Body System: Population-Based Care		
Session Topic: Safe Opiate Prescribing: A Review of the Guidelines		
Educational Format		**Faculty Expertise Required**
REQUIRED	Interactive Lecture	Expertise in the field of study. Experience teaching in the field of study is desired. Preferred experience with audience response systems (ARS). Utilizing polling questions and engaging the learners in Q&A during the final 15 minutes of the session are required.
OPTIONAL	Problem-Based Learning (PBL)	Expertise teaching highly interactive, small group learning environments. Case-based, with experience developing and teaching case scenarios for simulation labs preferred. Other workshop-oriented designs may be accommodated. A typical PBL room is set for 50-100 participants, with 7-8 each per round table. Please describe your interest and plan for teaching a PBL on your proposal form.

Professional Practice Gap	**Learning Objective(s) that will close the gap and meet the need**	**Outcome Being Measured**
• New CDC Guideline for Prescribing Opioids for Chronic Pain – physicians need to become aware • Physicians often lack knowledge of new FDA approved abuse-deterrent formulations of pain medications. • Physicians lack the confidence in their ability to design an on-going management plan for their patients with chronic pain that incorporates strategies related to titration for safety and efficacy, risk assessment screening tools, and prescribing agreements to minimize misuse and addiction of opioids. • Patients are often non-adherent to prescribed treatment therapies for managing chronic pain. • Only 3.6% of family physicians have obtained DEA authorization to	1. Determine when to initiate or continue opioids for chronic pain. 2. Determine appropriate opioid selection, dosage, duration, follow-up and discontinuation. 3. Establish protocols to assess risk, and address potential harms of opioid use.	Learners will submit written commitment to change statements on the session evaluation, indicating how they plan to implement presented practice recommendations.

prescribe buprenorphine.		

ACGME Core Competencies Addressed (select all that apply)			
X	Medical Knowledge		Patient Care
X	Interpersonal and Communication Skills		Practice-Based Learning and Improvement
	Professionalism		Systems-Based Practice

Faculty Instructional Goals

Faculty play a vital role in assisting the AAFP to achieve its mission by providing high-quality, innovative education for physicians, residents and medical students that will encompass the art, science, evidence and socio-economics of family medicine and to support the pursuit of lifelong learning. By achieving the instructional goals provided, faculty will facilitate the application of new knowledge and skills gained by learners to practice, so that they may optimize care provided to their patients.

- Provide up to 3 evidence-based recommended practice changes that can be immediately implemented, at the conclusion of the session; including SORT taxonomy & reference citations
- Facilitate learner engagement during the session
- Address related practice barriers to foster optimal patient management
- Provide recommended journal resources and tools, during the session, from the American Family Physician (AFP), Family Practice Management (FPM), and Familydoctor.org patient resources; those listed in the References section below are a good place to start
    - Visit http://www.aafp.org/journals for additional resources
    - Visit http://familydoctor.org for patient education and resources
- In general, provide an overview of the new CDC guidelines, including the rationale for the AAFP's "Affirmation of Value", rather than a full endorsement. Additionally, offer recommendations, based on other evidence-based clinical guidelines for safe opiate prescribing.
- Provide recommendations for determining when to initiate or continue opioids for chronic pain, including:
    - Selection of non-pharmacologic therapy, non-opioid pharmacologic therapy, opioid therapy
    - Establishment of treatment goals
    - Discussion of risks and benefits of therapy with patients
- Provide recommendations for determining the appropriate opioid selection, dosage, duration, follow-up and discontinuation, including:
    - Selection of immediate-release or extended-release and long-acting opioids
    - Dosage considerations
    - Duration of treatment
    - Considerations for follow-up and discontinuation of opioid therapy
- Provide recommendations for assessing risk, and address potential harms of opioid use, including:
    - Evaluation of risk factors for opioid-related harms and ways to mitigate/reduce patient risk
    - Review of prescription drug monitoring program (PDMP) data
    - Use of urine drug testing
    - Considerations for co-prescribing benzodiazepines
    - Arrangement of treatment for opioid use disorder

- Provide recommendations regarding guidelines for Medicare reimbursement.
- Provide recommendations to maximize office efficiency and guideline adherence to safe opiate prescribing.
- Provide an overview of newly available treatments, including efficacy, safety, contraindications, and cost/benefit relative to existing treatments.

Needs Assessment

Chronic pain affects approximately one-third of U.S. adults, is more prevalent in women than men, becomes more prevalent with age, and 5 percent receive opioid treatment.[1,2] The Institute of Medicine Report: *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research*, pain is a significant public health problem that costs society at least $560-$635 billion annually, an amount equal to about $2,000.00 for everyone living in the U.S.[3,4] Chronic pain is common, multidimensional, and individualized, and treatment can be challenging for healthcare providers as well as patients.

Prescribing and sales of opioids in the United States have quadrupled since 1999, which has led to a prescription opioid overdose epidemic. So as part of a unified and accelerated effort from the government to combat this crisis, on March 15, the CDC issued its final Guideline for Prescribing Opioids for Chronic Pain -- United States, 2016.(www.cdc.gov) The guideline is intended for use by primary care health professionals who are treating patients with chronic pain (i.e., pain lasting longer than three months or past the time of normal tissue healing) in outpatient settings.[5]

"More than 40 Americans die each day from prescription opioid overdoses; we must act now," said CDC Director Tom Frieden, M.D., M.P.H., in a news release.[6] "Overprescribing opioids -- largely for chronic pain -- is a key driver of America's drug-overdose epidemic. The guideline will give physicians and patients the information they need to make more informed decisions about treatment."

The American Academy of Family Physicians (AAF) CME Needs Assessment Survey data indicates that family physicians have statistically significant and meaningful gaps in the medical skill necessary to provide optimal pain management, manage drug abuse and addiction, and utilize risk evaluation mitigation strategies (REMS).[7] Additionally, CME outcomes data from the 2012-15 AAFP FMX (formerly Assembly) CME sessions related to chronic pain and/or opioid management, indicate family physicians have knowledge and practice gaps with regard to managing risk associated with chronic pain management; utilizing screening/assessment best practices; utilizing pain contracts, monitoring and random drug testing; increasing awareness of state drug monitoring programs; effective patient education and cognitive behavioral therapy; familiarity with current clinical guidelines; appropriate utilization of extended release/long-acting opioid medication; referral and coordination of care with pain specialists &/or addiction clinics; and using a stepwise approach to pain management.[8-11] A literature review confirms this data, suggesting frequent non-adherence to guidelines for the management of chronic pain, including substantial variability in the use of pain contracts.[12-14]

Data from the Centers for Disease Control and Prevention (CDC) reveals that deaths from unintentional drug overdoses in the United States have been rising steeply since the early 1990s and are the second-leading cause of accidental death, with 27,658 such deaths recorded in 2007.[15] That increase has been propelled by a rising number of overdoses of opioids, which caused 11,499 of the deaths in 2007—more than heroin and cocaine combined, and second only to motor vehicle crash deaths among leading causes of unintentional injury death.[16,17] Visits to emergency departments for opioid abuse more than doubled between 2004 and 2008, and admissions to substance-abuse treatment programs increased by 400% between 1998 and 2008, with prescription painkillers being the second most prevalent type of abused drug after marijuana.[15] Although both per capita opioid sales and death rates from the drugs vary widely among the 50 states, studies have found a strong correlation between states with the highest drug-poisoning mortality and those with the highest opioid consumption; per capita sales are most strongly linked with methadone- and oxycodone-related mortality.[16] In contrast, although rates of suicide caused by drug overdoses have also increased somewhat and chronic pain remains a risk factor for depression-linked suicide, the majority of opioid-overdose deaths are accidental. More often than not, laboratory tests reveal the presence of one or more substances in addition to the opioid, suggesting that the depressant effects of alcohol or other drugs on the central nervous system were additive with those of the pain reliever in causing death.[18]

Contributing physician factors include inappropriate prescribing along with inadequate counseling and monitoring, reflecting knowledge, competence, and performance deficits.[19] Physicians need to ensure that opioids are being given to the right patients under the appropriate circumstances and within the confines of set parameters to truly benefit patients.[20] To improve care, physicians must play a central role by being specific and write pain drug prescriptions with explicit directions. There is also a need to consider alternative agents in patients who don't require opioids.[16,19] These steps are critical to decreasing the potential for abuse and associated mortality risk in the future. Furthermore, methadone is implicated far more often than any other as a drug that is the subject of abuse and overdose potential. Yet its sales for chronic pain have increased partly in response to pressure from insurers and Medicaid programs, because the medication has been viewed as a cheaper and potentially less abusable alternative to other long-acting pain relievers. However, use of the drug presents problems to the treating physician as its very long half-life makes it difficult to manage and especially dangerous when combined with other drugs.[20]

Family physicians should be presented with continuing education, based on evidence-based recommendations and guidelines for the management of chronic nonterminal pain.[1,21] In order to minimize misuse or abuse, physicians should understand appropriate patient selection for opioid therapy using opioid risk tools, utilize visit checklists, urine testing, prescription monitoring, written agreements, selecting an initial opioid, understand when short-acting versus long-acting opioids are appropriate, know when to refer to a pain subspecialist, and understand how to taper or discontinue therapy.[1,22]

The CDC Guideline for Prescribing Opioids for Chronic Pain, was developed by the Centers for Disease Control and Prevention and was reviewed and categorized as Affirmation of Value by the American Academy of Family Physicians.[23,24]

The AAFP uses the category of "Affirmation of Value" to support clinical practice guidelines that provide valuable guidance, but do not meet our criteria for full endorsement. The primary reasons for not endorsing this guideline included:

- Strong (category A) recommendations were made based on limited or insufficient evidence. None of the recommendations are based on high quality evidence.
- Due to the poor evidence base, the recommendations are generally consensus and therefore are "good practice points" rather than category A recommendations.
- The methodology included inconsistent inclusion and exclusion criteria.

Physicians may improve their care of patients with chronic pain by engaging in continuing medical education that provides practical integration of current CDC guideline and recommendations into their standards of care. The guideline helps providers make informed decisions about pain treatment for patients 18 and older in primary care settings. The recommendations focus on the use of opioids in treating chronic pain—pain lasting longer than three months or past the time of normal tissue healing. The guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

Key recommendations from the CDC guideline are as follows:[24,25]

- Nonpharmacologic and nonopioid pharmacologic therapies are preferred for chronic pain. Opioid therapy should be considered only when benefits for both pain and function are anticipated to outweigh the risks. If opioids are used, they should be combined with nonpharmacologic and nonopioid pharmacologic therapy as appropriate.
- Realistic treatment goals for pain and function should be established before initiation of opioid therapy. Opioid treatment should be continued only if there is meaningful improvement in pain and function that outweighs risk.
- When starting opioid therapy for chronic pain, the lowest effective dose of immediate-release opioids should be prescribed instead of extended-release/long-active (ER/LA) opioids.
- Benefits and risks should be reassessed when increasing dosages to ≥50 morphine milligram equivalents (MME)/day. Dosages ≥90 MME/day should be carefully justified or avoided if possible.
- For acute pain, the lowest effective dose of immediate-release opioids should be prescribed in no greater quantity than is needed for severe pain.
- Benefits and harms should be evaluated with patients within one to four weeks of initiating or escalating dose of opioids for chronic pain and at least every three months thereafter. If benefits do not outweigh the harms, a plan to taper opioids and optimize other therapies should be developed.
- Risk factors for opioid-related harms should be evaluated prior to initiation and periodically during treatment. Strategies to mitigate risk should be developed, including offering naloxone to those at increased risk for overdose.
- A patient's history of controlled substance prescriptions using a prescription drug monitoring program (PDMP). PDMP data should be reviewed when starting opioid therapy and periodically during treatment.
- Urine drug testing may be used prior to initiating opioid therapy and periodically during treatment to asses for controlled prescription medications as well as illicit drugs.
- Co-prescription of opioids and benzodiazepines should be avoided whenever possible.

- Evidence-based treatment including medication-assisted treatment with buprenorphine or methadone and behavioral therapies should be offered to patients with opioid use disorder.

Resources: Evidence-Based Practice Recommendations/Guidelines/Performance Measures

- Rational use of opioids for management of chronic nonterminal pain[1]
- CDC Guideline for Prescribing Opioids for Chronic Pain[25]
- AAFP Opioid Prescribing for Chronic Pain. Clinical Practice Guideline(s)[24]
- Clinical guidelines for the use of chronic opioid therapy in chronic non-cancer pain[26]
- Thinking on paper: documenting decision making[27]
- Engaging Patients in Collaborative Care Plans[28]
- A systematic approach to identifying drug-seeking patients[29]
- How to monitor opioid use for your patients with chronic pain[22]
- Integrating a behavioral health specialist into your practice[30]
- FamilyDoctor.org: Substance Abuse (patient resource)[31]
- FamilyDoctor.org: Opioid Addiction (patient resource)[32]

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