**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 | Medium  High | 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. | High  High | Low  Medium  High |
| **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 | High  High  Low | Medium to Low  Medium  Low |
| **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 | Medium  High | Low  High |
| **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 |

**Bibliography and Resources**

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| --- | --- | --- | --- | --- |
| **Resource Name** | **Publishing Organization** | **Link** | **Driver** | **Audience** |
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| Initiating Buprenorphine Treatment in the Emergency Department | National Institute on Drug Abuse | <https://www.drugabuse.gov/nidamed-medical-health-professionals/initiating-buprenorphine-treatment-in-emergency-department> | 4 | ED Clinicians |
| Science to Medicine: Medication Treatment for Opioid Use Disorder | National Institute on Drug Abuse | <https://www.drugabuse.gov/nidamed-medical-health-professionals/science-to-medicine-medication-treatment-opioid-use-disorder> | 4 | Clinicians |
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| Tools to Stay Ahead of the Curve | National Association of Boards of Pharmacy | <https://nabp.pharmacy/initiatives/awarxe/pharmacist-resources/> | 1,2 | Clinicians |
| Accelerating Opioid Safety: Ambulatory Care Toolkit | California Quality Collaborative | <http://www.calquality.org/storage/documents/Toolkits/AcceleratingOpioidSafety_Ambulatory_Care_Toolkit.pdf> | 1,2 | Health care Administrators |
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| AAFP Chronic Pain Management Toolkit | American Academy of Family Physicians | <https://www.aafp.org/patient-care/public-health/pain-opioids/cpm-toolkit.html> | 2,3 | Clinicians |
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| Opioid Safety: Reducing Adverse Drug Effects Related to Opioids Implementation Guide | Society of Hospital Medicine | <https://www.hospitalmedicine.org/clinical-topics/opioid-safety> | 3,4 | Health care Administrators |
| Improving Pain Management for Hospitalized Patients | Society of Hospital Medicine | <https://www.hospitalmedicine.org/clinical-topics/pain-management/> | 1,2 | Health care Administrators |
| Six Building Blocks: A Team-Based Approach to Improving Opioid Management in Primary Care | Improvingopioidcare.org | <https://www.improvingopioidcare.org/> | 1,3 | Health care Administrators, Primary Care Clinicians |

**Selected Papers**

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