

**AMERICAN ACADEMY OF FAMILY PHYSICIANS  
PAIN MANAGEMENT AND OPIOID ABUSE:  
A Public Health Concern**

Position Paper  
EXECUTIVE SUMMARY

Statement of current status

Chronic nonmalignant pain is a health care condition that affects a significant number of Americans and is associated with significant morbidity. In addition to the physical discomfort, chronic pain causes significant work absenteeism, family disruption, and impairment of normal activities of daily living, resulting in secondary depression, social isolation, and low self-esteem among other consequences. As a result, chronic pain represents a significant public health issue with tremendous economic, social, and medical costs.

There has been a significant increase in the use of opioid analgesics for pain control. There is a corresponding growth in the rate of abuse, misuse, and overdose of these drugs.

Through advocacy, collaboration, and education, the American Academy of Family Physicians (AAFP) has been and is actively working toward a solution to America's pain management and opioid abuse epidemics.

The Food and Drug Administration (FDA) has tasked various stakeholders with developing a risk evaluation and mitigation strategy (REMS) to focus on the problem of misuse of long-acting and extended-release opioids. This process will include continuing medical education (CME) for prescribers. Congress has also proposed that this CME be made part of a mandatory requirement for Drug Enforcement Administration (DEA) certification and prescribing authority.

Many states have adopted model medical board prescribing policies, institution of prescription monitoring programs, guidelines about documentation requirements, and other measures.

Family physicians and other primary care clinicians play a vital role in effective pain management, including prescribing opioid analgesics. The creation of additional prescribing barriers for primary care physicians would limit patient access when there is a legitimate need for pain relief.

Recommendations

The AAFP remains dedicated to finding solutions to the crises of pain management care and opioid abuse. Some of the major recommendations follow:

**Advocacy**

- The AAFP urges all states to obtain physician input when considering pain management regulation and legislation.
- The AAFP urges all states to implement prescription drug monitoring programs and the interstate exchange of registry information as called for under the National All Schedules Prescription Electronic Reporting (NASPER) Act of 2005.

- The AAFP opposes mandated CME as a prerequisite to DEA or other licensure due to the limitations on patient access to legitimate pain management needs that may occur.
- The AAFP strongly advocates increased national funding to support research into evidence-based strategies for optimal pain management and their incorporation into the patient-centered medical home model.
- The AAFP urges all payers to recognize the increased visit requirements to perform the proper assessment and treatment of patients with chronic pain and calls for the appropriate payment for those services.

#### Clinical

- The AAFP views the goal of pain management to be primarily improvement and maintenance of function.
- The AAFP urges family physicians to individualize therapy based on review of the patient's potential risks, benefits, side effects, and functional assessments, and to monitor ongoing therapy accordingly.

#### Continuing education for family physicians

- The AAFP supports development of evidence-based physician education to ensure the safest and most effective use of long-acting and extended-release opioids, and to reduce the problem of opioid abuse.

#### Collaboration with other organizations

- The AAFP is hopeful to collaborate with The Partnership at Drugfree.org (formerly Partnership for a Drug-Free America) on projects aimed at patients and patient education .
- The AAFP will continue to work with appropriate government agencies, including the FDA, to ensure policies are in place to allow effective and safe opioid prescribing by family physicians for patients in their pain management programs. One such project is the FDA's Safe Use Initiative.
- The AAFP will form or join a coalition of medical organizations to address opioid management and abuse in a coordinated manner.
- The AAFP will work closely with its chapters to synergize efforts to assist members with opioid management and abuse.

## INTRODUCTION

Chronic nonmalignant pain is a health care condition that affects a significant number of Americans and is associated with significant morbidity. In addition to the physical discomfort, chronic pain causes significant work absenteeism, family disruption, and impairment of normal activities of daily living, resulting in secondary depression, social isolation, and low self-esteem among other consequences. As a result, chronic pain represents a substantial public health issue with tremendous economic, social, and medical costs. To address this issue, the American Academy of Family Physicians (AAFP) and other subspecialties have focused efforts on the improved function of patients with chronic pain.

Multiple modalities have been developed for the management of chronic pain, including procedural modalities; pharmacologic modalities; and adjunctive methods, such as acupuncture and relaxation training. Within the subset of pharmacologic modalities, there has been a rapid expansion in the prescribing of short-acting and long-acting opioids. Underlying the use of all of these and other modalities is the finding that there are few evidence-based guidelines regarding their use and efficacy.

As outlined below, the vast majority of patients with chronic pain initially consult their primary care physicians for treatment. The treatment strategy may ultimately involve subspecialists from various fields, but it is most often the primary care physician's responsibility to coordinate and manage that care, including the possible provision of opioid pain relievers. In view of the central role that family physicians play in the management of chronic nonmalignant pain, the AAFP has prepared the following background and recommendations for current activities and future efforts on this topic.

## BACKGROUND

At its July 20-23, 2011, meeting, the AAFP Board of Directors (BOD) considered a report regarding the Food and Drug Administration (FDA) requirements on opioids and the crises of opiate abuse and pain management. It also prepared *BOD Report O* for the 2011 Congress of Delegates, regarding the increasing public health crisis involving prescription drug abuse, as well as another crisis in the under treatment of patients with pain. [1] The AAFP has been active for some time in addressing these issues in the area of opioid abuse and pain management, and now, further addressing these topics as critical public health concerns. The BOD tasked the Commission on Health of the Public and Science to develop a comprehensive strategy for pain management and public health.

Over the past two decades, family physicians have recognized that there has been an increased emphasis on the recognition of pain and the lack of adequate pain care. The U.S. Congress, in response to the efforts of various advocacy groups, declared the Decade of Pain Control and Research, beginning on January 1, 2001, to address the issue. [2] Numerous professional organizations, including the American Academy of Pain Medicine, the American Pain Society, the American Headache Society, and others, were founded to improve pain care, increase research into pain and its management, and improve the training of physicians who manage pain. [3] The amount of research devoted to pain has grown significantly; the number of articles published with the keyword *pain* increased from approximately 30,000 between 1970 and 1979 to over 100,000 between 1990 and 1999. [4] In response to this attention, Congress again responded with the introduction of the National Pain Care Policy Act of 2009. This act called for the establishment of an Institute of Medicine (IOM) conference on pain care, promoted pain care research and the education of health care professionals, promoted a public awareness campaign, and called for the coordination of those efforts under the Department of Health and Human Services. [5] In response to that directive, the IOM produced its report, *Relieving Pain in America*, which called for a population-based strategy for reducing pain and its consequences, improved data collection about pain, improved educational opportunities for pain assessment and management in primary care, and improved collaboration between primary care physicians and subspecialists regarding pain patients. [6]

Concurrent with the increased emphasis on pain management has been a significant increase in the number of prescriptions written for opioid pain relievers. According to government statistics, sales of opioid pain relievers quadrupled between 1999 and 2010. [7] Enough opioid pain relievers were prescribed in 2010 to medicate every American adult with a dose of 5 mg of hydrocodone every 4 hours for 1 month. [7] It is estimated that 60 million Americans have some type of chronic nonmalignant pain. [8, 9] In spite of the large numbers of opioid pain relievers prescribed, it is estimated that 40% of patients with chronic pain do not to achieve adequate pain relief. [8, 10] The annual cost associated with all types of pain, both direct and indirect costs, is estimated to be in the range of \$560 to \$635 billion annually in the United States. [11]

In spite of the large number of prescriptions written for opioid pain relievers, significant disparities exist in the prescribing of those drugs. Various studies have indicated significant differences in analgesic administration; factors influencing prescribing practices include race/ethnicity in emergency pain care, [12, 13] chronic nonmalignant pain, [14, 15, and 16] and older adults with chronic pain. [17, 18] Underscoring those disparities in opioid prescribing is the fact that the majority of opioid prescriptions for these and other pain conditions are written by primary care physicians. [19]

## MISUSE AND OVERDOSE OF OPIOIDS

The use of prescription pain relievers for nonmedical purposes (without a prescription) is now the second most common form of drug abuse, exceeded only by marijuana use. [20] The most recent statistics indicate that in 2007, an estimated 5.2 million individuals older than 12 years reported nonmedical use of prescription pain relievers during the preceding month (2.1% of the general population, unchanged from 2002). [21] Further analysis of those numbers reveals a decrease in the percentage of youths between the ages of 12 and 17 years using pain relievers for nonmedical purposes (from 3.2% in 2002 to 2.7% in 2007). However, usage has increased among young adults ages 18 to 25 years (from 4.1% in 2002 to 4.6% in 2007) and adults 26 years and older (from 1.3 % in 2002 to 1.6% in 2007). [21] When analyzed by gender, the nonmedical use of pain relievers by males 12 years and older increased (from 2.0% in 2002 to 2.6% in 2007), with use by females in the same age group remaining about the same (from 1.7% in 2002 to 1.9% in 2007). [21] In a review of the sources of those prescription pain relievers taken for nonmedical use, 56.5% of individuals 12 years and older stated that they had obtained the drugs from a friend or relative for free; 8.9% bought them from a friend or relative; and 5.2% stated that they had stolen the drugs from a friend or relative. Additionally, 18.1% of all opioid pain relievers diverted for nonmedical use were acquired during a visit to a physician's office; 4.1% reported buying from a drug dealer or stranger; and 0.5% reported buying the drugs from the Internet. [20]

In 2009, there were an estimated 1.1 million emergency department (ED) visits for nonmedical use of prescription drugs, over-the-counter drugs, or other pharmaceuticals. [22] Over half (53.6%) of the ED visits for nonmedical use of prescription drugs involved multiple drugs, and almost one-fifth (17.8%) also involved alcohol. [22] Of the ED visits for nonmedical use of drugs, the majority involved opioid pain relievers (47.8%), including oxycodone (13.7%), hydrocodone (8.0%), and methadone (5.85). [22] When analyzed by age, there was no appreciable difference between gender (349.2 ED visits per 100,000 males and 354.0 ED visits per 100,000 females). [22] There were substantial differences in race/ethnicity when ED visits for nonmedical use of pharmaceuticals were analyzed, with white individuals accounting for 71.6% of ED visits, blacks accounting for 10.9%, and Hispanics accounting for 9.2%. [22]

Mortality data presented in the Centers for Disease Control and Prevention's (CDC) November 4, 2011, *Morbidity and Mortality Weekly Report*, "Vital Signs: Overdoses of Prescription Opioid Pain Relievers—United States, 1999-2008," revealed that there were an estimated 36,450 deaths in the United States secondary to a drug overdose, with a drug specified in 27,153 (74.5%) of those deaths. Prescription drugs were involved in 20,044 (73.8%) of those deaths, with opioid pain relievers involved in 14,800 (73.8%) of the deaths. [7] Review of that data by race/ethnicity revealed that the death rate among non-Hispanic whites and American Indians/Alaska Natives was three times higher than the rates among blacks and Hispanic whites. [7] Analysis of the data also revealed that the overdose rate from opioid pain relievers rose fourfold from 1999 to 2008, which also paralleled a fourfold increase in the sale of

these drugs during the same period. [7] Mortality rates were also positively linked with poverty levels, with some of the greatest mortality increases occurring in those states with some of the highest poverty levels among non-Hispanic whites. [7] Rural and impoverished counties in all states tended to have higher prescription drug overdose rates. [23] Medicaid enrollees, as a whole, are at a higher risk of overdose. [24] The AAFP has been monitoring, and continues to monitor, the data on morbidity and mortality as it is published.

### Risk Evaluation and Mitigation Strategy

The Food and Drug Administration Amendments Act of 2007, [25] gave the FDA the authority to require manufacturers to develop risk evaluation and mitigation strategies (REMSs) for products under review. In response to the increasing problem of opioid misuse and overdose, in February 2009, the FDA sent letters to the manufacturers of various long-acting and extended-release opioids asking them to develop a REMS to address the problem. [26] In a follow-up to that process, the FDA, in conjunction with the Office of National Drug Control Policy, issued a directive in April 2011 requiring stakeholders to develop comprehensive REMSs within 120 days to address those concerns. [27] As part of that REMS, manufacturers were asked to financially support the development of continuing education (CE) by accredited continuing medical education (CME)/CE provider organizations to be offered on a voluntary basis to the prescribers of these products. This education would cover such areas as the risks versus benefits of opioids; appropriate patient selection; counseling on the safe use of these drugs; recognizing misuse, abuse, and addiction; and proper monitoring of patients. [28]

During that same period, a bill was introduced in Congress (S. 507 by Sen. Jay Rockefeller) to change the voluntary aspect of CME to a mandatory 16 hours of training every 3 years to obtain Drug Enforcement Administration (DEA) certification to prescribe these drugs. This training would require education in the treatment and management of opioid-dependent patients, pain management guidelines, and early detection of opioid addiction. (The bill was read twice and referred to committee.) [29] In May 2012, Sen. Charles Grassley sent a letter to companies that produce opioids, along with other organizations, including the Federation of State Medical Boards (FSMB) and the Center for Practical Bioethics, requesting them to disclose their relationships with the pharmaceutical industry.

The AAFP has been aggressive in the area of REMS and has been actively engaged with the FDA and the Industry Working Group (IWG), a consortium of the 22 branded and generic pharmaceutical companies that have been asked by the FDA to organize and develop a proposal for a single, class-wide REMS to address the REMS CME/CE issue. The AAFP has also worked closely with other CME/CE accreditors, including the Accreditation Council for Continuing Medical Education (ACCME), to ensure that the guidelines put in place align with AAFP CME credit criteria and the ACCME Standards for Commercial Support. All organizations involved in accredited and certified CME in the United States have adopted and operate under the strict firewalls promulgated, monitored, and enforced through the ACCME's *Standards for Commercial Support: Standards to Ensure Independence in CME Activities*, <http://www.accme.org/requirements/accreditation-requirements-cme-physicians/standards-for-commercial-support>, to which the entire profession of medicine adheres. In addition, the AAFP has provided significant input into the formation of the FDA's *Blueprint for Prescriber Continuing Education Program* (Blueprint) to ensure it provides the opportunity to deliver education that best supports learners' needs and is compliant with the guidelines governing CME. The Blueprint can be found at <http://www.fda.gov/downloads/drugs/drugsafety/informationbydrugclass/ucm277916.pdf>. Additionally, AAFP chapters have engaged in supporting this initiative. The California Academy of Family

Physicians (CAFP) and its staff have been involved in the development of the final REMS directive to ensure that family medicine is represented in that process. The CAFP is also collaborating with the American Pain Society and other membership societies in the Collaborative for REMS Education (CO\*RE) in preparation for the educational component of the REMS. [30]

On July 7, 2012, the FDA released the final REMS for Extended Release/Long Acting Opioids including a Prescriber Education Program. The Risk Evaluation and Mitigation Program Agreement Committee (RPC), formerly known as the IWG, will provide oversight to the call for grant process for REMS CME/CE. As an accreditor of CME, the AAFP is implementing guidelines and processes to review, certify and track REMS CME/CE activities. The AAFP, as a provider of CME, is currently developing CME to align with the FDA Blueprint of the Prescriber Education Program and support members' continuing professional development.

### FEDERAL DEA REGISTRATION

Current federal DEA registration primarily involves the submission of practice-identifying data, completion of licensure and any revocation data, submission of any state controlled substance licensure data, designation of drug schedules requested, and signatures and payment of the appropriate fees. There is currently no federal DEA requirement for submission of any CME/training required for narcotic prescribing authority other than individual state requirements for prescribing authority. Current federal DEA certificates are valid for 3 years and must be kept at the registered location and be readily retrievable for inspection purposes. [31] DEA certification is required for a physician to prescribe a wide spectrum of other drugs in addition to opioids, including drugs for anxiety, insomnia, and other health conditions. Should voluntary education not improve the current crisis associated with opioid prescribing, there is current legislation that could mandate this, which would have significant impact on family physicians and the patients they serve. The AAFP has been very vocal on this issue in multiple meetings with federal officials, both legislative and administrative, as well as with medical organizations. The AAFP's policy is against mandated CME as a condition for prescribing specific drugs. The AAFP also has a policy that opposes any actions that limit patient access to physician-prescribed drugs, as well as any industry or regulatory action that would have the effect of limiting by specialty the use of any pharmaceutical product. [1]

### STATE MEDICAL BOARD PRESCRIBING GUIDELINES

The FSMB in 2004 issued a model policy for the various state boards to use in the development of controlled substances prescribing policies. Under that model policy, the FSMB outlined several suggested criteria addressing [32]:

- The evaluation of the patient
- Documentation of a written treatment plan
- Use of informed consent and written patient agreements
- Suggested elements of periodic review
- Use of appropriate consultants
- Appropriate recordkeeping
- Compliance with any appropriate federal and state controlled substance prescribing and dispensing policies

Many of the state medical boards have adopted aspects of this model policy with additional licensing/prescribing laws as passed by the state legislatures. For example, 37 out of 50 states have now

adopted/are adopting/have implemented prescription drug monitoring programs (PDMPs), [33] implemented in part by grant funding through the National All Schedules Prescription Reporting (NASPER) Act of 2005. [34] Many states have adopted wording that [33]:

- Limits the prescribing of controlled substances for self-use or family members
- Specifies required recordkeeping of the scheduled drugs prescribed
- Outlines what scheduled drugs can be called into pharmacies
- Specifies what aspects of a visit must be documented as part of an encounter for controlled substances
- Limits the amount of drugs (particularly schedule II) that can be prescribed at one time
- Specifies the characteristics of the prescription pad, etc.

Many state governments have recently passed some of these changes to their prescribing laws or are considering changes to those laws, according to a recent informal survey of chapter executives. Currently, several states have implemented policies calling for mandatory CME that physicians must complete prior to obtaining prescribing privileges for controlled drugs. The American Medical Association (AMA) maintains a list of state-mandated CME requirements for MD and DO licensure that can be accessed at the website listed in the *References*. [35]

## CURRENT PAIN MANAGEMENT TRAINING FOR FAMILY PHYSICIANS

The AAFP, 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), has developed a suggested guideline to teach residents how to care for patients with chronic pain. Skills include [36]:

- Understanding the pathophysiology of chronic pain
- Evaluating a patient's opioid abuse risk utilizing risk assessment tools
- Establishing opioid contracts with patients
- Interpreting urine toxicology screens
- Performing chart reviews and adjusting treatment plans based on those reviews
- Treating and monitoring patients at high risk of abuse
- Prescribing narcotic alternatives
- Performing selected joint injections

The American Board of Family Medicine (ABFM), through its maintenance of certification process, currently offers a self-assessment module (SAM) in pain management as an option along with other clinical topics, but it is not a required module. The ABFM does not offer a certificate of added qualifications (CAQ) in pain medicine but does offer one in hospice and palliative medicine. [37]

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 in the dual role the AAFP plays in the CME community as an accredited CME provider organization and more importantly, as the first of the three national standard-setting, credit-granting credit systems.

The AAFP CME accrediting system reviews CME activities developed by other CME provider organizations, including member chapters, to award AAFP Prescribed and Elective CME credit. Activities submitted for review by the credit system include the topic of pain. As an accreditor of certified CME, the AAFP has also actively worked with the other CME and CE credit systems to ensure that certified

CME can be a solution for the FDA REMS CME/CE requirement. To support this initiative, REMS CME/CE must be compliant with all current CME guidelines. The content of the REMS-compliant training will be based on the learning objectives established by the FDA in its Blueprint *for the extended-release/long-acting opioid class-wide REMS*. The Blueprint contains core messages to be conveyed to prescribers regarding the risks and appropriate prescribing practices for the safe use of extended-release and long-acting opioids. It is outlined that the education developed will be provided to licensed prescribers by an accredited provider, include all elements of the Blueprint, include a post-course knowledge assessment of all of the sections of the Blueprint, and be subject to independent audit to confirm that conditions of the REMS training have been met.

In addition to its involvement with the FDA and IWG, the AAFP has developed multiple certified CME activities to address the topic of pain for its members. These CME activities are available in live, online, and enduring formats, and will also be integrated at the AAFP Scientific Assembly. The AAFP plans to continue to support family physicians to enhance their knowledge, competence, and performance when treating patients with pain; it will also continue to provide CME to address the abuse, misuse, and safety of opioid prescribing. The AAFP's CME aligns with the accreditation criteria of the AAFP as well as with the ACCME Essential Areas and Their Elements and the ACCME Standards for Commercial Support. In the near future, the AAFP will develop additional CME activities to align with the FDA's Blueprint. Family physicians and constituent chapters need access to CE resources on opioid abuse and pain management.

## CURRENT PRESCRIBING CONCERNS

The issue of opioid prescribing remains contentious for most family physicians, including those in training. Studies have indicated that primary care physician attitudes regarding patients with chronic pain are often negative, [38] with such attitudes forming as early as medical school [39] and subsequently reinforced during residency training. [40] The reasons for the development of negative attitudes are complex, including:

- Difficult patient interactions [41]
- Concerns about opioid prescribing, including addiction
- Diversion and regulatory scrutiny [40]
- Coexistent psychiatric morbidities among these patients [40]
- Concerns about the time-consuming nature of care for these patients [40]
- Compliance issues [43]

Concerns such as these have affected the willingness of physicians to prescribe opioids for chronic pain; one study reported that over one-third of physicians were unwilling to prescribe long-term opioids. [38]

To improve the management of chronic pain in patients by physicians in training, a recent study reviewed the management of those patients cared for in a family medicine pain clinic utilizing various attributes of the patient-centered medical home (PCMH) model within the confines of the larger practice. For the study period reported, overall resident attitudes regarding the care of patients with chronic pain improved after participation in the departmental pain clinic. [43]

To improve the treatment of patients with chronic pain, a chronic care model [44] has been proposed as a mechanism to accomplish that goal. [45] This model would draw on various components of care such as self-management support, clinical information systems, community resources, decision support, delivery system redesign, and other measures [44] to improve the quality of care given to patients with



chronic pain and improve physician satisfaction. The IOM, in its report about chronic pain management, has called for a tailored approach to pain care, utilizing patient self-management strategies, primary care, specialty care, and pain centers [6]; but the IOM also acknowledges that most pain care should be provided by primary care physicians, including teams of physicians organized into medical homes. [46] To improve the delivery of chronic pain care, various professional organizations and institutions have now proposed that practice care guidelines be implemented for use by those who provide care for patients with chronic pain. [45,47]

## GUIDELINES

In response to the need for improved prescribing, treatment guidelines have recently been issued regarding opioid prescribing for chronic noncancerous pain. Some of these guidelines include comprehensive care recommendations for chronic pain management and prescribing, [48,49,50,51,52,53,54] whereas other guidelines are focused more on procedural aspects of chronic pain management. [55] *American Family Physician* published a tool in 2009 [56] which was based on the recommendations from the joint guidelines issued by the American Pain Society and the American Academy of Pain Medicine in that same year. [48] It is anticipated that guideline updates and other guidelines will follow, some addressing general pain management, whereas others will be more focused, addressing particular pain syndromes or presentations.

In a review of the currently available guidelines, it was noted that the guidelines share many common characteristics. Most guidelines typically start with a review of the current statistics about drug usage, a review of the pharmacology of opioid analgesics, and a review of the signs and symptoms of overdose. Most guidelines then include tools for assessing a patient's medical history/current health status for patterns of substance abuse and psychiatric comorbidities; consent tools and recommendations for opioid prescribing; patient/physician contracts outlining the terms of opioid prescribing by the physician; tools for monitoring patient success with therapy; and information about urine drug screening. A few guidelines contain decision trees referencing pain management strategies other than opioid pain relievers, although information about opioid prescribing is included in subsequent sections. Other information (i.e., patient educational materials) is included based on the patient population that the guideline is designed to address or the physician group that will be utilizing the guideline. On review of these guidelines by the AAFP, it is noted that there are limitations to all current guidelines, because they do not follow a rigorous, evidence-based methodology in assessing the strength of their recommendations with the level of evidence. More research is needed to determine evidence-based pain management strategies. As such, it must be recognized that pain management, generally, and the use of opioid pain relievers, specifically, to treat chronic pain, remain very much an art as well as a science.

## SUMMARY

In summary, the following points are to be taken from a review of this document:

- Through advocacy, collaboration, and education, the AAFP has been and is actively working toward a solution to America's pain management and opioid abuse epidemics.
- The FDA, through the Food and Drug Administration Amendments Act of 2007, has tasked various stakeholders with developing a (REMS) to focus on the problem of misuse of long-acting and extended-release opioids. The FDA has proposed that this process include CME for

prescribers of these drugs; Congress has also proposed that this CME be made part of a mandatory requirement for DEA certification and prescribing authority.

- Many states have started their own efforts to control the problem of opioid misuse, including adoption of model medical board prescribing policies, institution of prescription monitoring programs, guidelines about documentation requirements, and other measures.
- A growing percentage of the US population utilizes opioid analgesics for pain control, which has been accompanied by a corresponding growth in the rate of abuse, misuse, and overdose of these drugs.
- Family physicians and other primary care clinicians play a vital role in effective pain management, including the prescribing of opioid analgesics, for large segments of the population in the United States. This role is tempered by many factors that affect the prescribing habits of primary care physicians. The creation of additional prescribing barriers for primary care physicians would limit patient access when there is a legitimate need for pain relief.
- Various professional societies/organizations have developed/are developing prescribing guidelines for physicians to use in the care of patients with chronic noncancer pain.

The AAFP will continue to be an active participant in this issue and advocate the following regarding pain management and opioid abuse:

- The AAFP views the goal of pain management to be primarily improvement and maintenance of function.
- The AAFP remains dedicated to finding solutions to the crises of pain management care and opioid abuse.
- The AAFP will take actions to develop solutions for its members, including development of evidence-based CE and provision of helpful resources.
- The AAFP recognizes the need for evidence-based physician education to ensure the safest and most effective use of long-acting and extended-release opioids.
- The AAFP will continue to offer CME topics on pain management and, in conjunction with other key organizations, will offer CME related to REMS and opioid abuse.
- Pending funding, the AAFP will develop a CME webinar based on the needs of its members and constituent chapters regarding pain management and opioid prescribing.
- The AAFP opposes mandated CME as a prerequisite to DEA or other licensure due to the limitations on patient access to legitimate pain management and other clinical needs that may occur. The AAFP recognizes the role industry can play in financially supporting REMS CE that is aligned with the AAFP CME credit system requirements and the ACCME activities focused on safely prescribing of opioid analgesics.
- The AAFP will have a topic section on its webpage for pain management under the Public Health section within the Clinical & Research page.
- The AAFP's publication, *American Family Physician*, has an article planned on this topic, which will be added to an online module on chronic pain in "AFP by Topic."
- The AAFP will maintain topics on pain management within its patient education site, [familydoctor.org](http://familydoctor.org).
- The AAFP is hopeful to collaborate with The Partnership at Drugfree.org (formerly Partnership for a Drug-Free America) on projects aimed at patients and patient education.
- The AAFP will continue to work with appropriate government entities, including the FDA, to ensure policies are in place to allow effective and safe opioid prescribing by family physicians for patients in their pain management programs. One such project is the FDA's Safe Use Initiative.

- The AAFP urges its members who prescribe opioid analgesics to individualize therapy based on review of the patient’s potential risks, benefits, side effects, and functional assessments, and to monitor ongoing therapy accordingly.
- The AAFP views the solutions to the problems of analgesic overdose, suicide, and diversion to be broadly based. Those solutions require collaboration among multiple entities, drawing on representation from the medical, educational, public health, judicial, pharmacy, and public sectors in our communities.
- The AAFP urges all states to implement PDMPs and the interstate exchange of registry information as called for under the NASPER Act of 2005.
- The AAFP urges medical schools and family medicine residency programs to provide instruction in the use of multimodal pain management strategies and to include safe prescribing practices for opioid analgesics as one component of a comprehensive pain management plan.
- The AAFP strongly advocates increased national funding to support research into evidence-based strategies for optimal pain management and their incorporation into the PCMH model.
- The AAFP urges all states to obtain physician input when considering pain management regulation and legislation.
- The AAFP will seek to work with constituent chapters to compile CME resources.
- The AAFP urges all payers to recognize the increased visit requirements to perform the proper assessment and treatment of patients with chronic pain and calls for the appropriate payment for those services.

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