COLORADO ACADEMY OF
FAMILY PHYSICIANS

Managing Pain with Alternative Treatments and Fewer Opioids

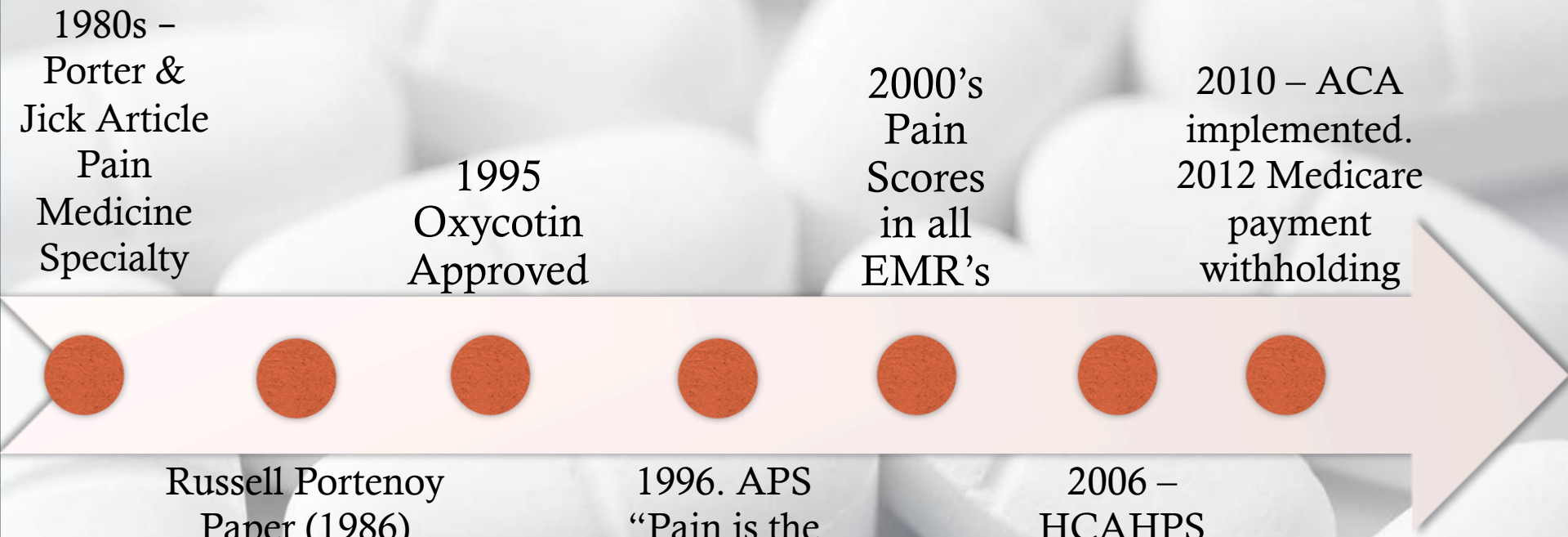
Rethinking and Redirecting Physician Strategies

Testimony before the Opioid and Other Substance Use Disorders Interim Study Committee August 1, 2017

Speakers

- Katie Lozano, MD, CMS President
- Don Stader, MD, CMS Advisor and Liaison to Interim Study Committee
- Shannon Jantz, MD, CAFP

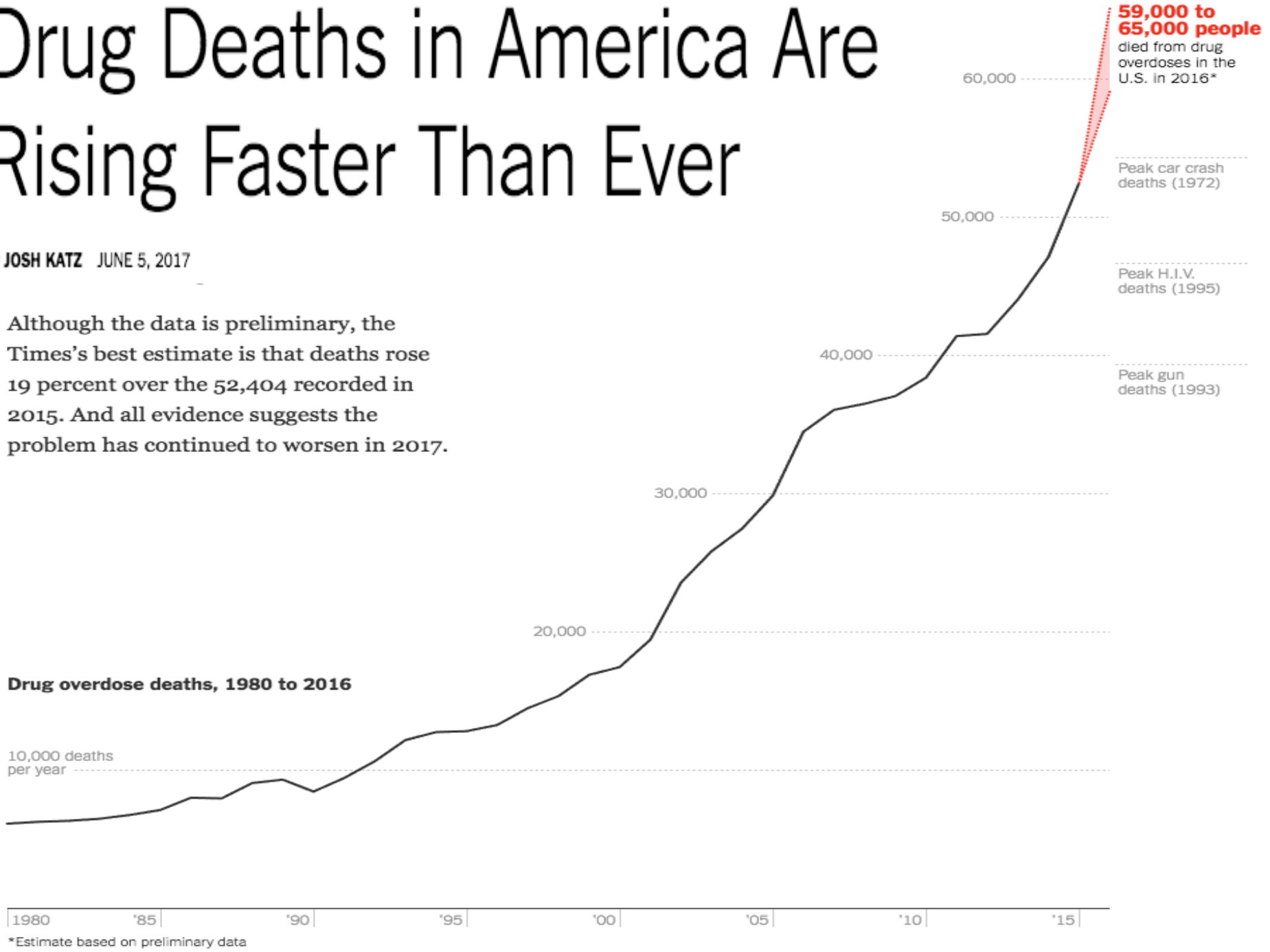
A BRIEF HISTORY OF OUR MODERN EPIDEMIC



Drug Deaths in America Are Rising Faster Than Ever

By **JOSH KATZ** JUNE 5, 2017

Although the data is preliminary, the Times's best estimate is that deaths rose 19 percent over the 52,404 recorded in 2015. And all evidence suggests the problem has continued to worsen in 2017.



Drug overdose deaths, 1980 to 2016

*Estimate based on preliminary data

CBS/AP / *July 30, 2017, 10:42 PM*

Nashville mayor's son dies of apparent drug overdose

Mayor Megan Barry with her son Max / **MAYOR MEGAN BARRY**


State of Colorado
Proclamation
Street Name
Blue Eyes
1950-2013
Jona
Farthing
10/10/89-2014
TINY
RIP

Colorado Physicians Ramp Up Response

- Reports about the rising epidemic of opioid abuse, misuse and death
- National Governors Association launches 7-state pilot project to address the growing epidemic
- Gov. Hickenlooper announced the opioid crisis as one of his winnable battles
- CMS immediately pledged full support and launched an aggressive plan
- Colorado Coalition for Prescription Drug Abuse Prevention created.

Others Step Up Physician Outreach Efforts

- **COPIC**
- **Center for Professional Education for Physicians**
- **Specialty and Component Medical Societies**
- **CU School of Public Health**

Reinventing Pain Management Strategies and Addiction Treatment: Core Objectives

1. Maintain and expand ongoing physician reach-out, CME, training on pain management and addiction treatment
2. Assure sustained treatment and support for addicted patients and support for both care givers and first responders
3. Assure optimal practice support to physicians evaluating and treating patients with pain conditions

Rebooting & Reinventing Opioid Strategies

A four and a half year CMS focus:

- Professional education and development;
- Bringing local and national expertise to the Consortium and coordinating with the Consortium
- Supporting public policy initiatives

Professional Education and Development: Components of Culture Change

CMS has emphasized:

- Safe opioid prescribing
- SBIRT mentor trainings
- Guidelines and tools for improving chronic pain management
- Promotion of National Take Back events
- ER/LA opioid REMS: Safe use
- Youth prescription drug abuse awareness, options
- Responses to state and federal government initiatives

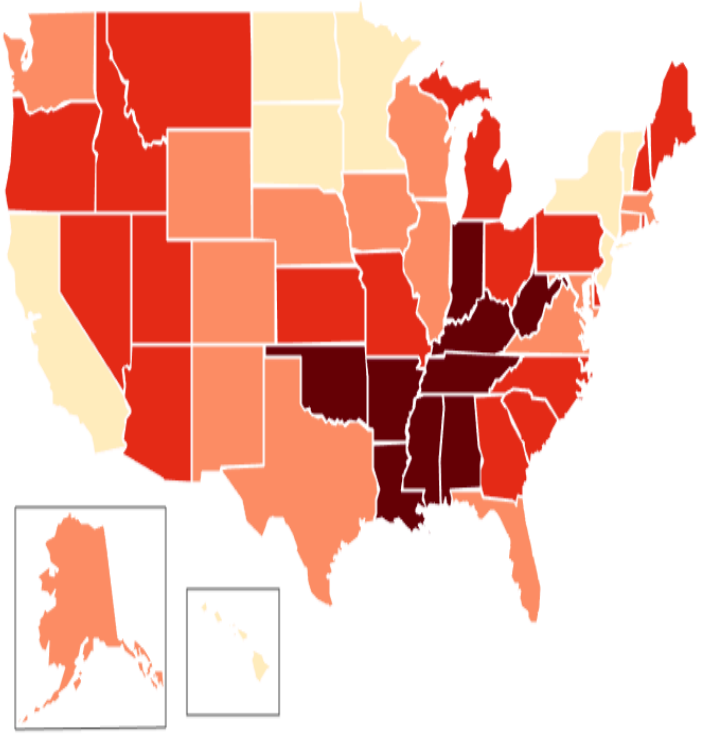
Bringing Expertise to the Consortium

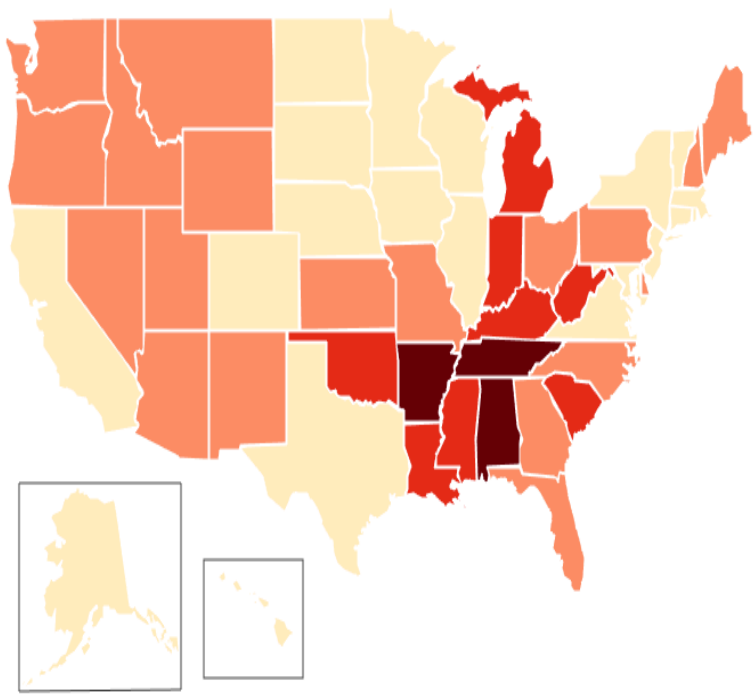
- Recruiting clinical experts to provide comments on prescribing guidelines.
- Actively participating in the PDMP workgroup
- Upcoming all-member survey on the PDMP
- Supported Consortium recommendation to enhance usability of PDMP for all prescribers

Colorado Data

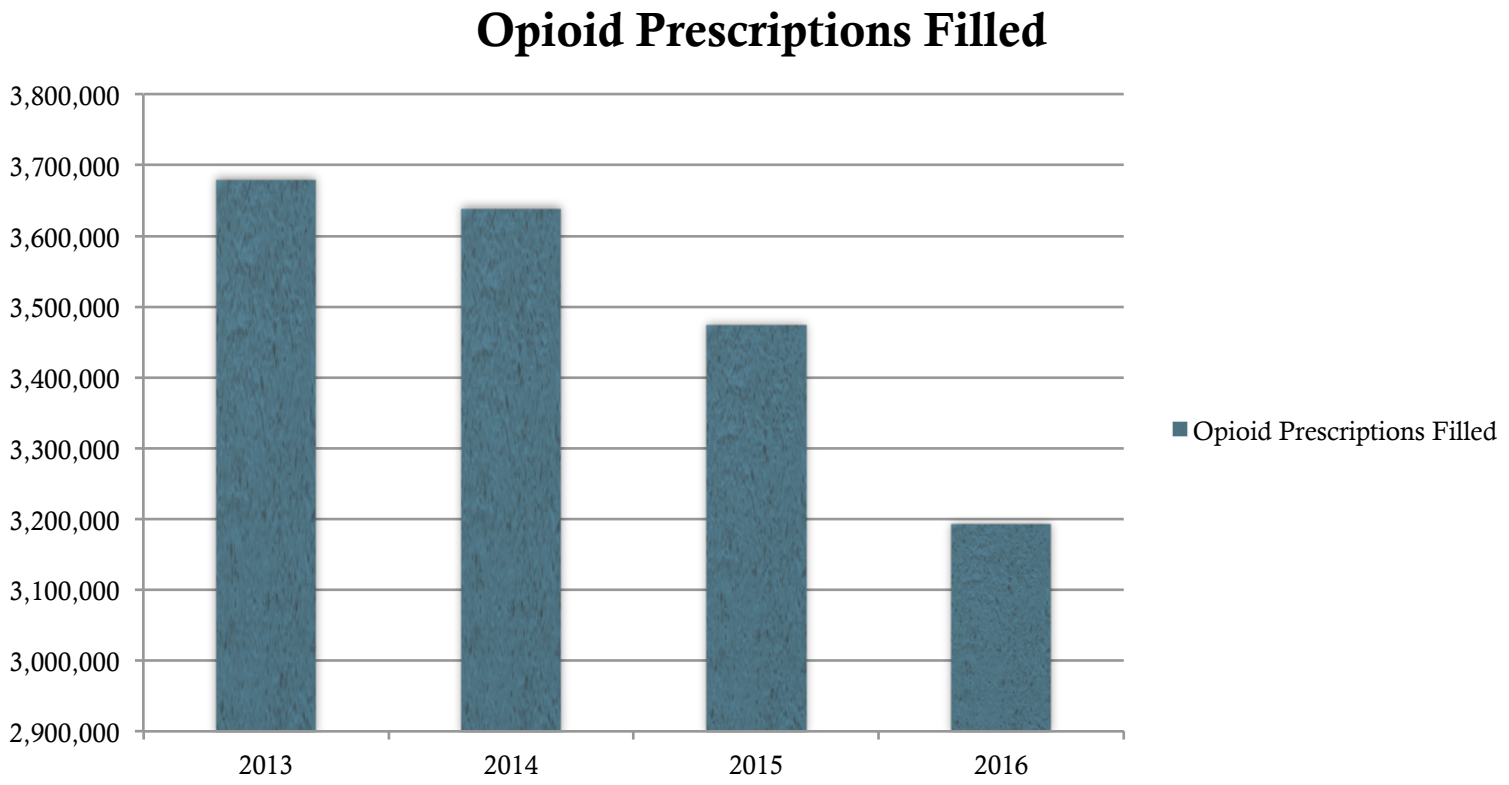
2012 – 73.5 Rx per 100

2016 – 59.8 Rx per 100



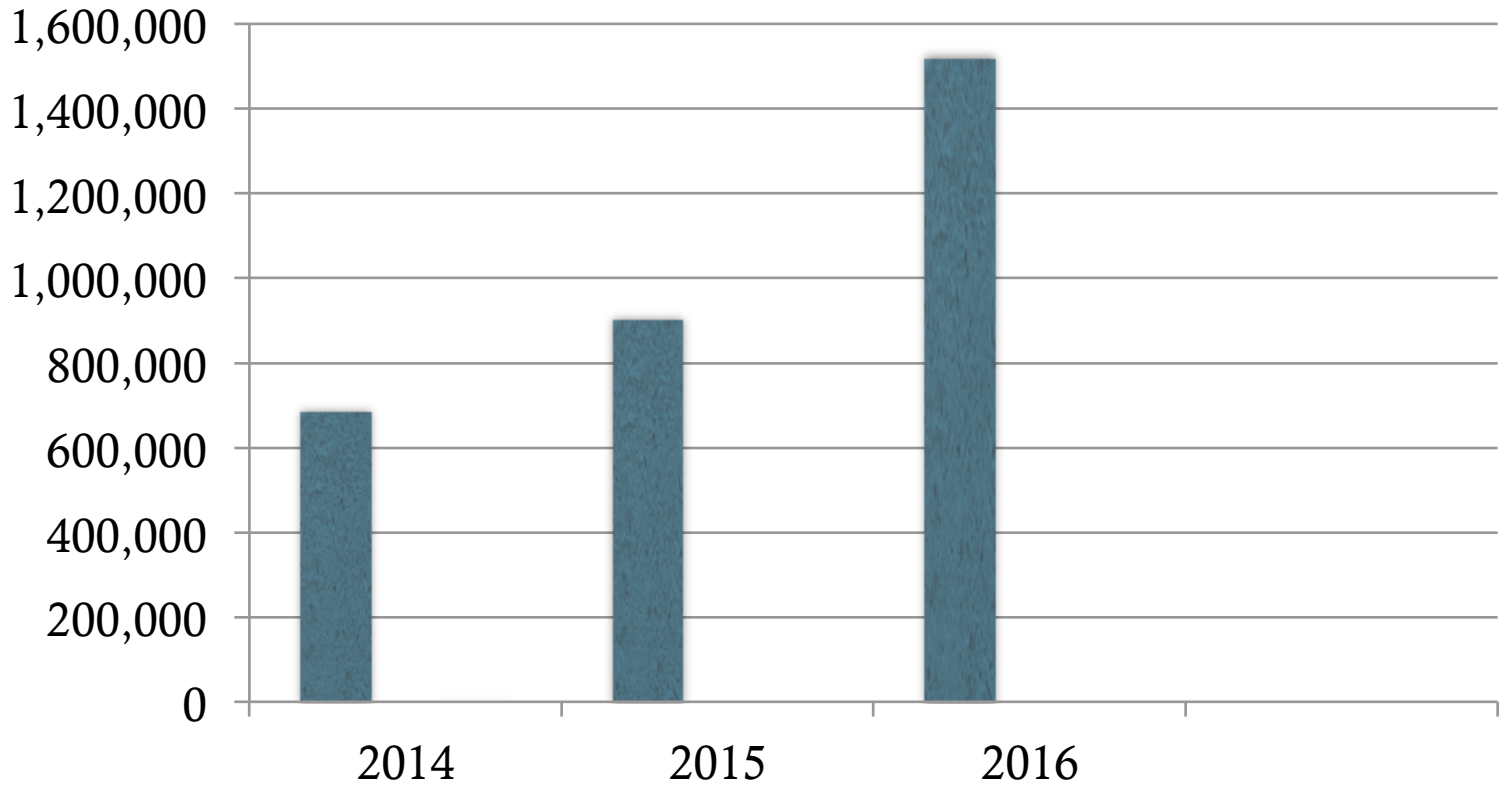


Colorado Data – From the AMA



13.3% Reduction in 3 year.
Over the same time period, Colorado Population has grown by 400,000!

Colorado PDMP Queries



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NEWS > HEALTH

As prescription opioid deaths drop 6 percent in Colorado, heroin deaths rise 23 percent

Increase in heroin deaths could be related to crackdown on prescription painkillers

Toby Talbot, The Associated Press
This 2013 file photo shows pills of the painkiller hydrocodone at a pharmacy in Montpelier, Vt.

The Denver Post Crime Data Report

Your neighborhood's crime stats.

CRIME NEWS NEWSLETTER

Policy and Outreach Options - Next Iterations

1. All options are on the table
2. Focus on what works
3. Commitment and expertise of CMS, CAFP, COACEP and other physician-led organizations are available

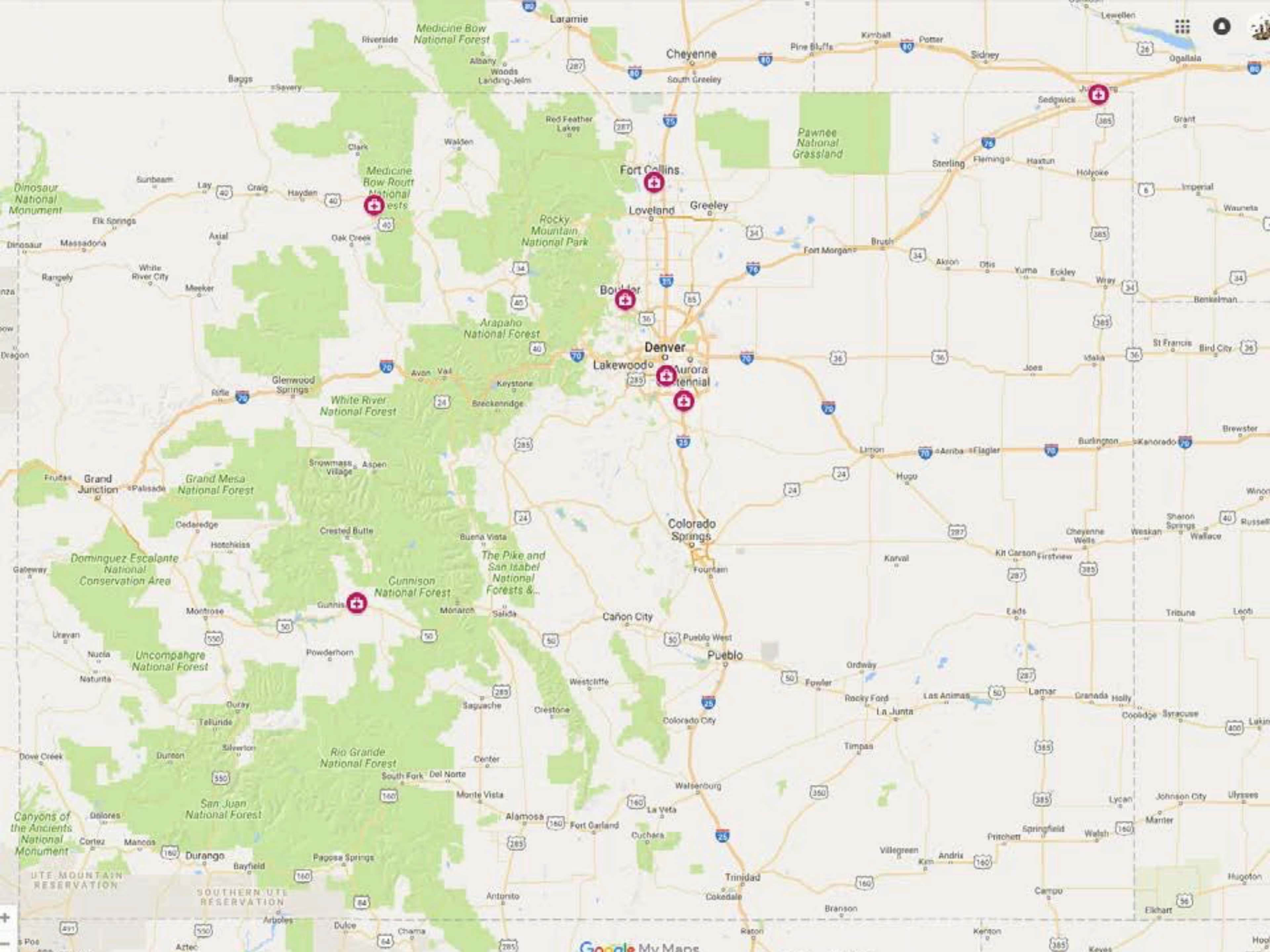
Colorado Physicians are Leaders & Innovators

cha
Colorado Hospital Association

COLORADO CHAPTER
American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

POWER IN NUMBERS

- Community-based, nonacademic study
- 8 participating hospitals across Colorado
- One of the largest opioid research efforts in the US.



Laramie
Medicine Bow National Forest
Riverside
Albany
Woods Landing-Jelm
Cheyenne
South Greeley
Pine Bluffs
Kimball
Potter
Sidney
Lewellen
Ogallala
Baggs
Savery
Sedgwick
Grant
Red Feather Lakes
Pawnee National Grassland
Clark
Walden
Sterling
Fleming
Haxtun
Holyoke
Medicine Bow-Routt National Forests
Fort Collins
Imperial
Dinosaur National Monument
Sunbeam
Lay
Craig
Hayden
Loveland
Greeley
Wauneta
Elk Springs
Axial
Oak Creek
Rocky Mountain National Park
Dinosaur
Massadona
Brush
Fort Morgan
Akron
Otis
Yuma
Eckley
Wray
Rangely
White River City
Meeker
Benkelman
Boulder
Arapaho National Forest
Denver
St Francis
Bird City
Lakewood
Aurora
Centennial
Idalia
Joes
Dragon
Glenwood Springs
Avon
Vail
Keystone
Rifle
White River National Forest
Breckenridge
Brewster
Burlington
Kanorado
Limon
Arriba
Flagler
Snowmass Village
Aspen
Hugo
Fruita
Grand Junction
Palisade
Grand Mesa National Forest
Cedaredge
Crested Butte
Buena Vista
Colorado Springs
Sharon Springs
Wallace
Weskan
Cheyenne Wells
Hotchkiss
Dominguez-Escalante National Conservation Area
The Pike and San Isabel National Forests &...
Karval
Kit Carson
Firstview
Gateway
Fountain
Gunnison
Gunnison National Forest
Montrose
Monarch
Salida
Cañon City
Eads
Tribune
Leoti
Uravan
Pueblo West
Pueblo
Powderhorn
Nucla
Uncompahgre National Forest
Naturita
Ordway
Westcliffe
Fowler
Rocky Ford
Las Animas
Lamar
Granada
Holly
La Junta
Coolidge
Syracuse
Ouray
Saguache
Crestone
Telluride
Colorado City
Silverton
Timpas
Dove Creek
Dunton
Rio Grande National Forest
Center
South Fork
Del Norte
Walsenburg
Monte Vista
La Veta
Johnson City
Ulysses
Lycan
Canyons of the Ancients National Monument
Dolores
San Juan National Forest
Alamosa
Fort Garland
Manter
Cortez
Mancos
Cuchara
Springfield
Pritchett
Walsh
Durango
Villegreen
Andrix
Kim
Bayfield
Pagosa Springs
UTE MOUNTAIN RESERVATION
Trinidad
Hugoton
SOUTHERN UTE RESERVATION
Antonito
Cokedale
Campo
Elkhart
Branson
Arboles
Dulce
Chama
Raton
Kenton
Aztec
Keyes
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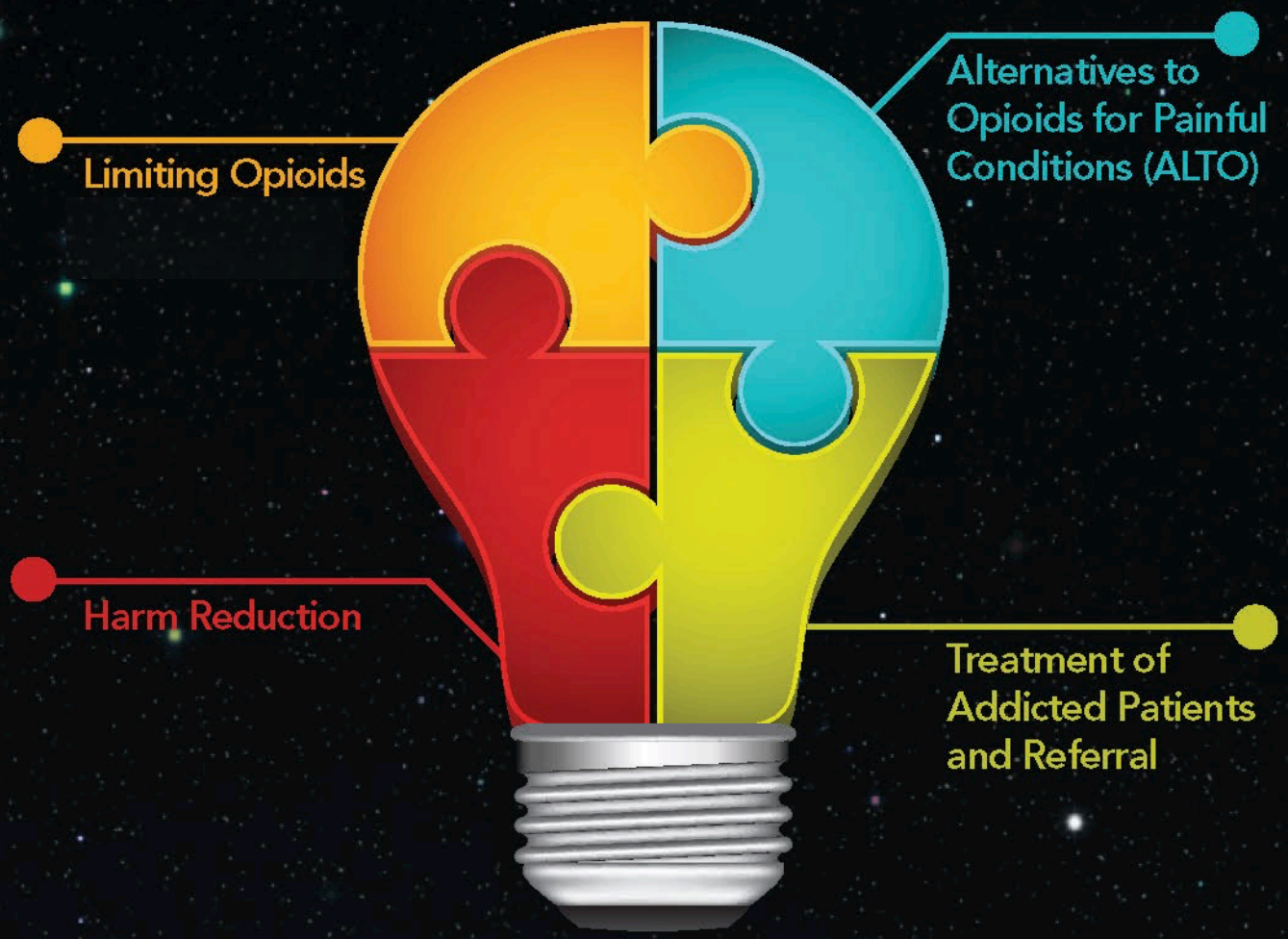
HOW TO ADDRESS THE OPIOID EPIDEMIC



Final Thoughts

1. Continue the decline in prescribing of opioids; Deploy more alternatives for pain control than ever before
2. Remove regulations and tactics that have caused this epidemic: Pain as the "fifth vital sign" has passed; Insurers should cover alternatives to opioids; Stop tying physician compensation to pain control.
3. Keep patients safe by considering novel Harm Reduction Techniques such as increased access to Syringe Access Program & Supervised Injection Facilities.
4. Lower barriers to treatment; Expand for patients to seek treatment & clinicians to get training.

CMS and physician groups are leading a culture change within their practices. We look forward to working with this Interim Committee & The Legislature to confront the Opioid Epidemic, meet the needs of our patients & to create a healthier Colorado

Shannon Jantz, MD
Family Physician

Colorado Academy of Family Physicians

Scope

- Family Physicians are unique in that we work across the state in:
  - Emergency Rooms (both rural and urban)
  - Outpatient clinical care
  - Urgent care
  - Hospitalist/Hospital work
  - Obstetrics
  - Both Rural and Urban presence
  - Deal equally in acute pain and chronic pain conditions

Urgent/Emergent Care

- Primarily deals with acute pain but there is some crossover of chronic pain patients utilizing the ER
- Improved interoperability between EHR's for transitions of care
- Need to recognize the limitations in rural & underserved communities
- Need improved PDMP usability.

Clinic

- Limit dosing to prevent high dose for at risk patients
- Good evidence that generally >50 morphine equivalents the risks of overdose increase
- Need better support for reducing opioids and pain management – with goal of pain management being dose de-escalation not just transferring someone
- Minimize opioid prescribing/dosing for more minor acute pain issues (back spasm, sprains)
- Need improved access to PDMP – integration with EMR

Rural vs Urban

URBAN	RURAL
- More access to clinical pharmacy - Some access to pain specialists (although still very limited based on cost/access) - More access to Physical therapy - Easier to recommend alternative therapy for some patients	- Often miles from closest hospital or specialty clinic - Little to no access for pain specialists - Family physicians are often the primary providers staffing both ER and clinics.

Chronic Pain

- There has been a lot more data and published guidelines for chronic pain and opioid limits.
- The AAFP has adopted as clinical practice guidelines the latest CDC recommendations to
  - Reassess and only prescribe >50 morphine equivalents per day after careful assessment
  - Try to limit or avoid dosages > 90 morphine equivalents
  - Set realistic goals (30% reduction in pain) and really focus on functional improvements
  - Avoid prescribing opioids and benzodiazepines

Acute Pain

- Less data and less published guidelines
- The AAFP had adopted CDC guidelines to use the lowest dose and shortest duration but this is not well defined.
- Avoid prescribing opioids and benzodiazepines
- Use of PDMP recommended prior to initiating prescriptions although many comments about limited ease of access

Challenges

- Access to care – we need to be cognizant of the limits of access to primary care
- Addressing the needs of patients – every patient is unique
- Needs a Huge public health campaign around dangers of opioids and alternative options
- Pain as 5th vital sign – sets expectations that pain should be 'cured'
- Educate public about appropriate pain reduction expectations.

Challenges

- Using pain management as a metric for satisfaction and HEDIS
- Physician burnout and the challenges in dealing with frustrated and/or angry patients
- Medicaid, underinsured, and socioeconomically disadvantaged do not have access to alternative treatments/adjuvants for pain like massage and acupuncture.
- Lack of access to treatment for opioid and other abuse disorders.

Recommendations

- Improve PDMP usability/integration
- Improve interoperability of systems to "talk to each other" so we can know when our patients have received care elsewhere
- Eliminate Pain as 5th Vital Sign
- Encourage non-opioid pain adjuvants.
- Promote insurance coverage of alternative pain treatments

Recommendations (cnt)

- Think about acute and chronic pain as two different but connected issues
- Recognize limitations in availability of pain specialists and advanced pain management
- Uncouple reimbursements or incentives from patient satisfaction surveys that incorporate pain.
- Promote a strong public health campaign to change public understanding of pain treatment and appropriate management.

Recommendations Cnt.

- Look at other states laws – **Voluntary** limits for both number of days of initial Rx And limiting number of Tab or Morphine equivalent
- Partial Fill option
- Incorporate PDMP into EHR for ease of access. The easier it is, you will see use go up without a mandate
- Offering clinician communication classes around denying opioid prescriptions and/or tapering down on doses.

Colorado Medical Society

Opioid-Related Policies

TABLE OF CONTENTS

I. THE PUBLIC HEALTH AND SAFETY CHALLENGES OF TREATING CHRONIC PAIN: THE MEDICAL PERSPECTIVE

Approved by the CMS House of Delegates September 20-22, 2013
Currently under review by the CMS Committee on Prescription Drug Abuse

Long-term CMS goal:

1. To assure access to compassionate, evidence-based care for patients who suffer from acute and chronic pain.

2. To significantly reduce the potential for medically inappropriate use and diversion of prescribed medications – that is, to help prevent the medical, psychological and social consequences, including addiction, overdose and death.

3. That the prescription drug diversion and abuse crisis requires a multi-pronged, coordinated strategy that includes a public-health focus, positive incentives to promote physician education and public awareness, useful tools that physicians can use at the point-of-care to support medical decision making, concerted attention to increase access to addiction treatment and recovery, and appropriate enforcement.

CMS strategies:
CMS will work collaboratively with all stakeholders and elected officials to achieve the CMS long-term goal. CMS supports:

1. Review of current evidence to understand the epidemiology of medically inappropriate use and diversion while concurrently developing strategies to address the misuse, abuse and diversion of opioids.

2. Development and promotion of new tools, along with existing resources and educational materials that enable physicians to appropriately prescribe opioids and narcotic medications, and to avoid inappropriate prescribing.

3. Development and implementation of an educational campaign for the public and providers that is continually assessed to further target outreach.

4. Partnering with other stakeholders to obtain the best consensually defined outcomes for Colorado.

5. Screening and referrals to treatment programs in Colorado. Advocate for increased resources and access to evidence based abuse and addiction treatment programs.

6. Recommendation 6: Establishment of a monitoring and tracking system for intervention strategies that allows expert evaluation and adjustments to intervention strategies.

See Exhibit 1, pages 5-8, for related policies on PDMP, Licensing Boards and Standardization, Physician Education, Law Enforcement and Public Safety

II. OPIOID PRESCRIBING AND TREATMENT GUIDELINES FOR EMERGENCY DEPARTMENTS

Adopted as CMS policy on July 14, 2017

CMS adopted the following new policies on emergency department opioid prescribing and treatment guidelines as found in the Colorado Chapter of the American College of Emergency Physicians *2017 Colorado Emergency Department Opioid Prescribing and Treatment Guidelines*. In adopting this policy, the board of directors emphasized that CMS:

1. Recognizes the current public health crisis caused by opioid misuse and abuse;

2. These emergency department guidelines are an important part of addressing this complex issue;

3. They do not replace clinical judgment;

4. Calls on other physician specialties to develop innovative, integrated approaches to help combat this crisis. The new policies are:
    a. Limiting opioid use in the emergency department
        - The Colorado prescription drug monitoring program (PDMP) should develop an automated query system that can be more readily integrated into electronic health records and accessed by emergency clinicians.
        - Pain control should be removed from patient satisfaction surveys, as they may unfairly penalize physicians for exercising proper medical judgment.
        - Opioid prepacks should be avoided or eliminated from emergency departments if 24-hour pharmacy support is available.
        - Pain should not be considered the "fifth vital sign."
    a. Alternatives to opioids for the treatment of pain
        - Hospitals should update institutional guidelines and put policies in place that enable clinicians to order and nurses to administer dose-dependent ketamine and IV lidocaine in non-ICU areas.
        - Emergency departments are encouraged to assemble an interdisciplinary pain management team that includes clinicians, nurses, pharmacists, physical therapists, social workers, and case managers.
    b. Reimbursement should be available for any service directly correlated to pain management, the reduction of opioid use, and treatment of drug-addicted patients.
    Harm reduction in the emergency department
        - Harm reduction agencies and community programs that provide resources for people who inject drugs (PWID) should be made readily available.
        - When local programs are unavailable for PWID, emergency departments should establish their own programs to provide services such as safe syringe exchanges.

    c. Treatment of opioid addiction
        - Emergency departments should work with medication assisted treatment (MAT) programs to facilitate direct referrals. When possible, physicians should consider performing a "warm handoff" where patients are initiated on medications such as buprenorphine until they are able to enroll in an appropriate MAT program.
        - Access to MAT services for patients should be expanded and local, state and federal funding for these resources should be increased.

5. CMS will pursue the following:
    a. Encourage all emergency medicine physicians to review and consider the application of the 2017 Colorado Emergency Department Opioid Prescribing and Treatment Guidelines in their practice. CMS shall specifically emphasize that these guidelines should neither be considered a definition or standard of care, nor should they replace clinical judgment.
    b. Help to disseminate the 2017 Colorado Emergency Department Opioid Prescribing and Treatment Guidelines by publishing them on the CMS web site.

III. SCHEDULE II CONTROLLED SUBSTANCE PARTIAL FILL PRESCRIPTIONS

See Exhibit 2, pages 8-9: Schedule II Controlled Substance Partial Fills: Background and initial draft legislative specifications

IV. ENSURING COMPLIANCE WITH SUBSTANCE USE DISORDERS ESSENTIAL HEALTH BENEFITS (EHB) PROVISION OF THE AFFORDABLE CARE ACT

Affordable Care Act: Approved as CMS policy on March 10, 2017.

CMS supports the Executive Branch in efforts to ensure that:

- The Colorado Division of Insurance (DOI) is evaluating and proactively monitoring whether payers are providing the substance use disorder EHB.
- DOI is enforcing against payers that are not providing this EHB to patients.
- That payer networks provide adequate access to treatment from an addiction and mental health specialist(s) for patients with substance use disorders in compliance with the EHB.
- Review current policies in Medicaid and the criminal justice system to determine whether patients with substance use disorders are receiving necessary, evidence-based treatment.

Exhibit 3, page 10: **Ensuring compliance with Substance Use Disorders Essential Health Benefits (EHB) Provision of the Affordable Care Act**

V. RECREATIONAL MARIJUANA

CMS does not have an opinion on the criminality of recreational marijuana use. CMS recognizes the published scientific data that recreational use of marijuana has a deleterious effect on the health of individuals and public health, particularly on the developing brains of adolescents.

VI. PHYSICIAN LEADERSHIP ON NATIONAL DRUG POLICY

The Colorado Medical Society (CMS) adopts and supports the consensus statement on "Physician Leadership on National Drug Policy." The CMS supports the continual review of evidence to identify and recommend medical and public health approaches that are likely to be more cost-effective, in both human and economic terms. The CMS encourages professional organizations to endorse and implement these policies.

[Permalink]

VII. DRUG ABUSE AND DRUG TESTING IN YOUTH ATHLETICS

The Colorado Medical Society (CMS) supports educational activities at the elementary school through high school level on drug abuse in athletes; the CMS supports drug testing for anabolic steroids of middle school and high school athletes in competitive sports.

VIII. USE OF ANABOLIC STEROIDS

The Colorado Medical Society (CMS) considers the prescription, recommendation, or use of anabolic steroids for the purpose of the hormonal manipulation of athletes that is intended as a performance aid for athletes to increase muscle mass, strength, or weight manipulation without a medical necessity to do so to be unethical and reason for immediate action by the Council on Ethical and Judicial Affairs of the CMS and prompt reporting to the Colorado Medical Board.

EXHIBIT 1: SPECIFIC RELATED POLICIES TO THE PUBLIC HEALTH AND SAFETY CHALLENGES OF TREATING CHRONIC PAIN: THE MEDICAL PERSPECTIVE

Prescription Drug Monitoring Program (PDMP)

1. Funding: CMS should support appropriate funding for PDMP and begin the process of exploring funding alternatives.

2. Work Flow: PDMPs should be reliable and available at the point-of-care as part of the prescriber's workflow process. To the extent possible, real-time access, or as close to real-time access should be available to physicians. PDMPs must be designed so that up-to-date information is available when physicians query the database and are considering a decision to prescribe a controlled substance.

3. Integration with other systems: The PDMP must be integrated with other systems. PDMP databases should ensure connectivity across state lines and to all patient populations, including those within the Veterans Administration health system, Indian Health Services, Department of Defense, Medicaid and Medicare.

4. Delegated Access: "Allow a physician to delegate to as many as three (3) qualified designees authority to access the PDMP database who are employed by the practice." Support the concept that a specific individual designated by a prescriber could be accredited to access the PDMP under specific conditions (e.g.-- unique identification code issued to the individual, and perhaps some legally binding certification to attest to that the designated person understands the legal restrictions and conditions under which they may access the PDMP, and the penalties for unauthorized access). The designee may need to have a different level of PDMP access, i.e., designees cannot view DEA numbers or names of prescribers.

5. Institutional Access: Provide for institutional access to the PDMP.

6. Require all physicians with a DEA number to register with the Prescription Drug Monitoring Program (mandatory registration is not mandatory usage). Colorado should conduct recruitment campaigns to increase awareness about the PDMP and induce prescribers and pharmacists to enroll.

7. Outcomes Data: The PDMP process should capture data on whether the use of the PDMP decreases abuse of prescription-controlled substances, diversion and abuse, and reduces overdose death rates, hospitalizations and ER visits, and improves health outcomes at the patient and community levels in Colorado.

8. Unsolicited Reports: Colorado physicians should explore the use of unsolicited reports provided by the PDMP to identify potential educational opportunities for physicians. Physicians will want to shape the types of unsolicited reports provided to prescribers and depending on the patient population served by the physician, i.e., pain management and palliative care would require different criteria.

Law Enforcement-Access to PDMPs

1. Support opportunities to train District Attorneys (DA) and law enforcement about PDMP (consistent with the legal access provided).

2. Options for law enforcement (LE) access to the PDMP should protect the confidentiality of patient-sensitive information and incorporate medical involvement. Support maintaining the current standard of PC (probable cause).

Licensing Boards Standardization

1. All prescribing Boards should agree upon and set the same minimal standards for opioid prescribing. All providers including pharmacists, nurse practitioners, dentists etc. should be held to using the same standards.

Physician Education

Background: Continuing voluntary medical education is a vital component to assure safe prescribing and effective relief of moderate to severe pain. Education about PDMPs, how to use them, and the value of the data for prescribers would likely encourage enrollment in and effective utilization of PDMP.

1. Educational programs for physicians should be from a peer reviewed recognized education source, be easily available to physicians and provide CME accredited documentation of completion of educational program. Professional school curriculum should include opioid education emphasizing concern for abuse and diversion as well as medically appropriate of chronic and acute pain.

2. Educational programs for physicians should help physicians to be able to identify at-risk prescribing practices and implement strategies to minimize the potential consequences of opioid prescribing (including abuse, diversion, as well as other adverse consequences).

3. Educational programs for physicians should be developed for physicians and should be tailored to meet a physician's practice and population needs and help physicians to be able to identify the best practices for the management of chronic, non-cancer pain.

4. Educational programs for physicians should work with others responsible for education of other health care professionals to ensure that education is coordinated, consistent in message, and promotes members of the health care team working together toward safer opioid prescribing.

5. Encourage the use of validated screening tools such as the NIDAMED's Clinical Screening Tool or the Screener and Opioid Assessment for Patients with Pain, as well as other tools to help physicians identify patients at risk for prescription drug abuse and to monitor patients who receive controlled substances for aberrant behaviors that may be indicative of addiction. These approaches can foster appropriate interventions and treatment.

6. The education programs for management of chronic non-cancer pain and for opioid prescribing practices should be evaluated for their ability to demonstrate understanding, intent to change practice behavior, and objective outcomes such as changes in prescription patterns, changes in utilization of alternative ways of treating chronic non-cancer pain, utilization of billing codes reflecting use of PDMP, counseling and other measures that are included in current treatment guidelines. Coroner death rates can be used to educate as well. If a feedback loop is created to let prescribers know that their patient died of drug related death it may promote safe prescribing.

Law Enforcement-Public Safety
Law enforcement also plays a vital role to support efforts to prevent abuse and diversion. This crisis, however, requires a public health focus-as opposed to strictly law enforcement focus-to emphasize the treatment and recovery needs of addicted patients.

1. CMS supports enforcement actions to halt "pill mill" activities, including efforts to halt criminal activities related to the prescribing and distribution of medically unindicated pain medications by rogue prescribers or dispensers.

2. CMS does not support unfettered access by LE to PDMP data that would allow "fishing expeditions."

Prescription Drug Abuse as a Public Health Issue: That CMS support:

1. Public awareness to address the role of opioids and safety.

2. Public health programs that include support for community-based programs that provide access to training for the use of opioid antagonists, such as naloxone, that have no potential for abuse and that saves lives.

3. Increased education, funding and support for take back events and disposal programs can help remove unused and unwanted prescription medications from the public environment.

4. Support for addressing the demand side for these prescriptions-more resources for prevention and addiction treatment and recovery as well as support for other non-medical measures to treat and self manage chronic pain.

5. Work with public health colleagues on public awareness around safe storage, not sharing medications.

EXHIBIT 2: SCHEDULE II CONTROLLED SUBSTANCE PARTIAL FILLS: BACKGROUND AND INITIAL DRAFT LEGISLATIVE SPECIFICATIONS

Basis for CMS Position: Approximately 70 percent of people who misuse opioids report obtaining them from family, friends or on the street – commonly referred to as "diversion."

a. One of the strategies to reduce diversion is to ensure that patients are prescribed the lowest effective dose for the shortest expected duration for expected pain following an acute injury or medical procedure.
b. Some patients, however, may not require medication for the full duration of expected pain.
c. Rather than rely on individuals to safely store and dispose of unwanted and unused medication, patients and prescribers can be empowered to request a partial fill of a Schedule II controlled substance, such as Hydrocodone, Morphine and Oxycodone.
d. Under Section 702 of the federal Comprehensive Addiction and Recovery Act, a pharmacist may partially fill a prescription for a schedule II controlled substance (such as an opioid) if: (1) such partial fills are not prohibited by state law, (2) a partial fill is requested by the patient or prescribing practitioner, and (3) the total quantity dispensed in partial fillings does not exceed the quantity prescribed.

The federal, bipartisan Comprehensive Addiction and Recovery Act (CARA) was enacted in 2016 includes:

- Authorizing state grants to increase access to naloxone
- Authorizing state grants to expand the availability of medication-assisted treatment (MAT)
- Expands the total number of patients that physicians can treat with in-office buprenorphine from 100 to 275
- Allows nurse practitioners and PAs to treat patients with buprenorphine for substance use disorders (with additional training)
- Authorizes a grant program to help treat pregnant and post-partum women who have an opioid use disorder
- Authorizes state grants to enhance a state-based PDMP
- Other provisions to help states to fight the opioid epidemic.

The following proposal can serve as a starting point for the Council on Legislation to consider transitioning the concept to a legislative reality.

Legalize authorization for Schedule II Partial Fill:

a. Authorize prescriptions for a Schedule II controlled substance to be partially filled if—
    i. The partial fill is requested by the patient or the practitioner who wrote the prescription; and
    ii. The total quantity dispensed in all partial fillings does not exceed the total quantity prescribed.
b. Require the pharmacist to retain the original prescription at the pharmacy where the prescription was first presented and the partially filled prescription dispensed.
c. Require that any subsequent fills occur at the pharmacy that initially dispensed the partial fill subject to the following:
    i. Any subsequent amount shall be filled within 30 days after the date on which the prescription is written
    ii. The original prescription becomes null and void 30 days after the date on which the prescription is written.

Notification to the Prescriber of a Partial Fill:

a. The pharmacist shall only record in the state prescription drug monitoring program the partial fill actually dispensed.
b. The pharmacist shall notify the prescribing practitioner of the partial fill and of the amount actually dispensed by one of the following:
    i. A notation in the interoperable electronic health record of the patient;
    ii. Electronic or facsimile transmission;
    iii. A notation in the patient's record maintained by the pharmacy, which shall be accessible to the practitioner upon request.

Insurance Coverage (this starting point should be worked out with assistance of pharmacy and health plans):

a. A person who presents a prescription for a partial fill pursuant to this Act shall be required to pay the required cost sharing and/or co-pay as required by the person's insurance coverage for the first partial fill.
b. A health plan or other payer shall not require the patient to pay any additional cost sharing for subsequent partial fills of the original prescription.
c. Under no circumstances shall a person be required to pay more in total cost sharing for partial fills than would be required to pay for the original prescription.

EXHIBIT 3: ENSURING COMPLIANCE WITH SUBSTANCE USE DISORDERS ESSENTIAL HEALTH BENEFITS (EHB) PROVISION OF THE AFFORDABLE CARE ACT:

The federal Affordable Care Act provides that treatment for substance use disorders are an Essential Health Benefit. This means that payers are required to provide the benefit to patients at the same level as other Essential Health Benefits. Payer compliance with this provision of the ACA is imperative. There is a broad evidence base supporting the benefits of treatment for substance use disorders, but also similar evidence that the treatment often is lacking. To fully address the nation's opioid epidemic, and to reverse the overdose and death attributed to opioids, states must commit resources along the entire continuum – from preventing youth and others from misusing opioids – to ensuring care for those in pain – and for treating those who have a substance use disorder. These are three of the main components to end the nation's opioid epidemic but they typically are not the three main components in state legislative consideration. An important step in state policy development should be a more aggressive focus on comprehensive treatment efforts. The national increase in heroin- and other opioid-related overdose and death demonstrates the need for greater emphasis and resources on treating patients with substance use disorders with medication assisted treatment (MAT) and concomitant mental health and behavioral and cognitive therapies. These proven methods are evidence-based therapies to reverse the opioid epidemic.

Opioid Education and Professional Development 2013-2017

CMS Annual Meeting and Spring Conference Programming

Colorado Medicine

ASAP- The CMS electronic newsletter

2013-present

CMS has recognized and committed resources to the current public health crisis caused by opioid misuse and abuse since January 2013. Publications documented in this document are available upon request.

Jan-Feb 2013 Colorado Medicine

- Feature: Acute and chronic pain management: Responsible opioid prescribing by Patricia L. VanDevander, MD, MBA; pg. 22-24

ASAP Jan. 25, 2013

- Report from Jan. 18 CMS board meeting: Board takes action on Medicaid expansion and other issues; top story

March-April 2013 Colorado Medicine

- Cover Story: Where does it hurt? Curbing abuse and preserving patient care
  - Cover suite included letter of support from the CMS President to Governor John Hickenlooper on pg. 11
- President's letter: Board sets aggressive 2013 agenda by CMS President; pg. 5
- Executive office update: Colorado in epicenter of non-medical prescription drug abuse by Alfred Gilchrist, CEO; pg. 7
- Final word: Gaining momentum as the healthiest state by Gov. John Hickenlooper; pg. 50

ASAP March 11, 2013

- For your information: King Soopers evaluating physicians' prescribing patterns; top story

ASAP March 27, 2013

- Encourage your patients to dispose of unused medications at National Take-Back Event: April 27; fifth story

ASAP April 26, 2013

- Encourage your patients to dispose of unused medications at National Take-Back Event: April 27; bottom story

May-June 2013 Colorado Medicine

- President's letter: Board takes action on myriad key issues by CMS President; pg. 5
- Executive office update: Governor invests in visionary Colorado wellness plan by Alfred Gilchrist, CEO; pg. 7
- Feature: Blueprint for success: CMS supports governor's vision for health and wellness by Kate Alfano; pg. 22-23
- Inside CMS: Prescription Drug Abuse Roundtable: CMS joins coalition to combat prescription drug abuse by Kate Alfano; pg. 31-32

July-August 2013 Colorado Medicine

- President's letter: Driving the future of medicine by CMS President; pg. 5

ASAP July 11, 2013

- Online CME available: SBIRT mentor training; third story

ASAP July 27, 2013

- Online CME available: SBIRT mentor training; third story

September-October 2013 Colorado Medicine

- Feature: Prescription drug abuse: CMS releases draft recommendation by Susan Koontz; pg. 19-20

September 21, 2013 – CMS Annual Meeting

Panel - *Where does it hurt? Prescription Drug Abuse in Colorado*

Panel on Prescription Drug Abuse:

- John Hughes, MD, Panel Moderator
- Cynthia Coffman, JD, Attorney General, Office of the Attorney General
- Joel Dickerman, DO, Member, CMS BOD
- Chris Gassen, Program Director, Colorado Board of Pharmacy
- Zach Pierce, Drug Policy Coordinator, Governor John W. Hickenlooper

ASAP Sept. 25, 2013

- CMS applauds launch of Consortium for Prescription Drug Abuse Prevention; third story
- Professional development: The Substance Use SBIRT mentor; sidebar
- Professional development: The Opioid Crisis: Guidelines and Tools for Improving Chronic Pain Management; sidebar

ASAP Oct. 17, 2013

- Encourage your patients to dispose of unused meds at National Take-Back Event; third story
- Mark your calendar for Nov. 20 Town Hall on Prescription Drug Abuse Among Youth; fifth story
- Professional development: The Substance Use SBIRT mentor; sidebar
- Professional development: The Opioid Crisis: Guidelines and Tools for Improving Chronic Pain Management; sidebar

ASAP Oct. 25, 2013

- Professional development: The Substance Use SBIRT mentor; sidebar
- Professional development: The Opioid Crisis: Guidelines and Tools for Improving Chronic Pain Management; sidebar
- Professional development: ER/LA Opioid REMS: Achieving Safe Use While Improving Patient Care; sidebar
- National prescription drug take-back event; sidebar

November-December 2013 Colorado Medicine

- Feature: Experts discuss multifaceted Rx drug abuse problem by Kate Alfano; pg. 21-22
- Feature: Governor's Rx abuse program: CMS applauds launch of Colorado Consortium for Prescription Drug Abuse Prevention by Kate Alfano; pg. 23
- Medical news: Save the date for Nov. 20 town hall on youth prescription drug abuse; pg. 47
- Final word: Curbing prescription drug abuse and preserving patient care by John Hughes, MD; pg. 50

ASAP Nov. 22, 2013

- Professional development: The Substance Use SBIRT mentor; sidebar
- Professional development: The Opioid Crisis: Guidelines and Tools for Improving Chronic Pain Management; sidebar

ASAP Dec. 17, 2013

- Professional development: The Substance Use SBIRT mentor; sidebar

- Professional development: The Opioid Crisis: Guidelines and Tools for Improving Chronic Pain Management; sidebar

ASAP Dec. 31, 2013

- Professional development: The Substance Use SBIRT mentor; sidebar
- Professional development: The Opioid Crisis: Guidelines and Tools for Improving Chronic Pain Management; sidebar

ASAP Jan. 23, 2014

- New prescription drug fact sheet available; fifth story
- Professional development: The Substance Use SBIRT mentor; sidebar
- Professional development: The Opioid Crisis: Guidelines and Tools for Improving Chronic Pain Management; sidebar

ASAP Feb. 13, 2014

- SAMHSA warns of increased deaths linked to fentanyl-contaminated heroin; sixth story
- Professional development: The Substance Use SBIRT mentor; sidebar
- Professional development: The Opioid Crisis: Guidelines and Tools for Improving Chronic Pain Management; sidebar

March-April 2014 Colorado Medicine

- Feature: Prescription drug abuse: CMS forms new committee to guide policy by Kate Alfano; pg. 21-22
    - Sidebar: Promotion of "The Opioid Crisis: Guidelines and Tools for Improving Chronic Pain Management;" pg. 22
- Medical news: SAMHSA warns of increased deaths linked to fentanyl-contaminated heroin; pg. 43

ASAP March 5, 2014

- Encourage your patients to dispose of medications at National Take-Back Event; third story
- Professional development: The Opioid Crisis: Guidelines and Tools for Improving Chronic Pain Management; sidebar

ASAP March 5, 2014

- Professional development: The Opioid Crisis: Guidelines and Tools for Improving Chronic Pain Management; sidebar

ASAP April 16, 2014

- Encourage your patients to dispose of medications at National Take-Back Event; fourth story
- Professional development: The Opioid Crisis: Guidelines and Tools for Improving Chronic Pain Management; sidebar

ASAP May 8, 2014

- Professional development: The Opioid Crisis: Guidelines and Tools for Improving Chronic Pain Management; sidebar

May 18, 2014 – CMS Spring Conference

Presentation by Dr. Robert Valuck – *And the Oscar for the Best Actor goes to… Hydrocodone? Prescription Drug Abuse in Modern American Film: Lessons for Treatment, Prevention and Public Health*

May-June 2014 Colorado Medicine

- Inside CMS: Prescription drug abuse update: Pharmacy board, legislature work on PDMP upgrades by Kate Alfano; pg. 37

ASAP May 30, 2014

- Governor signs bills into law on prescription drug misuse, clean claims; top story
- National Prescription Drug Take-Back Day brings in 780,000 pounds of unused meds; fourth story
- Clinical Challenges in Opioid Prescribing: Balancing Safety and Efficacy; sidebar
- Professional development: The Opioid Crisis: Guidelines and Tools for Improving Chronic Pain Management; sidebar
- Events: Colorado Chronic Opioid Symposium

ASAP June 16, 2014

- Colorado Opioid Epidemic Symposium to be held July 19; fifth story
- Safe Disposal leaflet available for distribution; sidebar
- Professional development: The Opioid Crisis: Guidelines and Tools for Improving Chronic Pain Management; sidebar
- Events: Clinical Challenges in Opioid Prescribing: Balancing Safety and Efficacy; sidebar
- Events: Colorado Chronic Opioid Symposium; sidebar

July-August 2014 Colorado Medicine

- Feature: Prescription drug abuse: State effort focuses on safe use, storage and disposal by Kate Alfano; pg. 30

ASAP Aug. 12, 2014

- Colorado publishes update on short-acting opiate policy change; second story

ASAP Sept. 11, 2014

- Hydrocodone combination products transfer to schedule II starting Oct. 6; third story
- Summary - Clinical Challenges in Opioid Prescribing: Balancing Safety and Efficacy; fourth story

ASAP Sept. 17, 2014

- Physicians: Register with the PDMP by Nov. 30; second story

ASAP Sept. 25, 2014

- ONDCP webinar: Opioid Misuse and Abuse - Sept. 30; sidebar

ASAP Oct. 8, 2014

- Hydrocodone reclassification took effect Oct. 6; fifth story
- DEA releases new rules that create secure prescription drug disposal options; sixth story
- Get help with your chronic pain patients with new management program
- Upcoming ECHO Pain Management Informational Webinar: Tuesday, Oct. 14; seventh story
- Don't forget: Register with PDMP by Nov. 30; ninth story

November-December 2014 Colorado Medicine

- Medical news: Changes make Colorado Prescription Drug Monitoring Program easier, more useful and will help stop doctor-shopping; pg. 50
- Medical news: DORA issues 600 notifications on potential doctor-shopping; physicians must register for PDMP by Nov. 30; pg. 51

ASAP Dec. 12, 2014

- Maintaining privacy protections in Colorado's Prescription Drug Monitoring Program; fifth story

ASAP Dec. 30, 2014

- Sign up for the ACC Chronic Pain Disease Management Program; fifth story

ASAP Feb. 11, 2015

- HCPF: Get help with your chronic pain clients; fourth story

March-April 2015 Colorado Medicine

- Features: Gov. Hickenlooper launches “Take Meds Seriously” campaign by Kate Alfano; pg. 28

ASAP March 23, 2015

- CPEP presents: "Prescribing Controlled Drugs: Critical Issues and Common Pitfalls" in Denver; fifth story
- Access patient education materials on prescription drugs on TakeMedsSeriously.org; sixth story

ASAP March 30, 2015

- Online CME: The Opioid Crisis: Guidelines and Tools for Improving Chronic Pain Management; sidebar

ASAP April 15, 2015

- Online CME: The Opioid Crisis: Guidelines and Tools for Improving Chronic Pain Management; sidebar

ASAP April 21, 2015

- Colorado Public Radio reports PDMP registrations are up but not complete for docs; third story
- Online CME: The Opioid Crisis: Guidelines and Tools for Improving Chronic Pain Management; sidebar

May-June 2015 Colorado Medicine

- Medical news: Colorado Public Radio reports PDMP registrations are up but still fall short; pg. 40

ASAP May 19, 2015

- Online CME: Opioid crisis; fourth story

ASAP June 3, 2015

- CPEP presents: "Prescribing Controlled Drugs: Critical Issues and Common Pitfalls" in Denver; fifth story

- Online CME: The Opioid Crisis: Guidelines and Tools for Improving Chronic Pain Management; sidebar

ASAP July 2, 2015

- Online CME: The Opioid Crisis: Guidelines and Tools for Improving Chronic Pain Management; sidebar

ASAP July 28, 2015

- Access new prescription drug abuse prevention resources; fifth story
- Online CME: The Opioid Crisis: Guidelines and Tools for Improving Chronic Pain Management; sidebar

ASAP Aug. 13, 2015

- Online CME: The Opioid Crisis: Guidelines and Tools for Improving Chronic Pain Management; sidebar

ASAP Sept. 23, 2015

- Online CME: The Opioid Crisis: Guidelines and Tools for Improving Chronic Pain Management; sidebar

ASAP Oct. 9, 2015

- Colorado Medicaid now covers opioid overdose antidote nasal spray; fourth story

November-December 2015 Colorado Medicine

- Features: Prescribing for pain: COPIC-funded study aims to optimize pain prescriptions by Jessica Ennis; pg. 24
- Medical news: News round-up: Prescription drug abuse and misuse prevention; pg. 36-37

ASAP Jan. 13, 2016

- CME: When chronic opioid therapy is no longer therapeutic/Identification and treatment of opioid use disorders in primary care; ninth story

ASAP Feb. 1, 2016

- Save the date: Drug Take Back Day - April 30; fourth story

March-April 2016 Colorado Medicine

- Medical news: Free support for Colorado providers to transform chronic pain care in the fight against prescription opioid abuse; pg. 36

ASAP March 1, 2016

- 7 strategies to achieve safe opioid prescribing; second story

ASAP April 10, 2016

- Free support for Colorado providers to transform chronic pain care in the fight against prescription opioid abuse; fifth story
- Peer Assistance Services and HCPF partner to provide substance abuse training; tenth story
- National Prescription Take-Back Day promo toolkit available for April 30 event; eleventh story

May-June 2016 Colorado Medicine

- Features: Confronting a crisis: An open letter to America's physicians on playing a role in reversing the opioid epidemic by Steven J. Stack, MD; pg. 24
- Features: Chronic pain management: ACC Chronic Pain Management Program: A clinician's experience by Kenneth Soda, MD; pg. 33-34

ASAP May 2, 2016

- Peer Assistance Services and HCPF partner to provide substance abuse training; seventh story

ASAP June 9, 2016

- Confronting a crisis: An open letter to America's physicians on the opioid epidemic; sixth story
- Collector applications now being accepted for the Colorado Household Medication Take-Back Program; seventh story

ASAP Aug. 16, 2016

- U.S. Surgeon General: "Turn the Tide" on the opioid epidemic; fifth story

September-October 2016 Colorado Medicine

- Inside CMS: Prescription drug abuse: New federal law to support fight against opioid epidemic by Kate Alfano; pg. 30-31
- Medical news: U.S. Surgeon General: 'Turn the tide' on opioid epidemic; pg. 42
- Medical news: White House drug policy director: U.S. needs trained doctors to provide treatment for the prescription opioid, heroin epidemic; pg. 43

ASAP Sept. 9, 2016

- U.S. Surgeon General: "Turn the Tide" on the opioid epidemic; sixth story
- White House drug policy director urges opioid treatment training for doctors; seventh story

September 17, 2016 – CMS Annual Meeting

Presentation by Abigail Anderson, MD - *Avoiding the Pitfalls of Opioid Prescribing*

Learning Objectives

1. Common pitfalls of opioid prescribing that can lead to poor patient outcomes and/or sanction by a privileging or licensing body;
2. Current guidelines and best practices, such as the Colorado Quad-Regulator Joint Policy for Prescribing and Dispensing Opioids and the new CDC Guideline for Prescribing Opioids for Chronic Pain, and how to apply these in your own practice; and
3. Tools, including prescription drug monitoring programs, that are appropriate for monitoring patients on opioids and other controlled substances and how to use them.

ASAP Oct. 12, 2016

- Colorado Naloxone for Life: Narcan Training and Distribution; sixth story

ASAP Oct. 19, 2016

- Take the pain out of opioid prescribing and management; top story
- Free SBIRT webinar on opioids and the workplace; fourth story
- Free access to PainNet system for Colorado primary care providers; sixth story

November-December 2016 Colorado Medicine

- Features: Pinnacol Assurance offers OpiSafe: Pinnacol seeks physician testers to pilot software to help address opioid misuse by Rick May, MD; pg. 30-31

ASAP Nov. 22, 2016

- Basics of chronic pain management: Enhance your knowledge with CPEP course; fourth story

ASAP Dec. 20, 2016

- Two surveys on opioids; sidebar

March-April 2017 Colorado Medicine

- President's letter: Working together on prescription drug abuse prevention by Katie Lozano, MD, FACR; pg. 5-6

ASAP March 30, 2017

- Event: "Moving From What to How: Practical Tools for Safe and Effective Opioid Prescribing" - May 4 in Aurora; sixth story

ASAP April 19, 2017

- Walgreens launches permanent prescription medication disposal sites in Colorado; third story
- CPEP to present programs on prescribing controlled drugs and pain management; tenth story

ASAP April 28, 2017

- April 29 is National Prescription Drug Take-Back Day; fourth story
- May 4 provider education event: Tools for safe and effective opioid prescribing; eighth story
- CPEP to present programs on prescribing controlled drugs and pain management; ninth story

May-June 2017 Colorado Medicine

- Medical news: AMA offers opioid guidance to doctors; pg. 45
- Medical news: Spike in Colorado heroin use, overdose leads to partnership; pg. 47-48

July-August 2017 Colorado Medicine

- Features: Legislative report: Colorado physicians achieve outstanding victories in 2017 General Assembly; pg. 16-17

July 14, 2017 Presidential Email to All CMS Members

- **July board of directors outcomes report including new opioid policies and appointment of Don Stader, MD, as CMS representative to advise the substance abuse interim legislative study committee**

ASAP July 20, 2017

- **AMA launches opioid education microsite**
- **CMS adopts new policies on opioid prescribing and treatment for the emergency department**

- **Take the CDPHE survey to identify strengths and weaknesses of the PDMP**
- **Help establish a permanent prescription drug drop box in each Colorado County**

September-October 2017: Colorado Medicine

- **Will be dedicated to the public health crisis caused by opioid misuse and abuse**

AMA
AMERICAN MEDICAL ASSOCIATION

Fact sheet: Physicians' and other health care professionals' use of state prescription drug monitoring programs increases 121 percent from 2014 to 2016; registration nearly triples.

State	Registrations 2014	Registrations 2015	Registrations 2016	Queries 2014	Queries 2015	Queries 2016
Alaska	923	1,122	1,847	45,145	69,282	147,378
Arizona		5,843	27,041		1,548,774	3,975,220
Arkansas	5,159	6,117	8,474	555,240	734,625	2,536,448
California	9,136	17,637	166,819	3,553,551	6,174,394	9,581,280
Connecticut			27,680	250,662	484,736	974,815
Colorado			39,554	682,600	898,000	1,515,839
Delaware		7,063	8,064	339,307	421,903	432,979
Florida	10,624	12,448	39,905	1,549,916	4,105,915	8,454,622
Georgia			18,048			1,139,116
Idaho	1,385	2,150	11,274	728	1,050	657,380
Illinois	26,156	29,524	32,856	1,906,999	2,539,448	2,696,653
Indiana	7,267	7,738	23,293	1,696,946	1,901,658	2,079,877
Iowa	5,147	5,909	16,357	170,696	236,663	392,819
Kansas	4,592	4,900	10,858	175,383	225,000	298,274
Kentucky	18,466	19,231	47,898	4,991,810	5,498,298	5,500,000
Louisiana	5,102	6,060	12,161	969,726	1,447,593	2,906,904
Maine	6,328	6,551		330,500	371,617	
Maryland	3,494	7,335	28,710	537,945	982,292	1,135,602
Massachusetts	27,711	45,063	51,856	860,260	1,467,392	2,768,130
Michigan	15,480	24,457	33,772	2,689,354	3,760,648	4,653,784
Minnesota	6,934	7,983	12,309	520,515	635,586	794,965
Mississippi			14,341			978,044
Montana	1,636	1,800	1,800	112,313	159,150	263,573
Nebraska	1,680	1,989	2,124	24,548	27,644	
Nevada	5,389	9,541	9,131	994,040	993,159	989,704
New Hampshire			15,213			320,683
New Jersey	25,442	28,484	49,808	1,404,614	2,077,870	2,486,000
New Mexico	6,199	7,310	11,543	368,283	487,844	938,940
New York	101,207	112,772	148,700	16,811,126	18,145,982	18,365,222
North Carolina			14,984			244,281
North Dakota	2,294	3,512	4,363	21,335	31,755	33,187
Ohio	27,500	37,400	84,613	7,500,000	10,500,000	24,094,984
Oklahoma	7,708	15,703	19,792	1,141,029	2,898,085	5,478,498
Oregon	4,046	4,413	14,779	257,614	271,232	1,210,440
Pennsylvania			65,831		65,831	2,345,018
Rhode Island	6,816	7,278	9,402	226,453	386,222	405,060
South Carolina	4,424	2,980	14,295	344,214	651,770	4,824,534
South Dakota	628	697	3,292	22,687	33,507	100,390
Tennessee	38,871	42,835	46,525	5,062,732	6,442,965	7,071,199
Texas	27,205	32,685	44,633	867,879	1,130,400	1,086,373
Utah	15,553	16,615		828,362	1,001,028	
Vermont	3,591	4,159	2,243	103,330	125,553	167,000
Virginia	16,628	54,613	66,000	1,870,196	4,860,636	5,400,000
Washington	11,606	12,968	16,925	522,872	958,246	3,880,532
West Virginia	4,210	6,339	10,353	840,557	909,508	1,010,753
Wisconsin	5,359	7,044	31,696	227,049	308,648	1,619,414
Wyoming			1,834	83,860	124,350	139,357
TOTAL	**471,896**	**628,268**	**1,322,996**	**61,462,376**	**86,096259**	**136,095,271**

Notes: The AMA sent inquiries to every state PDMP administrator in 2016 and 2017 to obtain this data. In some cases, the PDMP administrator did not respond to the inquiry, or due to other issues, was not able to provide the information. The data will be updated as new information becomes available. (last updated May 2017)

State and National Totals of Retail Filled Prescriptions: All Opioid Analgesics, 2013-2016

State	2013	2014	2015	2016	Rx per capita 2016	Cumulative % change 2013-2016
Alabama	6,814,305	6,393,791	5,840,754	5,638,226	1.2	-17.3%
Alaska	468,266	457,730	420,617	406,210	0.5	-13.3%
Arizona	5,050,348	5,038,497	4,813,236	4,549,927	0.7	-9.9%
Arkansas	3,477,289	3,523,762	3,312,715	3,240,776	1.1	-6.8%
California	21,047,372	20,561,933	18,666,608	17,441,819	0.4	-17.1%
Colorado	3,678,624	3,637,189	3,471,691	3,191,200	0.6	-13.3%
Connecticut	2,512,161	2,476,310	2,297,397	2,050,162	0.6	-18.4%
Delaware	823,522	814,682	768,974	717,686	0.8	-12.9%
District of Columbia	530,757	520,817	462,789	424,773	0.6	-20.0%
Florida	13,636,391	13,413,544	12,708,441	12,750,684	0.6	-6.5%
Georgia	8,643,869	8,305,929	7,880,524	7,856,894	0.8	-9.1%
Hawaii	717,220	694,579	645,508	612,090	0.4	-14.7%
Idaho	1,361,009	1,348,590	1,263,510	1,211,463	0.7	-11.0%
Illinois	8,800,796	8,518,837	8,003,978	7,665,040	0.6	-12.9%
Indiana	6,924,241	6,307,577	5,837,382	5,527,092	0.8	-20.2%
Iowa	2,274,401	2,246,454	2,121,545	1,983,098	0.6	-12.8%
Kansas	2,751,590	2,677,203	2,504,956	2,399,365	0.8	-12.8%
Kentucky	4,997,389	4,900,964	4,471,521	4,178,616	0.9	-16.4%
Louisiana	5,497,900	5,248,487	4,818,945	4,714,697	1.0	-14.2%
Maine	1,105,502	1,060,604	985,562	867,776	0.7	-21.5%
Maryland	4,229,380	4,181,855	3,941,165	3,664,825	0.6	-13.3%
Massachusetts	4,584,487	4,431,390	4,066,743	3,551,098	0.5	-22.5%
Michigan	10,482,299	10,315,827	9,528,806	8,858,912	0.9	-15.5%
Minnesota	3,330,832	3,250,152	2,975,420	2,688,110	0.5	-19.3%
Mississippi	3,514,236	3,407,069	3,212,366	3,087,482	1.0	-12.1%
Missouri	5,755,659	5,602,998	5,217,577	4,955,781	0.8	-13.9%
Montana	798,887	776,545	722,011	686,115	0.7	-14.1%
Nebraska	1,497,183	1,470,605	1,378,816	1,325,382	0.7	-11.5%
Nevada	2,436,691	2,467,414	2,393,881	2,276,188	0.8	-6.6%
New Hampshire	970,834	937,024	886,243	764,009	0.6	-21.3%
New Jersey	5,160,965	5,082,090	4,917,404	4,593,494	0.5	-11.0%
New Mexico	1,422,434	1,436,906	1,409,482	1,299,762	0.6	-8.6%
New York	10,957,729	10,450,786	10,164,060	9,534,858	0.5	-13.0%
North Carolina	9,482,526	9,232,258	8,717,746	8,276,712	0.8	-12.7%
North Dakota	505,227	495,555	466,131	441,930	0.6	-12.5%
Ohio	11,261,528	10,794,842	9,955,858	9,057,498	0.8	-19.6%
Oklahoma	4,666,575	4,242,737	3,972,838	3,765,604	1.0	-19.3%
Oregon	3,456,129	3,389,575	3,145,023	2,897,444	0.7	-16.2%
Pennsylvania	11,330,259	11,031,159	10,394,466	9,496,052	0.7	-16.2%
Rhode Island	871,892	823,219	732,367	655,736	0.6	-24.8%
South Carolina	4,866,458	4,797,342	4,490,916	4,296,073	0.9	-11.7%
South Dakota	570,917	585,432	581,534	554,246	0.6	-2.9%
Tennessee	8,525,017	8,239,110	7,800,947	7,366,191	1.1	-13.6%
Texas	18,569,734	17,959,748	15,903,061	15,444,180	0.6	-16.8%
Utah	2,364,661	2,308,830	2,186,792	2,107,481	0.7	-10.9%
Vermont	418,161	415,687	388,108	348,511	0.6	-16.7%
Virginia	6,346,359	6,047,580	5,608,460	5,240,314	0.6	-17.4%
Washington	5,163,236	5,121,469	4,881,633	4,607,428	0.6	-10.8%
West Virginia	2,420,990	2,389,802	2,076,883	1,752,690	1.0	-27.6%
Wisconsin	4,326,863	4,224,458	3,984,693	3,655,386	0.6	-15.5%
Wyoming	413,701	405,626	382,837	374,192	0.6	-9.6%
All States	**251,814,801**	**244,462,569**	**227,780,920**	**215,051,279**	**0.7**	**-14.6%**

Source: *Xponent*, QuintilesIMS, Danbury, CT

Management of Chronic Pain and Opioid Misuse: A Position Paper from the AAFP

Key Points for Practice

- Physicians should provide patient-centered care, including coordinating with other disciplines, to patients with chronic pain or dependence on opioids.
- Practices should encourage their physicians to use medication-assisted treatment options for patients with opioid dependence.
- Physicians are encouraged to use their state prescription drug monitoring programs for tracking purposes, to identify abuse or diversion, and recognize persons who might be at risk.
- Methadone, buprenorphine, and naltrexone are used as opioid substitutes in medication-assisted treatment.

From the AFP *Editors*

▶ **See related editorial on page 420.**

This series is coordinated by Sumi Sexton, MD, Associate Deputy Editor.

A collection of Practice Guidelines published in *AFP* is available at http://www.aafp.org/afp/practguide.

CME This clinical content conforms to AAFP criteria for continuing medical education (CME). See CME Quiz Questions on page 417.

Author disclosure: No relevant financial affiliations.

Managing chronic pain and opioid misuse can be challenging. Although data on the risks of opioid use have become clearer, knowledge of the long-term benefits is limited. Overprescribing, misuse, diversion, and dependence have occurred as a result of external pressures, physician behavior, inadequate evidence, and pharmacologic development. Family physicians could play an important role in alleviating these problems; therefore, the American Academy of Family Physicians (AAFP) is committed to ensuring family physicians are a part of the solution.

Call to Action

The AAFP formed an advisory committee to focus on the issues involved in addressing undertreated pain and opioid misuse at a variety of levels, and is calling for action from itself and its members.

PHYSICIANS

Physicians should provide patient-centered care to those with chronic pain or dependence on opioids, and should work with other health care professionals to provide multidisciplinary care. Evidence and guidelines regarding management of chronic pain and opioid dependence should be assessed. It is important to recognize risk factors for overdose or misuse in persons with chronic pain taking opioids, and to properly use prescription drug monitoring programs, drug screening, treatment agreements, or other methods to counter these factors. Obtaining a Drug Addiction Treatment Act of 2000 (DATA 2000) waiver should be considered to provide opioid treatment in the office. Persons at highest risk of overdose should be given information about antidotes, such as naloxone, as well as provided access.

OTHER GROUPS

In addition to physicians, there are opportunities to help at the practice, community, education, and advocacy levels. For practices, avoiding judgment and being knowledgeable about and sensitive to different cultures is important, as is researching practice patterns and procedures, and working with other research networks to build a knowledge base for patient care, especially higher-risk populations. Practices should encourage their physicians to use medication-assisted treatment options for patients with opioid dependence.

For communities, connecting with local medical organizations and offices will help ensure that patients with chronic pain or opioid dependence are provided with appropriate treatment, and working with organizations and patient advocacy groups in the community will assist with resolving problems and destigmatization. Facilitating the creation of education programs and naloxone distribution programs is also important.

On the education level, residency programs can be aligned and continuing medical education can be expanded to provide evidence-based information on best practices and opportunities for DATA 2000 waiver training.

On the advocacy level, payment models and insurance coverage can be adapted to allow physicians to provide appropriate care including coverage for medication-assisted treatment. Where needed, greater accessibility to naloxone should be supported and Good Samaritan protections provided for prescribers and laypersons who are rescuers. Partnering with other state and national groups can help improve monitoring programs and create best practices for their use, and support for research can be expanded, with specific focus on populations at higher risk.

Role of Family Medicine

No methods for evaluating risk have been validated in a variety of locations or patient populations, and common risk factors (e.g., psychological problems) can result in discrimination toward higher-risk populations. Physicians are encouraged to use their state prescription drug monitoring programs for tracking purposes, to identify abuse or diversion, and to recognize persons who might be at risk.

Knowledge of how naloxone works as a reversal agent in opioid overdose is important for reducing harm. Most data about naloxone are not of high quality; however, studies have routinely shown naloxone to be of benefit, and it is the standard treatment option for emergency medical service and emergency department personnel when treating opioid overdose. Physicians are encouraged to provide naloxone to patients at high risk of overdose. In the past 20 years, a substantial number of opioid reversals by laypersons have occurred, which are often the result of education and naloxone distribution programs.

Methadone, buprenorphine, and naltrexone (Revia, Vivitrol) are used as opioid substitutes in medication-assisted treatment. Adjunctive drugs (e.g., clonidine, nonsteroidal anti-inflammatory drugs) are appropriate for some symptoms of withdrawal. With DATA 2000, physicians meeting certain criteria can get a waiver to prescribe office-based opioid therapy with buprenorphine. The criteria include state licensure, Drug Enforcement Administration registration to provide Schedule III, IV, or V medications, completion of an online or live training course to manage opioid use disorder, and submitting documentation to the Substance Abuse and Mental Health Services Administration. Residents in training can also obtain a waiver if they have the proper license and Drug Enforcement Administration registration.

Only about 4% of family physicians have a DATA 2000 waiver. Although there are obstacles to getting a waiver and providing treatment in the office, this is a large opportunity for family physicians and, therefore, the AAFP encourages obtaining the waiver and implementing medication-assisted treatment.

Federal and state agencies, as well as professional organizations, have developed guidelines to assist with managing opioid use disorders. More information about these guidelines can be found in the full AAFP position paper. The AAFP also has a policy on substance abuse and addiction at http://www.aafp.org/about/policies/all/substance-abuse.html, and provides a chronic pain management toolkit at http://www.aafp.org/patient-care/public-health/pain-opioids/cpm-toolkit.mem.html.

Guideline source: American Academy of Family Physicians

Evidence rating system used? No

Literature search described? No

Guideline developed by participants without relevant financial ties to industry? Not reported

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LISA HAUK, *AFP* Senior Associate Editor ■

AAFP

Chronic Pain Management and Opioid Misuse: A Public Health Concern (Position Paper)

Executive Summary

The intertwined public health issues of chronic pain management and the risks of opioid use and misuse continue to receive national attention. Family physicians find themselves at the crux of the issue, balancing care of people who have chronic pain with the challenges of managing opioid misuse and abuse. Pain is one of the oldest challenges for medicine. Despite advances in evidence and understanding of its pathophysiology, chronic pain continues to burden patients in a medical system that is not designed to care for them effectively. Opioids have been used in the treatment of pain for centuries, despite limited evidence and knowledge about their long-term benefits, but there is a growing body of clear evidence regarding their risks. As a result of limited science, external pressures, physician behavior, and pharmacologic development, we have seen the significant consequences of opioid overprescribing, misuse, diversion, and dependence.

In the face of this growing crisis, family physicians have a unique opportunity to be part of the solution. Both pain management and dependence therapy require patient-centered, compassionate care as the foundation of treatment. These are attributes that family physicians readily bring to their relationships with patients. While our currently fragmented health care system is not well-prepared to address these interrelated issues, the specialty of family medicine is suited for this task. The American Academy of Family Physicians (AAFP) is actively engaged in the national discussion on pain management and opioid misuse. Committed to ensuring that our specialty remains

SEE ALSO

- Drugs, Prescribing (http://www.aafp.org/about/policies/all/drug prescribing.html)
- Drugs, Opposition to Mandatory Education for Drug Prescribing (http://www.aafp.org/about/policies/all/drug education.html)
- Substance Abuse and Addiction (http://www.aafp.org/about/policies/all/subs abuse.html)
- Pain Management and Opioid Abuse (http://www.aafp.org/patient-care/public-health/pain-opioids.html)
- AAFP Chronic Pain Management Toolkit (http://www.aafp.org/patient-care/public-health/pain-opioids/cpm-toolkit.html)

part of the solution to these public health crises, the AAFP challenges itself and its members at the physician, practice, community, education, and advocacy levels to address the needs of a population struggling with chronic pain and/or opioid dependence.

Call to Action

The AAFP is committed to addressing the dual public health crises of undertreated pain and opioid misuse/abuse at both the national and grassroots levels. To this end, the AAFP has formed a cross-commission advisory committee to address the multiple issues involved. Through its efforts with other physician and medical organizations, as well as governmental entities, the AAFP is committed to being a leader in promoting the advancement of safe pain management and opioid prescribing, and in addressing the growing burden of opioid dependence. The AAFP therefore challenges itself and its members to action in the following areas:

Physician Level

- Deliver patient-centered, compassionate care to patients struggling with chronic pain and/or opioid dependence
- Collaborate with other health care professionals to deliver the multidisciplinary care that patients struggling with chronic pain and/or opioid dependence need
- Critically appraise currently available evidence and guidelines on the treatment of chronic pain and opioid dependence
- Acknowledge risk factors for opioid overdose and misuse in patients who have chronic pain and in patients currently being treated with opioids, and appropriately use prescription drug monitoring programs (PDMPs), periodic drug screens, treatment agreements, and related tools to combat misuse
- Consider obtaining a Drug Addiction Treatment Act of 2000 (DATA 2000) waiver to deliver office-based opioid treatment (OBOT)
- Provide access to and information about appropriate antidotes (e.g. naloxone) for patients who are at highest risk of an intentional or unintentional overdose

Practice Level

- Create a nonjudgmental and culturally proficient environment for patients struggling with chronic pain and/or opioid dependence
- Review current practice patterns and protocols, considering the Federation of State Medical Boards (FSMB) and Centers for Disease Control and Prevention (CDC) guidelines for the treatment of chronic pain
- Identify key partners and community resources for collaboration in the treatment of chronic pain and opioid dependence
- Encourage and enable physicians to use protocols for medication-assisted treatment (MAT) to address opioid dependence within the clinic population
- Work with local, regional, and/or national practice-based research networks to develop science that will best inform the care of patients who have chronic pain and the appropriate management of opioid use, especially in vulnerable populations

Community Level

- Develop partners within the medical neighborhood to ensure successful multidisciplinary delivery of care for patients struggling with chronic pain and/or opioid dependence
- Work with local organizations and patient advocacy groups to develop community-based solutions to chronic pain and opioid dependence, with the goal of destigmatizing the issues surrounding both
- Inform, educate, and facilitate development of overdose education and naloxone distribution (OEND) programs in the community
- Increase collaboration among community behavioral health services, nurse care management services, other psychosocial support services, and primary care in order to support community providers of MAT
- Expand cross-coverage opportunities for solo, waivered family physicians working in rural and underserved areas, including the possible short-term use of nonwaivered physicians to provide coverage

Education Level

- Align residency program training to deliver evidence-based information on best practices in the management of chronic pain and opioid dependence
- Expand current continuing medical education (CME) offerings to deliver evidence-based information on best practices in the management of chronic pain and opioid dependence, including the appropriate use of naloxone
- Expand the opportunities for DATA 2000 waiver training during residency. For mentoring and training purposes, this will ideally include faculty members at each residency site who are trained in MAT. Sites where waivered family medicine faculty members are not available should utilize collaborative teaching and mentoring arrangements with other providers.
- Expand the availability of waivered training courses at national, state, and regional CME meetings, as well as the availability of online and other alternative models of waiver training
- Develop a list of DATA 2000-waivered family physicians across the United States who are willing to provide mentorship for newly waivered family physicians and residents, ideally with some form of reimbursement for their mentorship activities

Advocacy Level

- Work for adjustments in payment models to enable physicians to provide patient-centered, compassionate care in the treatment of chronic pain and opioid dependence and to appropriately compensate them for providing such care
- Expand governmental and private insurance coverage of MAT in the primary care setting, with adequate reimbursement for the increased time, staff, and regulatory commitments associated with MAT
- Expand the role of advanced practice nurses (APNs) and physician assistants (PAs) in providing MAT as part of a team supervised by a DATA 2000-waivered primary care physician
- In states that lack appropriate laws, advocate for better access to naloxone, and appropriate Good Samaritan protections for prescribers and lay rescuers
- Work with state and federal licensing boards, the Drug Enforcement Administration (DEA), and the Substance Abuse and Mental Health Services Administration (SAMHSA) to destigmatize MAT, particularly in the setting of the community provider
- Work with state and national partners to improve the functionality, utility, and interoperability of PDMPs, and develop best practices for their use and implementation

- Expand governmental and private support of research into the management of chronic pain, as well as methods to better identify and manage opioid misuse. Particular attention should be paid to vulnerable populations who are at higher risk for undertreatment of pain and/or for opioid misuse.

Introduction

Chronic pain and opioid misuse are significant and interrelated health care issues that are important to our patients, the medical community, and society as a whole. A core tenet of the practice of medicine is to relieve suffering, yet the undertreatment of pain has been deemed a public health crisis by the National Academy of Medicine (NAM).[1] The physician community struggles with uncertainties when managing a patient's chronic pain in the face of an epidemic of opioid misuse, as well as the morbidity and mortality associated with overdose. When a family physician sits down with a patient who is seeking help, the fundamental goals of relieving suffering and avoiding harm can come into clear opposition.

Sadly, our current health care system is poorly equipped to address the needs of a patient who has chronic pain and/or opioid dependence. Patients can feel abandoned in their care, such as when they are marked with the stigma of addiction, labeled as "drug seekers" by health care providers, or "fired" from medical practices for opioid misuse. No one disputes that chronic pain should be managed with a multidisciplinary approach, yet family physicians often do not have the resources or personnel to provide that approach. They must work within a fragmented health care system in which patients can obtain prescriptions from multiple sources and multiple physicians. Since family physicians treat the whole patient and not just a subset of diseases, they face the challenge of working with patients who have multiple comorbidities, which complicates both managing chronic pain and balancing competing priorities during the office visit. Furthermore, the payment structure for the system at large (and for medications in particular) often rewards a fast-track approach instead of the comprehensive and time-consuming processes required to deliver the most appropriate care to patients struggling with chronic pain and/or opioid dependence and opioid use disorder.

Despite these challenges, family physicians must understand the history of managing chronic pain and opioid dependence, as well as the current science. They must also be prepared to be a key part of the solution. This position paper provides family physicians with critical information and calls them to action to address chronic pain and opioid dependence and opioid use disorder.

Pain and Opioids: How Did We Get Here?

Pain is one of the oldest medical problems, with a long history in medicine, religion, and social science. Recent history demonstrates that we still do not have a full understanding of chronic pain, leading us to ineffective and counterproductive pain management strategies.[2] Opioid use for pain dates back to the 1800s. The use of opioids increased due to the need to treat devastating injuries sustained in warfare; opioid use was also affected by advancements in pain physiology, the discovery of endogenous endorphins and opioid receptors, and the development of synthetic opioids.[3-5] Opioid pain relievers can effectively reduce pain, as demonstrated by multiple randomized trials.[6] Unfortunately, almost all of these studies have lasted less than 16 weeks, and there are few data regarding the longer term effectiveness of opioids for chronic pain.[7] On the basis of limited data, the U.S. Food and Drug Administration (FDA)—using varying degrees of scrutiny—approved many of the current extended-release opioids.[8] The result was a false sense of security in the physician community about the efficacy and safety of these medications to address the growing issue of chronic pain.[8]

Chronic pain is common, with approximately 11% of the U.S. population reporting daily pain.[9] In addition, pain is often more severe and more frequently undertreated in vulnerable subpopulations, including the elderly, racial/ethnic minorities, women, and socioeconomically challenged groups.[1, 10] Efforts to address the significant morbidity of chronic pain led to an increased emphasis on the recognition and treatment of chronic pain. These efforts—which were highlighted by actions of the U.S. Congress, the National Academy of Medicine (NAM), and multiple professional organizations—focused on improving care, increasing research into pain and its management, and improving training of physicians who manage pain.[1, 11, 12]

Current Issues with Opioid Misuse and Abuse

Regular opioid use, including use in an appropriate therapeutic context, is associated with both tolerance and dependence. The presence of tolerance or dependence does not necessarily mean that an individual has an opioid use disorder. Tolerance is present when an individual needs to use more of a substance in order to achieve the same desired therapeutic effect. Dependence is characterized by specific signs or symptoms when a drug is stopped. “Opioid misuse” is a broad term that covers any situation in which opioid use is outside of prescribed parameters; this can range from a simple misunderstanding of instructions, to self-medication for other symptoms, to compulsive use driven by an opioid use disorder.[13] “Abuse” is also a nonspecific term that refers to use of a drug without a prescription, for a reason other than that prescribed, or to elicit certain sensory responses.[13]

While cause and effect is unclear, the fact that rates of opioid use increased at the same time that physicians were being criticized for their undertreatment of pain is probably not a coincidence. Efforts to improve pain control led to pain becoming the “fifth vital sign,” and physicians were encouraged to address pain aggressively. In 2012, the number of opioid prescriptions written (259 million) equaled the adult population of the United States.[14] Despite the increase in opioid prescribing, similar increases have not been observed with other analgesics, including nonsteroidal anti-inflammatory drugs (NSAIDs), acetaminophen, or other adjunctive nonopioid therapies, nor have we seen a concomitant change in the amount of pain that Americans report.[15, 16]

Increasing rates of opioid misuse and abuse have become a prominent topic in medical, public health, and mainstream media. The reality is that this growing trend is largely related to misuse of prescription medications. Prescription opioids are second only to marijuana as the first illicit substance people try, with approximately 1.9 million new initiates per year.[14] Sales of prescriptions opioids quadrupled between 1999 and 2014.[17] Not surprisingly, the prescribing practices of physicians have come under scrutiny. It is estimated that one out of five patients who have noncancer pain is prescribed opioids.[15] Family physicians have played a role in this rising trend; primary care providers are responsible for about half of the opioid pain relievers dispensed.[15]

These increased prescribing practices have clearly contributed to the growing opioid epidemic. In 2014, almost 2 million Americans abused or were dependent on prescription opioids.[18] In primary care settings, one in four people who receive prescription opioids chronically for noncancer pain struggles with opioid dependence.[19] Every day, more than 1,000 people are treated in emergency departments for misusing prescription opioids.[20] Concurrently, some of the challenges associated with obtaining prescription opioids, as well as cost issues, have led to a rise in heroin use.[21, 22]

Probably the most concerning consequence is the rise in intentional and unintentional opioid overdoses, which lead to substantial morbidity and mortality. While most people who abuse opioids get them for free from a friend or relative, those at highest risk of overdose (defined as individuals who use prescription opioids nonmedically

for 200 or more days a year) obtain opioids using their own prescriptions (27%), get them from friends or relatives for free (26%), buy them from friends or relatives (23%), or buy them from a drug dealer (15%).[23] The ultimate source remains prescribed medications. At least half of all U.S. opioid overdose deaths involve a prescription opioid.[24] Based on data from 1999 to 2014, risk factors for death from prescription opioid overdose included being between ages 25 and 54, being a non-Hispanic white, and being male.[24] Other risk factors include concomitant use of multiple prescribed and illicit substances (especially benzodiazepines),[25, 26] nicotine use, higher prescribed dosages, inappropriate prescribing procedures, methadone use, and having a history of substance abuse.[27]

Opioids and the Management of Pain

There are key differences between acute and chronic pain. Acute pain is a warning symptom that has a functional role in the immune system and resolves with tissue recovery. It is mediated by intact neural pathways and it can be, when needed, controlled with opioids.[28] Chronic pain arises from a complex web of heterogeneous illnesses and injuries, and affects a patient physically, psychologically, and emotionally. Frequently, it is associated with undue social and functional consequences, leading to lost productivity, reduced quality of life, and social stigma. Not surprisingly, addressing chronic pain requires a comprehensive approach, with an emphasis on safe and compassionate patient-centered care; chronic pain usually cannot be managed by prescription therapy alone.[1,29]

Recognizing this complexity, family physicians need guidance on how to best provide patient-centered, compassionate care. While guidelines and policy statements provide some assistance, the evidence available to support such recommendations and guidance is very limited. Previous guidelines have encouraged physicians to access and use specific resources, such as opioid risk assessment screeners,[30] urine drug screening, standardized pain scales, and prescription drug monitoring databases.[31, 32] Using these resources often adds time to already busy patient visits, so it is not surprising that many are not routinely used by physicians prescribing opioids for chronic pain.[33] It is also worth noting that a report from the 2014 National Institutes of Health (NIH) Pathways to Prevention Workshop on the role of opioids in treatment of chronic pain stated that “evidence is insufficient for every clinical decision that a provider needs to make about the use of opioids for chronic pain.”[8]

The Federation of State Medical Boards (FSMB) developed a model policy to help state medical boards ensure the practice of both appropriate pain management and safe, appropriate opioid prescribing. This policy addresses key areas for medical boards, physicians, and patients with respect to the following: understanding of pain; patient evaluation and risk stratification; development of a treatment plan and goals; informed consent and treatment agreement; initiation of an opioid trial; ongoing monitoring and adaptation of the treatment plan; periodic drug testing; consultation and referral; discontinuation of opioid therapy; medical records; and compliance with controlled substance laws and regulations.[34] Many states either have a medical board policy that is reflective of the FSMB’s model policy or are currently amending their medical board policy to reflect the model policy.

In 2016, the Centers for Disease Control and Prevention (CDC) published the *CDC Guideline for Prescribing Opioids for Chronic Pain--United States, 2016*,[35] which addresses many of the elements of the FSMB’s model policy. This CDC guideline was based on an evidence review that found no studies that evaluated the effectiveness of long-term (one year or greater) opioid therapy versus placebo or nonuse with regard to pain,

function, and quality of life.[35] Instead, the CDC based most of its recommendations on a review of contextual evidence using inconsistent inclusion and exclusion criteria for different pain management therapies. Because of these inconsistencies in methodology, and because strong recommendations were made on the basis of low-quality or insufficient evidence, the American Academy of Family Physicians (AAFP) did not endorse the guideline. However, the guideline does provide some useful information for family physicians; therefore, it was categorized as Affirmation of Value.[36, 37]

While guidelines and policies are available to physicians, there is a substantial deficit in the peer-reviewed research necessary to form a reliable evidence base. In order to fill this gap, it is imperative that family physicians actively advocate for and engage in research opportunities on appropriate pain management strategies.

Role of Family Medicine in Care of Patients with Opioid Use Disorders

Screening for Opioid Abuse and Misuse

Most guidelines recommend screening patients to determine risks of drug misuse and abuse and to mitigate those risks as much as possible. Screening is typically based on risk factors that can be identified through a thorough patient history, the use of prescription drug monitoring programs (PDMPs), and, on occasion, drug screening. Unfortunately, there are no risk assessment tools that have been validated in multiple settings and populations. Furthermore, cited risk factors, such as sociodemographic factors, psychological comorbidity, family history, and alcohol and substance use disorders,[38] may lead to discriminatory practices that affect care for vulnerable populations. As a member of the American Medical Association (AMA) Task Force to Reduce Prescription Opioid Abuse, the American Academy of Family Physicians (AAFP) encourages physicians to use their state PDMP.[39] These electronic databases are used to track prescribing and dispensing of controlled prescription drugs; they can be used to obtain information on suspected abuse or diversion and to help identify patients at risk so they can benefit from early intervention.[40]

Naloxone

Family physicians should be aware of the utility of naloxone in a harm-reduction strategy for combating opioid overdose. The use of naloxone as a reversal agent for opioid overdose is standard therapy for advanced emergency medical service (EMS) providers and in emergency departments. Increasingly over the last two decades, naloxone has been provided to lay people for use in an opioid overdose.[41] While little high-quality data is available, naloxone consistently shows benefit in the studies that are available, whether used by nonmedical first responders[42] or lay people.[41, 43] The Centers for Disease Control and Prevention (CDC) reports more than 26,000 opioid reversals by lay people from 1996 to 2014.[41] Often, these opioid reversals are part of an overdose education and naloxone distribution (OEND) program. The Substance Abuse and Mental Health Services Administration (SAMSHA)[44] and the AMA Task Force to Reduce Prescription Opioid Abuse[45] are encouraging physicians to identify patients at higher risk of overdose (e.g., use of higher opioid doses, concomitant benzodiazepine use, respiratory disease) and to provide them with naloxone. Most, but not all, states provide for increased layperson access to naloxone, and many have Good Samaritan provisions for prescribers and lay people.[45]

Medication-Assisted Treatment

Medication-assisted treatment (MAT) of opioid and heroin dependence has existed for more than five decades[46] and involves some form of opioid substitution treatment. Originally, only methadone (an opioid agonist) was available, but now clinicians have buprenorphine (a partial agonist used alone or in combination with naloxone) and naltrexone (an opioid antagonist with both oral and extended-release injectable formulations) as pharmacologic options for MAT. In addition, adjunctive medications such as clonidine, nonsteroidal anti-inflammatory medications (NSAIDs), and others are used in the treatment of specific opioid withdrawal symptoms.[47] Prior to the Drug Addiction Treatment Act of 2000 (DATA 2000), medications for the treatment of substance abuse were available only via federally approved opioid treatment programs (OTPs). In these programs, personnel specifically trained in addiction medicine dispense certain Schedule II medications (methadone and levo-alpha-acetylmethadol [LAAM]) on a daily basis. With passage of DATA 2000, qualified physicians can now get a waiver to prescribe or dispense approved Schedule III, IV, or V medications for the treatment of opioid dependence outside of an OTP.[48]

With the increase in opioid misuse and the passage and implementation of DATA 2000, various federal and state authorities and professional organizations have produced guidelines to help providers treat opioid use disorders.[47, 49-51] Since 2001, SAMHSA has provided the *Federal Guidelines for Opioid Treatment Programs* (http://store.samhsa.gov/shin/content/PEP15-FEDGUIDEOTP/PEP15-FEDGUIDEOTP.pdf), which outlines specific recommendations for the administrative and organizational structure and function of an OTP.[51] SAMHSA also published *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction* (http://www.ncbi.nlm.nih.gov/books/NBK64245/pdf/Bookshelf_NBK64245.pdf), which outlines the elements of office-based opioid treatment (OBOT) utilizing buprenorphine.[49] The American Society of Addiction Medicine (ASAM) guideline (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4605275/) for treatment of opioid use disorders describes a comprehensive strategy for management that encompasses elements of OTPs and OBOT.[47] Similar to the SAMHSA guidelines, it details the initial assessment and evaluation of the patient who has opioid use disorder, offers recommendations for managing opioid withdrawal, and describes and contrasts all of the available pharmacologic options for treatment of opioid use disorder. It concludes with a discussion of psychosocial therapy to be used in conjunction with pharmacologic treatments, and provides guidance in the management of various special populations (e.g., pregnant women and adolescents).

Under the DATA 2000 legislation, qualified physicians—including primary care physicians—can apply to SAMHSA for a waiver that allows them to treat patients who have opioid use disorder with buprenorphine in the office setting.[52] To get such a waiver, a physician needs to meet specific criteria (*Table 1*).

Table 1. Criteria For Physicians to Obtain DATA 2000 Waiver to Provide OBOT

- Be licensed to practice in the state in which the prescriber will be working
- Have an active Drug Enforcement Agency (DEA) registration to prescribe Schedule III, IV, or V medications
- Have completed an eight-hour training course in the treatment and management of patients who have opioid use disorder (available in live and online/ webinar formats)

- Supply documentation of successful completion of required training to SAMHSA

The waiver process allows a resident in training to get a waiver as long as the resident holds an unrestricted medical license and the appropriate DEA registration. Once SAMHSA verifies that the information submitted by the candidate is complete and valid, the DEA issues a special identification number that must be included along with the regular DEA number on all buprenorphine prescriptions for opioid treatment. In the first year after successful completion of waiver certification, the physician can manage up to 30 patients with buprenorphine. After the first year, the physician can submit a request to treat up to 100 patients per year. Under a proposal submitted by President Barack Obama in March 2016, the maximum number of patients that a qualified buprenorphine provider can treat would increase to 200 per year.[53]

As of the most recent statistics, only about 2% of all U.S. physicians (4% of primary care physicians) have a valid DATA 2000 waiver, with even fewer actively prescribing MAT.[54] Even if all of the waivered physicians prescribed MAT to the fullest extent possible, the workforce would only be able to treat 1.4 million of the patients who have a diagnosis of opioid dependence. *Table 2* lists some barriers to obtaining and utilizing the waiver and providing OBOT.[54]

Table 2. Barriers to Providing OBOT

- Lack of adequate funding; neither governmental nor private insurers adequately reimburse providers for all the costs associated with MAT in the office setting.
- Lack of institutional support for prescribing MAT
- Lack of cross-covering providers in the group or community setting when the MAT provider needs to take leave
- Lack of psychosocial support services in the community
- Concerns about the possibility of office auditing visits by the DEA
- Confidentiality rules that limit the integration of care for patients with substance use disorders into primary care
- Perceived increased scrutiny that providers face when prescribing MAT
- Increased care coordination and patient management requirements associated with MAT
- Lack of MAT training opportunities in residency
- Lack of MAT mentors and subspecialty backup

Despite these barriers, OBOT represents a critical opportunity for family physicians to address the opioid abuse epidemic. By working to reduce these barriers, the AAFP encourages family physicians to obtain a waiver and incorporate MAT into their practice.

AAFP Efforts to Tackle the Opioid Abuse Epidemic

Policies

The American Academy of Family Physicians (AAFP) recognizes the vital role that family physicians and other primary care clinicians play in the appropriate management of pain. To this end, the AAFP has developed policies, programs, and partnerships to advocate for and educate family physicians and the community. The

AAFP's policy[55] on substance abuse outlines the organization's support for training family physicians on the proper assessment, referral, and treatment of chronic pain. The AAFP also supports continued research into evidence-based guidelines for treatment of chronic pain. The AAFP supports implementation and use of prescription drug monitoring programs (PDMPs) and greater physician input into pain management regulation and legislation.[55] In conjunction with the Association of Departments of Family Medicine (ADFM), the Association of Family Medicine Residency Directors (AFMRD), and the Society of Teachers of Family Medicine (STFM), the AAFP supports appropriate training for pain management and has developed guidance for teaching residents how to care for patients who have chronic pain.[56] Through its maintenance of certification process, the American Board of Family Medicine (ABFM) offers a self-assessment module (SAM) in pain management, as well as a certificate of added qualifications (CAQ) in pain medicine and hospice and palliative medicine.[57]

Education and REMS

Since its inception in 1947, the AAFP has been committed to promoting and maintaining high standards in family medicine, and promoting the improvement of the health of the public. This is demonstrated by the dual role the AAFP plays in the continuing medical education (CME) community as an accredited CME provider, the first of three national standard-setting, credit-granting systems. While the AAFP opposes mandatory CME for physicians on opioid prescribing,[58] it strongly supports educating its members on effective and evidence-based pain management through CME and non-CME activities. The AAFP has offered several courses in risk evaluation and mitigation strategies (REMS). Additionally, the AAFP develops and provides multiple certified CME activities to address the topic of pain for its members. These CME activities are available in live, online, and enduring formats, which allows for increased access by members. The AAFP will continue to support family physicians to enhance their knowledge, competence, and performance when treating patients who have pain; it will also continue to provide CME to address the abuse, misuse, and safety of opioid prescribing.

Resources and Commitment

The AAFP collaborates with numerous external organizations on issues pertaining to opioids; these organizations include the American Medical Association (AMA), the Substance Abuse and Mental Health Services Administration (SAMHSA), the State Pain Policy Advocacy Network (SPPAN), and the American Academy of Pain Medicine (AAPM). The AAFP has a prominent role on the steering committee of the Providers' Clinical Support System (PCSS), which is sponsored by the American Academy of Addiction Psychiatry (AAAP). The PCSS provides training modules on pain management and medication-assisted treatment (MAT). Additionally, the AAFP joined 26 other medical associations in the AMA Task Force to Reduce Prescription Opioid Abuse. This task force was formed in 2014 to identify best practices for combating opioid abuse and to implement these practices across the country. The goals of the task force are to increase registration and use of PDMPs by physicians; enhance education on effective, evidence-based prescribing of opioids; reduce the stigma of pain and substance use disorder; enhance comprehensive assessment and treatment of pain; increase access to treatment for substance use disorder; and expand access to naloxone in communities.[39] With other members of the AMA Task Force and a number of other public- and private-sector partners, the AAFP joined the White House and President Obama to address the nation's epidemic of opioid abuse and heroin use by increasing education on opioid prescribing.

The U.S. Department of Health and Human Services (DHHS) has updated its National Pain Strategy (https://iprcc.nih.gov/docs/HHSNational_Pain_Strategy.pdf), which makes recommendations for improving pain management in the United States by addressing six key areas: population research; prevention and care; disparities; service delivery and payment; professional education and training; and public education and communication. The report also highlights opportunities to reduce the overreliance on opioid prescribing. Importantly, the strategy calls for better evidence and more research on pain management.[59] The AAFP supports the National Pain Strategy, which outlines the essential elements of a nationwide strategy and is in line with the AAFP's own position.

The AAFP provides its members with tools and resources for education, advocacy, and patient care (http://www.aafp.org/patient-care/public-health/pain-opioids.html). These resources include a chronic pain management toolkit, continuing medical education, office-based tools, and resources for community engagement, advocacy, and science and education. The AAFP also has formed a member advisory panel that comprises commission members and subject matter experts. This panel will provide input on and support for the AAFP's goals and initiatives related to opioids and pain management.

Summary

Effective pain management and care of patients with substance use disorders require patient centeredness and compassion, which are hallmarks of family medicine. The AAFP is committed to ensuring that the specialty of family medicine is a central component of the solutions to ongoing issues with the health care system and the growing public health crisis. The recommendations and resources outlined in this paper are provided to encourage family physicians to take action on all levels to address the needs of a population struggling with chronic pain and/or opioid dependence, and to facilitate family physicians' efforts.

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(July 2012 BOD) (2016 COD)

Chronic Pain Management and Opioid Misuse: A Public Health Concern (Position Paper) -- AAFP Policies
http://www.aafp.org/about/policies/all/pain-management-opioid.html

11400 Tomahawk Creek Parkway • Leawood, KS 66211-2680
800.274.2237 • 913.906.6000 • Fax: 913.906.6075 • aafp@aafp.org

AAFP Chronic Pain Resources

Chronic Pain Management Toolkit

Introduction

Chronic pain is common in the U.S. with approximately 11% of the population reporting daily pain. The use of pain medications has increased dramatically, with the sales of prescription opioids quadrupling from 1999 to 2014. The rates of opioid misuse and abuse have also risen leading to increased opioid overdoses and substantial morbidity and mortality. At least half of these overdoses are due to prescription medications resulting in a major public health concern. Numerous groups including medical societies, the National Academy of Medicine (formerly the Institute of Medicine), and the U.S. Congress have placed an emphasis on improving chronic pain care, increasing research into pain and pain management, improving training for physicians who manage chronic pain, and increased public awareness.

In response to the National Academy of Medicine Report outlining a blueprint for addressing the undertreatment of pain and the growing opioid misuse and abuse, several guidelines were created with recommendations for treating chronic pain. The Federation of State Medical Boards (FSMB) developed a model policy to assist state medical boards in ensuring that both appropriate pain management and safe and appropriate opioid prescribing is occurring. The Substance Abuse and Mental Health Services Administration (SAMHSA) has created resources for the appropriate prescribing of naloxone and medication assisted treatment to reduce opioid misuse/abuse and overdoses. The Centers for Disease Control and Prevention (CDC) released guidelines for Opioid Prescribing for Chronic Pain to provide guidance for primary care physicians to curb and prevent the opioid epidemic. Tools to help physicians incorporate these guidelines into their workflow, as appropriate, are valuable as many state licensing boards have or are developing policies reflecting these recommendations.

Scope of Toolkit

As chronic pain is a complex physiologic, psychologic, and emotional process, it is difficult to treat effectively. It requires a comprehensive approach that is patient-centered. Recognizing this complexity and the growing issues with opioid misuse and abuse, the American Academy of Family Physicians (AAFP) is offering the attached toolkit to help family physicians identify gaps in practice flow, standardize evaluation and treatment of chronic pain patients, and facilitate the necessary conversations surrounding pain, treatment goals, and risk identification and mitigation. The toolkit contains tools and resources with primary care, patient-centered approaches that highlight key features of workflow to streamline the delivery of best care medicine. The attached tools can be used together or separately, depending on the needs of the practice. It is important to note that all of the items in the toolkit are consistent with the CDC and FSMB guidelines to help family physicians adhere to those recommendations if needed.

Items Included in the Toolkit

Patient Assessment: The patient assessment section consists of the Brief Pain Inventory and the Work Questionnaire to collect information on patient pain history, current pain issues, function, mental health, and substance use. This should be completed by the physician or care team member with information provided by the patient.

a. Brief Pain Inventory – physician or team member will complete with patient input
b. Work Questionnaire – physician or team member will complete with patient input
c. Mental Health Assessment – PHQ9 or tool provided by EHR; can be completed by patient

Functional Goals and Action Plan: The patient assessment section consists of the Brief Pain Inventory and the Work Questionnaire to collect information on patient pain history, current pain issues, function, mental health, and substance use. This should be completed by the physician or care team member with information provided by the patient.

Risk Assessment: The purpose of these tools is to assess patient safety and risk for medication misuse. It includes the Opioid Risk Tool and a checklist for safety monitoring and discussions of potential risks.

continued

a. Opioid Risk Tool – Physician completes using patient input and score

b. Risk and Safety Checklist – Physician completes, documenting risk assessment and monitoring of red flags, Prescription Drug Monitoring Programs (PDMPs), and urine drug tests

Medication Agreement: The purpose of this tool is to provide a mechanism for the physician to discuss responsibilities of the patient and physician. It also provides a reminder for both physician and patient to document that discussion using either a contract (provided) or another form of the physician's choosing. The physician should review a contract or list of responsibilities with the patient and both should sign or initial. A copy should be kept in the patient file and also given to the patient.

Opioid Conversion Table: This tool can be used to calculate the total daily doses of opioids in morphine milligram equivalents to facilitate appropriate prescribing and/or tapering.

Opioid Tapering Resource and Worksheet: The purpose of this tool is to provide resources and recommendations for tapering of opioid medications. A worksheet to record and manage tapering doses is also provided.

Urine Drug Testing Resource: This tool offers a brief overview for urine drug testing along with a table outlining the tests used and potential false positives.

Additional Resources: A list of available resources from the AAFP and collaborators is included at the end of the toolkit. Links have been provided to allow members to access current guidelines and policies from the AAFP, relevant journal articles, and patient education materials.

STUDY ID #:_____ DO NOT WRITE ABOVE THIS LINE HOSPITAL #:_____

Brief Pain Inventory (Short Form)

Date:____/____/____ Time:_____

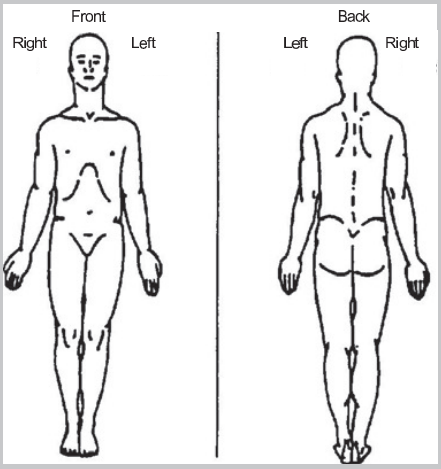
Name:_____ _____ _____

Last First Middle Initial

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these every-day kinds of pain today?

1. Yes ☐ ☐ 2. No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3. Please rate your pain by circling the one number that best describes your pain at its worst in the last 24 hours.

0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐
No Pain — Pain as bad as you can imagine

4. Please rate your pain by circling the one number that best describes your pain at its least in the last 24 hours.

0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐
No Pain — Pain as bad as you can imagine

5. Please rate your pain by circling the one number that best describes your pain on the average.

0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐
No Pain — Pain as bad as you can imagine

6. Please rate your pain by circling the one number that tells how much pain you have right now.

0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐
No Pain — Pain as bad as you can imagine

STUDY ID #:_____ DO NOT WRITE ABOVE THIS LINE HOSPITAL #:_____

Date:____/____/____ Time:_____

Name:_____ _____ _____

Last First Middle Initial

7. What treatments or medications are you receiving for your pain?

8. In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much relief you have received.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

No Relief — Complete Relief

9. Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General Activity

0 1 2 3 4 5 6 7 8 9 10

Does not Interfere — Completely Interferes

B. Mood

0 1 2 3 4 5 6 7 8 9 10

Does not Interfere — Completely Interferes

C. Walking Ability

0 1 2 3 4 5 6 7 8 9 10

Does not Interfere — Completely Interferes

D. Normal Work (includes both work outside the home and housework)

0 1 2 3 4 5 6 7 8 9 10

Does not Interfere — Completely Interferes

E. Relations with other people

0 1 2 3 4 5 6 7 8 9 10

Does not Interfere — Completely Interferes

F. Sleep

0 1 2 3 4 5 6 7 8 9 10

Does not Interfere — Completely Interferes

G. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10

Does not Interfere — Completely Interferes

Work Productivity and Activity Impairment Questionnaire

Chronic Pain Management Toolkit

The following questions ask about the effect of your health problems on your ability to work and perform regular activities. "Health problems" are defined as any physical or emotional problem or symptom. *Please fill in the blanks or check the appropriate box, as indicated.*

1. Are you currently employed (working for pay)?
   If NO, check "NO" and skip to question 6.
   ☐ Yes ☐ No

2. During the past seven days, not including today, how many hours did you miss from work because of **your health problems?**
   Include hours you missed on sick days, times you went in late, left early, etc., because of your health problems. Do not include time you missed to participate in this study.
   _____ HOURS

3. During the past seven days, not including today, how many hours did you miss from work because of any other reason, such as vacation, holidays, time off to participate in this study?
   _____ HOURS

4. During the past seven days, not including today, how many hours did you actually work?
   (If "0", skip to question 6.)
   _____ HOURS

5. During the past seven days, not including today, how much did your health problems affect your productivity while you were working?
   Think about days you were limited in the amount or kind of work you could do, days you accomplished less than you would like, or days you could not do your work as carefully as usual. If health problems affected your work only a little, choose a low number. Choose a high number if health problems affected your work a great deal.

   Consider only how much **health problems** affected productivity **while you were working.**

   Health problems had no effect on my daily activities — Health problems completely prevented me from doing my daily activities

   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

6. During the past seven days, not including today, how much did your health problems affect your ability to do your regular, daily, non-work activities?
   "Regular activities" are defined as the usual activities you do, such as work around the house, shopping, childcare, exercising, studying, etc. Think about times you were limited in the amount or kind of activities you could do and times you accomplished less than you would like. If health problems affected your activities only a little, choose a low number. Choose a high number if health problems affected your activities a great deal.

   Consider only how much **health problems** affected your ability to do your regular, daily, non-work activities.

   Health problems had no effect on my daily activities — Health problems completely prevented me from doing my daily activities

   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

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Reilly MC, Zbrozek AS, Dukes EM. The validity and reproducibility of a work productivity and activity impairment instrument. PharamcoEconomics 1993; 4(5):353-65

HOP 16050882

Patient Health Questionnaire-9

Chronic Pain Management Toolkit

Over the last two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3
2. Feeling down, depressed, or hopeless	☐ 0	☐ 1	☐ 2	☐ 3
3. Trouble falling or staying asleep, or sleeping too much	☐ 0	☐ 1	☐ 2	☐ 3
4. Feeling tired or having little energy	☐ 0	☐ 1	☐ 2	☐ 3
5. Poor appetite or overeating	☐ 0	☐ 1	☐ 2	☐ 3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐ 0	☐ 1	☐ 2	☐ 3
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐ 0	☐ 1	☐ 2	☐ 3
8. Moving or speaking so slowly that other people could have noticed, or the opposite — being so fidgety or restless that you have been moving a lot more than usual	☐ 0	☐ 1	☐ 2	☐ 3
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐ 0	☐ 1	☐ 2	☐ 3

FOR OFFICE CODING 0 + _____ + _____ + _____

= Total Score: 0

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

AMERICAN ACADEMY OF FAMILY PHYSICIANS

Developed by Drs. Robert L. itzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.

HOP 16050882

Global Health (Functional Assessment)

Chronic Pain Management Toolkit

Please respond to each item by filling in one box per row.

		Excellent	Very good	Good	Fair	Poor
1.	In general, would you say your health is:	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
2.	In general, would you say your quality of life it:	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
3.	In general, how would you rate your physical health?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
4.	In general, how would you rate your mental health, including your mood and your ability to think?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
5.	In general, how would your rate your satisfaction with your social activities and relationships?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
6.	In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work, and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

		Completely	Mostly	Moderately	A little	Not at all
7.	To what extent are you able to carry out everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

		Never	Rarely	Sometimes	Often	Always
8.	How often have you been bothered by emotional problems such as feeling anxious, depressed, or irritable?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

		None	Mild	Moderate	Severe	Very severe
9.	How would you rate your fatigue on average?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

10. How would you rate your pain on average?

No pain										Worst imaginable pain
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

Functional Goals

Which, if any, activities are limited due to pain? (Check all that apply)

- ☐ walking
- ☐ exercise
- ☐ sleep
- ☐ sexual activity
- ☐ work
- ☐ housework
- ☐ relationships (family, friends)
- ☐ self-care (bathing, dressing, eating)
- ☐ Other:_____

Which activites are most important to you?

Provider: Work with patient to determine realistic goals and on an action plan to achieve these goals.

Activity	Goal	Action

Reassess improvement/decline in function at regular intervals.

Action Plan

- ☐ Medication and Dosage: _____
- ☐ Follow up in: _____ (days, weeks, months)
- ☐ Increase dose to: _____
- ☐ Change medication to: _____
- ☐ Decrease dose to: _____
- ☐ Other therapies recommended: _____
- ☐ Referral to: _____

Does the patient report improvement in pain management?	☐ Yes	☐ No
Does the patient report improvement in function (see functional goals)?	☐ Yes	☐ No
Is the patient experiencing side effects from the medication?	☐ Yes	☐ No

Comments:

Opioid Risk Tool

Chronic Pain Management Toolkit

		Mark each box that applies	Item Score if Female	Item Score if Male
1. Family History of Substance Abuse	Alcohol	☐	☐ 1	☐ 3
	Illegal Drugs	☐	☐ 2	☐ 3
	Prescription Drugs	☐	☐ 4	☐ 4
2. Personal History of Substance Abuse	Alcohol	☐	☐ 3	☐ 3
	Illegal Drugs	☐	☐ 4	☐ 4
	Prescription Drugs	☐	☐ 5	☐ 5
3. Age *(Mark box if 16-45)*		☐	☐ 1	☐ 1
4. History of Preadolescent Sexual Abuse	Alcohol	☐	☐ 3	☐ 0
5. Psychological Disease	Attention Deficit Disorder, Obessive Compulsive Disorder, Bipolar, Schizophrenia	☐	☐ 2	☐ 2
	Depression	☐	☐ 1	☐ 1
	TOTAL		_____	_____

Total Score Risk Category

Low Risk 0-3

Moderate Risk 4-7

High Risk ≥ 8

Webster LR. Predicting abberrant behaviors in opioid-treated patients: Preliminary validation of the opioid risk tool. Pain Management. 2005;6(6):432-442.

HOP 16050882

Risk Assessment and Monitoring Checklist

Chronic Pain Management Toolkit

Prior to initiation of opioid therapy, it is imperative to assess the patient's risk for misuse/abuse. This toolkit provides resources to identify possible red flags for opioid misuse, links to find your state's prescription drug monitoring program (PDMP), opioid risk assessment, and mental health assessment tools. Use the table below to track completion and results for each potential risk item.

Document completion, results, and any action needed		
Tool/Test	**Completed (Results)**	**Additional action or comments**
Opioid Risk (ORT or external tool)		
Alcohol Use		
Other Substance/Drug Use		
Mental Health Screening		
State PDMP		
Urine Drug Test		

Additional resources: Included below are links to find your state's PDMP and a comprehensive document outlining red flags for opioid misuse. This document was created by AAFP and other collaborators.

Links to State PDMPs

Red Flags for Opioid Misuse

Opioid Medication for Chronic Pain Agreement

Chronic Pain Management Toolkit

This is an agreement between _____ (patient) and Dr. _____.

I am being treated with opioid medication for my chronic pain, which I understand may not completely rid me of my pain, but will decrease it enough that I can be more active. I understand that, because this medication has risks and side effects, my doctor needs to monitor my treatment closely in order to keep me safe. I acknowledge my treatment plan may change over time to meet my functional goals, and that my doctor will discuss the risks of my medicine, the dose, and frequency of the medication, as well as any changes that occur during my treatment. In addition, I agree to the following statements:

Patient Initials	Please read the statements below and initial in the box at the left.
	I understand that the medication may be stopped or changed to an alternative therapy if it does not help me meet my functional goals.
	To reduce risk, I will take medication as prescribed. I will not take more pills or take them more frequently than prescribed.
	I will inform my doctor of all side effects I experience.
	To reduce risk, I will not take sedatives, alcohol, or illegal drugs while taking this medication.
	I will submit to urine and/or blood tests to assist in monitoring my treatment.
	I understand that my doctor or his/her staff may check the state prescription drug database to prevent against overlapping prescriptions.
	I will receive my prescription for this medication only from Dr. _____.
	I will fill this prescription at only one pharmacy. (Fill in pharmacy information below.)
	I will keep my medication in a safe place. I understand if my medicine is lost, damaged, or stolen, it will not be replaced.
	I will do my best to keep all scheduled follow-up appointments. I understand that I may not receive a prescrption refill if I miss my appointment.

Medication name, dose, frequency _____

Pharmacy name _____

Pharmacy phone number _____

By signing below, we agree that we are comfortable with this agreement and our responsibilities.

_____ _____

Patient signature *Date*

_____ _____

Physician signature *Date*

Opioid Conversion Table

Chronic Pain Management Toolkit

Calculating total daily doses of opioids is important to appropriately and effectively prescribe, manage, and taper opioid medications. There are a number of conversion charts available, so caution is needed when performing calculations. As with all medications, consulting the package insert for dose titration instructions and safety information is recommended. Treatment should be individualized and begin with lower doses and gradual increases to manage pain.

Once the dose is calculated, the new opioid should not be prescribed at the equivalent dose. The starting dose should be reduced by 25-50% to avoid unintentional overdose due to incomplete cross-tolerance and individual variations in opioid pharmacokinetics. This dose can then be gradually increased as needed.

To calculate the total daily dose:

1. Determine the total daily doses of current opioid medications (consult patient history, electronic health record, and PDMP as necessary).
2. Convert each dose into MMEs by multiplying the dose by the conversion factor.
3. If more than one opioid medication, add together.
4. Determine equivalent daily dose of new opioid by dividing the calculated MMEs of current opioid by new opioid's conversion factor. Reduce this amount by 25-50% and then divide into appropriate intervals.

Calculating Morphine Milligram Equivalents (MME)*			
Opioid	**Conversion Factor** (convert to MMEs)	**Duration (hours)**	**Dose Equivalent Morphine Sulfate (30mg)**
Codeine	0.15	4-6	200 mg
Fentanyl (MCG/hr)	2.4		12.5 mcg/hr**
Hydrcodone	1	3-6	30 mg
Hydromorphone	4	4-5	7.5 mg
Morphine	1	3-6	30 mg
Oxydodone	1.5	4-6	20 mg
Oxymorphone	3	3-6	10 mg
Methadone†			
1-20 mg/d	4		7.5 mg
21-40 mg/d	8		3.75 mg
41-60 mg/d	10		3 mg
≥61 mg/d	12		2.5 mg

**The dose conversions listed above are an estimate and cannot account for an individual patient's genetics and pharmacokinetics.*

***Fentanyl is dosed in mcg/hr instead of mg/day, and absorption is affected by heat and other factors.*

†Methadone conversion factors increase with increasing dose.

Sample Case

Your patient is a 45-year-old man who is taking oxymorphone 10 mg 4 times a day for chronic pain. You have determined he is an appropriate candidate for a long-acting regimen and decide to convert him to extended release oxycodone.

1. Total daily dose of oxymorphone → 10 mg X 4 times /d = 40 mg/d
2. Convert to MMEs (oxymorphone conversion factor = 3) →40 X 3 = 120 MME
3. Determine MMEs of oxycodone (oxycodone conversion factor = 1.5) → 120/1.5 = 80 mg/d
4. Decrease dose by 25% → 25% of 80 = 20 → 80 – 20 = 60
5. Divide by interval (q 12 hours) → 60/2 = 30

The starting dose of extended release oxycodone is 30 mg q 12h.

Additional Resources

CDC Opioid Conversion Guide

https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf

Tapering Resource

The objective of a taper is to prevent significant withdrawal symptoms while reducing or discontinuing opiates.

Potential Reasons to Taper Opioids

- Patient request
- Lack of improvement in pain and/or function
- Nonadherence to treatment plan
- Signs of misuse and/or abuse
- Serious adverse events

Recommendations for Tapering

There is no evidence to support one tapering strategy over another. Any tapering protocol should be individualized as some patients may tolerate a more rapid taper, while others will require a more gradual decrease in medication. In general, the longer the patient has been on opiates, the more conservative (slow) the taper will need to be to minimize or avoid withdrawal symptoms. It is important to remember that tapering is unidirectional, and should not be reversed. However, tapering can be slowed or paused if needed. A starting point for tapering is to decrease the dose 10-20% every 1-2 weeks and adjust the rate according to patient response. Once the patient has reached about 1/3 of the original dose, smaller decreases of 5% every 2-3 weeks may be necessary.

For individuals on high dose or multiple opioids, switching to a single long acting opioid or methadone can be considered (see conversion table). Once stable on the long-acting regimen, proceed with a slow taper, 10-20% every 1-2 weeks, followed by an even slower taper once 1/3 of the original dose is reached. A worksheet to record and track doses for tapering is provided in this toolkit.

Caution patients that they may quickly lose their tolerance to opioids, so they are at risk for overdose if they abruptly resume their original dose.

It is important to note that pregnant patients on chronic opiate therapy should not be weaned due to risks to both the mother and the fetus. Patients with signs of misuse and/or abuse who are pregnant should be considered for MAT.

Management of Withdrawal

Physical withdrawal symptoms generally resolve 5-10 days after dose reduction/cessation, while psychological symptoms may take longer. Not all patients will experience the same withdrawal symptoms. The goal is to minimize these symptoms with a gradual taper. There are additional treatments that may help with specific symptoms (see chart below).

Additional Resources

CDC Tapering Pocket Guide
http://www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf

VA Tapering Fact Sheet
http://www.healthquality.va.gov/guidelines/Pain/cot/OpioidTaperingFactSheet-23May2013v1.pdf

Washington State Guideline
http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf

Stage	Grade*	Physical Signs and Symptoms	Treatment Options
Early Withdrawal (8-24 hrs after last use)	1	Lacrimation, Rhinorrhea, Diaphoresis, Yawning, Restlessness, Insomnia	- Antihistamines or trazodone for insomnia/restlessness
	2	Piloerection, Myalgias, Arthralgias, Abdominal pain	- NSAIDs/Acetaminophen for muscle and joint pain - Loperamide/bismuth subsalicylate for abdominal cramping
Fully Developed Withdrawal (1-3 days after last use)	3	Tachycardia, Typertension, Tachypnea, Fever, Anorexia, Nausea	- Clonidine for autonomic symptoms - Ondasetron/H2 blockers for nausea
	4	Diarrhea, Vomiting, Dehydration, Hypotension	- Loperamide for diarrhea - Oral rehydrating solutions
Post Acute Withdrawal Syndrome (PAWS)		Mood swings, Anxiety, Irritability, Anhedonia, Fatigue, Poor concentration, Insomnia	- Recovery services - Relapse prevention strategies

**The severity of opioid withdrawal is defined by symptoms and described by four categories or grades.*

Opioid Tapering Worksheet

Current Dose: _____

Target Dose: _____

Timeline: _____

Medication: _____

Date	Dose	Frequency	# of weeks	Total dose/day
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg

Urine Drug Testing

Screening (see chart on next page)

Most guidelines recommend screening patients to determine risks of drug misuse and abuse and to mitigate those risks as much as possible. Unfortunately, there are no risk assessment tools that have been validated in multiple settings and populations. Screening is typically based on risk factors that can be identified through a thorough patient history, the use of prescription drug monitoring programs (PDMPs), the opioid risk tool (provided in this toolkit), and, on occasion, drug screening. However, it is important to standardize testing as cited risk factors (e.g. sociodemographic factors, psychological comorbidity, substance use disorders, etc.) might unfairly impact certain vulnerable populations. Involvement of the whole health care team and full disclosure and discussion of the screening protocol with patients is central to providing patient-centered and comprehensive pain management. Prior to drug testing, physicians should inform the patient of the reason(s) for testing, how often they will be tested, and what the results might mean. This gives patients an opportunity to disclose any additional drug or substance use which may help with identification of false positives and appropriate interpretation of test results.

Physicians must understand the limitations of the urine and confirmatory tests available, including what substances are detected by a particular test, and the reasons for false-positive and false-negative tests. Changes in prescribing for a particular patient should not be based on the result of one abnormal screening test, but should only occur after looking at all available monitoring tools as well as repeating the drug screen with the most specific test available.

Interpretation of Results

Following initial testing, physicians should request confirmatory testing for the following results:

- Negative for the opioid(s) prescribed
- Positive for drugs not prescribed
- Positive for other substances such as alcohol, amphetamines, or cocaine (or metabolites)

Additional Resources

Washington State Medical Directors Guideline
http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf

SAMHSA Guideline for Drug Testing
https://store.samhsa.gov/shin/content/SMA12-4668/SMA12-4668.pdf

Urine Drug Testing for Commonly Used and Misused Drugs			
OPIATES			
Drug	**Detection Time**	**Test Order**	**False Positive**
Codeine	1-3 days	Opiates Immunoassay* Confirmatory test: GC/MS or LC/MS/MS**	Dextromethorpan, diphenhydramine, heroin, poppy seeds, quinine, quinolones, rifampin, verapamil, other opiates
Morphine	1-3 days	Opiates Immunoassay* Confirmatory test: GC/MS or LC/MS/MS	Dextromethorpan, diphenhydramine, heroin, poppy seeds, quinine, quinolones, rifampin, verapamil, other opiates
Fentanyl	1-3 days	GC/MS or LC/MS/MS Fentanyl	n/a
Meripidine	1-3 days	GC/MS or LC/MS/MS Meperidine	n/a
Methadone	3-7 days	Methadone Immunoassay Confirmatory test: GC/MS or LC/MS/MS Methadone	Diphenhydramine, clomipramine
Hydrocodone	1-3 days	Opiates immunoassay Confirmatory test: GC/MS or LC/MS/MS	Dextromethorpan, diphenhydramine, heroin, poppy seeds, quinine, quinolones, rifampin, verapamil, other opiates
Hydromorphone	1-3 days	Opiates immunoassay Confirmatory test: GC/MS or LC/MS/MS	Dextromethorpan, diphenhydramine, heroin, poppy seeds, quinine, quinolones, rifampin, verapamil, other opiates
Oxycodone	1-3 days	Opiates immunoassay Confirmatory test: GC/MS or LC/MS/MS	Dextromethorpan, diphenhydramine, heroin, poppy seeds, quinine, quinolones, rifampin, verapamil, other opiates
Oxymorphone	1-3 days	Opiates immunoassay Confirmatory test: GC/MS or LC/MS/MS	Dextromethorpan, diphenhydramine, heroin, poppy seeds, quinine, quinolones, rifampin, verapamil, other opiates
ADDITIONAL SUBSTANCES			
Drug	**Detection Time**	**Test Order**	**False Positive**
Alcohol	Up to 8 hours	Alcohol	n/a
Amphetamines	2-3 days	Amphetamines, methamphetamines, or MDMA immunoassay	Ephedrine, pseudoephedrine, selegiline
Barbiturates	1-3 days short acting Up to 30 days long-acting	Barbiturates Immunoassay	NSAIDs
Benzodiazeph-ines	1-3 days short acting Up to 30 days long-acting	Benzodiazepines Immunoassay*** Confirmatory test: GC/MS or LC/MS/MS Alprazolam, Diazepam, Clonazepam, Lorazepam, etc.	Sertraline, oxaprozin
Cocaine	2-4 days	Cocaine metabolites immunoassay	Coca leaf tea
Marijuana	2-4 days Up to 30 days with chronic use	Cannabinoids (THC) Immunoassay	NSAIDs, proton pump inhibitors, food containing hemp, efavirenz

**Opiates Immunoassay – Confirmatory test required to determine which opiate is present*

*** GC/MS/LC – Gas Chromatography/Mass Spectrometry/Liquid Chromatography*

****Benzodiazepine Immunoassay – High false-negative rate; consider confirmatory testing if high suspicion of use*

Urine Drug Testing for Commonly Used and Misused Drugs			
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Morphine	1-3 days	Opiates Immunoassay* Confirmatory test: GC/MS or LC/MS/MS	Dextromethorpan, diphenhydramine, heroin, poppy seeds, quinine, quinolones, rifampin, verapamil, other opiates
Fentanyl	1-3 days	GC/MS or LC/MS/MS Fentanyl	n/a
Meripidine	1-3 days	GC/MS or LC/MS/MS Meperidine	n/a
Methadone	3-7 days	Methadone Immunoassay Confirmatory test: GC/MS or LC/MS/MS Methadone	Diphenhydramine, clomipramine
Hydrocodone	1-3 days	Opiates immunoassay Confirmatory test: GC/MS or LC/MS/MS	Dextromethorpan, diphenhydramine, heroin, poppy seeds, quinine, quinolones, rifampin, verapamil, other opiates
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Benzodiazeph-ines	1-3 days short acting Up to 30 days long-acting	Benzodiazepines Immunoassay*** Confirmatory test: GC/MS or LC/MS/MS Alprazolam, Diazepam, Clonazepam, Lorazepam, etc.	Sertraline, oxaprozin
Cocaine	2-4 days	Cocaine metabolites immunoassay	Coca leaf tea
Marijuana	2-4 days Up to 30 days with chronic use	Cannabinoids (THC) Immunoassay	NSAIDs, proton pump inhibitors, food containing hemp, efavirenz

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Additional Resources

AAFP

AAFP Pain Management and Opioid Abuse Resources
http://www.aafp.org/patient-care/public-health/pain-opioids/toolkit.html

AAFP Opioid and Pain Management Position Paper
http://www.aafp.org/dam/AAFP/documents/patient_care/pain_management/opioid-abuse-position-paper.pdf

American Family Physician Chronic Pain Content
http://www.aafp.org/afp/topicModules/viewTopicModule.htm?topicModuleId=61

Family Practice Management Article on Opioids and Practice Management
http://www.aafp.org/fpm/2014/1100/p6.html

AAFP Collaborators

AMA Task Force Naloxone
http://www.aafp.org/dam/AAFP/documents/patient_care/pain_management/co-branded-naloxone.pdf

AMA Task Force
Links to State PDMPs

Red Flags for Opioid Misuse Consensus Document
https://www.nabp.net/system/rich/rich_files/rich_files/000/001/321/original/redflagsstakeholders.pdf

Guidelines and Policies

CDC Guidelines
Opioid Prescribing for Chronic Pain

Federation of State Medical Boards Model Policy for Opioids

SAMHSA Guideline for Medication-Assisted Treatment
http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214

SAMHSA Guideline for Buprenorphine
http://store.samhsa.gov/product/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction/SMA07-3939

SAMHSA Guideline for Drug Testing
https://store.samhsa.gov/shin/content/SMA12-4668/SMA12-4668.pdf

Washington State Guideline
http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf

continued

Physician Resources

CDC Opioid Conversion Guide
https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf

CDC tapering pocket guide
http://www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf

VA tapering fact sheet
http://www.healthquality.va.gov/guidelines/Pain/cot/OpioidTaperingFactSheet23May2013v1.pdf

For Patients

Safe Storage and Disposal
http://familydoctor.org/familydoctor/en/drugs-procedures-devices/prescription-medicines/safeuse.html

Opioid Addiction
http://familydoctor.org/familydoctor/en/diseases-conditions/opioid-addiction.html

Chronic Pain
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****Benzodiazepine Immunoassay – High false-negative rate; consider confirmatory testing if high suspicion of use*

COLORADO ACEP

2017 Opioid Prescribing & Treatment Guidelines

EXECUTIVE SUMMARY

Confronting the Opioid Epidemic in Colorado's Emergency Departments

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I. Introduction

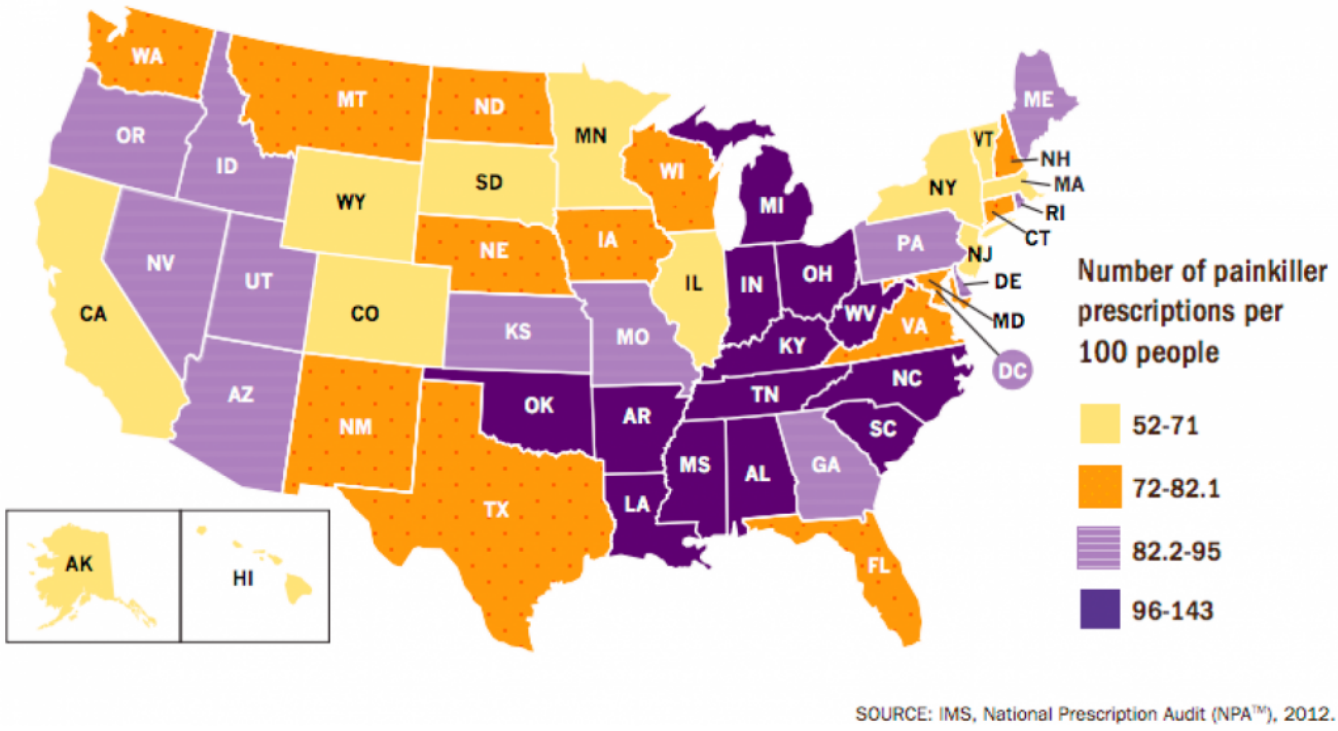
> As physicians, we are on the front lines of an opioid epidemic that is crippling communities across the country. We must accept and embrace our professional responsibility to treat our patients' pain without worsening the current crisis. These are actions we must take as physicians individually and collectively to do our part to end this epidemic.[1]
>
> *Stephen Stack, MD, AMA President & Emergency Physician (2016)*

Emergency providers across Colorado and our nation are facing one of the greatest public health crises of our generation. Opioids, both prescription and illicit, have become the leading cause of accidental death in the United States. Correspondingly, hospital visits for opioid overdose, drug-related complications, and "doctor shopping" have become an increasingly common part of emergency medicine practice. The number of lives impacted by this epidemic is astonishing. The Centers for Disease Control and Prevention (CDC) reports that opioid overdose killed nearly half a million Americans between 2000 and 2014, and another 78 are dying every day. What makes this crisis especially tragic is that organized medicine and the practice patterns of physicians have played a prominent role in creating it.

The pharmaceutical use of opioids skyrocketed between 1990 and 1996; prescriptions for fentanyl rose 1,000%, followed by morphine (49%), oxycodone (15%), and hydromorphone (12%).[2] Our appetite for these drugs has become insatiable. The number of prescription opioids sold in the US has quadrupled since 1999, with Americans consuming nearly 100% of the global supply of hydrocodone and 81% of oxycodone.[3,4] Despite a growing awareness about the addictive and potentially deadly effects of these drugs, their popularity thrives (*Figure 1*).

The number of emergency department (ED) visits precipitated by the nonmedical use of opioids has grown 183% since 2011.[5] From 2003 to 2013 treatment admissions for non-heroin opioid abuse escalated from 3% to 9%.[6] In the same decade, the prevalence of positive opioid tests tripled among drivers who died within one hour of a motor vehicle accident.[7] The financial implications of this epidemic are equally staggering; the nonmedical use of opioid pain relievers costs insurance companies an estimated $78.5 billion annually.[8]

FIGURE 1. PAINKILLERS IN AMERICA



SOURCE: IMS, National Prescription Audit (NPA™), 2012.

Physicians are the kingpins of opioid abuse. While a number of external factors have contributed to the liberal use of these potentially lethal drugs, the medical community is compelled to acknowledge its significant role our national addiction. We also have the power to reverse these grim statistics, however, by reforming our practices with resolve and innovation.

Colorado ACEP is proud to present its *Colorado Emergency Department Opioid Prescribing and Treatment Guidelines*. Among the most comprehensive ever published, these recommendations were developed by a panel of more than 20 experts, including emergency physicians, addiction and harm reduction specialists, pharmacologists, paramedics, emergency department nurses, and medical students.

These guidelines are not meant to replace clinical judgment, but rather inform and augment it. Although we acknowledge the value of opioids in certain clinical situations, including the treatment of cancer or hospice patients, we advocate extreme caution in all cases. Here we provide an approach to pain management aimed at decreasing the morbidity and mortality associated with opioid use and abuse.

II. Executive Summary

It's no secret that the United States has been gripped by opioid addiction. This public health crisis has been magnified by the frequency with which these potent drugs are prescribed, a rate that has quadrupled since 1999. These prescriptions also are the principal culprit behind our nation's escalating heroin addiction; Colorado alone has seen a 170% increase in heroin-related felony arrests since 2011, a 205% increase in non-heroin narcotic deaths, and a 250% rise in heroin-related deaths since 2000.

A multitude of factors have contributed to this epidemic, including inaccurate (but widely accepted) reporting on the safety of opioid analgesics, deception by profit-driven pharmaceutical companies, and a misguided emphasis on national pain and patient satisfaction policies by regulatory agencies such as the Joint Commission and the Center for Medicare and Medicaid Services.

As emergency clinicians, we are obliged to provide appropriate pain relief to our patients, but we also bear a growing responsibility to help stem the tide of addiction. *The Colorado Emergency Department Opioid Prescribing and Treatment Guidelines* offer an approach to pain management aimed at decreasing the morbidity and mortality associated with narcotic use and abuse. This document provides concrete recommendations about when and how opioids can be avoided, describes an array of alternative treatments for addressing pain in the acute setting, empowers emergency providers to become champions of harm reduction, and explains best practices and resources for the treatment of drug-addicted patients. The Colorado Chapter of the American College of Emergency Physicians strives to build a community of clinicians dedicated to ending this national epidemic with resolve and innovation.

Limiting Opioids in the ED

PRACTICE RECOMMENDATIONS

1. Opioids are inherently dangerous, highly addictive drugs with significant abuse potential, numerous side effects, lethality in overdose, rapid development of tolerance, and debilitating withdrawal symptoms. They should be avoided whenever possible and, in most cases, initiated only after other modalities of pain control have been trialed.
2. Prior to prescribing an opioid, physicians should perform a rapid risk assessment to screen for abuse potential and medical comorbidities. Alternative methods of pain control should be sought for patients at increased risk for abuse, addiction, or adverse reactions.
3. Emergency physicians should frequently consult Colorado's prescription drug monitoring program (PDMP) to assess a patient's history of prescription drug abuse, misuse, or diversion.
4. Opioid alternatives and nonpharmacological therapies should be used to manage patients with acute low back pain, in whom opioids are particularly detrimental. Opioids should be prescribed only after alternative treatments have failed.
5. Potential drug interactions must be evaluated, and opioids should be avoided in patients already taking benzodiazepines, barbiturates, or other narcotics.
6. Patients with chronic pain should receive opioid medications from one practice, preferably their primary care provider or pain specialist. Opioids should be avoided in the emergency department treatment of most chronic conditions. Emergency physicians should coordinate care with a patient's primary care or pain specialist whenever possible, and previous patient-physician contracts regarding opioid use should be honored.
7. Clinicians should abstain from adjusting opioid dosing regimens for chronic conditions and avoid routinely prescribing narcotics for acute exacerbations of chronic non-cancer pain.
8. "Long-acting" or "extended-release" opioid products should be avoided for the relief of acute pain.
9. Patients receiving controlled medication prescriptions should be able to verify their identity.
10. Patients who receive opioids should be educated about their side effects and potential for addiction, particularly when being discharged with an opioid prescription.
11. When considering opioids, clinicians should prescribe the lowest possible effective dose in the shortest appropriate duration (eg, <3 days).
12. Emergency departments should refuse to refill lost or stolen opioid prescriptions.

POLICY RECOMMENDATIONS

1. As has been done in other states, the Colorado PDMP should develop an automated query system that can be more readily integrated into electronic health records and accessed by emergency clinicians.
2. Pain control should be removed from patient satisfaction surveys, as they may unfairly penalize physicians for exercising proper medical judgement.
3. Opioid prepacks should be eliminated from the emergency department if 24-hour pharmacy support is available.
4. Pain should be removed as the "fifth vital sign."

Alternative Treatments

PRACTICE RECOMMENDATIONS

1. All emergency medicine providers should be proficient in Alternatives to Opioids (ALTO) protocols by learning new skills such as trigger-point injections, nerve blocks, and the appropriate administration of medications such as ketamine, haloperidol, lidocaine (IV and topical), gabapentin, and nonsteroidal anti-inflammatory drugs (NSAIDs).
2. Low-dose, subdissociative ketamine (0.1-0.3 mg/kg) is an effective analgesic that can be opioid-sparing for many acute pain syndromes. Institutional guidelines and policies should be in place to enable clinicians and nurses who administer this agent for pain. (See Appendix 3 for example of Denver Health Ketamine for Acute Pain Policy).
3. For musculoskeletal pain, consider a multimodal treatment approach using acetaminophen, NSAIDs, steroids, topical medications, and low-dose ketamine. Trigger-point injections also can be considered.
4. For headache and migraine, consider a multimodal treatment approach that includes the administration of antiemetics, valproic acid, steroids, and triptans. Strongly consider administering a cervical or trapezius trigger-point injection.
5. For pain with a neuropathic component, consider gabapentin.
6. For pain with a tension component, consider a muscle relaxant.
7. For pain caused by renal colic, consider an NSAID, lidocaine infusion and desmopressin nasal spray.
8. For chronic abdominal pain, consider low doses of haloperidol, olanzepine, benadryl, and lidocaine infusion.
9. For extremity fracture or joint dislocation, consider the immediate use of nitrous oxide and low-dose ketamine while setting up for ultrasound-guided regional anesthesia.
10. For arthritic or tendinitis pain, consider an intra-articular steroid/anesthetic injection.

POLICY RECOMMENDATIONS

1. All emergency departments should implement ALTO programs and provide opioid-free pain treatment pathways for the following conditions:
    a. Acute on chronic opiod-tolerant radicular lower back pain
    b. Opioid-naive musculoskeletal pain
    c. Migraine or recurrent primary headache
    d. Extremity fracture or joint dislocation
    e. Gastroparesis-associated or chronic functional abdominal pain
    f. Renal colic
2. Emergency departments are encouraged to assemble an interdisciplinary pain management team that includes clinicians, nurses, pharmacists, physical therapists, social workers, and case managers.
3. Reimbursement should be available for any service directly correlated to pain management, the reduction of opioid use, and treatment of drug-addicted patients.

Harm Reduction

PRACTICE RECOMMENDATIONS

1. Patients who abuse opioids should be managed without judgement; addiction is a medical condition and not a moral failing. Caregivers should endeavor to meet patients "where they are," infusing empathy and understanding into the patient/medical provider relationship.
2. Every emergency clinician should be well-versed in the safe injection of heroin and other intravenous (IV) drugs, and understand the practical steps for minimizing the dangers of overdose, infection, and other complications. When treating patients with complications of IV drug use, injection habits should be discussed and instruction should be given about safe practices.
3. Emergency department patients who inject drugs should be referred to local syringe access programs, where they can obtain sterile injection materials and support services such as counseling, HIV/hepatitis testing, and referrals.
4. Emergency departments should provide naloxone to high-risk patients at discharge. If the drug is unavailable at the time of release, patients should receive a prescription and be informed about the over-the-counter availability of the drug in most Colorado pharmacies.
5. Emergency departments should share information about their own overdose prevention initiatives to offer reassurance about the legality of providing and prescribing naloxone.
6. Emergency department patients who receive prescriptions for opioids should be educated on their risks, safe storage methods, and the proper disposal of leftover medications.

POLICY RECOMMENDATIONS

1. Harm reduction agencies and community programs that provide resources for people who inject drugs (PWID) should be made readily available.
2. When local programs are unavailable for these patients, emergency departments should establish their own programs to provide services such as safe syringe exchanges.

Treatment and Referral

PRACTICE RECOMMENDATIONS

1. The use of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) protocol and SBIRT-trained health educators in the acute setting is associated with a significant decrease in continued drug abuse and an increase in patient follow up for treatment programs. Every Colorado emergency department should consider implementing such a program.
2. The use of alpha^2-agonists, antihistamines, antiemetics, and NSAIDs should be used to ameliorate withdrawal symptoms.
3. Any patient willing to consider treatment and recovery should be directed to a nearby medication assisted treatment (MAT) program.
4. The initiation of buprenorphine/naloxone (Suboxone) is among the most effective methods for transitioning patients into treatment and recovery. Emergency departments with a high prevalence of opioid-addicted patients should strongly consider implementing a coordinated program that allows those suffering from drug withdrawal to be receive the medication and expeditiously transferred to a MAT program.

POLICY RECOMMENDATIONS

1. Emergency departments should work with MAT programs to facilitate direct referrals. When possible, physicians should consider performing a "warm handoff" where patients are initiated on medications such as buprenorphine until they are able to enroll in an appropriate MAT program.

2. Unfortunately, there are not enough facilities to accommodate the number of would-be patients. COACEP strongly advocates for the expansion of MAT services and increased local, state, and federal funding for these resources.

Call to Action

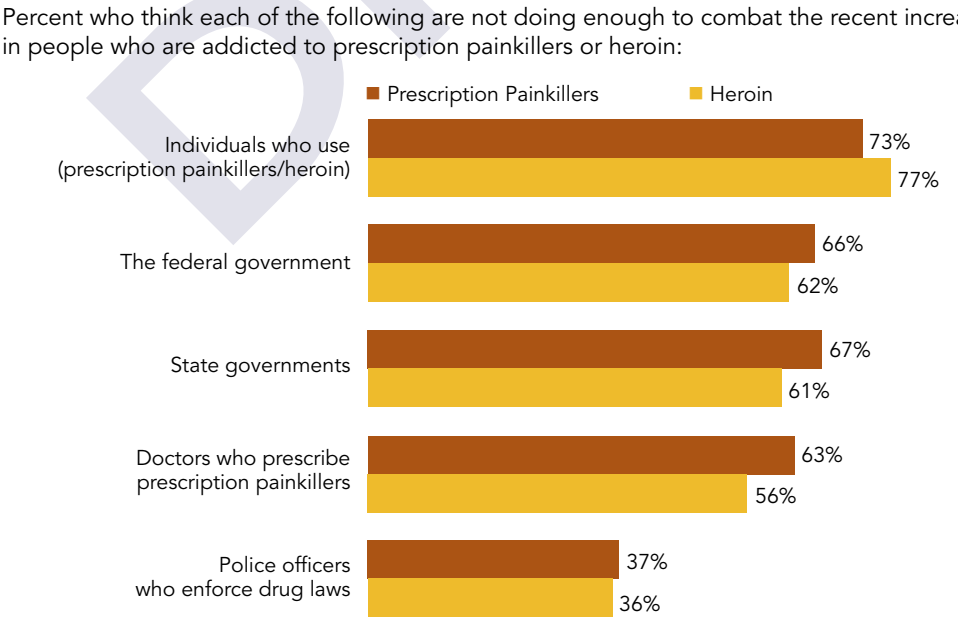
We must harbor hope for our patients and view addiction not as a moral failing, but as a medical disease. Opioid harm reduction should be an integral part of everyday practice with the ultimate goal of keeping patients safe until they are ready for recovery. We will need to improve our referral patterns and access syringe access and MAT programs.

Multimodal pain control strategies must become a part of every emergency medical practice. Swedish Medical Center, which implemented ALTO protocols and training for its staff in 2016, reported a preliminary 33% reduction in prescriptions for hydromorphone and opioids in the emergency department without significant detriment to patient satisfaction scores.

The opioid epidemic belongs to the medical community and we must help extinguish it. To this end, Colorado ACEP is collaborating with the Colorado Hospital Association on a pilot program to implement ALTO protocols in five hospitals across the state. The initiative aims to quantify the benefits of implementing guidelines and gauge their effects on opioid usage and patient satisfaction scores.

Finally and perhaps most importantly, we must reject the status quo, revolutionize our own practices, and endeavor to stem the tide of opioid addiction (*Figure 2*). We challenge you to join us in becoming an agent for change. We in Colorado can make a profound difference by setting the standard for every emergency department in the country, and together we can bring this deadly epidemic to an end.

FIGURE 2. LARGE SHARES SAY INDIVIDUALS, GOVERNMENT AND DOCTORS AREN'T DOING ENOUGH TO FIGHT OPIOID ADDICTION



NOTE: Questions asked of separate half samples
Source: Kaiser Family Foundation Health Tracking Poll (conducted April 12–19, 2016)

What Can You Do?

- Work with your emergency department medical director, physician group, pharmacists, and hospital administrators to fully integrate as many of these recommendations into your clinical practice as possible.
- Share these guidelines with the clinicians and medical staff in your emergency department.

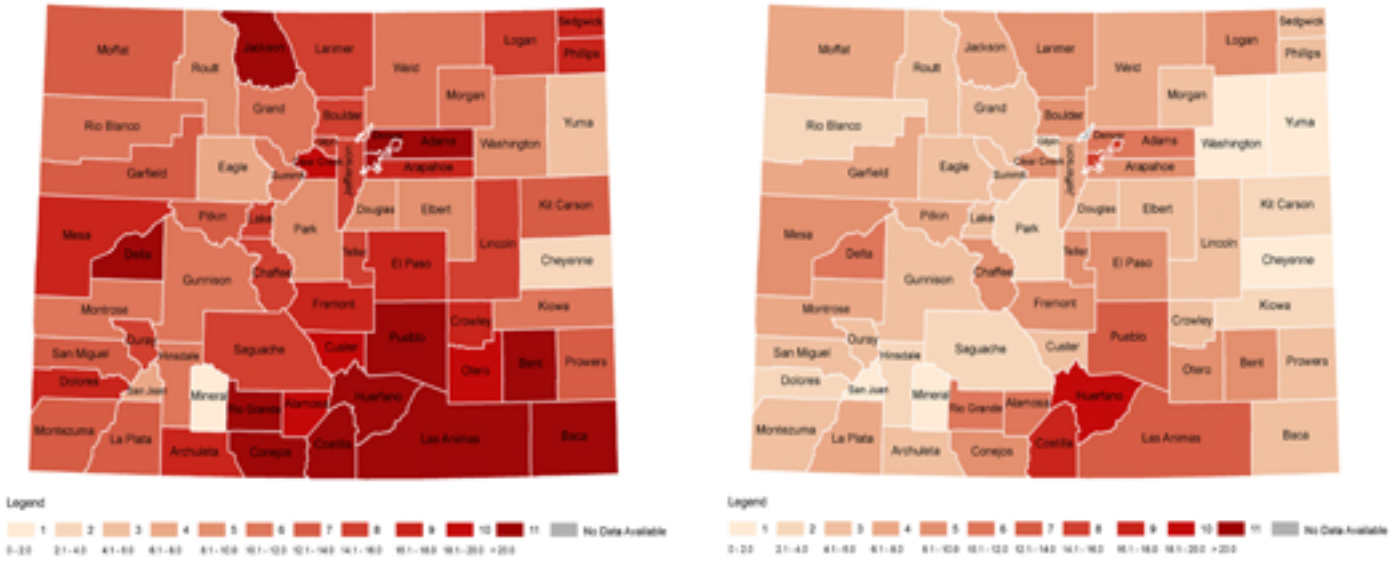
III. The Opioid Epidemic in Colorado

The US has seen a fourfold spike in the number of opioid prescriptions written since 1999; Colorado alone has seen a 100% increase (7.9:100,000 vs 15.8:100,000).[12] The statistics for opioid-related poisoning deaths are equally worrisome (*Figure 3*). The age-adjusted death rate for non-heroin opioid overdose in Colorado rose from 2.0 per 100,000 in 2000 to 6.1 in 2014 (205% increase), while heroin-related deaths increased from 0.8 to 2.8 per 100,000 (250% increase).[12]

Colorado Statistics

- From 2012 to 2013, Colorado ranked 12th nationally in the self-reported nonmedical use of opioids.[13]
- 25% of Coloradans admit to using pain medications in non-prescribed ways.[14]
- 29% of Coloradans have used pain medications belonging to others.[14]
- The number of heroin-related felony arrests increased 170% between 2011 and 2015.[15]
- The number of prescription drug arrests increased 27% between 2011 and 2015.[15]
- The amount of heroin seized annually has increased 827% since 2011.[15]
- Nearly 20,000 dosage units of prescription drugs have been seized annually between 2011 and 2015; however, this number appears to be decreasing.[15]

FIGURE 3. OPIOID-RELATED DEATH IN COLORADO



How Did We Get Here?

In 1986 prominent pain expert Russell Portenoy published a limited case series of 38 patients, which suggested that chronic noncancer pain could be managed safely with high doses of opioids without posing a risk of addiction.[16] His proposal was embraced by those involved in the care of chronic pain patients and endorsed by both the American Academy of Pain Medicine and the American Pain Society.[17] Subsequently, many pharmaceutical companies began to aggressively market their opioids for wider use at increased dosages. This movement — whether intentional or not — was encouraged by the Joint Commission, which in 2001 named pain the "fifth vital sign."[18,19]

The growing emphasis on pain control was further encouraged by the Institute of Medicine in its seminal report, *Relieving Pain in America*, which stated that "effective pain management is a moral imperative, a professional responsibility, and the duty of people in the healing professions." The report also stated that "relieving pain should be a national priority."[20] Additional pressure also has been brought to bear on clinicians by the increasing prevalence of patient satisfaction surveys, which often stress timely and "adequate" pain control. These surveys have been tied to clinician remuneration.[21,22]

Of note, the scientific validity of Portenoy's original work has been called into question; in recent years, the researcher himself has publicly doubted the relative efficacy and safety of long-term opioid use for the treatment of chronic noncancer pain.[23-26]

WHAT'S OUR ROLE?

Emergency physicians write 12% of the opioids taken by patients between the ages of 10 and 29 years, putting our specialty third in the number of prescriptions written, behind family physicians and dentists.[29] Clinicians must rely on their own discretion when treating pain, while striking a balance between oligoanalgesia (ie, inadequate pain control) and the unnecessary use of opioids. Likewise, pain management in the prehospital setting also presents a dilemma for EMS professionals, who are compelled to provide adequate relief while remaining cognizant of the potential for opioid misuse and abuse.[33]

Despite a prevalent fear that failing to give patients "what they want" might violate the Emergency Medical Treatment & Labor Act (EMTALA), this concern is unfounded. Pain is not considered an "emergency medical condition," and discharging patients without relieving their reported discomfort does not violate this mandate.[32]

There soon may be additional consequences to the prescribing of opioids. In 2015 the West Virginia Supreme Court ruled that patients who become addicted to prescription medications may sue care providers and pharmacies for addiction-related damages.[34] Although the short- and long-term impact of this ruling on emergency medicine remains unclear, it is another important reason to make judicious decisions when administering potentially addictive drugs.

IV. Limiting Opioid Use in the ED

"An ounce of prevention is worth a pound of cure."

—Benjamin Franklin

The vast majority of those who become addicted to opioids, both prescription and illicit, received their first dose from a doctor. For many years medical providers were taught that oligoanalgesia was morally reprehensible — a rampant problem that could be solved by narcotics. This marketing campaign was further fueled by the rising popularity of patient satisfaction surveys and similar ideologies, US opioid sales from 1999 to 2014 rose by nearly 400%.[35] Once reserved for only the most severe pain, these agents quickly became routine even for the treatment of minor discomfort.

Heroin use has increased an estimated 37% per year since 2010; 4 in 5 new heroin users start by misusing prescription opioids.[36] Many patients who begin with prescription opioid abuse eventually transition to intravenous (IV) use or IV heroin abuse when they can no longer acquire or afford prescription drugs, or when tolerance dictates injection to achieve the same "high" or prevent withdrawal symptoms.

The first step in reversing these alarming trends is to decrease the frequency and ease with which opioids are dispensed. Emergency clinicians must be vigilant when screening patients, prescribe narcotics conservatively, and provide thorough counsel on the risks of dependency prior to discharge.

PRACTICE RECOMMENDATIONS

1. **Opioids are inherently dangerous, highly addictive drugs with significant abuse potential, numerous side effects, lethality in overdose, rapid development of tolerance, and debilitating withdrawal symptoms. They should be avoided whenever possible and, in most cases, initiated only after other modalities of pain control have been trialed.**

   Opioids are among the three broad categories of medications that present abuse potential, the other two being central nervous system (CNS) depressants and stimulants. Much like heroin, these agents act by attaching to opioid receptors on nerve cells in the brain, spinal cord, gastrointestinal tract, and other bodily organs. The resultant spike in dopamine not only reduces the perception of pain, it also can manufacture a powerful sense of well-being and pleasure by affecting the brain's limbic reward system.

   When used repeatedly, opioids induce tolerance; greater amounts are required over time as the patient grows increasingly immune to the drug's effects.[38] This mechanism also contributes to the high risk of overdose following a period of abstinence.[39] Tolerance can be lost in times of sobriety, leading relapsed users to take a previously "safe" dose with disastrous results.[40] The effects of opioids are also mediated by specific subtype opioid receptors (mu, delta, and kappa) that are activated by endogenous endorphins and enkephalins. The production of endogenous opioids is inhibited by the repeated administration of outside opioids, which accounts for the discomfort that ensues when the drugs are discontinued.

   Besides the significant abuse potential, rapidly developing tolerance, and agonizing withdrawal symptoms that accompany opioids, patients also experience serious side effects such as drowsiness, mental confusion, constipation, and nausea (*Table 1*).[41] These complications, which often necessitate additional medical care, can prevent patients from performing daily tasks and remaining active in the workforce.

TABLE 1. SIGNS AND SYMPTOMS OF OPIOID INTOXICATION AND WITHDRAWAL

Intoxication	Withdrawal
Activation or "rush" (with low dosages) and sedation/apathy (with high dosages)	Depressed mood and anxiety. Dysphoria
Euphoria or dysphoria	Cravin
Feelings of warmth, facial flushing, or itching	Piloerection, lacrimation or rhinorrhea
Impaired judgment, attention or memory	Frequently, "high" attention
Analgesia	Hyperalgesia, joint and muscle pain
Constipation	Diarrhea and gastrointestinal cramping, nausea, or vomiting
Pupillary constriction	Pupillary dilatation and photophobia
Drowsiness	Insomnia
Respiratory depression, areflexia, hypotension, tachycardia	Automatic hyperactivity (eg. hyperreflexia, tachycardia, hypertension, tachypnea, sweating, hyperthermia
Apneia, sedacao, coma	Yawning

Source: Martin e Hubbard, 2000[23]

2. **Prior to prescribing an opioid, physicians should perform a rapid risk assessment to screen for abuse potential and medical comorbidities. Alternative methods of pain control should be sought for patients at increased risk for abuse, addiction, or adverse reactions.**

Multiple agencies, including the CDC and Colorado DORA, advocate using an Opioid Risk Tool to evaluate for factors that might predispose patients to addiction and misuse. While this approach has been only validated in cases of chronic pain (see *Appendix 1*), screening tools may help emergency clinicians identify high-risk patients.[42]

High-risk criteria include:

- Personal or family history of substance abuse (alcohol, illicit drugs, prescription drugs)
- Age between 16 and 45
- Mental health/psychological history (eg, depression, attention deficit disorder, bipolar disorder, schizophrenia)
- History of sexual abuse

In addition, emergency clinicians should consider comorbid health conditions and exercise caution when prescribing opioids to those at increased risk for adverse drug reactions and accidental overdose.

High-risk comorbidities include:

- Pulmonary comorbidities (COPD, sleep apnea)
- Cardiac comorbidities (CHF)
- Organ dysfunction (eg, renal or hepatic)
- Elderly age

3. **Emergency physicians should frequently consult Colorado's Prescription Drug Monitoring Program (PDMP) to assess for a history of prescription drug abuse, misuse, or diversion.**

As of 2014, with the introduction of House Bill 14-1283, all Colorado-licensed prescribing practitioners with Drug Enforcement Administration (DEA) registrations are required to create an account with the Colorado PDMP.[43] Drug monitoring programs have been shown to influence opioid prescribing practices, especially in the case of lost or long-term prescriptions.[44]

These programs can aid providers in identifying patients with multiple recent prescriptions from various providers (doctor shopping) and help spot those already using other controlled medications on a chronic basis.[45] Although there is limited data to indicate the utility of PDMPs in patient outcomes, they clearly can help inform the conversations physicians have with their patients.

4. **Opioid alternatives and nonpharmacological therapies should be used to manage patients with acute low back pain, in whom opioids are particularly detrimental. Opioids should be prescribed only after alternative treatments have failed.**

   Countless patients present to US emergency departments every year for acute low back pain, many of whom expect and are prescribed narcotic pain medications.[46] However, research shows no significant difference in relief between nonsteroidal anti-inflammatory medications and opioids.[47] Moreover, opioids appear to increase the risk of prolonged disability at 1 year and decreased function at 6 months.[48,49] Alternative treatments, including early mobilization and physical therapy, can improve return to function and decrease disability and should be used as first-line agents in the treatment of this complaint.

5. **Potential drug interactions must be evaluated, and opioids should be avoided in patients already taking benzodiazepines, barbiturates, or other narcotics.**

   The concomitant prescribing of opioids for a patient taking benzodiazepines increases the risk of unintentional overdose, respiratory depression, and death.[50] Patients taking opioids and benzodiazepines together have 10 times the risk of fatal overdose over those taking opioids alone.[51] Patients who are taking multiple opioid prescriptions at higher doses also are at a significant risk of overdose.[52]

6. **Patients with chronic pain should receive opioid medications from one practice, preferably their primary care provider or pain specialist. Opioids should be avoided in the emergency department treatment of most chronic conditions. Emergency physicians should coordinate care with a patient's primary care or pain specialist whenever possible, and previous patient-physician contracts regarding opioid use should be honored.**

   Clinicians often require patients with chronic pain to sign an opioid contract, which may mandate the use of a single prescribing provider and pharmacy.[53] It is important to honor these control documents, which frequently outline what the patient can do to manage acute exacerbations of pain and provide guidance for emergency medical providers.,

7. **Clinicians should abstain from adjusting opioid dosing regimens for chronic conditions and avoid routinely prescribing narcotics for acute exacerbations of chronic non-cancer pain.**

   According to the CDC, it is inappropriate for emergency medicine clinicians to treat chronic pain.[73] Long-term medication regimens should be escalated and managed only by a single provider outside the acute setting. In the rare instance that a patient's drug regimen must be adjusted in the emergency department, it should only be done in direct collaboration with a pain specialist.

   Nonopioid treatments can and should be provided for acute exacerbations (see Alternative Pathways section for recommended modalities). Benzodiazepines and other sedating agents can place the patient at higher risk of overdose and should be avoided. If the patient is not being seen by a pain specialist, a referral should be initiated.

8. **"Long-acting" or "extended-release" opioid products should be avoided for the relief of acute pain.**

   Long-acting or extended-release opioids are indicated only for chronic pain and should not be used for the treatment of acute or intermittent symptoms.[54] These agents are especially dangerous in opioid-naïve patients, even at recommended dosages.

Short-acting opioids are appropriate for the treatment of acute pain that cannot be managed with other modalities. They include:[55]

- Codeine
- Oxycodone — immediate release (eg, Percocet, Percodan)
- Hydrocodone (eg, Vicodin, Lorcet, Lortab, Norco)
- Morphine — immediate release
- Hydromorphone (eg, Dilaudid)

Long-acting and extended-release forms include:

- Oxycodone — sustained release (eg, OxyContin)
- Methadone (eg, Dolophine)
- Morphine — sustained release (eg, MS Contin, Avinza, Kadian)
- Fentanyl — transdermal (eg, Duragesic)
- Oxymorphone — extended release (Opana ER)

Any clinician who prescribes long-acting or extended-release opioids should complete the FDA Risk Evaluation and Mitigation Strategies (REMS) training program.

9. **Patients receiving controlled medication prescriptions should be able to verify their identity.**

   Patients should be prepared to show identification if opioid pain prescriptions are to be filled. This corroboration enables a thorough evaluation of the individual's prescription drug monitoring profile and adds another safeguard against "doctor shopping."[56]

10. **Patients who receive opioids should be educated about their side effects and potential for addiction, particularly when being discharged with an opioid prescription.**

    Evidence suggests that clinicians do a poor job of educating patients on the risks of opioids (*Figure 4*). More than 50% of emergency department patients discharged with opioid prescriptions admit to misusing them in the 30-day period following their visit.[57] In addition, nearly 80% of new heroin users between the ages of 12 and 49 report the previous nonmedical use of opioids.[58]

    All patients are at risk for opioid misuse and abuse. A prior history of substance abuse, use of psychotropic drugs, and younger age increase this potential; however, even an opioid-naïve patient with no risk factors can develop dependence.[60,61] When prescribing these agents, it is always appropriate to initiate a detailed discussion about the significant risk of addiction.

FIGURE 4. PUBLIC PERCEPTION OF OPIOID RISK

Only 1 in 5 Americans consider prescription plan medication to be a serious safety threat.

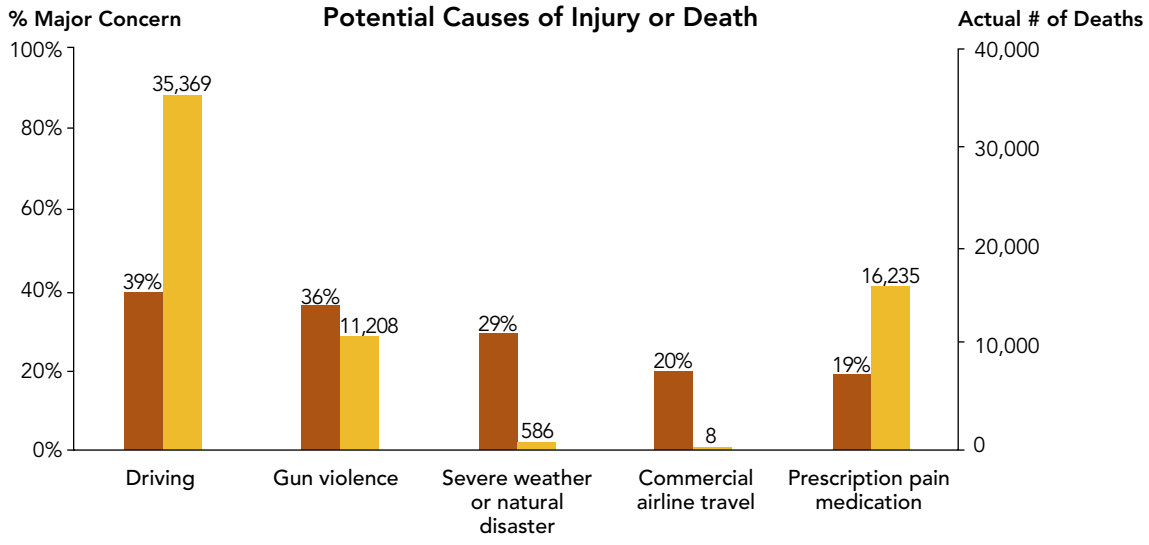


TABLE 2. THE DANGERS OF OPIOIDS (INFORMATION TO BE SHARED WITH PATIENTS)

Common side effects:[59]	Serious side effects of chronic opioid use:
• Nausea/vomiting • Constipation • Pruritus • Euphoria • Respiratory depression, particularly with the simultaneous use of alcohol, benzodiazepines, antihistamines, muscle relaxants, or barbiturates • Lightheadedness • Dry mouth	• Cardiac abnormalities, including prolonged QTc and torsades de pointes[62] • Sudden cardiac death with the concomitant use of benzodiazepines and methadone[63] • Hormonal disruptions, including decreased testosterone in males[64] • Decreased LH and FSH and fertility in women[65] • Musculoskeletal compromise, including an increased risk of osteoporosis[66] • Immunosuppression[67] • Inhibition of cellular immunity via delta and kappa receptors[68] • Hyperalgesia (ie, upregulation of receptors and increased tolerance)[69] • Sleep disturbances (eg, shortened deep sleep cycle)[70] • Delayed or inhibited gastric emptying, increased sphincter tone, and blockade of peristalsis[71]

11. **When considering opioids, clinicians should prescribe the lowest possible effective dose in the shortest appropriate duration (eg, <3 days).**

    Differences in pharmacological potency largely are determined by the actual doses prescribed.[74] Studies have demonstrated a strong correlation between high daily doses and overdose death.[75-77] When these agents are selected for pain management, they should be prescribed at the lowest possible effective dose and for the shortest duration, generally no more than 3 days.[78-80] Leftover medications frequently are misused; 70% of abusers report receiving these drugs from friends or family members. [81]

12. **Emergency departments should refuse to refill lost or stolen opioid prescriptions.**

    Patients who divert or abuse controlled medications may claim their prescription was lost or stolen. In these clinical scenarios, it is best to refuse refill requests; however, it may be reasonable to administer a single dose in the emergency department.[1] When warranted, clinicians should contact the patient's prescribing physician to discuss the situation and confirm the request. If this cannot be done, the prescriptions should not be filled.[82]

POLICY RECOMMENDATIONS

1. **As has been done in other states, the Colorado PDMP should develop an automated query system that can be more readily integrated into electronic health records and accessed by emergency clinicians.**

    Although the Colorado PDMP is an important tool for preventing inappropriate opioid prescribing and misuse, it is cumbersome to implement and often incompatible with high-acuity emergency department workflows. We favor the integration of a process that provides automatic queries and responses that obviate time-consuming manual data entry. To help improve functionality and encourage widespread use, the PDMP should be optimized with improvements such as automatic queries linked to emergency department registration, and automatic queries and/or data population in electronic medical records.[83] Systems that incorporate such technology are overwhelmingly favored by clinicians, 98-100% of whom report improved access.[84]

2. **Pain control should be removed from patient satisfaction surveys, as they may unfairly penalize physicians for exercising proper medical judgement.**

    When used as a barometer of quality medical care, patient surveys regarding pain control may unfairly punish physicians for exercising proper medical judgement. This fear of patient dissatisfaction and its ensuing penalties can lead clinicians to prescribe potentially harmful medications, even when not medically indicated. Despite mixed evidence on the connection between opioids and poor hospital survey scores, the effects of these questionnaires on clinician behavior is well understood.[85-87] A reported 28% admit prescribing these drugs for reasons that can be tied directly and indirectly to patient satisfaction.[88]

Pain management should be removed from future drafts of the Emergency Department Patient Experience of Care (EDPEC) survey, inpatient Hospital Value-Based Purchasing Program (HCAHPS) questionnaire, and instruments used by private medical groups to gauge patient satisfaction. Physicians should be empowered to manage pain using their own clinical acumen, and high scores should be removed as a proxy for appropriate medical care.

3. **Opioid prepacks should be eliminated from emergency departments if 24-hour pharmacy support is available.**

   Dispensing opioids from the emergency department should be discouraged. Although drug prepacks carry the same risks as any other prescription, small doses of opioids (<24-hour supply) are not tracked by the Colorado Prescription Drug Monitoring Program. This loophole makes it difficult to identify overuse or addiction, particularly in the acute setting or when treating an unfamiliar patient.

   If 24-hour pharmacy support is unavailable (eg, in a rural community), providers should use their best clinical judgement when dispensing opioids from the emergency department. In in the interim, only the minimum quantity anticipated for pain control should be administered and the patient should be directed to the nearest pharmacy for additional medication.

4. **Pain should not be considered the "fifth vital sign."**

   Long regarded as the "fifth vital sign," pain has developed enormous leverage in the American medical lexicon. While there is great merit to assessing a patient's discomfort, it should not be given the same level of consideration as heart rate, respiratory rate, blood pressure, and other concrete measurements of health.

   We have overemphasized pain; as a result, physicians often feel pressured to prescribe opioids to normalize this "vital sign." Rather than making informed medical decisions about the best way to address a patient's complaints, many providers have come to equate an abnormally high pain score to physical abnormalities such as hypotension, tachycardia, or hypoxia. While emergency physicians are trained to address the latter elements immediately, pain is a more complex process that involves significant provider discretion.

   In addition, pain scores should be excluded from triage questionnaires and should not carry the same weight as other vital signs measured during a patient's stay in the emergency department.

V. Alternatives to Opioids for the Treatment of Pain

"We cannot solve our problems with the same thinking we used when we created them."

—Albert Einstein

Using nonopioids to address pain management is a novel strategy called Alternatives to Opioids (ALTO). The first Colorado ALTO program was implemented in 2016 at Swedish Medical Center in Englewood, a busy level-1 trauma center. The press has inaccurately branded such emergency departments as "opioid-free EDs," an exclusionary term that misrepresents the care provided. ALTO simply recommends using opioids infrequently, primarily as second-line treatments and only after effective nonopioid alternatives have been trialed.

Such programs should be studied by all ED providers and uniformly adopted by hospitals. Through education, the implementation of novel concepts, and partnerships within the community, an ALTO-based multidisciplinary approach can transform pain management practice in Colorado.

Treatment Goals

- Utilize nonopioid approaches as the first-line therapy.
- Utilize opioids as a second-line treatment.
- Opioids can be given as rescue medication.
- Discuss realistic pain management goals with patients.
- Discuss addiction potential and side effects with those using opioids.

The ALTO program utilizes the CERTA concept: **c**hannels, **e**nzymes, **r**eceptors, **t**argeted, **a**nalgesia. The CERTA concept optimizes the following medication classes in place of opioids: Cox-1, 2, 3 inhibitors, NMDA receptor antagonists, sodium channel blockers, nitrous oxide, inflammatory cytokine inhibitors, and GABA agonists/modulators. Specific agents include NSAIDs and acetaminophen, ketamine, lidocaine, nitrous oxide, corticosteroids, benzodiazepines, and gabapentin.

The protocol targets multiple pain receptors, making use of nonopioid medications, trigger-point injections, nitrous oxide, and ultrasound-guided nerve blocks to tailor a patient's pain management needs and substantially decrease opioid use. Examples of this approach include:

- Treating renal colic with intravenous lidocaine;
- Managing acute lower back pain with a combination of oral nonopioids and topical pain medications with directed trigger-point injections;
- Treating extremity fractures with ultrasound-guided nerve blocks; and
- Using an algorithm to manage acute headache/migraine pain with a variety of nonopioid medications.

Only if patients' pain is not adequately managed using ALTO techniques are opioids used as a rescue medication.

Alternative Medications

Ketamine

Ketamine has been used extensively in the emergency department for procedural sedation and rapid-sequence intubation. Recent research has demonstrated that a low (subdissociative) dose (0.1-0.3 mg/kg IV) is safe and effective for pain management. Due to the relatively short-lived analgesic effects of the drug, the initial bolus can be followed by an infusion (9-30 mg/hour) for sustained effect.[92-95]

Lidocaine

Lidocaine is an ideal agent for treating visceral and central pain, and also may be useful when narcotics are inefficient or lead to undesirable side effects. Intravenous or topical (5% transdermal patch) doses are effective for controlling renal

colic and neuropathic pain associated with conditions such as diabetic neuropathy, postoperative or post-herpetic pain, headaches, and neurological malignancies.[96,97] Topical lidocaine also is an appropriate treatment for low-back pain.[98-102] Side effects of the drug are minimal when used sparingly.

Trigger-Point Injections

A focal area of spasm and inflammation (eg, trapezius, rhomboid, low back) can be associated with chronic myofascial pain syndrome. Palpation of the trigger point should fully reproduce pain, which may be referred to other areas (eg, nodule or taut band of spasm). Dry needling will cause a disruption of the spastic feedback loop by interrupting abnormal activity in the sensory and motor nerve endings and muscle fibers. Using local anesthetics such as marcaine or lidocaine for this procedure often resolves pain and decreases soreness. Indications for this approach include a palpable, taut band or nodule, reproducible pain with palpitation, or a chronic painful condition.[103-106] Trigger-point injection has also been found to be a successful treatment strategy for migraines.[107-109]

Nitrous Oxide

Nitrous oxide is a tasteless, colorless gas administered in combination with oxygen via mask or nasal hood at a maximum concentration of 70%. The gas is absorbed via pulmonary vasculature and does not combine with hemoglobin or other body tissues. Featuring a rapid onset and elimination (<60 sec), the agent contains both analgesic and anxiolytic properties. It typically is used in combination with a local anesthetic or other pain medications. Pulse oximetry is the only patient monitoring required. There are no NPO requirements; patients can drive after administration; and no IV line is needed. There is solid evidence to support its role in the management of pediatric pain and sedation, prehospital pain relief, colonoscopy, and bronchoscopy.[110-113] Indications for the use of nitrous oxide include laceration repair, incision and drainage, wound care, foreign body removal, central venous access, peripheral venous access, fecal disimpaction, and as an adjunct for dislocations and splinting.

Haloperidol

Haloperidol is a "typical" or first-generation antipsychotic agent. It can be administered intravenously, intramuscularly, and orally and often is used for the treatment of psychiatric emergencies. The drug also can be used in low doses as an adjunct treatment for pain and nausea. At doses of 2.5 to 5 mg, haloperidol is effective for the management of abdominal pain and migraine-associated headaches.[26] Anecdotally there has been a rise in the number of haldol "allergies." If a patient's reaction is suspected to stem from a true allergy rather than an extrapyramidal side effect of the drug, olanzepine ODT is a reasonable alternative.

PRACTICE RECOMMENDATIONS

Many of the recommendations in the following section are based on the ALTO clinical model.

(*Note: A full discussion of each drug and procedure is beyond the scope of these guidelines. Appropriate references are listed, however. See Appendix I for specific treatment pathways by indication.*)

All emergency departments should implement ALTO programs and prepare narcotic-free pain pathways for managing the following conditions: acute on chronic opioid-tolerant radicular lower back pain, opioid-naive musculoskeletal pain, migraine or recurrent primary headache, extremity fracture or joint dislocation, gastroparesis-associated or chronic functional abdominal pain, and renal colic.

1. All emergency medicine providers should be proficient in Alternatives to Opioids (ALTO) protocols by learning new skills such as trigger-point injections, nerve blocks, and the appropriate administration of medications such as ketamine, haloperidol, lidocaine (IV and topical), gabapentin, and NSAIDs.
2. Low-dose, subdissociative ketamine (0.1-0.3 mg/kg) is an effective analgesic that can be opioid-sparing for many acute pain syndromes. Institutional guidelines and policies should be in place to enable clinicians and nurses who administer this agent for pain. (See Appendix 3 for example of Denver Health Ketamine for Acute Pain Policy).
3. For musculoskeletal pain, consider a multimodal treatment approach using acetaminophen, NSAIDs, steroids, topical medications, and low-dose ketamine. Trigger-point injections also can be considered.

4. For headache and migraine, consider a multimodal treatment approach that includes the administration of antiemetics, valproic acid, steroids, and triptans. Strongly consider administering a cervical or trapezius trigger-point injection.
5. For pain with a neuropathic component, consider gabapentin.
6. For pain with a tension component, consider a muscle relaxant.
7. For pain caused by renal colic, consider an NSAID, lidocaine infusion and desmopressin nasal spray.
8. For chronic abdominal pain, consider low doses of haloperidol, olanzepine, benadryl, and lidocaine infusion.
9. For extremity fracture or joint dislocation, consider the immediate use of nitrous oxide and low-dose ketamine while setting up for ultrasound-guided regional anesthesia.
10. For arthritic or tendinitis pain, consider an intra-articular steroid/anesthetic injection.

FIGURE 5. PAIN PATHWAYS BY INDICATION

POLICY RECOMMENDATIONS

1. All emergency departments should implement ALTO programs and provide opioid-free pain treatment pathways for the following conditions:
    a. Acute on chronic opioid-tolerant radicular lower back pain
    b. Opioid-naive musculoskeletal pain
    c. Migraine or recurrent primary headache
    d. Extremity fracture or joint dislocation
    e. Gastroparesis-associated or chronic functional abdominal pain
    f. Renal colic
2. Emergency departments are encouraged to assemble an interdisciplinary pain management team that includes clinicians, nurses, pharmacists, physical therapists, social workers, and case managers.
3. Reimbursement should be available for any service directly correlated to pain management, the reduction of opioid use, and treatment of drug-addicted patients.

Marijuana Use in Chronic Pain

Patients frequently inquire about the use of medical marijuana for the treatment of painful conditions. Although a number of studies have been conducted on the drug's potential role in the treatment of chronic pain, results are limited. Most of the trials have been short, and many have focused on neuropathic pain resulting from a narrow range of etiologies; fewer than 3,000 patients have been studied.

Marijuana plants are comprised of more than 65 cannabinoids, including tetrahydrocannabinols (THC) and cannabidiols (CBD). It is important to note that while studies have shown the effectiveness of treating pain with a combination of these two chemicals, more research is needed to identify the positive and negative attributes of the remaining active ingredients.[26-28]

The current scheduling nature of the drug presents several roadblocks for researchers.[24,25] While previous studies have focused on the use of medical marijuana for alleviating chronic pain, there are interesting links between recently enacted state laws and an overall decline in opioid-linked overdoses and deaths. According to a study that examined medical marijuana laws and opioid analgesic overdose rates from 1999 to 2010, "States with medical cannabis laws had a 24.8% lower mean annual opioid overdose mortality rate compared with states without medical cannabis laws."[29]

At this time COACEP takes no position on the use of medical marijuana for the control of chronic pain, and recommends that emergency physicians refrain from prescribing or advocating its use until definitive studies have been conducted.

What is Harm Reduction?

Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. The approach is predicated on respecting patients and their choices, removing stigma, and meeting them "where they are" and not where we believe they *should* be. In a perfect world, patients would be compelled to quit by logical physician counseling. In reality, however, patients must possess the internal resolve to pursue sobriety before they can enter into recovery; even the most well-meaning advice can be counterproductive if it is disconjugate with the situation. The simplistic directive to "stop using because you may die" is ineffective and often deleterious to the physician-patient relationship.

Harm reduction aims to prevent the spread of infection, including HIV/AIDS, hepatitis B and C, sepsis, and endocarditis; reduce the risk of overdose and other drug-related fatalities; and decrease the negative effects drug use may have on individuals and communities.[120]

Of the thousands of patients who present with opioid-related emergencies, ranging from withdrawal to constipation to overdose to injection-related infections, the fact is that most are not ready to quit on the day they visit the ED. Given the unprecedented scope and destruction of this epidemic, clinicians can and must do better in counseling and treating the addicted patient who is not ready to stop using.

Initially developed in response to the US AIDS epidemic, the harm reduction philosophy primarily has been used in recent years for the treatment of people who inject drugs (PWID); however, its principles are broadly applicable to most substance-abusing patients. Injection drug use is intertwined with the growing opioid epidemic; roughly 75% of IV heroin addictions originate with prescription opioids.[114] Significant risks are associated with this behavior, as IV drug use accounts for between 12% and 26% of new HIV diagnoses and the majority of new hepatitis C infections.[115,116]

Health care providers have been shown to have a negative view of patients with substance abuse problems, a dynamic that erodes both clinician empathy and patient care.[117] A quote from the National Harm Reduction Coalition patient manual captures the stigma these patients feel when receiving treatment in the emergency department:

> *"Only use the emergency room as a last resource for getting your abscess drained. Chances are the doctor you see will not be too sympathetic to your plight, under-medicate you for pain, make a large incision, and provide no follow-up or aftercare."*

As a result, patients who abuse opioids and IV drugs often go to great lengths to avoid medical care or sign out before treatment is complete. It is imperative that we begin to change these perceptions by making the ED a welcoming place for those who seek care (*Table 2*). Drug addiction truly is a physiological disease, defined by genetic predisposition and long-term changes in brain structure and function. Clinically, patients often suffer from uncontrollable, compulsive drug cravings that render them powerless even in the face of catastrophic social and health-related consequences.[118]

TABLE 2. PITFALLS IN THE TREATMENT OF PWIDS

- It is not uncommon for clinicians to assume that drug users don't care about their health; such misperceptions are noticed by patients. Fearing this negativity and condescension, many drug users avoid the emergency department by trying to "doctor" themselves.
- Some providers automatically undertreat or minimize pain when they suspect drug-seeking behavior, or perform procedures (eg, abscess drainage) with inadequate anesthesia in order to "teach the patient a lesson.
- Health care providers occasionally bring in other colleagues to gawk at patients without their permission. However, these insensitive "Look at the crazy thing this junkie did to herself/himself!" conversations are inappropriate.
- Nurses and doctors should not contact law enforcement without the patient's knowledge.
- Vague or unrealistic aftercare plans are futile.
- Long speeches and shaming life lectures about drug use can and should be replaced by educational information about risk reduction.
- Patients often overhear health care providers talking about them negatively outside of the room or behind a curtain. Assuming the patient can't hear them, clinicians can be heard warning other providers about the "druggie" or "drug seeker."

Harm reduction and therapeutic relationship-building is especially pertinent in Colorado, where in-patient Suboxone and methadone treatment programs are scarce and plagued by prohibitively long waiting lists. This inaccessibility means that most opioid users will continue to abuse these medications, many within hours of discharge. There is one great barrier that remains to be addressed, namely the fact that most emergency providers are unfamiliar with harm reduction principles, unaware of how to perform effective interventions, and lacking the education and resources needed to integrate harm reduction into their practices.

PRACTICE RECOMMENDATIONS

1. **Patients who abuse opioids should be managed without judgment; addiction is a medical condition and not a moral failing. Caregivers should endeavor to meet patients "where they are," infusing empathy and understanding into the patient/medical provider relationship.**

   It is imperative that we work to better understand addiction and end the stigma associated with prescription opioid abuse. A harm reduction mentality, as outlined below, offers a pragmatic approach to mitigating the associated risks without casting blame or alienating those who seek help.

   Allow patients to seek treatment—or not—at their own pace (*Table 3*). Pressuring or forcing patients into treatment for substance abuse is fruitless, violates the autonomy, and creates an adversarial rather than therapeutic relationship.

TABLE 3. COUNSELING PATIENTS WITH ADDICTION

DO	DON'T
• Use neutral language when referring to drug use. • Respect the patient's decisions regarding treatment. • Encourage patients to be honest with providers about any drug use. • Make information available that is specific to the needs of the patient. • Remember harm reduction principles: — Accept and don't condemn patients who use drugs. — Offer resources without pressure or judgment. — Improve quality of life for patients with addiction. — See the individual as a person, rather than their addiction.	• Use negative terminology such as "addict" or "junkie." • Tell the patient they are ruining their life or are going to die. • Attempt to pressure the patient to begin substance abuse treatment. • Make assumptions about the mental or physical health of patients with addiction. • Let the stigma associated with injection drug use affect how a patient is treated.

2. **Every emergency clinician should be well-versed in the safe injection of heroin and other intravenous drugs, and understand the practical steps for minimizing the dangers of overdose, infection, and other complications. When treating patients with complications of IV drug use, injection habits should be discussed and instruction should be given about safe practices.**

   Heroin offers a cheaper high for patients addicted to prescription opioids, a factor that has contributed to the drug's increasing popularity and contributed to a rise in communicable (eg, HIV and hepatitis C and B) and noncommunicable diseases (eg, abscesses, cellulitis, and endocarditis). Data collected by Denver's Harm Reduction Action Center estimates that 24% of PWID are hepatitis C-positive; injection drug use is the leading transmission method of this pathogen in the US. A notorious HIV outbreak in one tiny, rural Indiana town is a cautionary tale about what can happen when safe injection practices are ignored. The tightknit community of Austin (population 4,000) was ravaged by the virus in 2015 when 190 new cases were diagnosed — all of which could be attributed to a local epidemic of IV oxymorphone abuse.

   The vast majority of medical providers are unfamiliar with drug injection methods and are unprepared to discuss safeguards with their patients. Most IV drug users learn from their peers, from whom they can inherit dangerous habits. Counseling about safer injection practices should be offered prior to discharging any IV drug user (*Figure 6*). The following guidelines can be shared to help reduce the substantial risk of infection and overdose.

Avoid using alone. Drug users should inject in the presence of others for safety. Colorado's Good Samaritan Law protects individuals who call 911 to report an overdose, exempting them and the patient from arrest and prosecution for small drug charges.

Always carry naloxone. The evidence in support of naloxone is staggering. Since 1996 the opioid reversal agent has saved more than 26,000 lives.[121] Because most overdoses are witnessed and transpire over hours, naloxone is our patients' most powerful tool for preventing overdose and death. The antidote should be dispensed in the emergency department to anyone suspected of abusing IV drugs, and at-risk patients should be encouraged to keep the naloxone within reach at all times.

Try tester shots. Variations in drug potency are common, especially with the popular practice of cutting or substituting heroin for fentanyl or carfentanyl. When trying a new product, patients should use a small test dose (ie, tester shot) to gauge its potency.

Avoid sharing equipment. Although HIV can survive only minutes outside the body, it can live for days to weeks inside hollow-bore needles. The risk of transmission is highest when drug paraphernalia is shared between multiple users within a short period of time. Hepatitis B and C are particularly virulent, and can survive between 1 and 3 weeks outside of the body. These pathogens can be spread easily via injection equipment (eg, needles, syringes, cookers (spoons), injection water, and cottons) (*Figure 7*).

Practice good hygiene. Always encourage hand washing and cleansing of the injection site. If no running water is available, benzalkonium chloride towelettes can be a good substitute. Recommend the use of alcohol pads to sterilize skin prior to injection.

Use sterile equipment. Communicable disease can be avoided by not sharing needles. Reusing equipment increases the risk of bacterial contamination. Patients can obtain new equipment for free through local syringe access programs (formerly referred to as needle exchange programs). If such resources are unavailable, advise patients to purchase needles, syringes, and alcohol pads at pharmacies. If new paraphernalia cannot be obtained, patients should clean their existing equipment with bleach for at least 2 minutes, flushing all components, and rinsing with clean cold water. The average IV drug user injects 3 to 5 times per day.

Use sterile water to prepare the product. Many infections stem from unsafe water supplies; some users report using river water, toilet water, or saliva to dissolve product into an injectable form. **Bottled water is NOT sterile!** Optimally, patients will have access to single-use containers of sterile water. If these are unavailable, water should be sterilized by heating it at rolling boil for 10 minutes.

Protect your veins. Patients should be advised to use highest gauge (smallest) needle possible; rotate injection sites, starting distally; drink water to remain well; use citric acid if an acidic solution is required to dissolve product (never lime, lemon, or orange juice, which are more sclerotic and carry a higher risk of infection). Advise against using the jugular, femoral, or pedal veins, which can further increase the danger of infection.

FIGURE 6. EDUCATING IV DRUG USERS

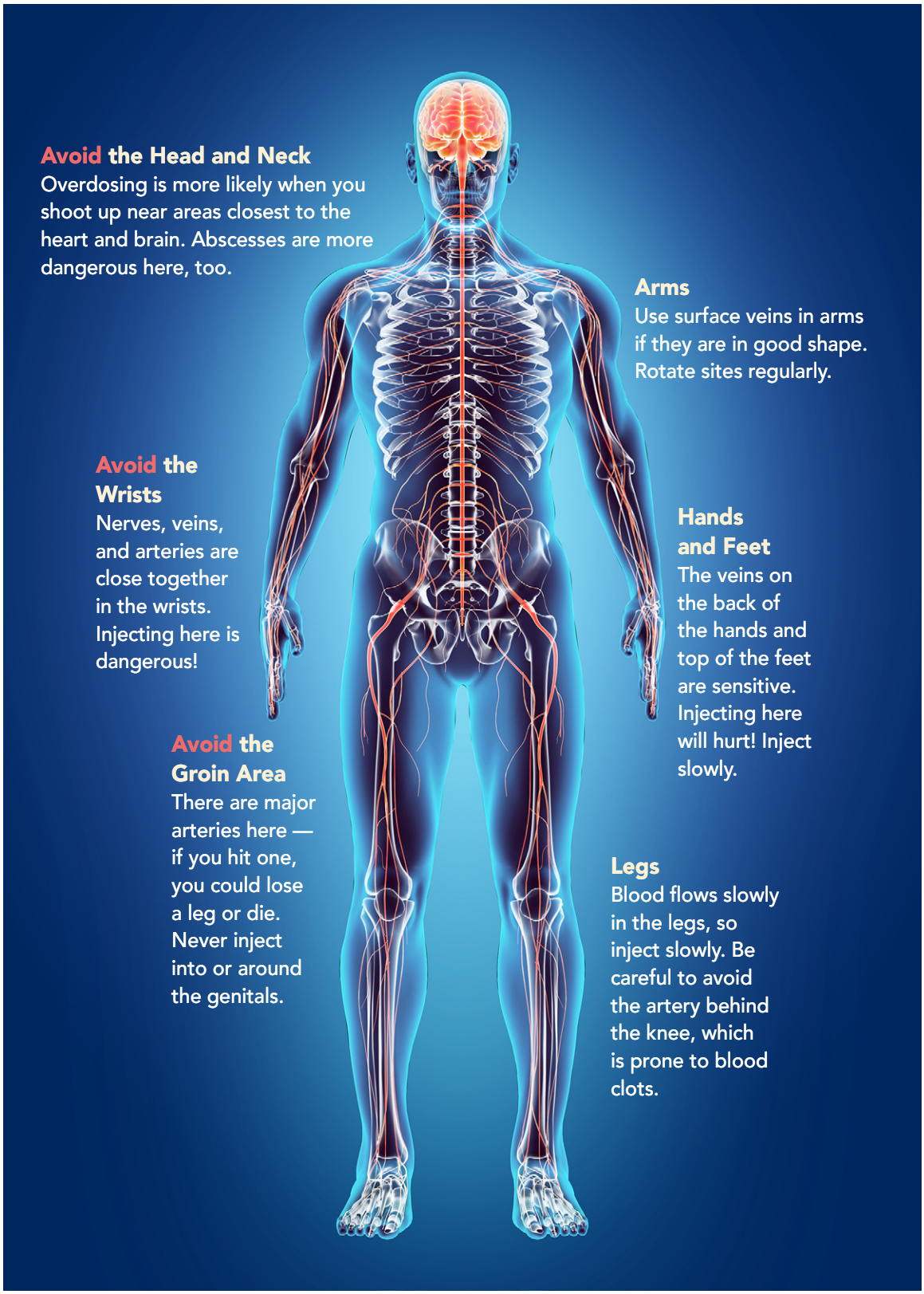


FIGURE 7. COMMON SUPPLIES DISPENSED THROUGH SYRINGE ACCESS PROGRAMS

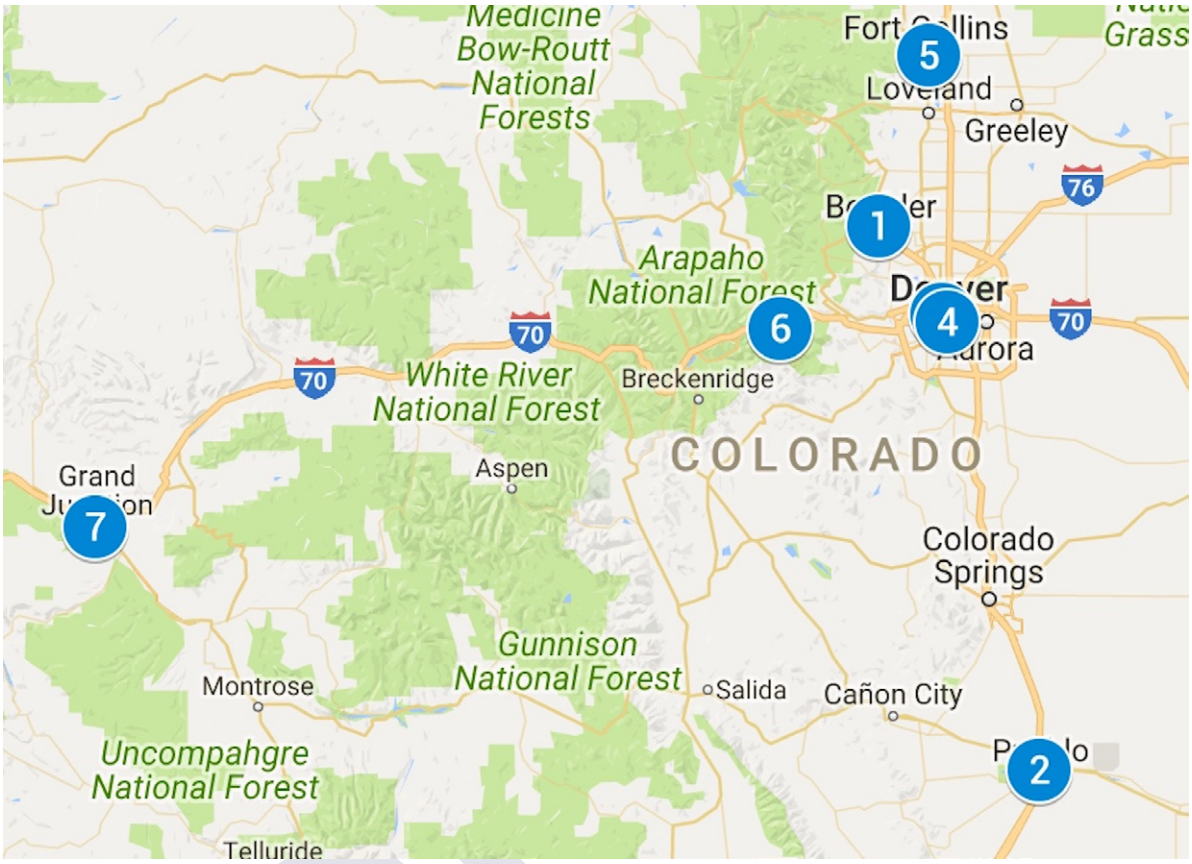
3. **Emergency department patients who inject drugs should be referred to local syringe access programs, where they can obtain sterile injection materials and support services such as counseling, HIV/hepatitis testing, and referrals.**

   Patients engaged in such behavior should be counseled on the risks of bloodborne pathogens, particularly HIV and hepatitis, which can be transmitted via shared needles and drug preparation equipment. Syringe access programs have demonstrated cost-effectiveness in reducing HIV transmission and prevalence.[122] The additional resources these centers often provide (eg, sterile water, cooking units, and cleaning solutions) also can help reduce such dangers.

   The World Health Organization (WHO) suggests a "compelling case that needle and syringe programs substantially and cost effectively reduce the spread of HIV among IV drug users and do so without evidence of exacerbating injecting drug use at either the individual or societal level."[123] In 2000 the American Medical Association (AMA) adopted a position strongly supporting the efficacy of these programs when combined with addiction counseling.[124]

   A complete list of local syringe access/harm reduction programs can be found through the North American Syringe Exchange Network (*Figure 8*).

FIGURE 8. LOCATIONS OF COLORADO SYRINGE ACCESS PROGRAMS



1. The Works
3450 Broadway
Boulder, CO 80304
(303) 413-7533

2. Access Point Pueblo
Available Fridays Only
505 West 8th Street
Pueblo, CO 81003
(719) 621-1105

3. Denver Colorado AIDS Project
2480 W 26th Avenue, Suite B-26
Denver, CO 80211
(303) 837-0166

4. Harm Reduction Action Center
231 E. Colfax Avenue
Denver, CO 80203
(303) 572-7800

5. Northern Colorado AIDS Project
400 Remington, Suite 100
Ft Collins, CO 80524
(970) 484-4469

6. Rocky Mountain Morpheus Project
414 Taos Street, #B
Georgetown, CO 80444
720-401-6569
(Syringe services not currently offered at this site.)

7. West Colorado Aids Project
805 Main Street
Grand Junction, CO 81501
(970) 243-2437

8. Aurora Syringe Access Services
1475 Lima Street
Aurora, CO 80010
(Only available Wednesdays 1–3:30 pm.)

4. **Emergency departments should provide naloxone to high-risk patients at discharge. If the drug is unavailable at the time of release, patients should receive a prescription and be informed about the over-the-counter availability of the drug in most Colorado pharmacies.**

   Multiple federal agencies have responded to the national opioid epidemic by endorsing the role of naloxone, an opioid antagonist that reverses opioid overdoses.[125-127] Although Colorado community programs have been distributing the drug with great success since 1996, an increasing number of emergency departments across the country are implementing lifesaving policies to improve naloxone access.[128-134]

   Ready-to-use naloxone should be given directly to high-risk patients at discharge who:

   - Receive emergency care for opioid intoxication or overdose
   - Have suspected substance abuse or nonmedical opioid use
   - Are taking >100 mg morphine equivalents/day
   - Are receiving an opioid prescription for pain ***PLUS***:
     - — A prescription for methadone or buprenorphine
     - — A history of poorly controlled respiratory disease or infection
     - — A history of renal dysfunction, hepatic disease, or cardiac comorbidities
     - — Known or suspected excessive alcohol use or dependency
     - — Concurrent use of benzodiazepines or other sedatives
     - — Suspected poorly controlled depression
   - Are taking opioids but have unreliable access to emergency medical services
   - Have been recently incarcerated/released from prison
   - Have resumed opioid use after a period of abstinence

   If unable to provide naloxone in the emergency department, consider writing a prescription and counseling the patient on its appropriate use. Patients should be informed about the wide-availability of naloxone and where it can be obtained. Pharmacies who participate in Colorado's standing naloxone protocols can be found at stoptheclockcolorado.org

5. **Emergency departments should share information about their own overdose prevention initiatives to offer reassurance about the legality of providing and prescribing naloxone.**

   Colorado State-Specific Policy Summaries

   Third-Party Naloxone Bill (Colorado SB 13-014)

   Passed in 2013, the bill removes the following:

   - Civil liability for prescribers
   - Criminal liability for prescribers
   - Civil liability for layperson administration
   - Criminal liability for layperson administration

   Colorado Good Samaritan Law (CO revised Statute 18-1-711 and HB 16-1390)

   - Samaritan acting in good faith
   - No arrest or prosecution for possession
   - No arrest or prosecution for paraphernalia and protection from other crimes

Standing Orders for Naloxone (SB 15-053)

- Any medical professional with prescriptive authority can write a standing order for naloxone that can be dispensed by other designed individuals (such as pharmacists and harm reduction organizations).
- Find participating pharmacies at stoptheclockcolorado.org
- With these standing orders, pharmacists and harm reduction organizations can now provide naloxone to those who might benefit from it the most, including:
  - A family member, friend or other person in a position to assist a person at risk of overdose
  - An employee or volunteer of a harm reduction organization
  - A first responder
  - An individual at risk of overdose

***Means of distribution*:** Clinicians can provide patients naloxone through direct distribution, by writing a prescription, or through referral to a community organization or pharmacy with a standing order agreement.

Additional Resources

http://prescribetoprevent.org/prescribers/emergency-medicine
https://www.colorado.gov/cdphe/naloxoneorders

6. **Emergency department patients who receive prescriptions for opioids should be educated on their risks, safe storage methods, and the proper disposal of leftover medications.**

Most patients who misuse opioids receive them from friends and/or family. Prescriptions should be stored safely, ideally in a locked location. Once the acute pain phase has ended and medication is no longer required, it is critical to dispose of the leftovers promptly. In an exception to the general rule, the FDA allows opioids to be flushed down the toilet; however, more environmentally friendly disposal methods are encouraged.[72] An increasing number of communities also offer prescription take-back programs.

If disposing of the medication at home, patients should be instructed to:

1. Remove the medication from its original container, and remove any labels or cross out identifying information.
2. Mix the pills with something that can't be eaten (eg, kitty litter, coffee grounds, sawdust, home cleanser, etc.)
3. Place the mixture in a sealable bag, empty can, or other durable container that prevents leakage.
4. Wrap the container in newspaper or a plain brown bag to conceal its contents. Place it in your trash the day your trash is collected.

Additional Colorado Resources

takemedsseriously.org
http://www.corxconsortium.org/wp-content/uploads/Safe-Disposal-Brochure.pdf
(http://www.deadiversion.usdoj.gov/drug_disposal/takeback/index.html)

POLICY RECOMMENDATIONS

1. **Harm reduction agencies and community programs that provide resources for people who inject drugs (PWID) should be made readily available.**

The passage of C.R. S. §25-1-520 in 2010 legalized the establishment of syringe access programs with local jurisdiction approval. Community programs aimed at providing needle exchange asnd disposal services, sterile equipment, free counseling, and HIV/hepatitis screening are cost effective strategies for preventing the transmission of bloodborne pathogens. These programs, many of which also provide basic medical and social services to this high-risk population, should be well funded and expanded beyond their current levels.

2. **When local programs are unavailable for these patients, emergency departments should establish their own programs to provide services such as safe syringe exchanges.**

   This recommendation is especially applicable to rural communities, which are particularly vulnerable to communicable disease outbreaks and are unlikely to have local syringe access programs. Emergency clinicians in these environments have a unique opportunity to intervene when caring for high-risk patients. Hospitals should partner with their local health departments and state and federal authorities to establish programs that foster harm reduction. Ideally, such initiatives should be funded by national or state governments, nonprofit organizations, or grants to make this service cost effective for participating hospitals.

VI. Treatment of Opioid Addiction

"We have an obligation to fight for the world as it should be."

—Michelle Obama

The Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that 2.1 million people in the United States suffer from substance use disorders related to prescription opioid pain relievers — a population larger than that of New Mexico and 14 other states. Although opioid abuse cuts across all social demographics, it is particularly prevalent in emergency department patients. Indeed, clinicians are in an ideal position to not only identify addiction, but intervene and point these patients toward treatment and recovery.

Most opioid-addicted patients can benefit from the "Screening, Brief Intervention and Referral to Treatment" (SBIRT) approach developed and recommended by the Institute of Medicine. Although the use of SBIRT in the ED has elicited positive results in addressing alcohol and illicit drug use, the protocol is used infrequently in Colorado.

As outlined and endorsed by SAMHSA, MAT centers provide behavioral therapy in concert with pharmaceutical treatments such as buprenorphine or methadone. In a more perfect system, patients seeking treatment for opioid addiction would be identified in the ED, referred to MAT and, when possible, initiated on Suboxone to bridge them to recovery. Unfortunately, the number of treatment centers is limited and relationships between EDs and MATS are uncommon. In 2017 the US government appropriated $1 billion to improve access to opioid addiction services; however, at this juncture a coordinated system of referral and treatment is more of an aspiration than a reality.

PRACTICE RECOMMENDATIONS

1. **The use of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) protocol and SBIRT-trained health educators in the acute setting is associated with a significant decrease in continued drug abuse and an increase in patient follow up for treatment programs. Every Colorado emergency department should consider implementing such a tool.**

   SBIRT has been studied since the 1960s as a way to identify and address the behavior of patients at risk for alcohol and substance addiction.[141,142] Studies consistently have shown these programs can increase the likelihood of patient follow up and significantly decrease the risk of future substance abuse (by nearly 70%, by some accounts).[145] A number of Colorado EDs employ trained health educators specifically to identify and provide brief interventions and referrals to treatment.

   Multiple resources, including Improving Health Colorado, also provide valuable resources for health care practitioners and those interested in developing SBIRT programs of their own. In addition, a SBIRT mobile application has been developed to aid in the bedside identification of high-risk patients and provide a template for interventions and treatment referrals.

Institutions across the country have integrated similar SBIRT screening questions into their electronic medical record documentation systems:

- Do you currently smoke/use any form of tobacco? (Yes/No)
- Do you have >7 (women) or >14 (men) drinks per week? (Yes/No)
- When was the last time you had 4 or more (all women and men >65) or more (men <65) drinks in one day?
- In the past year have used/experimented with illegal drugs or prescriptions drugs for nonmedical reasons? (Yes/No)
- Are you or anyone worried your use of prescription pain meds have or will become a problem? (Yes/No)
- How many times in the past year have you used marijuana?

SCORING

Risky use: <2 Women & Men

Require further diagnostic evaluation and referral: ≥2 Women & Men

2. **The use of alpha^2-agonists, antihistamines, antiemetics, and NSAIDs should be used to ameliorate withdrawal symptoms.**

   While generally not life-threatening, opioid withdrawal causes significant discomfort and dysphoria. Although a general lack of evidence exists, anecdotal therapies can be used to suppress symptoms; supportive and symptomatic treatment with non-narcotic agents also is encouraged.

   Clonidine. An oral alpha^2-agonist, clonidine is effective for ameliorating withdrawal symptoms.[146] Typical regimens consist of 0.1-0.3 mg given orally in 2 to 4 doses/day (up to a maximum of 1.2 mg/day) for 7-10 days. Compared to placebo, the drug is associated with a greater incidence of adverse effects, including hypotension, lethargy, drowsiness, and dry mouth (most commonly seen in the first few days of treatment). Transdermal systems deliver doses that are equivalent to oral formulations, but in an easy-to-use weekly patch. For example, the Catapres-TTS-1 patch delivers a dose that is equivalent to an oral dose of 0.1 mg twice daily for 7 days; however, adverse effects are unpredictable due to the lack of titration.

   Lofexidine. A new alpha^2-agonist, lofexidine currently is undergoing FDA clinical trials. According to early results, the drug appears to be as effective as clonidine with a safer side effect profile.

   Antiemetics. Agents such as ondansetron, promethazine, and prochlorperazine are very familiar to emergency physicians and can be used for nausea and vomiting associated with withdrawal.

   Antihistamines. Medications such as dicyclomine may be given to alleviate abdominal cramping and pain.

   Hydroxyzine. This drug can be used for anxiety and dysphoria.

   NSAIDs. Ibuprofen, naproxen, and ketorolac can be used for headache, myalgias, and pain.

   Benzodiazepines. This agents generally are not recommended, as their potential for abuse and side effects typically outweigh the benefits; patients must be strictly monitored.

3. **Any patient willing to consider treatment and recovery should be directed to a nearby medication assisted treatment (MAT) program.**

   Medication-assisted treatment for addiction is one of the most effective ways emergency physicians can start patients on a path to sobriety. This approach can help alleviate withdrawal symptoms and drug cravings while patients turn their attention to other aspects of recovery such as avoiding triggers and reducing harmful behaviors. A stable source of medication may help stem the pursuit of illegal behaviors motivated by the need to obtain opioids elsewhere.

   Medication-assisted treatment programs address addiction with a combination of drug (eg, buprenorphine, methadone and naltrexone) and behavioral therapies. This whole-patient approach has been shown to improve substance abuse-related disorders and psychosocial functioning.

   MAT programs typically are directed by physicians certified in addiction medicine. If a formal relationship exists between your institution and a MAT center, patients should be referred upon discharge. A list of current MAT facilities can be accessed on the Colorado Consortium for Prescription Drug Abuse website.

4. **The initiation of buprenorphine/naloxone (Suboxone) is among the most effective methods for transitioning patients into treatment and recovery. Emergency departments with a high prevalence of opioid-addicted patients should strongly consider implementing a coordinated program that allows those suffering from drug withdrawal to be receive the medication and expeditiously transferred to a MAT program.**

   Buprenorphine, a partial mu-receptor agonist and kappa-receptor antagonist, has chemical properties that make it effective for treating opioid withdrawal without causing the marked euphoria or "high" common with the use of heroin and other opioids. Buprenorphine has a much higher affinity for the mu-receptor than most opioids; if other opioids are in a patient's system, buprenorphine will displace them, often precipitating significant withdrawal. It is important for the patient to be exhibiting at least moderate withdrawal symptoms before the medication is initiated.

Although the DEA has restricted the prescribing of buprenorphine to physicians who hold a special certification and waiver, there is an exception for emergency situations. Called the "3-day rule," the caveat allows non-certified physicians to dispense the medication by adhering to certain guidelines. A physician may administer but not prescribe a daily dose of Suboxone to relieve withdrawals and cravings for 3 consecutive days (72 hours). This protocol may only occur once per patient, cannot be extended, and must be carried out with a simultaneous referral for treatment.

An emergency department treatment algorithm can help provide clear-cut guidelines for the initiation of buprenorphine therapy and minimize the amount of time required for each individual patient. The algorithm should include a clinical opioid withdrawal scale (COWS), which can help determine the appropriate course for each individual (*Figure 9*).

If initiating the drug in the emergency department, clinicians should remain mindful of co-addictions that may interact with buprenorphine; alcohol and benzodiazepines, for example, can trigger respiratory depression. It also is important to gather information about community resources for outpatient referral, MAT programs, and addiction counseling, which can be provided to patients on discharge. Some buprenorphine providers may be reached via phone to arrange close follow up. Finally, the patient should be provided with written materials that clearly explain the drug's indications and side effects. (See *Appendix 3* for dosing information.)

FIGURE 9. CLINICAL OPIOID WITHDRAWAL SCALE

For each item, circle thenumber that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increased pulse rate would not add to the score.

Patient' s Name _____ Date and Time _____

Reason for this assessment _____

Resting Pulse Rate: _____beats/minute *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81- 1 00 2 pulse rate 101-1 20 4 pulse rate greater than 1 20	**GI Upset:** *over last 1/2 hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: *over past 1/2 hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	**Tremor:** *observation ofoutstretched hands* 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness: *observation during assessment* 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	**Yawning:** *observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 Yawning several times/minute
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	**Anxiety or Irritability** 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches: *if patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	**Gooseflesh skin** 0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection
Runny nose or tearing: *not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	**Total Score** _____ The total score is the sum of all 11 items Initials of person completing assessment _____

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

The DEA requires every emergency department that dispenses methadone to register separately as an "opioid treatment program." Given the long half-life of this medication and the intricacies of determining tolerance and appropriate dosing, methadone is not recommended in the acute setting and hence has been precluded from these guidelines.

POLICY RECOMMENDATIONS

1. Emergency departments should work with MAT programs to facilitate direct referrals. When possible, physicians should consider performing a "warm handoff" where patients are initiated on medications such as buprenorphine until they are able to enroll in an appropriate MAT program.
2. Unfortunately, there are not enough facilities to accommodate the number of would-be patients. COACEP strongly advocates for the expansion of MAT services and increased local, state, and federal funding for these resources.

VII. The Future

"The best way to predict the future is to create it."

—Abraham Lincoln

The Colorado Chapter of the American College of Emergency Physicians stands with the families and patients currently afflicted with opioid addiction and abuse. We must harbor hope for our patients and view addiction not as a moral failing, but as a medical disease. Opioid harm reduction should be an integral part of everyday practice with the ultimate goal of keeping patients safe until they are ready for recovery. We will need to improve our referral patterns and access syringe access and MAT programs.

Multimodal pain control strategies, including ALTO, must become a part of every emergency medical practice. Swedish Medical Center, which implemented ALTO protocols and training for its staff in 2016, reported a preliminary 33% reduction in prescriptions for hydromorphone and opioids in the emergency department without significant detriment to patient satisfaction scores.

The opioid epidemic belongs to the medical community and we must help extinguish it. To this end, Colorado ACEP is collaborating with the Colorado Hospital Association on a pilot program to implement ALTO protocols in five hospitals across the state. The initiative aims to quantify the benefits of implementing guidelines and gauge their effects on opioid usage and patient satisfaction scores.

Finally and perhaps most importantly, we must reject the status quo, revolutionize our own practices, and endeavor to stem the tide of opioid addiction. We challenge you to join us in becoming an agent for change. We in Colorado can make a profound difference by setting the standard for every emergency department in the country, and together we can bring this deadly epidemic to an end.

What Can You Do?

- Work with your emergency department medical director, physician group, pharmacists, and hospital administrators to fully integrate as many of these recommendations into your clinical practice as possible.
- Share these guidelines with the clinicians and medical staff in your emergency department.

Appendix 1. ALTO Protocols and References

Musculoskeletal Pain

Note: This includes sprains, strains, or opioid-naïve lower back pain, acute neck, joint and soft tissue pain; rotator cuff tendonitis, arthritis of knee, lateral epicondylitis, greater trochanteric bursitis, biceps tendonitis, etc.

- Acetaminophen 1000 mg PO
- Ibuprofen 600 mg PO ***OR*** ketorolac 15 mg IV/IM (APAP + Motrin)
- Muscle relaxant: cyclobenzaprine 5 mg PO ***OR*** diazepam 5 mg PO/IV
- Intranasal ketamine 50 mg
- Dexamethasone 8 mg IV
- Ketamine 0.1-0.3 mg/kg IV infusion over 10 min (0.1 mg/kg/hr drip)
- Trigger-point injection with 1-2 mL of lidocaine 1%
- Consider for all patients:
  - Lidocaine 5% patch to most painful area (ma. 3 patches); instruct patient to remove after 12 hours
  - Gabapentin 300-600 mg PO (neuropathic component of paint)
- Acute on chronic radicular lower back pain (opioid tolerant):
  - Acetaminophen 1,000 mg PO
  - Ibuprofen 600 mg PO ***OR*** ketorolac 15 mg IV/IM
- Muscle relaxant (choose one):
  - Cyclobenzaprine 5 mg PO
  - Diazepam 5 mg PO/IV
  - Dexamethasone 8 mg PO/IV
  - Ketamine 0.1-0.3 mg/kg in 50 mL NS over 10 minutes (ketamine 0.1 mg/kg/hour until pain is tolerable)
- Consider for all patients:
  - Gabapentin 300-600 mg (neuropathic component of pain)
  - Lidocaine 5% patch to most painful area (max 3 patches); instruct patient to remove after 12 hours
  - Trigger-point injection with lidocaine 1% 1-2 mL

Headache/Migraine

The American Academy of Neurology and the American Headache Society do not recommend opioids except in extraordinary cases in which other agents are contraindicated (eg, pregnancy, etc.) Numerous studies reveal that opioids are not as effective as standard treatments for the management of headaches, and can render acute migraine medications less efficacious (eg, triptans). Opioid use can, in fact, promote chronic migraine and medication overuse headaches, and increase anxiety, disability, and depression in patients who suffer from migraine pain.

- Acetaminophen 1,000 mg PO
- Ibuprofen 600 mg PO ***OR*** ketorolac 15 mg IM/IV
- Metoclopramide 10 mg PO/IV ***OR*** prochlorperazine 10 mg PO/IV
- 1 L 0.9% NS bolus

- Sumatriptan 6 mg SC
- Cervical or trapezius trigger-point injection with lidocaine 1%
- If < 50% pain relief then:
  - Magnesium 1 gm IV over 60 min
  - Valproic acid 500 mg/50 mL NS over 20 min
  - Dexamethasone 4-8 mg IV (migraine only)
- If < 50% pain relief then:
  - Haloperidol 5 mg IV over 10 min
  - Propofol 10-20 mg IV bolus every 10 min (max 2.5 mg/kg)
- If < 50% pain relief then:
  - Place in observation unit with neurology consultation
- If tension component:
  - Cyclobenzaprine 5 mg ***OR*** diazepam 5 mg PO/IV
  - Trigger-point injection (see above)
  - Lidocaine 5% patch

Renal Colic

- Ketorolac 15 mg IV
- Acetaminophen 1,000 mg PO
- 1 L 0.9% NS bolus
- If < 50% pain relief: lidocaine 1.5 mg/kg IV in 100 mL NS over 10 min (max 200 mg)

Extremity Fracture or Joint Dislocation

- Focused non-sedating pain control
- Long-lasting relief for fracture pain
- Short-acting relief for joint reduction
- Proximal blocks (eg, brachial plexus)
- Distal blocks (eg, ulnar nerve)
- Immediate therapy (while setting up for block):
  - Ketamine intranasal 0.5 mg/kg (concentration 100 mg/mL); (max dose 50 mg; max. volume per nare 1 mL)
  - Nitrous oxide titrated up to 70%
  - Acetaminophen 1,000 mg PO
- Followed by ultrasound-guided regional anesthesia:
  - Joint dislocation: lidocaine 0.5% perineural infiltration (max 5 mg/kg)
  - Extremity fracture: lidocaine 0.5% perineural infiltration (max 5 mg/kg)
- Discharge medications:
  - Acetaminophen 1,000 mg PO every 4-6 hrs ***PLUS*** naprosyn 500 mg PO every 12 hrs

Gastroparesis-Associated/Chronic Abdominal Pain

- Metoclopramide 10 mg IV ***OR*** prochlorperazine 10 mg IV
- Diphenhydramine 25 mg IV
- Haloperidol 2.5 mg IV
- If <50% pain relief:
  - Lidocaine 1.5 mg/kg in 100 mL NS over 10 min (max 200 mg)
  - Dicyclomine 20 mg PO/IM
  - Ketamine 0.1-0.3 mg/kg in 50 mL NS over 10 min (0.1 mg/kg/hr until pain is tolerable)

Appendix 2. Low-Dose Ketamine Pain Guideline

https://drive.google.com/open?id=0BxSkXXc496q6VFlJbE5ZVmZ4LUE

Appendix 3. Suboxone for Withdrawal

Buprenorphine and buprenorphine/naloxone (Suboxone or Zubsolv) are viable alternatives for those seeking opioids. The following rules only apply to patients taking short-acting opioids (eg, morphine, oxycodone, hydrocodone, heroin). For patients on long-acting opioids (eg, methadone, oxycontin ER), induction and treatment with buprenorphine should be performed by an addiction specialist.

1. Provide information about the drug and how it is dispensed and administered. Determine the patient's COWS score (a score between 11 and 20 is required for treatment).
2. Begin with an initial dose of 2 to 4 mg of Suboxone (buprenorphine HCl 8 mg/naloxone HCI dihydrate 2 mg) or Subutex (buprenorphine HCl) sublingual tablets after moderate opioid withdrawal symptoms have developed. (Subutex should be reserved for patients with liver compromise, pregnancy, or a severe documented allergic reaction to naloxone). Discuss available strengths with your pharmacist. Suboxone 8-mg strips can be divided in half or quartered to accommodate lower requirements.
3. Reassure the patient that opioid withdrawal symptoms are usually alleviated in 20 to 40 minutes following the first dose of buprenorphine. The strip or pill should be placed fully under the tongue or within the cheek, and should not be chewed or swallowed. Nothing else should be put in the mouth at the same time, and the patient should not eat or drink anything until the medication is fully dissolved. The patient should be told to spit out any accumulated saliva to limit the ingestion of naloxone, which can cause nausea. It may take up to 30 minutes for the strip or pill to dissolve.
4. If possible, the patient should be observed for 1 to 2 hours. A second dose of Suboxone (4 mg) or Subutex can be dispensed or prescribed if no precipitated withdrawal is observed. (A Suboxone waiver is required to prescribe the drug. If a waiver is unavailable, patients can be instructed to return to the emergency department under the 3-day rule.)

DAY 1. The usual first-day dose is 8 mg up to a typical maximum of 12 mg; a maximum dose of 16 mg may be required for significant dependence. A third dose (2-4 mg) may be taken later in the evening as needed for withdrawal symptoms. If the patient cannot be observed in the emergency department after taking the the second dose, another responsible adult should be available to monitor the patient's response.

DAY 2. If the patient returns to the emergency department for a second day, the response to the initial dose should be assessed. If opioid withdrawal symptoms were fully suppressed and cravings were absent between doses, the dose can remain the same; otherwise increase by 2 or 4 mg. All attempts should be made to maintain the dose at 16 mg a day; however, a maximum daily dose of 24 mg may be required. In such rare cases, the dose should be decreased as rapidly as possible.

DAY 3. Provided the withdrawal symptoms were fully suppressed, the third and final dose can remain the same as the day 2 dose. It can be increased by 2 or 4 mg on day 3 if needed.

Next Steps

The primary goal is to induce treatment smoothly and suppress withdrawal as completely and rapidly as possible. Failure to do so may cause the patient to turn to opioids, alcohol, benzodiazepines, or other medications to alleviate withdrawal symptoms, and may lead to early treatment dropout.

Drug withdrawal can cause significant anxiety and may interfere with patient management. Symptomatic care using IV fluids, antiemetics (eg, ondansetron or promethazine), and IV nonopioid pain relievers (eg, ketorolac 15 mg) may help calm the patient; opioids and benzodiazepines should be avoided.

It also can be useful to obtain baseline laboratory measurements prior to initiating buprenorphine. At minimum, these should include liver function and blood alcohol level tests, a urine drug screen, and a pregnancy test in females. Also consider testing for HIV and hepatitis, particularly for injection drug users. Patients also should be screened for other mental health issues such as suicidal or homicidal ideations, hallucinations, and severe depression. These findings may warrant more intensive inpatient treatment.

If the initial dose of Suboxone appears to worsen withdrawal symptoms, symptomatic treatment can be offered. These effects can be exacerbated if the last opioid dose was too recent and/or underreported by the patient. An additional 2 mg to 4 mg can be given hourly until symptoms dissipate. It is important for both the patient and physician to understand that this complication does not indicate treatment failure.

Discussions should be initiated with your hospital's pharmacy about the amount of buprenorphine that should be kept on hand. Suboxone 8 mg/2 mg films are most common; however, 4 mg/1 mg films may be more useful in the acute setting.