**Evidence-Based Changes to Support A Community Approach to Addressing the Opioid Crisis**

**DRAFT – January 2, 2019**

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| **PRIMARY DRIVER: LIMIT SUPPLY OF OPIOIDS** |
| **Secondary Driver** | **Specific Change/Project** | **Degree of belief in importance** | **Level of supporting evidence** |
| **Improve prescribing practices for patients with acute or chronic pain - including safe and appropriate use of opioids and dose, duration, and type of opioid used** | *Acute Pain Management:**Opioids are not first line medications for acute pain. Alternative medications and treatments should be tried. May be indicated for (moderate to) severe acute pain for short period of time**Recommended Dose** Start with lowest dose and duration possible (only intermediate acting medications, not Long Acting)
* Do not exceed 50 MME/day and avoid > 90 MME/day

*Recommended Duration** For acute pain, prescribe < 3 days
* Use shortest course, 3-7 days
* No more than (28) 30-day supply given at a time and no refills in fewer than 30 days
* Patients who do not experience relief early in treatment – within 1 month – are unlikely to experience relief with longer-term use – discontinue use

*Chronic Pain:[[1]](#footnote-1)**Opioids are not first line medications for chronic pain and have no to limited effectiveness. Generally avoid for chronic pain, especially chronic axial back pain, fibromyalgia, headaches, arthritis, etc.**Alternative medications and treatments should be tried.**If provider decides to prescribe a trial of opioids for chronic pain:** Mandated discussion of risks and benefits about opioids with patient
* Signed treatment agreement with patients, including realistic goals for pain and function while on opioids and a tapering plan
* Check PDMP
* Urine Drug Test – regular monitoring

*Recommended Dose (intermediate acting)** Start with lowest dose and duration possible
* Do not exceed 50 MME/day and avoid > 90 MME/day

*Recommended Duration** No more than (28) 30 day supply given at a time and no refills in fewer than 30 days
* Patients who do not experience relief early in treatment – within 1 month – are unlikely to experience relief with longer-term use – discontinue use

*Recommended type of opioid:** Short-acting (immediate release) medications
* Avoid long-acting/extended release opioids
* Generics (brand names have higher street value and are more likely to be diverted)

*Guidance on co-prescribing with other drugs:** Daily acetaminophen dose no greater than 2500-3250 mg/day
* Avoid opioids in combination with benzodiazepines and/or carisoprodol (Soma)

*Re-evaluate / stop opioids*:* Prescribing more than 90 mg morphine equivalent (MME)/day without obvious functional improvement
* Prescribing opioids with benzos and/or carisoprodol
* Prescribing > 40 mg methadone per day
* Patient shows signs of misuse or illicit drug use
* Re-evaluate as appropriate to condition, but at least every 3-6 months
* Consultation with pain management for complex/ difficult patients
* Consultation/referral for addiction medicine for opioid use disorder, dependency
 | High | High |
| **Improve dispensing practices - pharmacy and payers** | *Pharmacy** Use existing data (claims, payment form, location of prescription fills) to identify patients, providers, and prescribers who are inappropriately using or prescribing opioids.
* Require checking PDMP before dispensing opioids.
* Empower pharmacists to question appropriate prescribing (aka, “corresponding responsibility”) and escalate issues to prescribing clinician or higher authority.
* Empower pharmacists to decline to fill prescriptions and direct patients to substance abuse treatment and to non-opioid pharmacologic pain treatment when abuse is suspected.
* Dispense narcotics with Deterra or other, similar bags for safe disposal

*Payers** Require that pharmacies and physicians check PDMP to be able to prescribe covered opioids.
* Claims data surveillance to identify patients, providers, and prescribers who are inappropriately using or prescribing opioids.
* Change reimbursement for different types of opioids (e.g. do not pay for extended release opioids)
* Formulary controls – type of opioid to be dispensed; number of pills per covered prescription; refill frequency; authorized specialty
* Support education of physicians about safe use of opioids for chronic pain
 | MediumHigh | Low |
| **Prevent diversion of unused opioids**  | * Educate the public/patients about the risks of becoming addicted to prescription opioids and the link between Rx opioids and future illicit medication and heroin use.
* Educate the public/patients about the risks of diversion and how to properly dispose of unused medication.
* Install permanent, bin-based safe drug disposal sites in community spaces such as pharmacies, police stations, and social service agency offices.
* Organize and publicize community-wide drug take back days to encourage people to bring in unused medication.
 | High | Medium |
| **Enhance availability of multimodal pain management strategies** | *Physicians** Improve physician training in pain management, particularly primary care physicians.
* Increase physician knowledge about effective, non-opioid treatments for different types of chronic pain, such as NSAIDs, acetaminophen, anti-depressants), physical therapy, acupuncture, massage therapy, exercise, yoga, and cognitive behavioral therapy (CBT).

*Payers** Provide adequate benefit coverage and reimbursement for non-opioid pain management options to increase uptake.
* Incentivize use of less costly, non-opioid pain treatments.
 | HighHigh | Low MediumHigh |
| **PRIMARY DRIVER: RAISE AWARENESS OF RISK OF OPIOID USE DISORDER** |
| **Secondary Driver** | **Specific Change/Project** | **Degree of belief in importance** | **Level of supporting evidence** |
| **Educate health care professionals, patients, and adolescents about risks of opioids and opioid use disorder** | * Educate providers at every point in their training about safe and appropriate use of opioids - medical school, residency, maintenance through CME courses throughout career.
* Educate pediatricians and pediatric orthopedists
* Educate the public about the risks of opioid use and that opioids are equivalent to heroin.
* Patient education should focus on:
	+ Risks of taking opioids
	+ Appropriate use of opioids
	+ Opioids are not safer than illicit drugs because they are prescribed by a physician.
	+ Safe drug disposal
* Provide clear information to patients being prescribed opioids about the risk of addiction, including that opioids are chemically similar to heroin.
* Educate adolescents in schools and elsewhere about the risks of prescription opioids and heroin.
* Focus on making smart decisions rather than the drugs themselves
 | HighHighLow | Medium to LowMediumLow |
| **Reduce stigma around substance abuse** | * Increase public and provider awareness to reframe substance use disorders as a chronic disease rather than a moral failing, to be managed like other chronic conditions like diabetes.
 | Medium | Low |
| **PRIMARY DRIVER: IDENTIFY INDIVIDUALS AT HIGH RISK OF DEVELOPING OPIOID USE DISORDER** |
| **Secondary Driver** | **Specific Change/Project** | **Degree of belief in importance** | **Level of supporting evidence** |
| **Identify and educate patients at high risk for developing opioid use disorder** | * Screen all patients who are being prescribed opioids for risk of misuse, abuse, and substance use disorder.
	+ Previous or current mental illness
	+ Personal history of substance misuse, including alcohol and nicotine
	+ Family history of alcohol/substance abuse
	+ Opioid Risk Tool (ORT)
	+ Screener for Opioid Assessment for Patients with Pain – Revised (SOAPP-R)
* Provide clear information to patients being prescribed opioids about the risk of addiction, including that opioids are chemically similar to heroin.
 | High | High |
| **Taper individuals on chronic, high dose, opioids** | *Provide compassionate, consistent care for patients who are dependent on opioids* * Regular monitoring of patients on opioids to screen for misuse, abuse, and dependence.
* Develop compassionate treatment plan to address dependence (tapering + connection to treatment).
* If abuse is suspected: immediate cessation (begin tapering plan) and refer to treatment program
* Do not cut off patients on opioids completely when abuse or dependence is identified.

*Tapering Guidance** Reduce opioid dose by 10% of the daily dose per week until opioids can be discontinued completely and opioids can be moved to a non-opioid management regimen.
* Individualize treatment plan to ensure compliance and mitigate withdrawal symptoms.
* Consider Medication-Assisted Treatment (e.g. buprenorphine) to transition and taper patients on high dose opioids.
* Convey to patients the facts around opioid dependence
* Set reasonable expectations for next steps – tapering, treatment, ongoing management of chronic pain
 | MediumHigh | LowHigh |
| **Provide pain management education** | * Educate providers about effective pain management for patients who are opioid tolerant and/or dependent when tapering off opioids to mitigate effects of dependency and hyperalgesia seen among chronic opioid users.
 | Medium | Low |
| **Enhance availability of multimodal pain management strategies** | In addition to above:* Educate providers about pain management modalities for patients still experiencing chronic pain after tapering off of opioids.
* Provide appropriate reimbursement and insurance coverage for non-opioid pain management modalities.
 | High | Medium |
| **PRIMARY DRIVER: TREAT INDIVIDUALS WITH OPIOID USE DISORDER** |
| **Secondary Driver** | **Specific Change/Project** | **Degree of belief in importance** | **Level of supporting evidence** |
| **Identify individuals with opioid use disorder** | * Physicians regularly screen and monitor patients on opioids for signs of abuse and dependence / opioid use disorder:
	+ Urine drug testing, including tests for synthetic opioids
	+ Assessment for substance abuse (opioid use disorder), including Current Opioid Misuse Measure (COMM) and DSM-V diagnostic criteria.
	+ Review medical record data for signs of abuse, including number of opioid prescriptions, current or historical mental health/substance abuse conditions.
	+ Check PDMP for prescriptions written by other physicians.
* Educate family members to identify signs of abuse and dependence.
* Law enforcement identifies individuals in community who are addicted to opioids. Use legal pressure to direct into treatment rather than focus on primarily punitive response.
 | High | Medium |
| **Improve availability of detox facilities** | * Improve transition between inpatient detox and outpatient treatment (warm handoff) when patient is hospitalized for related medical problems.
 | High | High |
| **Enhance capability to provide long-term ongoing, comprehensive treatment (medication-assisted treatment + behavior-based therapy)** | * Expand availability of medication-assisted treatment (MAT) (e.g. buprenorphine/suboxone, methadone) by encouraging more providers to become certified
* Increase reimbursement for comprehensive substance abuse treatment.
* Educate physicians and patients about the effectiveness of MAT to reduce stigma and encourage uptake.
 | High | High |
| **Enhance availability of supportive social services** | * Closely inspect and regulate “sobriety houses”, aka halfway or recovery homes for individuals who are leaving treatment. Work to reduce resistance to MAT within sobriety houses.
* Increase access to and availability of social services often required by recovering addicts to support continued recovery and prevent relapse, including affordable housing, employment support, and child care.
 | High | Medium |
| **Prevent fatal overdoses with naloxone** | * Increase prescribing and other access to naloxone kits, including among pharmacists, community and family members, and non-paramedic first responders. This varies by state.
* Initiate naloxone co-prescribing processes when opioids are prescribed
 | High | High |

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