Pain Management and Best Practices

Chris Echterling, M.D.
Medical Director for Vulnerable Populations, WellSpan Health

"My drug dealer was a doctor, doctor
Had the plug from Big Pharma, Pharma
He said that he would heal me, heal me
But he only gave me problems, problems"

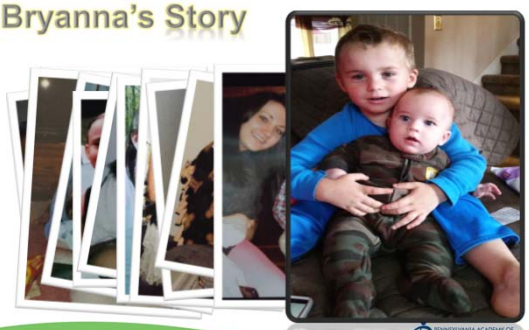
Lyrics from "Drug Dealer"
by Macklemore

PAFP Annual Business Meeting & CME Conference,
Wyndham Gettysburg, March 10, 2019

Disclosure

- This educational activity is funded in part by an educational grant from Daiichi Sankyo, Inc., which has no control over its content.

Bryanna's Story

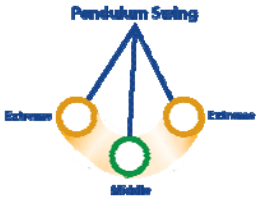


Toxicology Results

Results:	Concentration	Units	Therapeutic Range	Detection Limit
Blood (Femoral)	Collection Time: 12/17/15 08:00			
Ethanol	None Detected	%		0.01
Morphine, Total	107	ng/mL	Not established	20
Sertraline	86	ng/mL	30-100	20
Fentanyl	24.4	ng/mL		0.5
After a single 2 ug/kg IV dose: Up to 11 ng/mL After application of a 100 ug/hour transdermal patch: Up to 1.9-3.8 ng/mL After a single oral transmucosal dose of 15 ug/kg: Up to 2-4 ng/mL at 20 minutes				
Norfentanyl	5.0	ng/mL		0.5

"a tattoo she got when she completed 1 year clean. For every year after, she was going to add another bird flying.."

Addressing the opioid crisis is a strategic priority for WellSpan



Annals of Internal Medicine REVIEW

The Effectiveness and Risks of Long-Term Opioid Therapy for Chronic Pain: A Systematic Review for a National Institutes of Health Pathways to Prevention Workshop

Roger Chou, MD; Judith A. Turner, PhD; Emily B. Devine, PharmD, PhD, MBA; Ryon N. Hansen, PharmD, PhD; Sean D. Sullivan, PhD; Ian Blazina, MPH; Tracy Dana, MLS; Christina Bougatsos, MPH; and Richard A. Deyo, MD, MPH

Background: Increases in prescriptions of opioid medications for chronic pain have been accompanied by increases in opioid overdoses, abuse, and other harms and uncertainty about long-term effectiveness.

Purpose: To evaluate evidence on the effectiveness and harms of long-term (>3 months) opioid therapy for chronic pain in adults.

Data Sources: MEDLINE, the Cochrane Central Register of Controlled Trials, the Cochrane Database of Systematic Reviews, PsycINFO, and CINAHL (January 2008 through August 2014); relevant studies from a prior review; reference lists; and ClinicalTrials.gov.

Study Selection: Randomized trials and observational studies that involved adults with chronic pain who were prescribed long-term opioid therapy and that evaluated opioid therapy versus placebo, no opioid, or nonopioid therapy; different opioid dosing strategies; or risk mitigation strategies.

Data Extraction: Dual extraction and quality assessment.

Data Synthesis: No study of opioid therapy versus no opioid therapy evaluated long-term (>1 year) outcomes related to pain, function, quality of life, opioid abuse, or addiction. Good- and

be assessed. No placebo-controlled trials met inclusion criteria, evidence was lacking for many comparisons and outcomes, and observational studies were limited in their ability to address potential confounding.

Conclusion: Evidence is insufficient to determine the effectiveness of long-term opioid therapy for improving chronic pain and function. Evidence supports a dose-dependent risk for serious harms.

Primary Funding Source: Agency for Healthcare Research and Quality.

www.annals.org

Conclusion: Evidence is insufficient to determine the effectiveness of long-term opioid therapy for improving chronic pain and function. Evidence supports a dose-dependent risk for serious harms.

Scope of the problem

100 million suffer from chronic pain, more than diabetes, CAD and cancer combined

"Relieving Pain in America" – IOM 2011

JAMA | Original Investigation

Effect of Opioid vs Nonopioid Medications on Pain-Related Function in Patients With Chronic Back Pain or Hip or Knee Osteoarthritis Pain
The SPACE Randomized Clinical Trial

Key Points

Question For patients with moderate to severe chronic back pain or hip or knee osteoarthritis pain despite analgesic use, does opioid medication compared with nonopioid medication result in better pain-related function?

Findings In this randomized clinical trial that included 240 patients, the use of opioid vs nonopioid medication therapy did not result in significantly better pain-related function over 12 months (3.4 vs 3.3 points on an 11-point scale at 12 months, respectively).

Meaning This study does not support initiation of opioid therapy for moderate to severe chronic back pain or hip or knee osteoarthritis pain.

Adverse medication-related symptoms were significantly more common in the opioid group over 12 months

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Effect of a Single Dose of Oral Opioid and Nonopioid Analgesics on Acute Extremity Pain in the Emergency Department: A Randomized Clinical Trial

- JAMA 2017 Nov. 7;318(17):1661-1667
- Patients presenting to the ED with acute extremity pain
- No statistically significant or clinically important differences in pain reduction at 2 hours
  - Single-dose treatment with ibuprofen and acetaminophen
    Vs.
  - 3 different opioid and acetaminophen combination analgesics

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Health & Science

U.S. life expectancy declines again, a dismal trend not seen since World War I

The Washington Post

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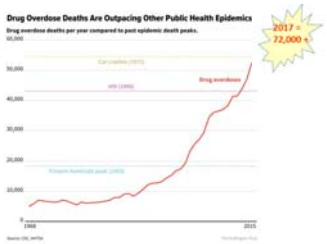
Pennsylvanians a day dying of drug overdoses



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PRESS RELEASE, PUBLIC HEALTH, SUBSTANCE USE DISORDER

Governor Wolf Declares Heroin and Opioid Epidemic a Statewide Disaster Emergency

January 10, 2018

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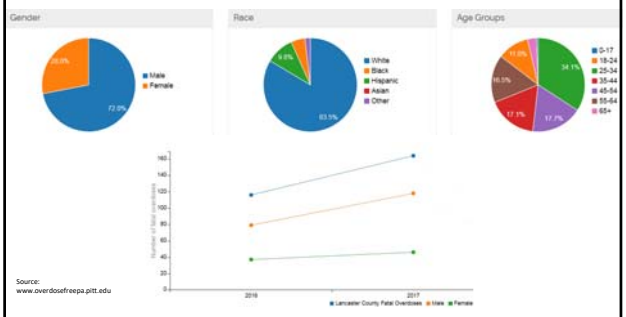
164 Opioid Overdoses - Lancaster County 2017



Source:
www.overdosefreepa.pitt.edu

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Acute Pain Management

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Centers for Disease Control and Prevention
MMWR Morbidity and Mortality Weekly Report
Weekly / Vol. 66 / No. 10 March 17, 2017

Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015

- 1,294,247 opioid naïve adult Tricare patients without cancer or OUD
- Likelihood of chronic opioid use increased with:
  - each additional day of medication supplied starting with the 3rd day
  - with the sharpest increases after:
    - the 5th and 31st day
    - a second prescription or refill
    - 700 MME cumulative dose
    - an initial 10- or 30-day supply
- Highest probability of continued opioid use at 1 and 3 years was Pts:
  - started on a long-acting opioid
  - followed by patients who started on tramadol

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ACUTE PAIN MANAGEMENT

- The risk of Acute becoming Chronic
- Setting the expectation
- Safe storage and disposal
- Acute on Chronic pain management
- Prescribing opioids on discharge from the hospital/post operative

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SETTING THE EXPECTATION

- Alternatives to opioids
  - ice, heat, acetaminophen, NSAID, breathing
- Adjunct to opioids
  - ice, heat, acetaminophen, NSAID, breathing
- Temporary - set the expectation
  - "You're not going to need this for long", you should be able to decrease this over the next 3-7 days"
- Warnings
  - Driving, securing meds, disposal
- It is about function, not just pain – document!

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FIRST DO NO HARM" ≠ STOP PRESCRIBING ALTOGETHER

- "National Trend: Pharmacy Benefit Managers Setting Limits on Opioid Prescriptions"
  - 7 Day acute, 90 MME, etc.
- Agree with partners on violations (Epic letter)
- "Not safe to continue prescribing, but I will still help Tx your pain and improve your function"
- Taper patient compassionately and wisely
- Offer Medication Assisted Tx for Opioid Use Disorder

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Early Release / Vol. 65 March 15, 2016

CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016

CDC Opioid Guideline App: Prescribe with Confidence

Opioid Prescribing Guideline Mobile App

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.
2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CLINICAL REMINDERS

- Opioids are not first-line or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss benefits and risks and availability of nonopioid therapies with patient

CDC RECOMMENDATIONS

6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

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CDC RECOMMENDATIONS

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering **naloxone** when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

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WHAT SHOULD BE ASSESSED AT FOLLOW UP VISITS?

- Benefits in **function**
- Pain control
- Quality of life (PEG-3)
- Common adverse effects such as constipation and drowsiness

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WHAT SHOULD BE ASSESSED AT FOLLOW UP VISITS? (CONTINUED)

- Effects that may be early warning signs for serious problems such as overdose
  - Sedation
  - Slurred speech
- Effects that may be early warning signs for opioid use disorder
  - Cravings
  - Wanting to take greater quantities than prescribed
  - Wanting to take opioids more frequently than prescribed
  - Difficulty controlling opioid use
  - Work or family problems related to opioid use

PHYSICIAN/APC'S SHOULD ASK THE PATIENT:

- Their preferences for continuing opioids
- Whether the benefits of opioids continue to outweigh the risks
- Whether opioid dosage can be reduced or discontinued

	Office Visit from 12/26/2017 in WellSp... 3/20/18	
Jump To (Alt+Comma)	2145	2200
PEG3		
What number best describes your pain on average in the past week:	10	
What number best describes how, during the past week, pain has interfered with your enjoyment of life?	7	
What number best describes how, during the past week, pain has interfered with your general activity	10	
PEG Score:	9	
Adverse Effects:		
Nausea	yes	
Constipation		
Drowsiness/mental cloudiness	no	
Aberrant Behavior		
Early refill request or unapproved dose increase	yes	
Arguments with or criticism from others about controlled medication use	no	
OTHER		
Discussed ongoing risk/benefits of continuing opioids	yes	
Non-opioid treatments discussed	Meditation/Min...	

ELECTRONIC PRESCRIBING OF CONTROLLED SUBSTANCES (EPCS)

- Safer, more efficient
- Delegates can still pend order
- If it was a bad idea clinically before EPCS – it still is
  - Ex. Prescribing opioid on call
  - Exception may be post-op in order to decrease usual prescribing
- Not required yet by law, but anticipate it will be
- WS asking all to enroll in Imprivata with Practice Manager or Medical Affairs now so prepared

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Controlled Substance Agreement (CSA)

- Purpose of CSA
- Historically, patients didn't read the CSA and most staff didn't review key points
  - Narrated PowerPoint (video)– 10 min, Examples, FAQ
  - Answers questions like: "Why are you treating me like a drug addict?"
  - Letter to our patients from Practice/WMG – "The Why"
  - www.WellSpan.org/opioids

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Opioid Analgesic REMS — Patient Counseling Guide

What You Need to Know About Opioid Pain Medicines

This guide is for you! Keep this guide and the Medication Guide that comes with your medicine so you can better understand what you need to know about your opioid pain medicine. Go over this information with your healthcare provider. Then, ask your healthcare provider about anything that you do not understand.

What are opioids?

Opioids are strong prescription medicines that are used to manage severe pain.

What are the serious risks of using opioids?

- Opioids have serious risks of addiction and overdose.
- Too much opioid medicine in your body can cause your breathing to stop – which could lead to death. This risk is greater for people taking other medicines that make you feel sleepy or people with sleep apnea.
- Addiction is when you crave drugs (like opioid pain medicines) because they make you feel good in some way. You keep taking the drug even though you know it is not a good idea and bad things are happening to you. Addiction is a brain disease that may require ongoing treatment.

Risk Factors for Opioid Abuse:

- You have:
  - a history of addiction
  - a family history of addiction
- You take medicines to treat mental health problems
- You are under the age of 65 (although anyone can abuse opioid medicines)

- You can get addicted to opioids even though you take them exactly as prescribed, especially if taken for a long time.
- If you think you might be addicted, talk to your healthcare provider right away.
- If you take an opioid medicine for more than a few days, your body becomes physically "dependent." This is normal and it means your body has gotten used to the medicine. You must taper off the opioid medicine (slowly take less medicine) when you no longer need it to avoid withdrawal symptoms.

How can I take opioid pain medicine safely?

- Take your opioid medicine exactly as prescribed.
- Do not cut, break, chew, crush, or dissolve your medicine. If you cannot swallow your medicine whole, talk to your healthcare provider.
- When your healthcare provider gives you the prescription, ask
  - How long should I take it?
  - What should I do if I need to taper off the opioid medicine (slowly take less medicine)?
- Call your healthcare provider if the opioid medicine is not controlling your pain. Do not increase the dose on your own.
- Do not share or give your opioid medicine to anyone else. Your healthcare provider selected this opioid and the dose just for you. A dose that is okay for you could cause an overdose and death for someone else. Also, it is against the law.
- Store your opioid medicine in a safe place where it cannot be reached by children or stolen by family or visitors to your home. Many teenagers like to experiment with pain medicines. Use a lock- box to keep your opioid medicine safe. Keep track of the amount of medicine you have.
- Do not operate heavy machinery until you know how your opioid medicine affects you. Your opioid medicine can make you sleepy, dizzy, or lightheaded.

What should I avoid taking while I am taking opioids?

Unless prescribed by your healthcare provider, you should avoid taking alcohol or any of the following medicines with an opioid because it may cause you to stop breathing, which can lead to death:

- Alcohol. Do not drink any kind of alcohol while you are taking opioid medicines.

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Urine Drug Screens

- Remember – Unexpected Screening results need to be confirmed. Tramadol, fentanyl, methylphenidate always send out quantitative
- There are no "opioid emergencies" other than respiratory arrest
- Be firm but empathetic
  - "I can't prescribe this medicine safely without these tests" (compare - DM, DVT)
  - "I'm not accusing you of being a drug addict. Our system has decided for the safety of our patients and community – we need to apply these approaches to safe prescribing and monitoring to ALL" (compare – child abuse clearances)

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Urine Drug Tests: Ordering and Interpretation

Neelima Kale, PhD, MD, MBA, University of Texas Southwestern Medical Center, Dallas, Texas

Urine drug testing is an essential component of monitoring patients who are receiving long-term opioid therapy, and it has been suggested for patients receiving long-term benzodiazepine or stimulant therapy. Family physicians should be familiar with the characteristics and capabilities of screening and confirmatory drug tests. Immunoassays are qualitative tests used for initial screening of urine samples. They can give false-positive and false-negative results, so all results are considered presumptive until confirmatory testing is performed. Immunoassays for opioids may not detect commonly prescribed semisynthetic and synthetic opioids such as methadone and fentanyl; similarly, immunoassays for benzodiazepines may not detect alprazolam or clonazepam. Immunoassays can cross-react with other medications and give false-positive results, which have important implications for a patient's pain treatment plan. False-negative results can cause missed opportunities to detect misuse. Urine samples can be adulterated with other substances to mask positive results on urine drug testing. Family physicians must be familiar with these substances, the methods to detect them, and their effects on urine drug testing. (*Am Fam Physician*. 2019;99(1):33-39. Copyright © 2019 American Academy of Family Physicians.)

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Naloxone Prescribing

- Going in and coming out of
  - Jail, rehab
- daily opioid dose > 50 mg morphine equivalent
- methadone any dose
- h/o Substance Abuse
- PA Standing order
- educate Pt/family

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Community Acupuncture
Summer 2017 Groups
Opioid Safety Efforts
Community Coordination & Planning
Group Therapy
Chronic Pain Management
For Individuals Coping with Chronic Pain or Illness
Non-opioid pain interventions are being expanded
• WS Mind Body Center
(Community Acupuncture)
• WS Philhaven
Pain Management series
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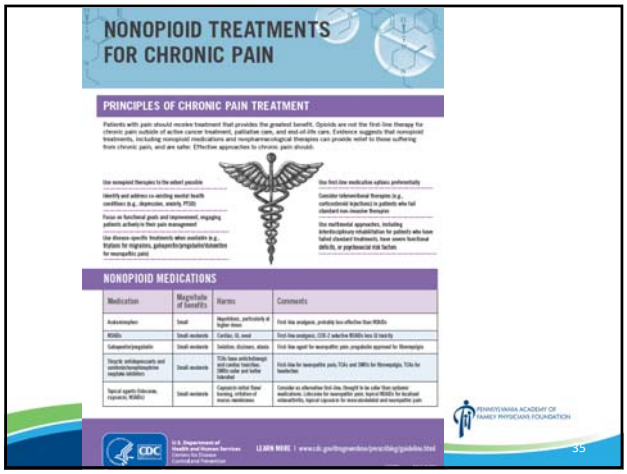
NONOPIOID TREATMENTS FOR CHRONIC PAIN
PRINCIPLES OF CHRONIC PAIN TREATMENT
NONOPIOID MEDICATIONS
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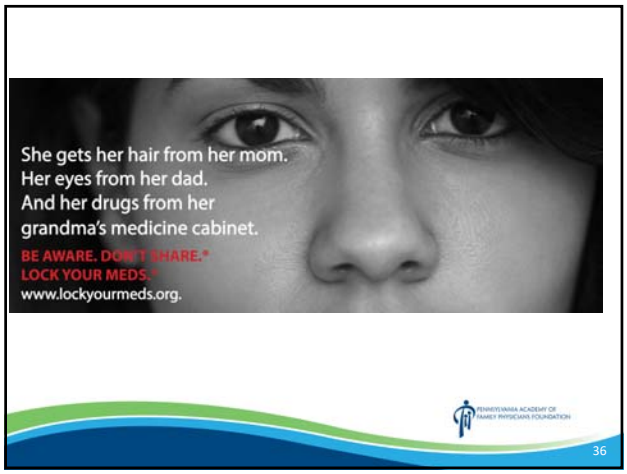
She gets her hair from her mom.
Her eyes from her dad.
And her drugs from her grandma's medicine cabinet.
BE AWARE. DON'T SHARE.®
LOCK YOUR MEDS.®
www.lockyourmeds.org.
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Securing and Disposing of Meds

- $10 can save a life
- May still steal or break open – but at least you will know
- "It is important for you to destroy any leftover medicine"
- OpioidAware.org for takeback locations

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2015 PENNSYLVANIA YOUTH SURVEY

- Heroin Use 0.4%
- Opioid Prescription Drug Use 5.7%
  - 42.4% took them from a family member living in their home
  - 46.8% received them from a friend or family member
  - 21.7% bought them from someone
- 26% of youth say it is "sort of easy" or "very easy" to access prescription pain drugs

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PRESCRIPTION OPIOID ANALGESICS COMMONLY UNUSED AFTER SURGERY - A SYSTEMATIC REVIEW

- 6 studies
- 810 unique patients
- Orthopedic, thoracic, obstetric, and general surgical procedures
- 67% - 92% reported unused opioids
- Rates of safe storage and/or disposal of unused opioids were low

Mark C. Bicket, MD, et al. Johns Hopkins
JAMA Surgery. Published online August 2, 2017

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JOHNS HOPKINS EXPERT RECOMMENDATIONS
JOURNAL OF THE AMERICAN COLLEGE OF SURGEONS (2018), DOI: 10.1016/J.JAMCOLLSURG.2018.07.659

Procedure	Range (minimum-maximum)
General surgery	
Laparoscopic cholecystectomy (1)*	0-10
Laparoscopic inguinal hernia repair, unilateral (2)*	0-15
Open inguinal hernia repair, unilateral (3)*	0-10
Open umbilical hernia repair	0-15
Breast surgery	
Partial mastectomy without sentinel lymph node biopsy (4)*	0-10
Partial mastectomy with sentinel lymph node biopsy (5)*	0-15
Thoracic surgery	
Video assisted thoracoscopic wedge resection	0-20
Orthopaedic surgery	
Arthroscopic partial meniscectomy	0-10
Arthroscopic ACL/PCL repair	0-20
Arthroscopic rotator cuff repair	0-20
ORIF of the ankle	0-20
Gynecologic surgery and obstetric delivery	
Open hysterectomy	0-20
Minimally invasive hysterectomy	0-10
Uncomplicated cesarean delivery	0-10
Uncomplicated vaginal delivery	0
Urologic surgery	
Robotic retropubic prostatectomy	0-10
Otolaryngology	
Thyroidectomy, partial or total	0-15
Cochlear implant	0
Cardiac surgery	
Coronary artery bypass grafting	0-20
Cardiac catheterization	0

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Managing Surgical Pain: Non-opioid Options and Safe Opioid Use

https://youtu.be/kW6ovg3Ceww

Procedure	Baseline Avg Pills	Oct Avg Pills	Opioid reduction
Hernia	26	15	42%
Lap Chole	20	16	18%
C-Section	24	16	36%
Total Hip	74	41	44%
Total Knee	77	49	37%
Cervical Fusion	40	30	25%
Lumbar Fusion	50	25	50%

Decrease in opioid prescriptions at discharge:

13,405
Oxycodone 5mg pills

By 5 surgical teams in 2018

WELLSPAN HEALTH

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OB/GYN Opioid Reduction Work

Total MME of Oxy Given Quarterly on T4	Lower is better	BASELINE -QUARTER 1= 44,235 MMEs
		QUARTER 3=14,205 MME

January	Feburary	March	Aug	Sept	Oct
1290 doses of oxycodone 10mg given			258 doses of oxycodone 10mg given		
1008 doses of oxycodone 5mg given			1257 doses of oxycodone 5mg given		

- Tylenol Given Pre-Op C/Sec
- Post-Op Abdominal Binder Use
- Gum Chewing Used
- Simethicone Used
- Regularly Scheduled Ibuprofen/Tylenol Received

WELLSPAN HEALTH

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Who Does that?
What's Wrong with Her?

Addiction is a Chronic Disease

"I was never a bad person, but drugs made me do bad things."

Ashley Potts
Certified Recovery Specialist, Washington County Drug and Alcohol Commission

A Windsor Township woman allegedly admitted to snorting heroin before she passed out in her running car on Friday, York Area Regional police said. Her infant son was in the back of her car for about 20 minutes before officers and paramedics arrived

Need to increase:
- Our staff's understanding of addiction
- Identify patients (and staff) with addiction
- Support for addicted patients and for care teams

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Safe Disposal of Drugs and Medicines

Prescription medication is important, to be used when you are sick and have certain health problems. It also needs to be stored correctly and you should never reuse leftover medicines without talking to your doctor first. There is a right way to get rid of leftover medicines. Learn more about safe disposal methods and local drug take-back programs.

Additional Resources

- Video: Understanding addiction
- Drug abuse and dependence
- Questions about substance abuse treatment programs
- Inpatient and outpatient treatment for substance abuse
- Residential treatment for substance abuse
- Teen substance abuse: choosing a treatment program

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Scope of the problem

Non-Medical Opioid Users

Estimated 825 non-medical users of opioids for every overdose death and that 4 of 5 people that overdose had an opioid pain medicine prescribed to them or a family member.

Increase in Overdose Deaths

In South Central PA 442% increase in overdose admission due to prescription opioids, 305% increase in overdose admissions due to heroin

Opioid Withdraw Cases

Admissions to WellSpan York Hospital NICU for Neonatal Abstinence Syndrome (opioid withdraw) has increased from 10 cases in 2007 to 99 cases in 2015

In Recovery (2012 Survey)

10 % of all American adults, ages 18 and older, consider themselves to be in recovery from drug or alcohol abuse problems (23.5 million)

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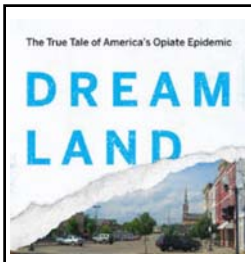
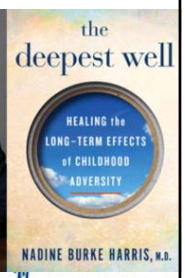


Sam Quinones
LA Times Reporter/Author

ACEs and Health



Medication Assisted Treatment For Addiction

- Buprenorphine (Suboxone), Vivitrol
- 1-844-PHILHAVEN

Challenges Ahead

- Accessibility of comprehensive coordinated pain evaluation (physical health, cognitive behavioral therapy, physical therapy, pharmacy, complimentary medicine, and addiction evaluation as appropriate)
  - Available centers
  - Insurance coverage, co-pays
- Addiction treatment
  - Availability and Coordination
- Public Attitude – "let them die" (Naloxone)

Questions? – cechterling@wellspan.org

Opioid Resources and Stats

www.wellspan.org/opioids

Pain resources, “Understanding Addiction” and “Managing Surgical Pain: Non-opioid Options and Safe Opioid Use” videos (bottom of page), Controlled Substance Agreement Video, “Safe Disposal of Drugs and Medicines” handout, addiction resources

www.wellspan.org/MAT

videos and materials explaining Medication Assisted Treatment for Addiction

CDC Opioid Guideline Mobile App: https://www.cdc.gov/drugoverdose/prescribing/app.html

www.OpioidAware.org

South Central Opioid Awareness Coalition – co-founded by WellSpan Health

Over Dose Free PA – County Overdose statistics, local treatment resources, naloxone and drug takeback boxes

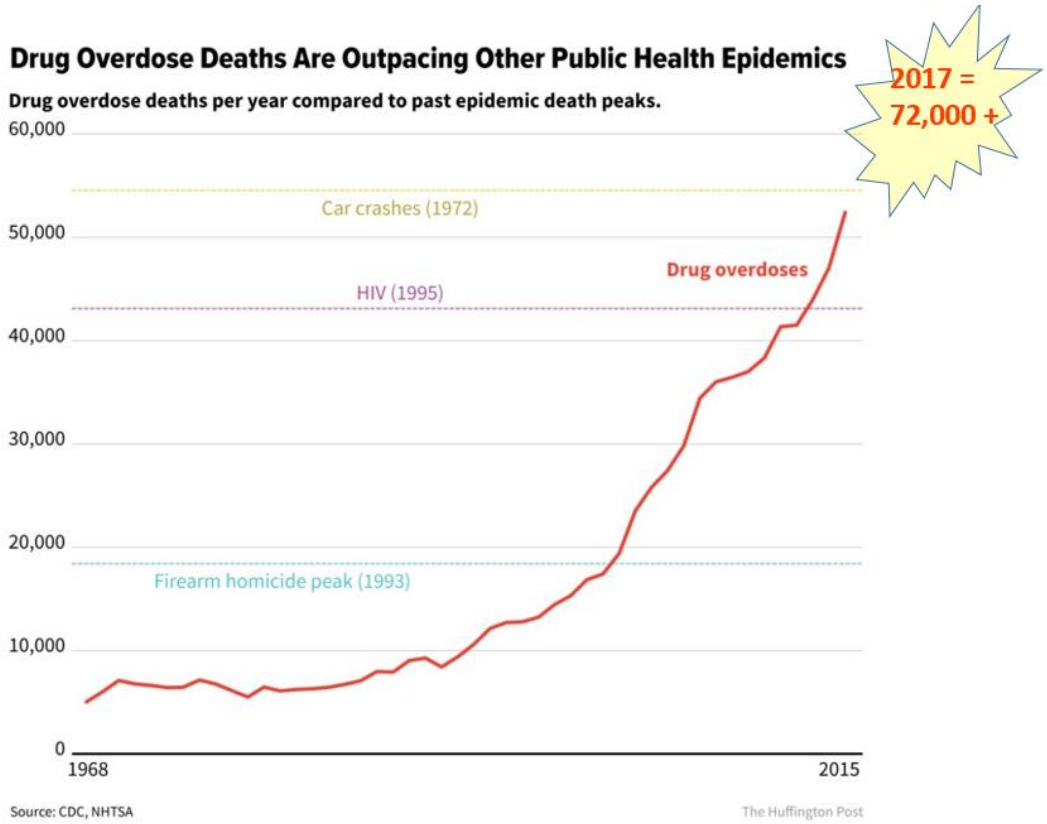
https://www.overdosefreepa.pitt.edu/

Dreamland - The True Tale Of America's Opiate Epidemic by Sam Quinones

https://www.npr.org/books/titles/406835887/dreamland-the-true-tale-of-americas-opiate-epidemic

The Deepest Well: Healing the Long-Term Effects of Childhood Adversity by Nadine Burke Harris

Ted Talk by Dr. Burke Harris: https://www.ted.com/speakers/nadine_burke_harris_1



Safe Disposal of Medicines

Medicines are drugs prescribed by your doctor such as antibiotics, opioids for pain, and other over the counter drugs. They need to be stored in a correct way for use. You should never reuse leftover medicines without talking to your doctor first. There is a right way to get rid of leftover medicines. Look at the medicines you have on hand. Old out dated and unused ones should be thrown away.

How do I safely dispose of drugs and medicines?

Throwing away expired or unused medicines in the right way can protect you and your loved ones from harm. It will also prevent the medicines from getting into someone else's hands for use. Follow the instructions on the label or package inserts to know how to safely dispose of your drugs and medicines. DO NOT flush down the toilet or sink unless the label or patient information insert tells you to do this.

Follow these steps before throwing away medicines in the trash:

1. Pour medicine into a plastic bag that seals. Add water to help dissolve the medicine.
2. Add kitty litter, dirt or coffee grounds (something that will make it less appealing for pets and children to eat) to the plastic bag.
3. Seal the plastic bag and put it in the trash.
4. Remove and destroy any personal information (such as the label with your name) from the medicine container before recycling or throwing it away.

Drug Take-back Programs

Drug take-back programs are a good way to get rid of expired, unwanted or unused medicines and drugs from the home. This will lower the risk that others may accidentally take the medicine.

Local drug take-back program information:

Many police stations have drug take-back boxes in their lobbies. To find the nearest take back box:

- Adams County - call 717-783-8200
- Lancaster County - call 717-397-9968
- Lebanon County - call 717-783-8200
- York County - call 717-845-1066

Other resources:

- York County Solid Waste Authority
  www.ycswa.com
- PA Dept. of Drug and Alcohol Programs - Drug Take-back Program
  www.ddap.pa.gov

*** WellSpan Medical Groups and other facilities DO NOT accept medicine or drugs for disposal.**

At this time, the following WellSpan Outpatient Pharmacy locations will accept medicines for disposal:

- **WellSpan Pharmacy, York Hospital**
- **WellSpan Pharmacy, Apple Hill Medical Center**
- **WellSpan Pharmacy, Fairfield**
- **WellSpan Pharmacy, Good Samaritan Hospital**
- **WellSpan Pharmacy, Ephrata Community Hospital**

Poison help: 1-800-222-1222

Keep all drugs and medicines out of sight and reach of children.

15007 PE INTELLIPRINT 09/17

[PATIENT LABEL]

Controlled Substance Agreement – WellSpan Health

Patient Name: _____ DOB: _____

Active Controlled Drug List: _____

These drugs are controlled by state and federal laws and include opioid (narcotic) pain drugs, ADHD drugs, anxiety drugs, and drugs to help with sleep.

Controlled drugs are prescribed to:

- Reduce pain, anxiety, or attention problems
- Improve function or activity (such as: sleep or school performance)
- Be used along with other treatments- drugs work best this way (such as: Physical & Occupational Therapy, exercise, and modifying study habits)

Controlled drugs have risks of:

- Side effects (nausea, constipation, confusion, some times more pain)
- Negative interactions with certain drugs (including alcohol) which should not be used
- Dependence, Tolerance & Withdrawal (illness with sudden stopping of drug – including newborns)
- Abuse & Addiction (loss of control over the use of the drug)

To ensure health and safety for you and the community, WellSpan Health and you should agree upon the following terms prior to controlled drugs being prescribed to you. **Not following this Controlled Substance Agreement may result in WellSpan Health not being able to prescribe your controlled drugs.**

Patient Agrees:

- I will get my controlled drugs from this office only. If I get *ANY* controlled drugs from anywhere else, I will call or secure message this office the next business day.
- I will tell other health care providers about this Controlled Substance Agreement, including emergency departments and urgent care centers.
- I will not miss appointments and I am willing to use other treatments that may be recommended.
- I will request refills 2 business days before I run out, and only during office hours
- I will not use more than prescribed, and I will not request early refills.
- I will keep all drugs out of the reach of children and in a secure place. I will not request a prescription for lost or stolen drugs.
- I will not share or sell these drugs with anyone.
- I will not take street drugs or any form of marijuana.
- I agree to pill counts and urine drug screens when requested, even if I must pay for the tests
- Treat my treatment team with dignity and respect

I read (or have had read to me) and agree to the above:

Patient Signature: _____

Patient Name (Print): _____

Date: _____

Medical Office Agrees:

- To protect privacy of your medical information as required by law. We may share information, such as the use, or concern for misuse, of controlled drugs with other health care providers.
- To do our best to help you function better, even if we need to stop your controlled drugs.
- To be aware of medical guidelines when prescribing
- We will help you avoid side effects, misuse, abuse, and addiction.
- To tell you if we are concerned about controlled drug misuse, and if needed, we will help you heal from addiction.
- By law, to report to the Department of Transportation, if we believe that the drugs may affect your ability to safely drive a vehicle.
- To follow state and federal laws, like checking computer records when prescribing controlled drugs.
- To always treat you with dignity and respect as a partner in your care.

I agree to hold my office to the above:

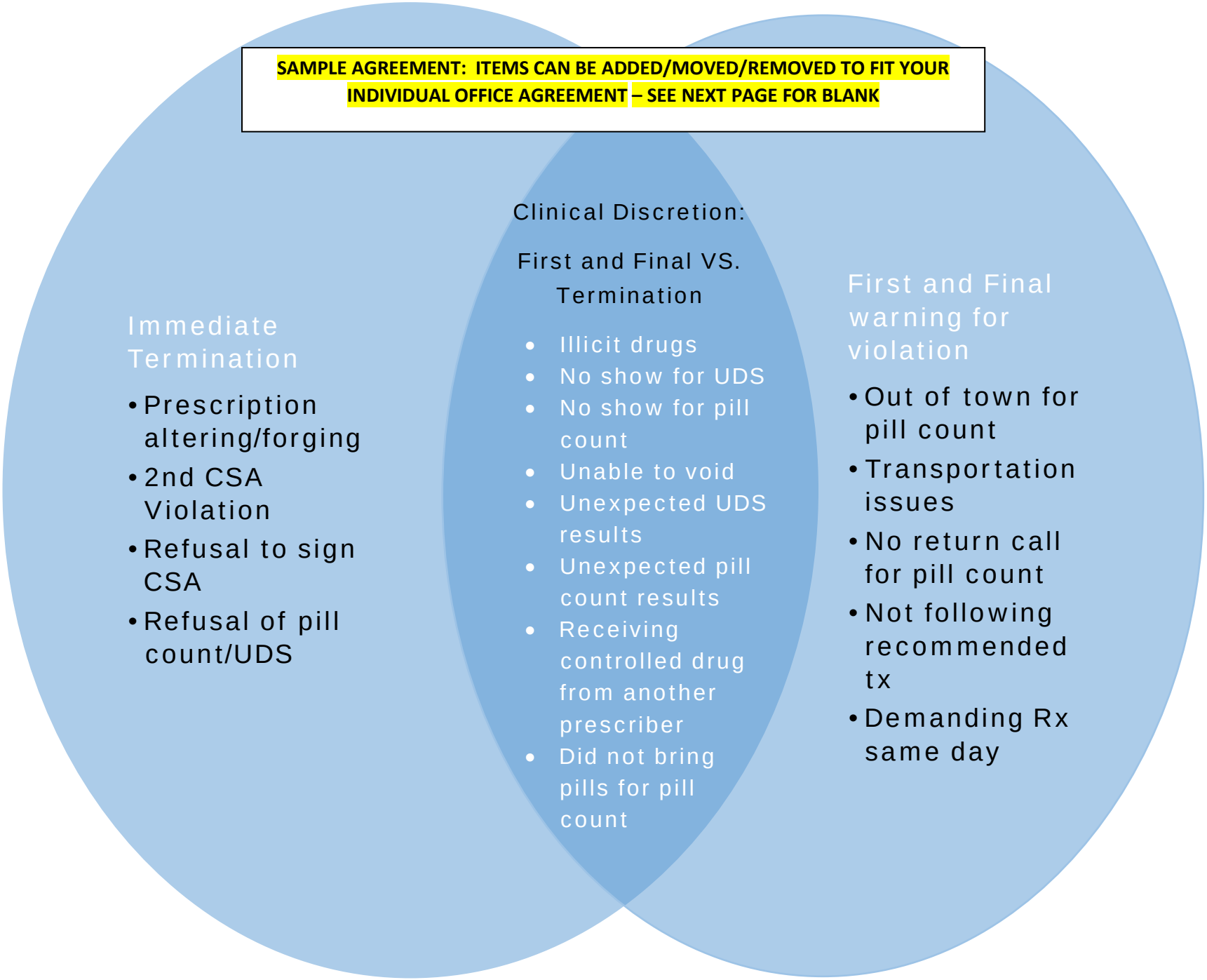
Physician/APC Signature: _____

Name (print): _____

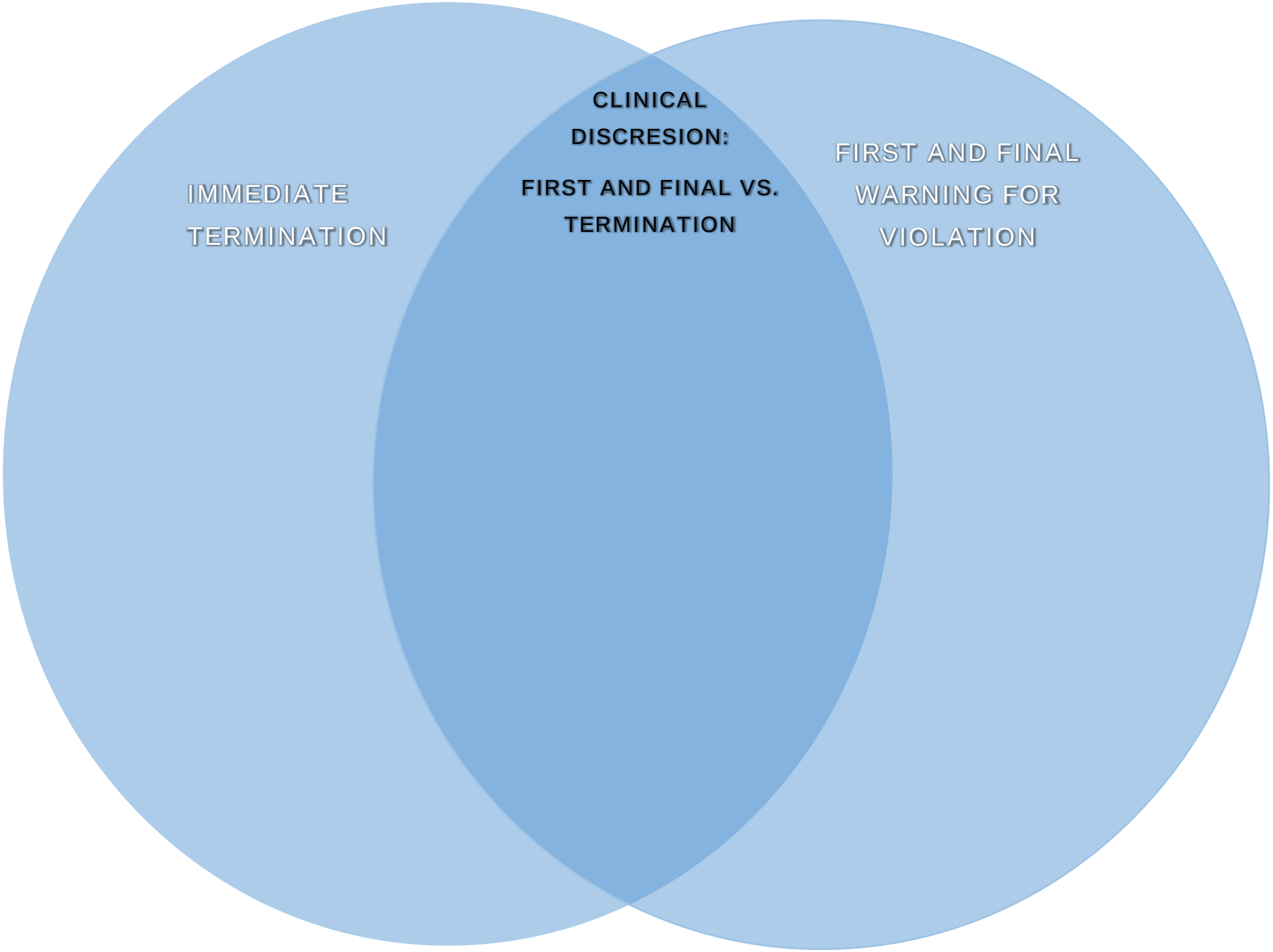
Office: _____

Date: _____

SAMPLE AGREEMENT: ITEMS CAN BE ADDED/MOVED/REMOVED TO FIT YOUR INDIVIDUAL OFFICE AGREEMENT – SEE NEXT PAGE FOR BLANK



CSA VIOLATION SCENARIOS/PRESCRIBER AGREEMENT PRACTICE NAME DATE



CSA VIOLATION SCENARIOS/PRESCRIBER AGREEMENT PRACTICE NAME DATE

PHYSICIAN/APC AGREEMENT

- All violation decisions must be made by the prescribing provider or previous shared agreement of the practice.
- The provider may choose not to give a first and final warning for a first violation listed in the middle section above and instead issue a CSA termination and no longer prescribe controlled substances to the patient.
- Warnings/Violations will be documented in the overview section of "Controlled Substance Agreement Violation" and/or "Controlled Substance Agreement Termination" on the patient's Problem List by the provider or designee.
- A provider should NOT give a 2nd "first and final" warning without the agreement of the provider group during the next provider meeting or by conversations with colleagues

I agree to the above CSA violation scenarios. I have come to a unified agreement with my colleagues in the practice and will be accountable for my adherence to this agreement. I will not discriminate based on age/sex/race/personal relationship with my patient(s). I will not deviate from the above scenarios unless presented to the entire group and we come to a shared decision.

Signature_____Date_____

Signature_____Date_____

Signature_____Date_____

Signature_____Date_____

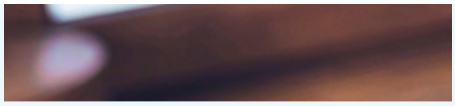
Signature_____Date_____

Signature_____Date_____

Signature_____Date_____



Opioid addiction can affect anyone.




Addiction is a life-threatening illness that takes over the brain. It impacts your chance to enjoy life, hold a job, keep good relationships and be healthy.

Help is available.

No treatment is one-size-fits-all. We take a customized, whole-person approach to make sure all of your needs are met on your path to recovery.

MEDICATION

Medication-Assisted Treatment (MAT) reduces opioid cravings, providing physical relief so that you can focus on getting your life back on track.

COUNSELING

Specialists can help you uncover what led to your addiction and what needs must be met to achieve recovery.

RECOVERY SUPPORT

From help with legal needs to transportation, getting a job and fixing relationships, we connect you with the help you need.

With support, recovery is possible. We'll help you get back to a healthy life.

Ready to begin treatment? Call 1-844-Philhaven (1-844-744-5428)

Your Journey

Our team is ready to help you get back on your feet. Medication Assisted Treatment (MAT) can quickly reduce your opioid cravings so that you can begin your path toward recovery.

Here's what you can expect:

- More frequent visits to start; appointments will then become weekly for several weeks
- Urine drug screens and medication counts as a routine part of treatment
- Discussion with your MAT prescriber about which medicines are safe to use when in MAT
- Assistance from a recovery specialist in overcoming barriers, like finances and transportation issues, so that you can follow your treatment plan
- Open talk about relapse; relapse is not uncommon and should not be seen as a complete failure or a sign that recovery is not possible. If, despite support, a person still uses non-prescribed drugs, this might mean that MAT is not the right treatment, and a different recovery program may be needed.

This project is led by WellSpan Health as a community resource and is funded, in part, under a grant with the Pennsylvania Department of Health. Basic data for use in this study were supplied by the Pennsylvania Department of Health, Harrisburg, Pennsylvania. The Department takes no part in and is in no way responsible for any analyses, interpretations or conclusions.

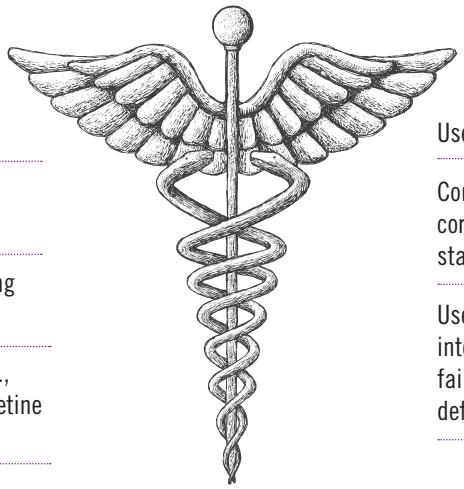
WellSpan Health

NONOPIOID TREATMENTS FOR CHRONIC PAIN

PRINCIPLES OF CHRONIC PAIN TREATMENT

Patients with pain should receive treatment that provides the greatest benefit. Opioids are not the first-line therapy for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. Evidence suggests that nonopioid treatments, including nonopioid medications and nonpharmacological therapies can provide relief to those suffering from chronic pain, and are safer. Effective approaches to chronic pain should:

- Use nonopioid therapies to the extent possible
- Identify and address co-existing mental health conditions (e.g., depression, anxiety, PTSD)
- Focus on functional goals and improvement, engaging patients actively in their pain management
- Use disease-specific treatments when available (e.g., triptans for migraines, gabapentin/pregabalin/duloxetine for neuropathic pain)



- Use first-line medication options preferentially
- Consider interventional therapies (e.g., corticosteroid injections) in patients who fail standard non-invasive therapies
- Use multimodal approaches, including interdisciplinary rehabilitation for patients who have failed standard treatments, have severe functional deficits, or psychosocial risk factors

NONOPIOID MEDICATIONS

Medication	Magnitude of benefits	Harms	Comments
Acetaminophen	Small	Hepatotoxic, particularly at higher doses	First-line analgesic, probably less effective than NSAIDs
NSAIDs	Small-moderate	Cardiac, GI, renal	First-line analgesic, COX-2 selective NSAIDs less GI toxicity
Gabapentin/pregabalin	Small-moderate	Sedation, dizziness, ataxia	First-line agent for neuropathic pain; pregabalin approved for fibromyalgia
Tricyclic antidepressants and serotonin/norephinephrine reuptake inhibitors	Small-moderate	TCAs have anticholinergic and cardiac toxicities; SNRIs safer and better tolerated	First-line for neuropathic pain; TCAs and SNRIs for fibromyalgia, TCAs for headaches
Topical agents (lidocaine, capsaicin, NSAIDs)	Small-moderate	Capsaicin initial flare/ burning, irritation of mucus membranes	Consider as alternative first-line, thought to be safer than systemic medications. Lidocaine for neuropathic pain, topical NSAIDs for localized osteoarthritis, topical capsaicin for musculoskeletal and neuropathic pain

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LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

CS263451 March 14, 2016

RECOMMENDED TREATMENTS FOR COMMON CHRONIC PAIN CONDITIONS

Low back pain

Self-care and education in all patients; advise patients to remain active and limit bedrest

Nonpharmacological treatments: Exercise, cognitive behavioral therapy, interdisciplinary rehabilitation

Medications

- First line: acetaminophen, non-steroidal anti inflammatory drugs (NSAIDs)
- Second line: Serotonin and norepinephrine reuptake inhibitors (SNRIs)/tricyclic antidepressants (TCAs)

Migraine

Preventive treatments

- Beta-blockers
- TCAs
- Antiseizure medications
- Calcium channel blockers
- Non-pharmacological treatments (Cognitive behavioral therapy, relaxation, biofeedback, exercise therapy)
- Avoid migraine triggers

Acute treatments

- Aspirin, acetaminophen, NSAIDs (may be combined with caffeine)
- Antinausea medication
- Triptans-migraine-specific

Neuropathic pain

Medications: TCAs, SNRIs, gabapentin/pregabalin, topical lidocaine

Osteoarthritis

Nonpharmacological treatments: Exercise, weight loss, patient education

Medications

- First line: Acetamionphen, oral NSAIDs, topical NSAIDs
- Second line: Intra-articular hyaluronic acid, capsaicin (limited number of intra-articular glucocorticoid injections if acetaminophen and NSAIDs insufficient)

Fibromyalgia

Patient education: Address diagnosis, treatment, and the patient's role in treatment

Nonpharmacological treatments: Low-impact aerobic exercise (i.e. brisk walking, swimming, water aerobics, or bicycling), cognitive behavioral therapy, biofeedback, interdisciplinary rehabilitation

Medications

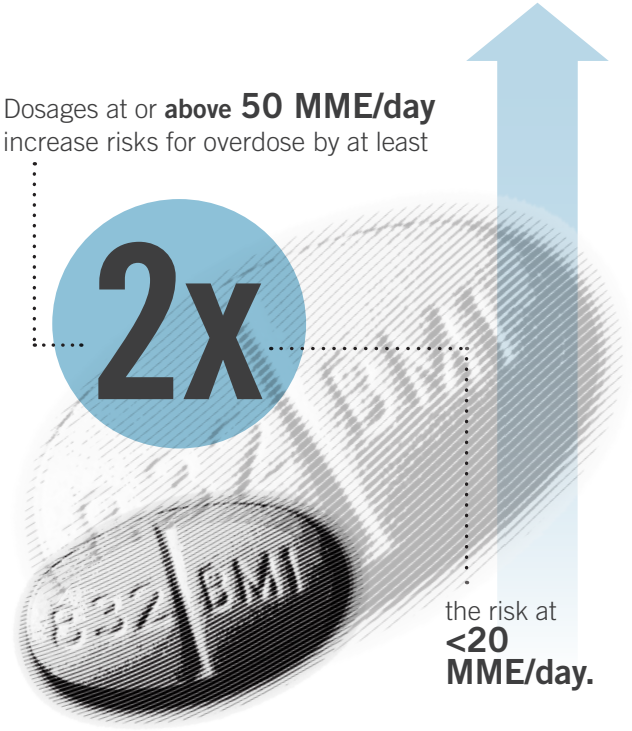
- FDA-approved: Pregabalin, duloxetine, milnacipran
- Other options: TCAs, gabapentin

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

CALCULATING TOTAL DAILY DOSE OF OPIOIDS FOR SAFER DOSAGE

Higher Dosage, Higher Risk.

Higher dosages of opioids are associated with higher risk of overdose and death—even relatively low dosages (20-50 morphine milligram equivalents (MME) per day) increase risk. Higher dosages haven't been shown to reduce pain over the long term. One randomized trial found no difference in pain or function between a more liberal opioid dose escalation strategy (with average final dosage 52 MME) and maintenance of current dosage (average final dosage 40 MME).



WHY IS IT IMPORTANT TO CALCULATE THE TOTAL DAILY DOSAGE OF OPIOIDS?

Patients prescribed higher opioid dosages are at higher risk of overdose death.

In a national sample of Veterans Health Administration (VHA) patients with chronic pain receiving opioids from 2004–2009, **patients who died** of opioid overdose were prescribed an average of **98 MME/day**, while **other patients** were prescribed an average of **48 MME/day**.

Calculating the total daily dose of opioids helps identify patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose.

HOW MUCH IS 50 OR 90 MME/DAY FOR COMMONLY PRESCRIBED OPIOIDS?

50 MME/day:

- 50 mg of hydrocodone (10 tablets of hydrocodone/acetaminophen 5/300)
- 33 mg of oxycodone (~2 tablets of oxycodone sustained-release 15 mg)
- 12 mg of methadone (<3 tablets of methadone 5 mg)

90 MME/day:

- 90 mg of hydrocodone (9 tablets of hydrocodone/acetaminophen 10/325)
- 60 mg of oxycodone (~2 tablets of oxycodone sustained-release 30 mg)
- ~20 mg of methadone (4 tablets of methadone 5 mg)

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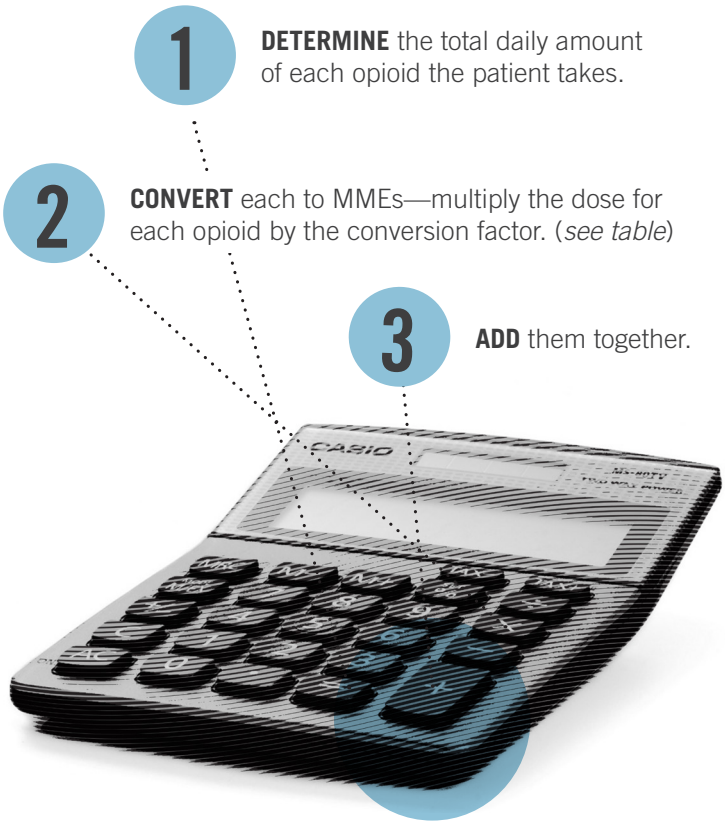
LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

HOW SHOULD THE TOTAL DAILY DOSE OF OPIOIDS BE CALCULATED?



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

These dose conversions are estimated and cannot account for all individual differences in genetics and pharmacokinetics.

CAUTION:

- Do not use the calculated dose in MMEs to determine dosage for converting one opioid to another—the new opioid should be lower to avoid unintentional overdose caused by incomplete cross-tolerance and individual differences in opioid pharmacokinetics. Consult the medication label.

USE EXTRA CAUTION:

- **Methadone:** the conversion factor increases at higher doses
- **Fentanyl:** dosed in mcg/hr instead of mg/day, and absorption is affected by heat and other factors

HOW SHOULD PROVIDERS USE THE TOTAL DAILY OPIOID DOSE IN CLINICAL PRACTICE?

- Use caution when prescribing opioids at any dosage and prescribe the lowest effective dose.
- Use extra precautions when increasing to ≥50 MME per day* such as:
  - Monitor and assess pain and function more frequently.
  - Discuss reducing dose or tapering and discontinuing opioids if benefits do not outweigh harms.
  - Consider offering naloxone.
- Avoid or carefully justify increasing dosage to ≥90 MME/day.*

* These dosage thresholds are based on overdose risk when opioids are prescribed for pain and should not guide dosing of medication-assisted treatment for opioid use disorder.

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

PRESCRIPTION OPIOIDS: WHAT YOU NEED TO KNOW

Prescription opioids can be used to help relieve moderate-to-severe pain and are often prescribed following a surgery or injury, or for certain health conditions. These medications can be an important part of treatment but also come with serious risks. It is important to work with your health care provider to make sure you are getting the safest, most effective care.

WHAT ARE THE RISKS AND SIDE EFFECTS OF OPIOID USE?

Prescription opioids carry serious risks of addiction and overdose, especially with prolonged use. An opioid overdose, often marked by slowed breathing, can cause sudden death. The use of prescription opioids can have a number of side effects as well, even when taken as directed:

- Tolerance—meaning you might need to take more of a medication for the same pain relief
- Physical dependence—meaning you have symptoms of withdrawal when a medication is stopped
- Increased sensitivity to pain
- Constipation
- Nausea, vomiting, and dry mouth
- Sleepiness and dizziness
- Confusion
- Depression
- Low levels of testosterone that can result in lower sex drive, energy, and strength
- Itching and sweating

As many as **1 in 4** PEOPLE*

receiving prescription opioids long term in a primary care setting struggles with addiction.

* Findings from one study

RISKS ARE GREATER WITH:

- History of drug misuse, substance use disorder, or overdose
- Mental health conditions (such as depression or anxiety)
- Sleep apnea
- Older age (65 years or older)
- Pregnancy

Avoid alcohol while taking prescription opioids. Also, unless specifically advised by your health care provider, medications to avoid include:

- Benzodiazepines (such as Xanax or Valium)
- Muscle relaxants (such as Soma or Flexeril)
- Hypnotics (such as Ambien or Lunesta)
- Other prescription opioids

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

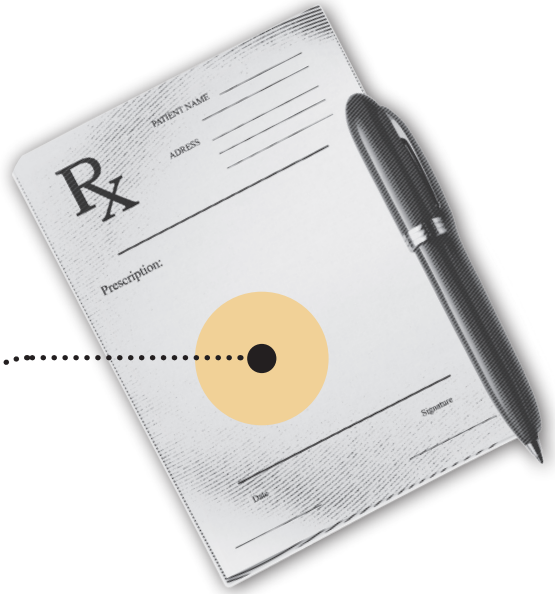
American Hospital Association®

CS264107C May 9, 2016

KNOW YOUR OPTIONS

Talk to your health care provider about ways to manage your pain that don't involve prescription opioids. Some of these options **may actually work better** and have fewer risks and side effects. Options may include:

- Pain relievers such as acetaminophen, ibuprofen, and naproxen
- Some medications that are also used for depression or seizures
- Physical therapy and exercise
- Cognitive behavioral therapy, a psychological, goal-directed approach, in which patients learn how to modify physical, behavioral, and emotional triggers of pain and stress.



Be Informed!

Make sure you know the name of your medication, how much and how often to take it, and its potential risks & side effects.

IF YOU ARE PRESCRIBED OPIOIDS FOR PAIN:

- Never take opioids in greater amounts or more often than prescribed.
- Follow up with your primary health care provider within ____ days.
  - Work together to create a plan on how to manage your pain.
  - Talk about ways to help manage your pain that don't involve prescription opioids.
  - Talk about any and all concerns and side effects.
- Help prevent misuse and abuse.
  - Never sell or share prescription opioids.
  - Never use another person's prescription opioids.
- Store prescription opioids in a secure place and out of reach of others (this may include visitors, children, friends, and family).
- Safely dispose of unused prescription opioids: Find your community drug take-back program or your pharmacy mail-back program, or flush them down the toilet, following guidance from the Food and Drug Administration (www.fda.gov/Drugs/ResourcesForYou).
- Visit www.cdc.gov/drugoverdose to learn about the risks of opioid abuse and overdose.
- If you believe you may be struggling with addiction, tell your health care provider and ask for guidance or call SAMHSA's National Helpline at 1-800-662-HELP.

CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

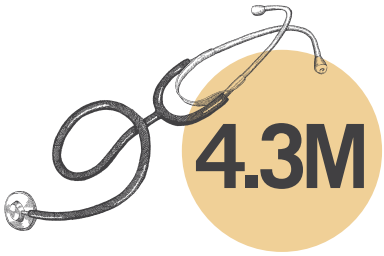
Promoting Patient Care and Safety

THE US OPIOID OVERDOSE EPIDEMIC

The United States is in the midst of an epidemic of prescription opioid overdoses. The amount of opioids prescribed and sold in the US quadrupled since 1999, but the overall amount of pain reported by Americans hasn't changed. This epidemic is devastating American lives, families, and communities.

More than 40 people die every day from overdoses involving prescription opioids.[1]

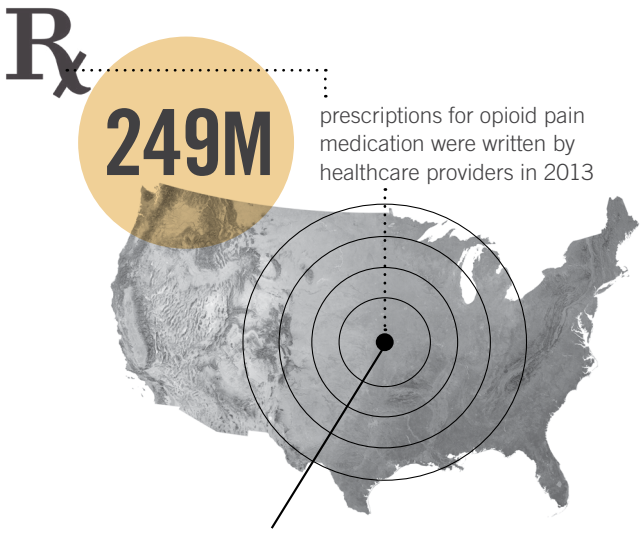
Since 1999, there have been over 165,000 deaths from overdose related to prescription opioids.[1]



4.3 million Americans engaged in non-medical use of prescription opioids in the last month.[2]

PRESCRIPTION OPIOIDS HAVE BENEFITS AND RISKS

Many Americans suffer from chronic pain. These patients deserve safe and effective pain management. Prescription opioids can help manage some types of pain in the short term. However, we don't have enough information about the benefits of opioids long term, and we know that there are serious risks of opioid use disorder and overdose—particularly with high dosages and long-term use.



enough prescriptions were written for every American adult to have a bottle of pills

[1] Includes overdose deaths related to methadone but does not include overdose deaths related to other synthetic prescription opioids such as fentanyl.

[2] National Survey on Drug Use and Health (NSDUH), 2014

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

NEW CDC GUIDELINE WILL HELP IMPROVE CARE, REDUCE RISKS

The Centers for Disease Control and Prevention (CDC) developed the *CDC Guideline for Prescribing Opioids for Chronic Pain* (Guideline) for primary care clinicians treating adult patients for chronic pain in outpatient settings. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care. The Guideline was developed to:

- Improve communication between clinicians and patients about the benefits and risks of using prescription opioids for chronic pain
- Provide safer, more effective care for patients with chronic pain
- Help reduce opioid use disorder and overdose

The Guideline provides recommendations to primary care clinicians about the appropriate prescribing of opioids to improve pain management and patient safety. It will:

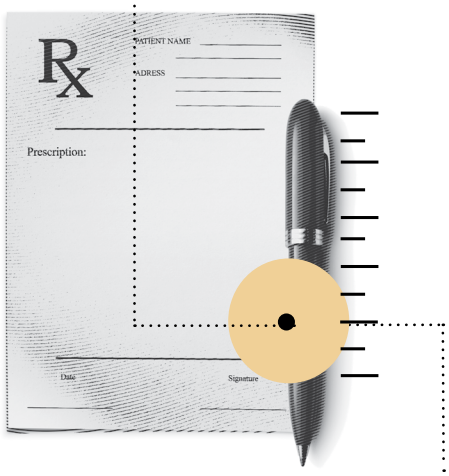
- Help clinicians determine if and when to start prescription opioids for chronic pain
- Give guidance about medication selection, dose, and duration, and when and how to reassess progress, and discontinue medication if needed
- Help clinicians and patients—together—assess the benefits and risks of prescription opioid use

Among the 12 recommendations in the Guideline, there are three principles that are especially important to improving patient care and safety:

- ☑ Nonopioid therapy is preferred for chronic pain outside of active cancer, palliative, and end-of-life care.
- ☑ When opioids are used, the lowest possible effective dosage should be prescribed to reduce risks of opioid use disorder and overdose.
- ☑ Clinicians should always exercise caution when prescribing opioids and monitor all patients closely.

To develop the Guideline, CDC followed a transparent and rigorous scientific process using the best available scientific evidence, consulting with experts, and listening to comments from the public and partners.

patients receiving long-term **opioid therapy** in primary care settings



struggle with **opioid use disorder.**

PATIENT CARE AND SAFETY IS CENTRAL TO THE GUIDELINE

Before starting opioids to treat chronic pain, patients should:

- Make the most informed decision with their doctors
- Learn about prescription opioids and know the risks
- Consider ways to manage pain that do not include opioids, such as:
  - Physical therapy
  - Exercise
  - Nonopioid medications, such as acetaminophen or ibuprofen
  - Cognitive behavioral therapy (CBT)

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

CDC RECOMMENDATIONS

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

1 OPIOIDS ARE NOT FIRST-LINE THERAPY

Nonpharmacologic therapy and **nonopioid pharmacologic therapy** are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

Nonpharmacologic therapies and nonopioid medications include:

- Nonopioid medications such as acetaminophen, ibuprofen, or certain medications that are also used for depression or seizures
- Physical treatments (eg, exercise therapy, weight loss)
- Behavioral treatment (eg, CBT)
- Interventional treatments (eg, injections)

2 ESTABLISH GOALS FOR PAIN AND FUNCTION

Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3 DISCUSS RISKS AND BENEFITS

Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

4 USE IMMEDIATE-RELEASE OPIOIDS WHEN STARTING

When starting opioid therapy for chronic pain, clinicians should prescribe **immediate-release opioids** instead of extended-release/long-acting (ER/LA) opioids.

Immediate-release opioids: faster acting medication with a shorter duration of pain-relieving action

Extended release opioids: slower acting medication with a longer duration of pain-relieving action

5 USE THE LOWEST EFFECTIVE DOSE

When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 **morphine milligram equivalents (MME)/day**, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

Morphine milligram equivalents (MME)/day: the amount of morphine an opioid dose is equal to when prescribed, often used as a gauge of the abuse and overdose potential of the amount of opioid that is being given at a particular time

6 PRESCRIBE SHORT DURATIONS FOR ACUTE PAIN

Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

7 EVALUATE BENEFITS AND HARMS FREQUENTLY

Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

ASSESSING RISK AND ADDRESSING HARMS

8 USE STRATEGIES TO MITIGATE RISK

Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering **naloxone** when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent **benzodiazepine** use, are present.

9 REVIEW PDMP DATA

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 dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10 USE URINE DRUG TESTING

When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11 AVOID CONCURRENT OPIOID AND BENZODIAZEPINE PRESCRIBING

Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

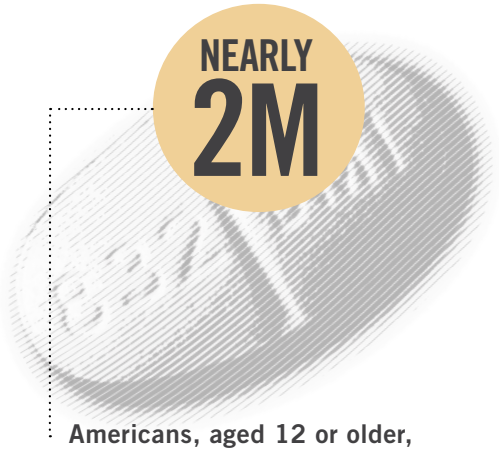
12 OFFER TREATMENT FOR OPIOID USE DISORDER

Clinicians should offer or arrange evidence-based treatment (usually **medication-assisted treatment** with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

Naloxone: a drug that can reverse the effects of opioid overdose

Benzodiazepine: sometimes called "benzo," is a sedative often used to treat anxiety, insomnia, and other conditions

PDMP: a prescription drug monitoring program is a statewide electronic database that tracks all controlled substance prescriptions



Americans, aged 12 or older, either abused or were dependent on prescription opioids in 2014

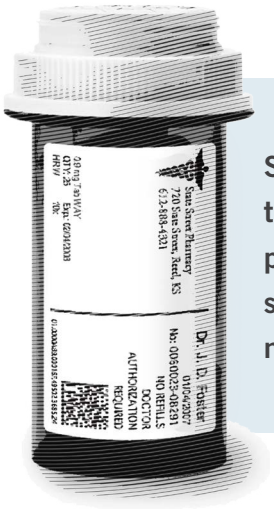
Medication-assisted treatment: treatment for opioid use disorder including medications such as buprenorphine or methadone

CDC OPIOID PRESCRIBING GUIDELINE MOBILE APP

Safer Opioid Prescribing at Your Fingertips

THE OPIOID GUIDE APP

Opioids can have serious risks and side effects, and CDC developed the CDC Guideline for Prescribing Opioids for Chronic Pain to encourage safer, more effective chronic pain management. CDC's new Opioid Guide App makes it easier to apply the recommendations into clinical practice by putting the entire guideline, tools, and resources in the palm of your hand.

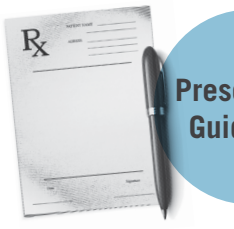


Since 1999, the amount of prescription opioids sold in the U.S. has nearly quadrupled.

FEATURES INCLUDE:

MME Calculator

Patients prescribed higher opioid dosages are at higher risk of overdose death. Use the app to quickly calculate the total daily opioid dose (MME) to identify patients who may need closer monitoring, tapering, or other measures to reduce risk.



Prescribing Guidance

Access summaries of key recommendations or link to the full Guideline to make informed clinical decisions and protect your patients.

Motivational Interviewing (MI)

To provide safer, more effective pain management, talk to your patients about the risks and benefits of opioids and work together towards treatment goals. Use the interactive MI feature to practice effective communication skills and prescribe with confidence.

MANAGING CHRONIC PAIN IS COMPLEX, BUT ACCESSING PRESCRIBING GUIDANCE HAS NEVER BEEN EASIER.

Download the free Opioid Guide App today!

www.cdc.gov/drugoverdose/prescribing/app.html

Available on the App Store

ANDROID APP ON Google play

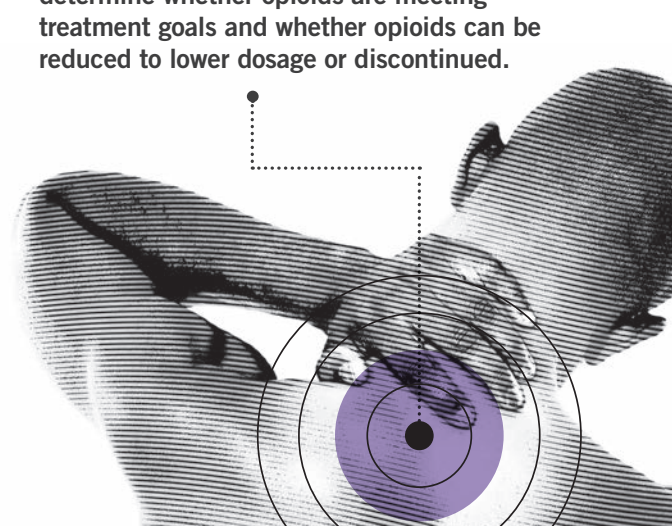
This App, including the calculator, is not intended to replace clinical judgment. Always consider the individual clinical circumstances of each patient.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

POCKET GUIDE: TAPERING OPIOIDS FOR CHRONIC PAIN*

Follow up regularly with patients to determine whether opioids are meeting treatment goals and whether opioids can be reduced to lower dosage or discontinued.

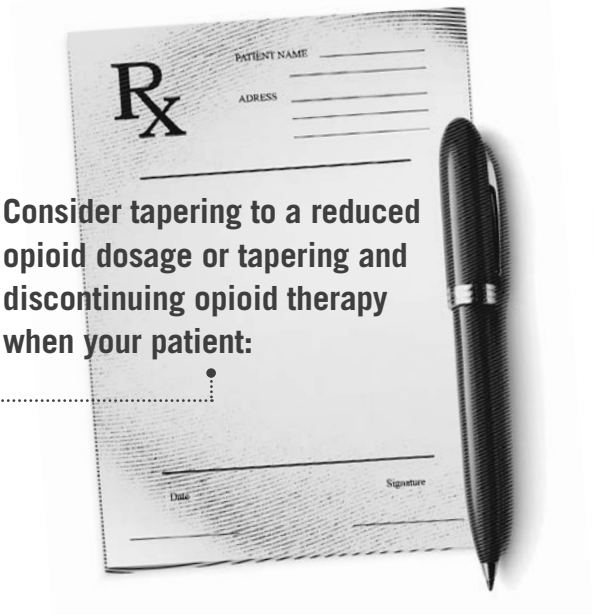


CDC

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

*Recommendations focus on pain lasting longer than 3 months or past the time of normal tissue healing, outside of active cancer treatment, palliative care, and end-of-life care.

WHEN TO TAPER



Consider tapering to a reduced opioid dosage or tapering and discontinuing opioid therapy when your patient:

- requests dosage reduction
- does not have clinically meaningful improvement in pain and function (e.g., at least 30% improvement on the 3-item PEG scale)
- is on dosages ≥ 50 MME*/day without benefit or opioids are combined with benzodiazepines
- shows signs of substance use disorder (e.g. work or family problems related to opioid use, difficulty controlling use)
- experiences overdose or other serious adverse event
- shows early warning signs for overdose risk such as confusion, sedation, or slurred speech

*morphine milligram equivalents

HOW TO TAPER

Tapering plans should be individualized and should minimize symptoms of opioid withdrawal while maximizing pain treatment with nonpharmacologic therapies and nonopioid medications. In general:

Go Slow

A decrease of 10% of the original dose per week is a reasonable starting point. Some patients who have taken opioids for a long time might find even slower tapers (e.g., 10% per month) easier.

Discuss the increased risk for overdose if patients quickly return to a previously prescribed higher dose.

Consult

Coordinate with specialists and treatment experts as needed—especially for patients at high risk of harm such as pregnant women or patients with an opioid use disorder.

Use extra caution during pregnancy due to possible risk to the pregnant patient and to the fetus if the patient goes into withdrawal.

Support

Make sure patients receive appropriate psychosocial support. If needed, work with mental health providers, arrange for treatment of opioid use disorder, and offer naloxone for overdose prevention.

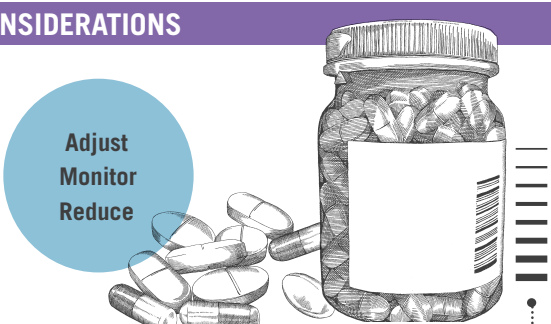
Watch for signs of anxiety, depression, and opioid use disorder during the taper and offer support or referral as needed.

Encourage

Let patients know that most people have improved function without worse pain after tapering opioids. Some patients even have improved pain after a taper, even though pain might briefly get worse at first.

Tell patients "I know you can do this" or "I'll stick by you through this."

CONSIDERATIONS



1. Adjust the rate and duration of the taper according to the patient's response.
2. Don't reverse the taper; however, the rate may be slowed or paused while monitoring and managing withdrawal symptoms.
3. Once the smallest available dose is reached, the interval between doses can be extended and opioids may be stopped when taken less than once a day.

RESOURCES:

CDC Guideline for Prescribing Opioids for Chronic Pain
www.cdc.gov/drugoverdose/prescribing/guideline.html

Washington State Opioid Taper Plan Calculator
www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf

Tapering Long-Term Opioid Therapy in Chronic Noncancer Pain
www.mayoclinicproceedings.org/article/S0025-6196(15)00303-1/fulltext

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

www.cdc.gov/drugoverdose

What You Need to Know About Opioid Pain Medicines

This guide is for you! Keep this guide and the Medication Guide that comes with your medicine so you can better understand what you need to know about your opioid pain medicine. Go over this information with your healthcare provider. Then, ask your healthcare provider about anything that you do not understand.

What are opioids?

Opioids are strong prescription medicines that are used to manage severe pain.

What are the serious risks of using opioids?

- Opioids have serious risks of addiction and overdose.
- **Too much opioid medicine in your body can cause your breathing to stop – which could lead to death.** This risk is greater for people taking other medicines that make you feel sleepy or people with sleep apnea.
- **Addiction** is when you crave drugs (like opioid pain medicines) because they make you feel good in some way. You keep taking the drug even though you know it is not a good idea and bad things are happening to you. Addiction is a brain disease that may require ongoing treatment.

Risk Factors for Opioid Abuse:

- You have:
  - » a history of addiction
  - » a family history of addiction
- You take medicines to treat mental health problems
- You are under the age of 65 (although anyone can abuse opioid medicines)

- **You can get addicted to opioids even though you take them exactly as prescribed, especially if taken for a long time.**
- If you think you might be addicted, talk to your healthcare provider right away.
- If you take an opioid medicine for more than a few days, your body becomes physically "dependent." This is normal and it means your body has gotten used to the medicine. You must taper off the opioid medicine (slowly take less medicine) when you no longer need it to avoid withdrawal symptoms.

How can I take opioid pain medicine safely?

- Tell your healthcare provider about **all** the medicines you are taking, including vitamins, herbal supplements, and other over-the-counter medicines.
- Read the Medication Guide that comes with your prescription.
- Take your opioid medicine exactly as prescribed.
- Do not cut, break, chew, crush, or dissolve your medicine. If you cannot swallow your medicine whole, talk to your healthcare provider.
- When your healthcare provider gives you the prescription, ask:
  - » How long should I take it?
  - » What should I do if I need to taper off the opioid medicine (slowly take less medicine)?
- Call your healthcare provider if the opioid medicine is not controlling your pain. Do not increase the dose on your own.
- Do not share or give your opioid medicine to anyone else. Your healthcare provider selected this opioid and the dose just for you. A dose that is okay for you could cause an overdose and death for someone else. Also, it is against the law.
- Store your opioid medicine in a safe place where it cannot be reached by children or stolen by family or visitors to your home. Many teenagers like to experiment with pain medicines. Use a lock- box to keep your opioid medicine safe. Keep track of the amount of medicine you have.

- Do not operate heavy machinery until you know how your opioid medicine affects you. Your opioid medicine can make you sleepy, dizzy, or lightheaded.

What should I avoid taking while I am taking opioids?

Unless prescribed by your healthcare provider, you should avoid taking alcohol or any of the following medicines with an opioid because it may cause you to stop breathing, which can lead to death:

- Alcohol: Do not drink any kind of alcohol while you are taking opioid medicines.
- Benzodiazepines (like Valium or Xanax)
- Muscle relaxants (like Soma or Flexeril)
- Sleep medicines (like Ambien or Lunesta)
- Other prescription opioid medicines

What other options are there to help with my pain?

Opioids are not the only thing that can help you control your pain. Ask your healthcare provider if your pain might be helped with a non-opioid medication, physical therapy, exercise, rest, acupuncture, types of behavioral therapy, or patient self-help techniques.

What is naloxone?

- Naloxone is a medicine that treats opioid overdose. It is sprayed inside your nose or injected into your body.
- Use naloxone if you have it and call 911 or go to the emergency room right away if:
  - You or someone else has taken an opioid medicine and is having trouble breathing, is short of breath, or is unusually sleepy
  - A child has accidentally taken the opioid medicine or you think they might have
- Giving naloxone to a person, even a child, who has not taken an opioid medicine will not hurt them.

Naloxone is never a substitute for emergency medical care. Always call 911 or go to the emergency room if you've used or given naloxone.

Where can I get naloxone?

- There are some naloxone products that are designed for people to use in their home.
- Naloxone is available in pharmacies. Ask your healthcare provider about how you can get naloxone. In some states, you may not need a prescription.
- When you get your naloxone from the pharmacy, read the **Patient Information** on how to use naloxone and ask the pharmacist if anything is unclear.
- Tell your family about your naloxone and keep it in a place where you or your family can get to it in an emergency.

When you no longer need your opioid medicine, dispose of it as quickly as possible. The Food and Drug Administration recommends that most opioid medicines be promptly flushed down the toilet when no longer needed, unless a drug take-back option is immediately available. A list of the opioid medicines that can be flushed down the toilet is found here: https://www.fda.gov/drugdisposal

What things should I know about the specific opioid medicine that I am taking?

- Your healthcare provider has prescribed _____ for you. Read the Medication Guide for this medicine, which is information provided by your pharmacy.
- Remember this other important information about your opioid medicine:

Dosing instructions: _____

Any specific interactions with your medicines: _____

_____

What if I have more questions?

- Read the Medication Guide that comes with your opioid medicine prescription for more specific information about your medicine.
- Talk to your healthcare provider or pharmacist and ask them any questions you may have.
- Visit: www.fda.gov/opioids for more information about opioid medicines.