, use the opioid, or recover opioids.

4.Craving, or a strong desire or urge to use opioids.

5. Recurrent opioid use with failure to fulfill major obligations at work, school, or home.

Assessing Risk and Potential Harms

Recommendation 12
Offer treatment with evidence-based medications to treat OUD.

6. Continued use despite having recurrent social or interpersonal problems caused by opioids.

7. Important social, occupational, or recreational activities are reduced because of opioid use.

8. Recurrent opioid use in situations in which it is physically hazardous.

9. 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.

Assessing Risk and Potential Harms

Recommendation 12
Offer treatment with evidence-based medications to treat OUD.

10. Tolerance, as defined by either of the following:
    a need for markedly increased amounts of opioids to achieve intoxication or desired effect, or
    a markedly diminished effect with continued use of the same amount of an opioid.

11. Withdrawal, as manifested by either of the following:
    1. the characteristic opioid withdrawal syndrome, or
    2. opioids (or a closely related substance) are taken to relieve or avoid withdrawal symptoms.

Criteria 10 and 11 are not considered to be met for those persons taking opioids solely under appropriate medical supervision. Severity is specified as mild (2–3 criteria), moderate (4–5 criteria), or severe (≥6 criteria).

Agenda

The First 30 Hour:

Why We Are here

The current situation

Assessment of Risk

Assessment of Need

BOP

Contracts

The Hour After That:

Prescribing Opioids

Opioid equivalents

Testing:
Urine
Pill counts

The Last Hour:

The New CDC Guidelines

The WV Opioid Reduction Act

The 2018 WV Opioid Legislation-SB 273

WEST VIRGINIA LEGISLATURE

2018 REGULAR SESSION

Enrolled

Committee Substitute

for

Committee Substitute

for

Senate Bill 273

BY SENATORS CARMICHAEL (MR. PRESIDENT) AND PREZIOSO

(BY REQUEST OF THE EXECUTIVE)

[Passed March 9, 2018; in effect 90 days from passage]

AN ACT to amend and reenact §16-5H-2 and §16-5H-9 of the Code of West Virginia, 1931, as amended; to amend and reenact §16-5Y-2, §16-5Y-4, and §16-5Y-5 of said code; to amend said code by adding thereto a new article, designated §16-54-1, §16-54-2, §16-54-3, §16-54-4, §16-54-5, §16-54-6, §16-54-7, §16-54-8, and §16-54-9; to amend and reenact §30-9-14 of said code; to amend and reenact §30-3A-1, §30-3A-2, §30-3A-3, and §30-3A-4 of said code; to amend and reenact §30-4-19 of said code; to amend and reenact §30-5-8 of said code; to amend and reenact §30-7-11 of said code; to amend and reenact §30-8-18 of said code; to amend and reenact §30-10-19 of said code; to amend and reenact §30-14-12a of said code; to amend and reenact §30-38-2 of said code; to amend said code by adding thereto a new section, designated §60A-5-509; and to amend and reenact §60A-9-4, §60A-9-5, and §60A-9-5a of said code, all relating to reducing the use of certain prescription drugs; providing for an exemption from registration for office-based, medication-assisted treatment program in specified cases; providing for an exemption for medication-assisted treatment programs; clarifying physician responsibility for medication-assisted treatment; clarifying definition of "pain management clinic"; providing for emergency rulemaking; defining terms; providing for an advance directive; requiring consultation with patients prior to prescribing an opioid; limiting the amount of opioid prescriptions; requiring a narcotics contract in certain circumstances; providing exceptions to prescribing limits; providing for referral to a pain clinic or pain specialist; providing reports to licensing boards regarding abnormal or unusual prescribing practices; requiring referral to certain alternative treatments; requiring insurance coverage for certain procedures to treat chronic pain; updating board's titles; requiring the Board of Pharmacy to report quarterly to various licensing boards; exempting the Board of Pharmacy from certain purchasing requirements; clarifying who must report to the Controlled Substances Monitoring Program Database; clarifying the practice of acupuncture; precluding retaliation against a heath care provider for declining to prescribe a narcotic; and permitting the investigation and discipline for abnormal and unusual prescribing and dispensing of prescription drugs.

A summary of **SB 273** is available on the WVBOM website:

https://wvbom.wv.gov/article.asp?id=55&action2=showArticle&ty=CTTS

The entirety of **SB 273**:

https://legiscan.com/WV/bill/SB273/2018

The 2018 WV Opioid Legislation-SB 273

SB 273 was amended during the 2019 by passage of **HB 2768**

HB 2768's amendments to the ORA became **effective on June 7, 2019.**

https://www.wsaz.com/content/news/Members-of-WVaHouse-of-Delegates-respond-to-education-omnibus-bill-passing-in-Senate-505327291.html

House Bill 2768

- Clarifies that the Opioid Reduction Act **applies only to Schedule II opioid drugs**;

- Clarifies that the Opioid Reduction Act **does not apply** to a patient being prescribed, or ordered, any medication **in an inpatient setting at a hospital**;

- Clarifies that a prescription for a four-day supply of a Schedule II **opioid drug issued to a patient in the emergency room** for outpatient use **is not an initial prescription**;

https://wvbom.wv.gov/article.asp?id=69&action2=showArticle&ty=CTTS

House Bill 2768

- Clarifies that, “[t]he physical exam **should be relevant to the specific diagnosis** and course of treatment, and should assess whether the course of treatment would be safe and effective for the patient;”

- Clarifies that **a narcotics contract is not required until the issuance of a third prescription for a Schedule II** opioid drug and adds a new provision that a narcotics contract must include whether another physician is approved to prescribe to the patient;

House Bill 2768

- Clarifies that a **pharmacist is not responsible** for enforcing the requirements of the Opioid Reduction Act;

- Allows for a subsequent Schedule II opioid drug **prescription less than six days after the initial prescription**; and,

House Bill 2768

- Amends the ORA in circumstances when a practitioner acquires a patient from another practitioner, at a different practice or practice group. .

- **The first Schedule II opioid drug prescription issued by the new practitioner to the acquired patient is considered an initial prescription**, such that the prescription **must be limited to a seven-day supply**, unless the acquiring physician and the previous prescriber are members of the same practice group.

The 2018 WV Opioid Legislation-SB 273

§16-5H-2. Definitions.

"**Chronic pain**" means pain that has persisted after reasonable medical efforts have been made to relieve the pain or cure its cause and that has continued, either continuously or episodically, for **longer than three continuous months**. For purposes of this article, "chronic pain" does not include pain directly associated with a terminal condition.

The 2018 WV Opioid Legislation-SB 273

More Definitions..

ARTICLE 3A.

"**Pain**" means an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.

"**Acute pain**" means a time limited pain caused by a specific disease or injury.

"**Chronic pain**" means a noncancer, non-end of life pain lasting more than three months or longer than the duration of normal tissue healing.

The 2018 WV Opioid Legislation-SB 273

"**Pain management clinic**" means all privately-owned pain management clinics, facilities, or offices not otherwise exempted from this article and which meet both of the following criteria:

(1) Where in any month more than **50%** of patients of the clinic are prescribed or dispensed Schedule II opioids or other Schedule II controlled substances specified in rules promulgated pursuant to this article for chronic pain resulting from conditions that are not terminal; and

(2) The facility meets any other identifying criteria established by the secretary by rule.

The 2018 WV Opioid Legislation-SB 273

"**Addiction**" means a primary, chronic disease of brain reward, motivation, memory, and related circuitry. Addiction is characterized by inability to consistently abstain; impairment in behavioral control; craving; diminished recognition of significant problems with one's behaviors; interpersonal problems with one's behaviors and interpersonal relationships; a dysfunctional emotional response; and as addiction is currently defined by the American Society of Addiction Medicine.

The 2018 WV Opioid Legislation-SB 273

Steps to Compliance:

1. Determine if patient is **exempt.**

2. Determine the **type of controlled substance** being used.

3. Determine if controlled substance treatment began prior to **1/1/2018.**

The 2018 WV Opioid Legislation-SB 273

Who is Exempt?

- Patients with active cancer
- Hospice patients
- Palliative care patients
- Patients in long term care facilities
- Controlled substances being used to treat a substance use disorder
- **Patients in an inpatient setting at a hospital-HB 2768**

The 2018 WV Opioid Legislation-SB 273

Management Determined by TYPE and TIME

TYPES:

1. **Schedule II Opioids,**
2. ~~Schedule II Non-Opioids-Benzodiazepines~~, per HB 2768
3. ~~Non-Schedule II Opioids,~~ per HB 2768

TIME: Either before or after **1/1/18**

The 2018 WV Opioid Legislation-SB 273

Opioids That Are C II and Began Prior to 1/1/18..

No changes

Yearly review of **PDMP** and documentation

Physical Exam every **3** months. Not from SB273 but per professional guidelines and standards of care.

The 2018 WV Opioid Legislation-SB 273

Opioids that are Not C II

No changes

Review PDMP prior to prescribing and at least yearly. Document the review.

Examples: Tramadol, Some formulation of codeine

The 2018 WV Opioid Legislation-SB 273

C II Opioids began on/after 1/1/18
First Prescription

1. Ask if the patient has a **Non-Opioid Advanced Directive**? **NOAD**

2. Inform the patient .. they can fill the Rx in a lesser quantity.

3. Are there multiple serious **risks** from opioids?

4. If the patient is a **minor** then **the parent or guardian must be aware** of the reasons why the prescription is necessary.

5. Limited to **seven** days worth of medication by PCP.

The 2018 WV Opioid Legislation-SB 273

C II Opioids began on/after 1/1/18
First Prescription -Document:

6. Non-opioid medications that have been tried.
7. Non-Pharmacological approaches tried.
8. Substance abuse history.
9. Plan for determining the cause of pain.
10. CSMP/PDMP database reviewed.

The 2018 WV Opioid Legislation-SB 273

C II Opioids began on/after 1/1/18

Second Prescription

HB 2768 allows a subsequent prescription **less than six days after issuing the initial prescription**.

HB 2768 provide that the **narcotics contract is not required until the third prescription** for the Schedule II opioid drug.

The 2018 WV Opioid Legislation-SB 273

C II Opioids began on/after 1/1/18

Second Prescription-Document:

1. **Rationale** for the 2nd Prescription.

2. That there is not an undue **risk** of abuse, addiction or diversion.

3. **Discussion** **of the risks** of addiction, dependence, and overdose and the dangers of taking opioids with alcohol, benzodiazepines, or other depressants;

4. **Discussion** of alternative treatments.

The 2018 WV Opioid Legislation-SB 273

C II Opioids began on/after 1/1/18

Third Prescription

1. **Consider referral to pain management**.
2. Discuss the benefits of being referred and the risks of choosing not to be referred.
3. If the patient declines pain management then you must:
4. **Document: that the patient knowingly declined treatment** from a pain clinic or pain specialist.

The 2018 WV Opioid Legislation-SB 273

C II Opioids began on/after 1/1/18

Third Prescription

Review, every three months,

- the course of treatment,
- any new information about the etiology of the pain, and
- the patient's progress toward treatment objectives and
- document the results of that review.

Periodically make efforts to either..

- stop the use of the controlled substance,
- decrease the dosage,
- try other drugs or treatment modalities and
- document with specificity the efforts undertaken.

Assess the patient risk of dependence and document the assessment.

The 2018 WV Opioid Legislation-SB 273

West Virginia Controlled Substances Monitoring Act

§60A-9-7. Criminal penalties; and administrative violations.

(f) Any practitioner who **fails to register with the West Virginia Controlled Substances Monitoring Program and obtain and maintain online or other electronic access to the program database** as required .. shall be subject to an administrative penalty of $1,000 by the licensing board of his or her licensure .. The provisions of this subsection shall become effective on July 1, 2016

Prescribers are required to register with the WVBOP and Check BOPs!!

The 2018 WV Opioid Legislation-SB 273

The WVBOP

Compiles and reports to licensing boards provider prescriber data.

§30-3A-4. Abnormal or unusual prescribing practices.

(a) Upon receipt of the **quarterly report .. ** the licensing board shall notify the prescriber that he or she has been identified as a potentially **unusual or abnormal prescriber**. The board may take appropriate action, including .. an investigation or disciplinary action based upon the findings .. in the report.

(b) A licensing board may upon receipt of .. information independent of the quarterly report .. **initiate an investigation into any alleged abnormal prescribing or dispensing practices of a licensee.**

The 2018 WV Opioid Legislation-SB 273

§60A-5-509. Unlawful retaliation against health care providers**.**

(a) A .. provider has **the right to exercise .. professional judgment** to decline to .. prescribe narcotics without being subject to actual or threatened acts of reprisal.

(b) It shall be **unlawful for any person .. to engage in any form of threats or reprisal** .. the purpose of which is to punish, embarrass, deny, or reduce privileges or compensation .. as a result of, or in retaliation for, the refusal of .. that provider to .. prescribe narcotics.

(c) **Any person or entity who violates the foregoing .. shall be liable in the amount of three times the economic loss** sustained as a direct and proximate result of the reprisal.

Done.

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