

Dio, Nifty L - DSPS

From: Ryan, Thomas - DSPS
Sent: Friday, April 15, 2016 6:02 AM
To: Dio, Nifty L - DSPS
Subject: FW: AAPM&R Launches Free Training with CME to Combat the Opioid Crisis

Follow Up Flag: Follow up
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For the CS Committee agenda. Thanks.

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From: Sridhar Vasudevan [REDACTED]
Sent: Thursday, April 14, 2016 6:07 PM
To: Ryan, Thomas - DSPS
Subject: Fwd: AAPM&R Launches Free Training with CME to Combat the Opioid Crisis

Tom:

My academy of PMR is offering CME, as well as the AAPM-American Academy of Pain Medicine. Thus there are numerous organizations offering CME- and physicians can easily meet the CME requirements.

Share with the Controlled Substance Committee

SRI

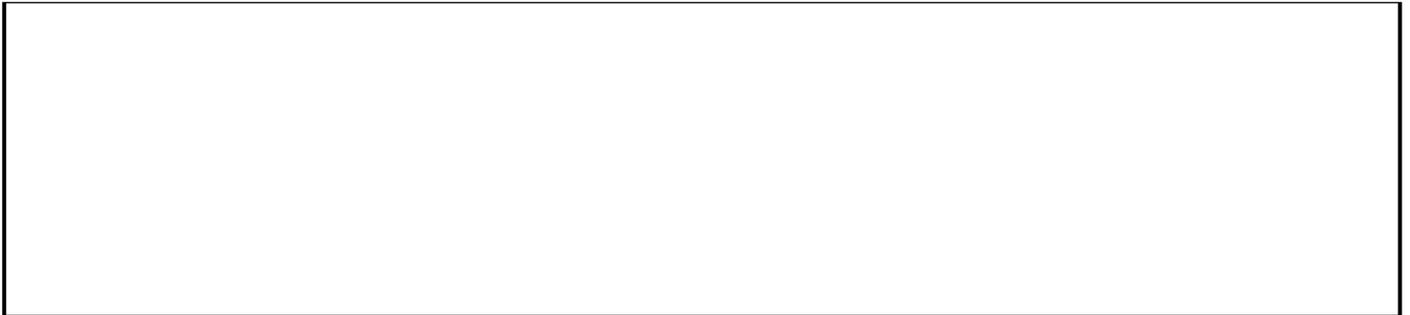
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Begin forwarded message:

From: "AAPM&R" [REDACTED]
Date: April 14, 2016 at 9:01:06 AM CDT
To: [REDACTED]
Subject: AAPM&R Launches Free Training with CME to Combat the Opioid Crisis
Reply-To: [REDACTED]

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AAPM&R Launches REMS Playbook for Opioid Prescribing

AAPM&R has developed a highly interactive educational activity for physicians who want to take a leadership role in balancing the benefits of prescribing extended-release (ER) and long-acting (LA) opioid analgesics to treat pain against the risks of serious adverse outcomes.

The online activity, **REMS Playbook for Opioid Prescribing**, is [now available](#) on the mē@ Catalog. Earn up to 3.00 *AMA PRA Category 1 Credits™* with this complimentary activity!

The experience features 6 online interactive learning modules and games:

- The “*Know the Play Book Video Series*” is comprised of 4 interactive episodes with leading pain specialists. Faculty share experiences and clinical pearls for opioid treatment through video clips, information crawl, and case study.
- The “*Test Your Knowledge*” section includes interactive gaming quizzes that will help familiarize and reinforce physician knowledge of both the general drug information as well as the specific characteristics of ER/LA opioids. These games can be played at any time to reinforce learning along the way.

This activity is free for all physicians, so share this email with your peers! [Watch this video](#) and visit www.aapmr.org/REMSplaybook to learn more.

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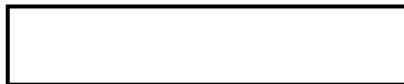
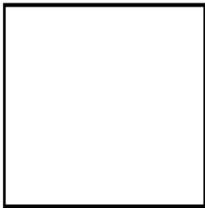
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Draft MEB Guidelines for Opioid Prescribing

1. **Scope of guidelines:** These guidelines apply to acute and chronic pain in adults. They do not apply to pediatric, end-of-life, palliative, and cancer pain, although many of the principles upon which they are based could be applied to those areas.
2. **A practitioner's first priority in treating a patient in pain is to identify the cause of the pain and, if possible, to treat it.** While keeping the patient comfortable during this treatment is important, it is critical to address to the extent possible the underlying condition as the primary objective of care.
 - a. Patients unwilling to obtain definitive treatment for the condition causing their pain should be considered questionable candidates for opioids. If opioids are prescribed to such patients, documentation of a clear and compelling justification should be present on the chart.
 - b. Opioids should not be prescribed unless there is a medical condition present which would reasonably be expected to cause pain severe enough to require an opioid. For conditions where this is questionable, use of other treatments instead of opioids should be strongly considered.
 - c. Consultation should be considered if diagnosis of and/or treatment for the condition causing the pain is outside of the scope of the prescribing practitioner.
3. **Patients presenting for pain treatment must have a thorough evaluation, to include:**
 - a. Medical history and physical examination targeted to the pain condition
 - b. Nature and intensity of the pain
 - c. Current and past treatments, with response to each treatment
 - d. Underlying or co-existing diseases or conditions, including those which could complicate treatment (i.e., renal disease, sleep apnea, COPD, etc.)
 - e. Effect of pain on physical and psychological functioning
 - f. Personal and family history of substance abuse
 - g. History of psychiatric disorders associated with opioid abuse (bipolar, ADD/ADHD, sociopathic, borderline, untreated/severe depression)
 - h. Medical indication(s) for use of opioids
4. **Opioids should be the last choice in treating acute or chronic pain.**
 - a. Acute pain: Evidence for opioids is weak. Other treatments such as acetaminophen, nonsteroidal anti-inflammatories, and non-pharmacologic treatments should be attempted prior to initiating opioid therapy, although opioids could be simultaneously prescribed if it is apparent from the patient's condition that he/she will need opioids in addition to these.
 - b. Acute pain lasting beyond the expected duration: A complication of the acute pain issue (surgical complication, nonunion of fracture, etc.) should be ruled out. If complications are ruled out, a transition to non-opioid therapy (tricyclic antidepressant, serotonin-norepinephrine reuptake inhibitor, anticonvulsant, etc.) should be attempted.
 - c. Chronic pain: Evidence for opioids is poor. Multiple meta-analyses demonstrate that the benefits are slight, while annualized mortality rates are dramatically increased. There are few if any treatments in medicine

with this poor a risk/benefit ratio, and there should be adequate justification on the chart to indicate why chronic opioid therapy was chosen in a given patient. Note: There is no high-quality evidence to support opioid therapy longer than 6 months in duration. Despite this fact, it is considered acceptable although not preferable to continue patients on treatment who have been on chronic opioid therapy prior to the release of these Guidelines and have demonstrated no evidence of aberrant behavior.

- d. Patients unwilling to accept nonpharmacological and/or nonnarcotic treatments (or those providing questionably credible justifications for not using them) should not be considered candidates for opioid therapy.

5. Initiation of opioids for chronic pain should be considered a clinical trial.

Prior to starting opioids, objective symptomatic and functional goals should be established with the patient. If, after a reasonable trial, these goals are not met, opioids should be weaned or discontinued. Visual analog scales, 0-10 scales, and smiling/frowning faces are good measures of pain levels. Instruments for assessing function include but are not limited to: 1) The Oswestry Disability Index, 2) The Brief Pain Inventory, 3) The SF-12, 4) For fibromyalgia patients, the Fibromyalgia Impact Questionnaire.

6. Practitioners must always consider the risk-benefit ratio when deciding whether to start or continue opioids.

Risks and benefits must be discussed with patients prior to initiating chronic opioid therapy, and they must be continually reassessed during that therapy. If evidence of increased risk develops, weaning or discontinuation of opioid should be considered. If evidence emerges that indicates that the opioids put a patient at the risk of imminent danger (overdose, addiction, etc.), or that they are being diverted, opioids should be immediately discontinued and the patient should be treated for withdrawal, if needed.

- a. Exceptions to this include patients with unstable angina (withdrawal could precipitate a myocardial infarction) and pregnant patients, especially in the 3rd trimester (withdrawal could precipitate pre-term labor).
- b. Components of ongoing assessment of risk include:
 - i. Review of the Prescription Drug Monitoring Program (PDMP) website at least every three months. (Note: This will be mandatory in Wisconsin before every prescription is written by April 1, 2017.)
 - ii. Periodic urine drug testing – at least yearly in low risk cases, more frequently if evidence of increased risk (including chromatography is strongly recommended)
 - iii. Periodic pill counts – at least yearly and low risk cases, more frequently if evidence of increased risk
 - iv. Violations of the opioid agreement

7. All patients on chronic opioid therapy should sign a form consisting of:

- a. **Opioid informed consent**, specifically detailing significant possible adverse effects of opioids, including (but not limited to) addiction, overdose, and death
- b. **Treatment agreement**, documenting the behaviors required of the patient by the prescribing practitioner to ensure that they are remaining safe from these adverse effects

8. **Initial dose titration for both acute and chronic pain should be with short-acting opioids.** For chronic therapy, it would be appropriate once an effective dose is established to consider long-acting agents for a majority of the daily dose.
9. **Opioids should be prescribed in the lowest effective dose.** If daily doses for chronic pain reach 50 morphine equivalent mgs. (MEMs), additional precautions should be implemented (see #5.b. above). Given that there is no evidence base to support efficacy of doses over 90 MEMs, with dramatically increased risks, dosing above this level is strongly discouraged, and clear and compelling documentation to support such dosing should be present on the chart.
10. **The use of oxycodone is discouraged.** There is no evidence to support that oxycodone is more effective than other oral opioids, while there are multiple studies indicating that oxycodone is more abused and has qualities that would promote addiction to a greater degree than other opioids. As a result, oxycodone should be considered an opioid of last resort and should be used only in patients who cannot tolerate other opioids and who have been evaluated for and found not to demonstrate increased risk of abuse.
11. **Prescribing of opioids is very strongly discouraged for patients abusing illicit drugs.** These patients are at extremely high risk for abuse, overdose, and death. If opioids are prescribed to such patients, a clear and compelling justification should be documented in the chart.
12. **In treating acute pain, the lowest dose and lowest number of pills needed should be prescribed.** In most cases, less than 3 days' worth are necessary, and rarely more than 7 days' worth. Untaken pills in medicine cabinets are the primary source for illicit opioid abuse in teens and young adults.
13. **During initial opioid titration, practitioners should re-evaluate patients every 1-4 weeks. During chronic therapy, patients should be seen at least every 3 months, more frequently if they demonstrate higher risk.**
14. **Practitioners should consider prescribing naloxone for home use in case of overdose for patients at higher risk, including:**
 - a. History of overdose (a relative contraindication to chronic opioid therapy)
 - b. Opioid doses over 50 MEMs/day
 - c. Clinical depression
 - d. Evidence of increased risk by other measures (behaviors, family history, PDMP, UDS, risk questionnaires, etc.)

The recommended dose is 0.4 mg for IM or intranasal use, with a second dose available if the first is ineffective or wears off before EMS arrives. Family members can be prescribed naloxone for use with the patient, and Wisconsin prescribers can leave standing orders for this without a prescription at pharmacies in Wisconsin.

15. **Prescribing of opioids is strongly discouraged in patients concurrently taking benzodiazepines or other respiratory depressants (barbiturates, carisoprodol, sedative-hypnotics, etc.).** Benzodiazepines triple the already extremely high increases in annual mortality rates from opioids. If they are used concurrently, clear and compelling justification should be documented in the chart.

16. **All practitioners are expected to provide care for potential complications of the treatments they provide, including opioid use disorder.** As a result, if a patient receiving opioids develops behaviors indicative of opioid use disorder, the practitioner has an obligation to assist the patient in obtaining addiction treatment, either by providing it directly (buprenorphine, naltrexone, etc. plus behavioral therapy) or referring them to an addiction treatment center which is willing to accept the patient. Simply discharging a patient from the provider's practice is not considered an acceptable alternative.

17. **Definitions**

a. Terms to avoid

- i. **Addiction.** This is a term which carries a very negative stigma and has been replaced by "opioid use disorder."
- ii. **Drug-seeking.** This term also has a very negative stigma. It is highly preferable to use the term "aberrant opioid behavior."
- iii. **Opioid dependency.** This has been used as a synonym for addiction prior to the DSM-V and is often confused with physiologic dependence. The proper term is now "opioid use disorder."

b. Questionable term

- i. **Pseudoaddiction.** This highly controversial term was used in the past to justify aberrant opioid behaviors due to under-treatment. It has been found, however, that many people to whom this term is applied go on to develop opioid use disorder. For example, patients not improving from an antibiotic don't go behind their provider's back to get antibiotics from someone else, they simply call their practitioner to tell them it isn't working. Most leading pain clinicians now view this term as highly suspect.

c. Terms to understand

- i. **Opioid Use Disorder.** This is a DSM-V diagnosis with clear and specific criteria. The use of those criteria is essential if this term is to be applied to a patient. Based on the number of criteria met, it is classified as mild (2-3), moderate (4-5), or severe (> 5).
- ii. **Tolerance.** The tendency for the body to compensate for the effect of a medication, causing reduced effect. This is a physiologic process and should not be confused with opioid use disorder.
- iii. **Physiologic dependence.** The tendency to have a characteristic withdrawal syndrome if a medication is suddenly stopped. This is due to unopposed physiologic mechanisms underlying tolerance, and it should not be confused with opioid use disorder. (Note: this also occurs with certain antidepressants, beta blockers, etc.)
- iv. **Aberrant behavior.** Any behavior calling into question a patient's relationship with their opioids. Causes for such behaviors can include patient idiosyncrasies, life situation, drug liking, or opioid use disorder. It is important to understand that not all aberrant behaviors indicate opioid use disorder. They do, however, significantly raise the risk of it.