- Arizona Center for Rural Health
- State Office of Rural Health Webinar Series

THE UNIVERSITY OF ARIZONA
MEL & ENID ZUCKERMAN COLLEGE OF PUBLIC HEALTH
Center for Rural Health

- Webinar Notes:

- Audience is muted during the presentation.
- Please enter your questions into the chat box.
- You will receive an email post webinar with a survey link and the link to the recorded webinar.

LAND ACKNOWLEDGEMENT

We respectfully acknowledge the University of Arizona is on the land and territories of Indigenous peoples. Today, Arizona is home to 22 federally recognized tribes, with Tucson being home to the O'odham and the Yaqui. Committed to diversity and inclusion, the University strives to build sustainable relationships with sovereign Native Nations and Indigenous communities through education offerings, partnerships, and community service.

Jason Gillette, CEO of Guild Health Group
and
Mark P. Martz, Founder and CEO of Martz & Associates

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Learning Objectives

- Become familiar with the 2022 Clinical Practice Guideline for Prescribing Opioids
- Learn how prescribers and public health professionals can utilize the Guideline within a rural setting
- Learn ways practitioners can integrate the Guideline into their practice EHR, policies, and workflows

Disclaimer

We do not have any conflicts or financial interests to disclose.

We are not licensed medical professionals. Information presented in this webinar is for educational purposes only and not to be used to diagnose or treat medical conditions.

For Today, We will…

- Cover a brief history of the Guideline
- Present the national and Arizona context
- Utilizing the Guideline within a rural setting
- Discuss integrating the Guideline with an EHR workflow-CSPMP
- Open discussion

Our Perspective

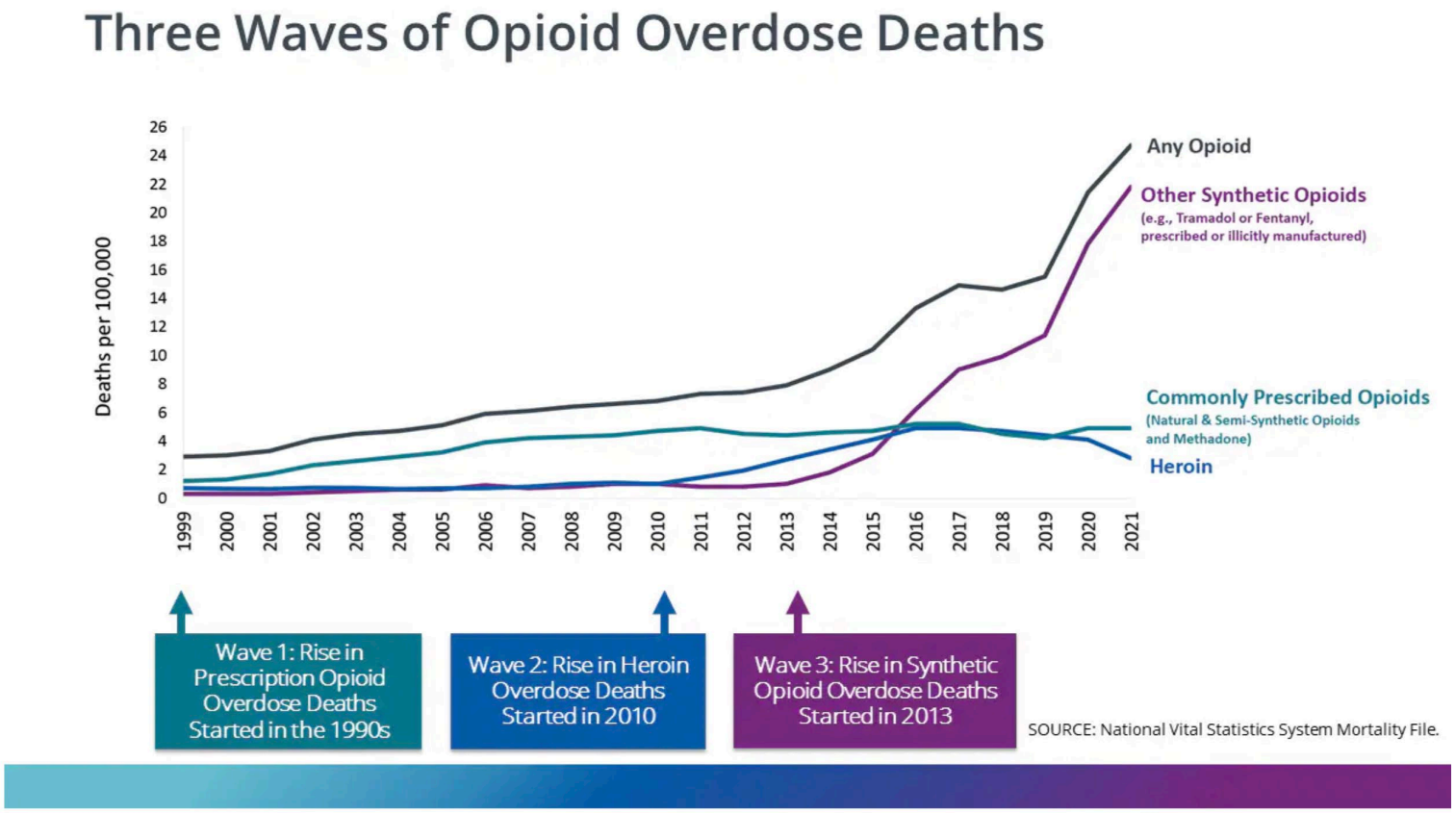
- As public health professionals…
- Through the lens of the 10 Essential Services
- What is our golden thread….
- Mindful thinking and planning…
- Operationalize into action, evolve and sustain over time

Guideline in a Rural Context - 10 Essential Public Health Services Framework

History of the Guideline

A cursory look

National Evolution of the Opioid Epidemic

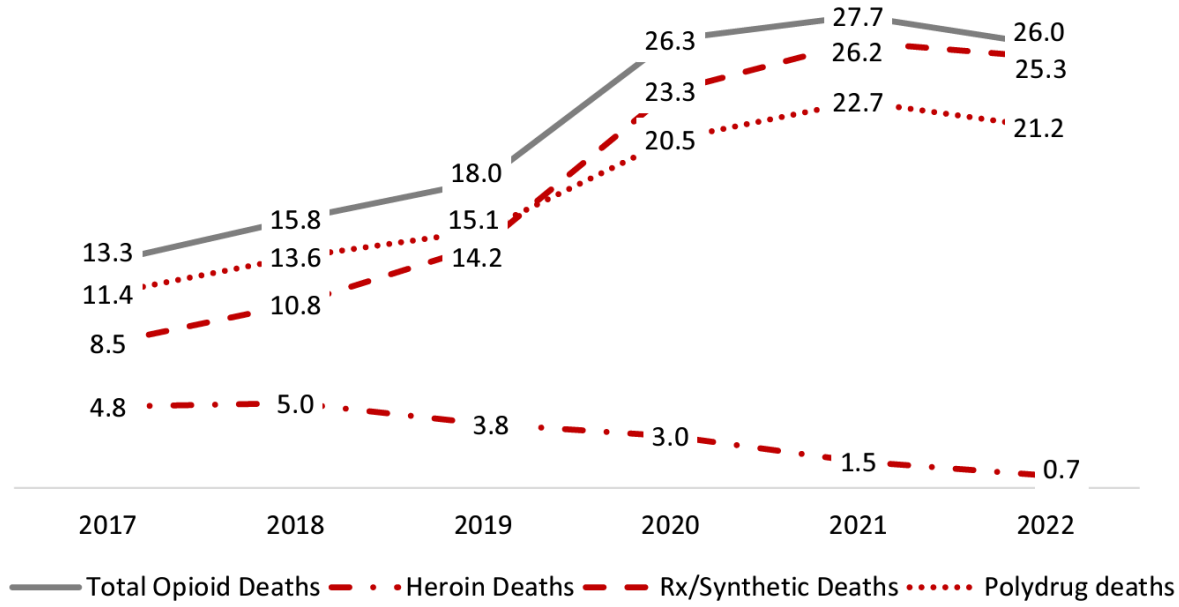


This rise in opioid overdose deaths is shown in three distinct waves.

https://www.cdc.gov/overdose-prevention/about/understanding-the-opioid-overdose-epidemic.html

Arizona Evolution of the Opioid Epidemic

Figure 17. Opioid Overdose Fatality Rate per 100,000 Population, Arizona, 2017-2022 (n=9,171)



Data Source: Arizona Vital Statistics, Death Certificates. Notes - Heroin: Opioid deaths involving heroin (T40.1); Rx/Synthetic: Opioid deaths involving all "other opioids" except heroin (T40.2, T40.3, T40.4, and T40.6); Polydrug: Opioid deaths involving opioids in combination with other non-opioid substances. All polydrug deaths are also counted in either the Heroin or Rx/Synthetic Drug Category.

Tasnim L. Annual Report on Opioid Overdoses in Arizona, 2022. Phoenix, AZ. Arizona Department of Health Services; 2023.

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

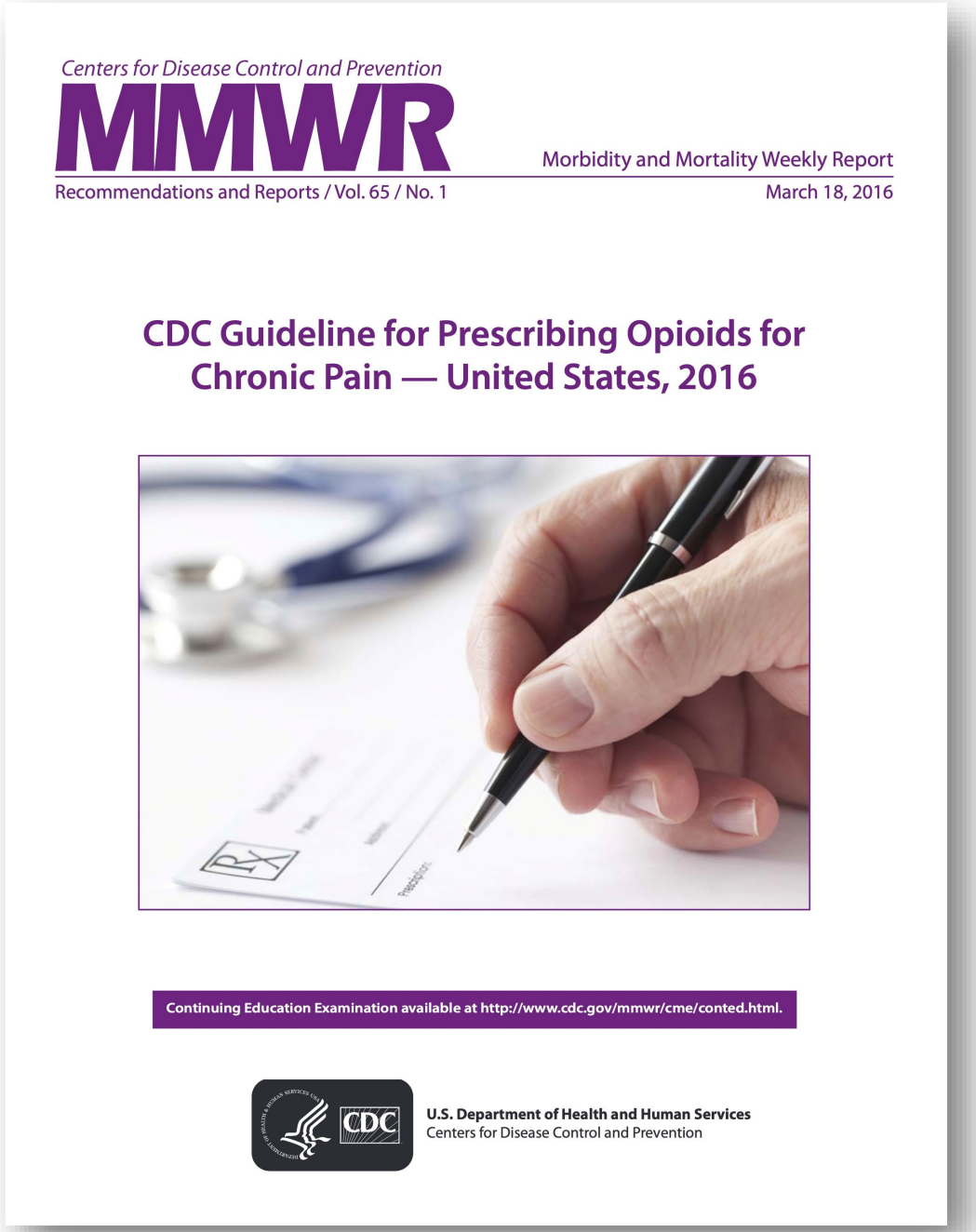
12 Recommendations

3 Categories

Category A recommendation

Category B recommendation

Evidence: Type 1, Type 2, Type 3, Type 4

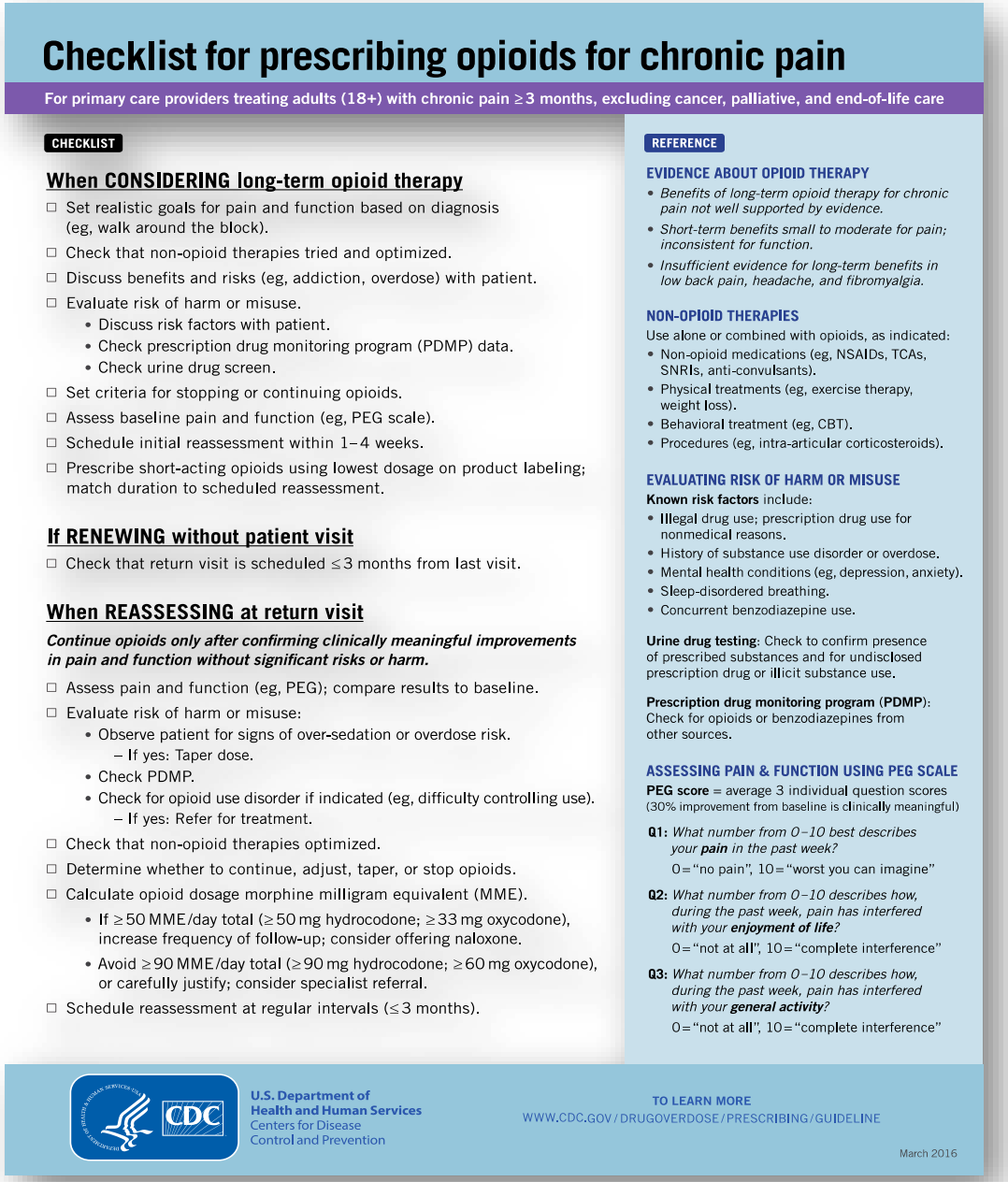


https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

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

Checklist:

https://stacks.cdc.gov/view/cdc/38025



Checklist for prescribing opioids for chronic pain

For primary care providers treating adults (18+) with chronic pain ≥3 months, excluding cancer, palliative, and end-of-life care

CHECKLIST

When CONSIDERING long-term opioid therapy

- ☐ Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- ☐ Check that non-opioid therapies tried and optimized.
- ☐ Discuss benefits and risks (eg, addiction, overdose) with patient.
- ☐ Evaluate risk of harm or misuse.
  - Discuss risk factors with patient.
  - Check prescription drug monitoring program (PDMP) data.
  - Check urine drug screen.
- ☐ Set criteria for stopping or continuing opioids.
- ☐ Assess baseline pain and function (eg, PEG scale).
- ☐ Schedule initial reassessment within 1–4 weeks.
- ☐ Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

If RENEWING without patient visit

- ☐ Check that return visit is scheduled ≤3 months from last visit.

When REASSESSING at return visit

Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.

- ☐ Assess pain and function (eg, PEG); compare results to baseline.
- ☐ Evaluate risk of harm or misuse:
  - Observe patient for signs of over-sedation or overdose risk.
    - If yes: Taper dose.
  - Check PDMP.
  - Check for opioid use disorder if indicated (eg, difficulty controlling use).
    - If yes: Refer for treatment.
- ☐ Check that non-opioid therapies optimized.
- ☐ Determine whether to continue, adjust, taper, or stop opioids.
- ☐ Calculate opioid dosage morphine milligram equivalent (MME).
  - If ≥50 MME/day total (≥50 mg hydrocodone; ≥33 mg oxycodone), increase frequency of follow-up; consider offering naloxone.
  - Avoid ≥90 MME/day total (≥90 mg hydrocodone; ≥60 mg oxycodone), or carefully justify; consider specialist referral.
- ☐ Schedule reassessment at regular intervals (≤3 months).

REFERENCE

EVIDENCE ABOUT OPIOID THERAPY

- *Benefits of long-term opioid therapy for chronic pain not well supported by evidence.*
- *Short-term benefits small to moderate for pain; inconsistent for function.*
- *Insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.*

NON-OPIOID THERAPIES

Use alone or combined with opioids, as indicated:

- Non-opioid medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants).
- Physical treatments (eg, exercise therapy, weight loss).
- Behavioral treatment (eg, CBT).
- Procedures (eg, intra-articular corticosteroids).

EVALUATING RISK OF HARM OR MISUSE

Known risk factors include:

- Illegal drug use; prescription drug use for nonmedical reasons.
- History of substance use disorder or overdose.
- Mental health conditions (eg, depression, anxiety).
- Sleep-disordered breathing.
- Concurrent benzodiazepine use.

Urine drug testing: Check to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.

Prescription drug monitoring program (PDMP): Check for opioids or benzodiazepines from other sources.

ASSESSING PAIN & FUNCTION USING PEG SCALE

PEG score = average 3 individual question scores (30% improvement from baseline is clinically meaningful)

Q1: *What number from 0–10 best describes your **pain** in the past week?*
0="no pain", 10="worst you can imagine"

Q2: *What number from 0–10 describes how, during the past week, pain has interfered with your **enjoyment of life**?*
0="not at all", 10="complete interference"

Q3: *What number from 0–10 describes how, during the past week, pain has interfered with your **general activity**?*
0="not at all", 10="complete interference"

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

TO LEARN MORE
WWW.CDC.GOV/DRUGOVERDOSE/PRESCRIBING/GUIDELINE

March 2016

CDC Clinical Practice Guideline for Prescribing Opioids for Pain - United States, 2022

Updates 2016 guideline

"Clinicians providing pain care ***and*** those prescribing opioids for outpatients 18 and older…"

Includes recommendations for managing ***acute*** (duration of <1 month), ***subacute*** (duration of 1–3 months), and ***chronic*** (duration of >3 months) pain

A clinical tool to improve communication between clinicians and patients and empower them to make informed, person-centered decisions related to pain care together

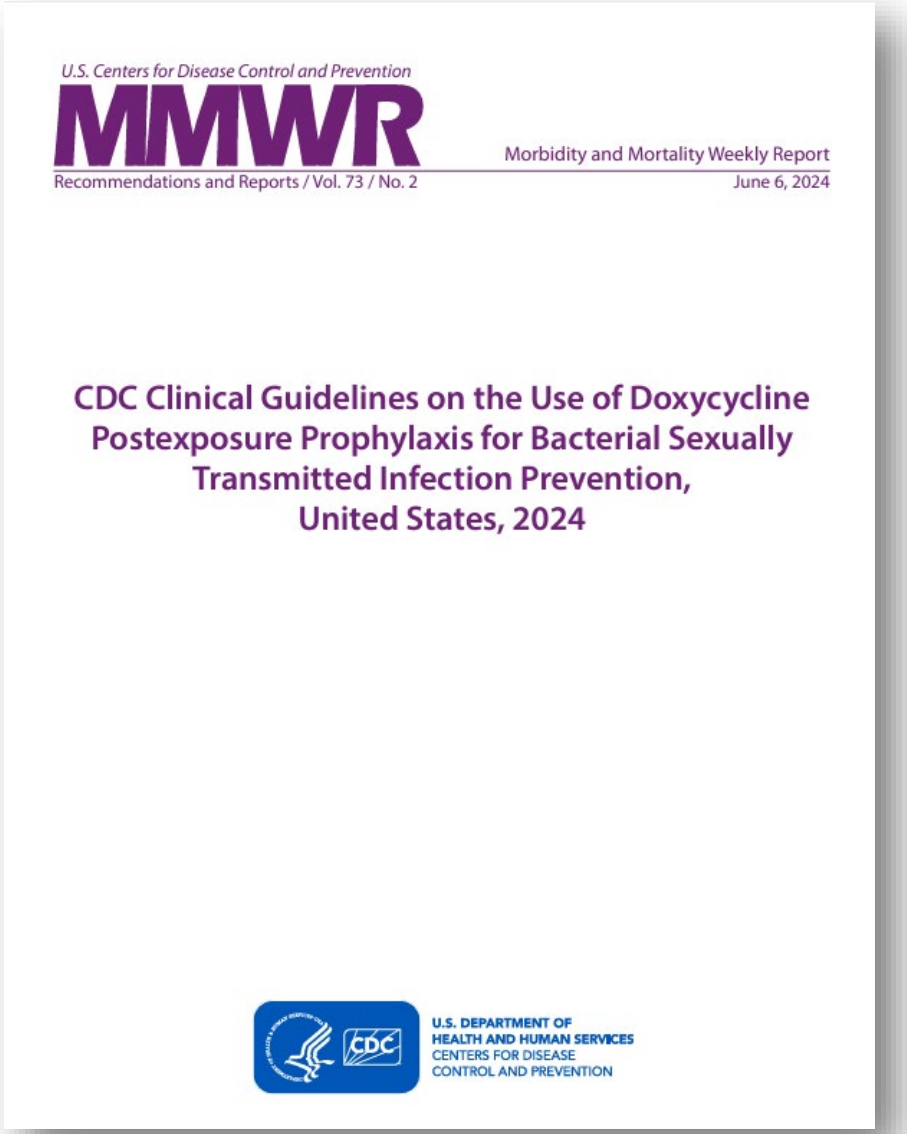
4 Key Areas

1) determining whether or not to initiate opioids for pain

2) selecting opioids and determining opioid dosages

3) deciding duration of initial opioid prescription and conducting follow-up, and

4) assessing risk and addressing potential harms of opioid use



https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm?s_cid=rr7103a1_w

CDC Clinical Practice Guideline for Prescribing Opioids for Pain - United States, 2016/2022

Examples of similarities between 2016 and 2022 guideline

- GRADE and systematic review of the current literature, experts, peers, and public comment
- 12 guideline Category A and B, Type 1 through Type 4 evidence
- Not to replace or supplant clinical judgement

Examples of differences between 2016 and 2022 guideline

- Changes in some Category A and Category B classifications
- Changes in Evidence Type (1 through 4) to support recommendations

https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm?s_cid=rr7103a1_w

CDC Clinical Practice Guideline for Prescribing Opioids for Pain - United States, 2022

12 Recommendations

Determining Whether or Not to Initiate Opioids for Pain (Recommendations 1 and 2)

1. **Nonopioid therapies are at least as effective as opioids** for many common types of acute pain. Clinicians should maximize use of nonpharmacologic and nonopioid pharmacologic therapies as appropriate for the specific condition and patient and only consider opioid therapy for acute pain if benefits are anticipated to outweigh risks to the patient. Before prescribing opioid therapy for acute pain, clinicians should discuss with patients the realistic benefits and known risks of opioid therapy (recommendation category: B; evidence type: 3).

2. **Nonopioid therapies are preferred for subacute and chronic pain.** Clinicians should maximize use of nonpharmacologic and nonopioid pharmacologic therapies as appropriate for the specific condition and patient and only consider initiating opioid therapy if expected benefits for pain and function are anticipated to outweigh risks to the patient. Before starting opioid therapy for subacute or chronic pain, clinicians should discuss with patients the realistic benefits and known risks of opioid therapy, should work with patients to establish treatment goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks

Selecting Opioids and Determining Opioid Dosages (Recommendations 3, 4, and 5)

3. **When starting opioid therapy for acute, subacute, or chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release and long-acting** (ER/LA) opioids (recommendation category: A; evidence type: 4).

4. When opioids are initiated for opioid-naïve patients with acute, subacute, or chronic pain, **clinicians should prescribe the lowest effective dosage.** If opioids are continued for subacute or chronic pain, clinicians should use caution when prescribing opioids at any dosage, should carefully evaluate individual benefits and risks when considering increasing dosage, and should avoid increasing dosage above levels likely to yield diminishing returns in benefits relative to risks to patients (recommendation category: A; evidence type: 3).

5. For patients already receiving opioid therapy, **clinicians should carefully weigh benefits and risks and exercise care when changing opioid dosage.** If benefits outweigh risks of continued opioid therapy, clinicians should work closely with patients to optimize nonopioid therapies while continuing opioid therapy. If benefits do not outweigh risks of continued opioid therapy, clinicians should optimize other therapies and work closely with patients to gradually taper to lower dosages or, if warranted based on the individual circumstances of the patient, appropriately taper and discontinue opioids. Unless there are indications of a life-threatening issue such as warning signs of impending overdose (e.g., confusion, sedation, or slurred speech), opioid therapy should not be discontinued abruptly, and clinicians should not rapidly reduce opioid dosages from higher dosages (recommendation category: B; evidence type: 4).

Deciding Duration of Initial Opioid Prescription and Conducting Follow-Up (Recommendations 6 and 7)

6. When opioids are needed **for acute pain, clinicians should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids** (recommendation category: A; evidence type: 4).

7. **Clinicians should evaluate benefits and risks with patients within 1–4 weeks of starting opioid therapy** for subacute or chronic pain or of dosage escalation. Clinicians should regularly reevaluate benefits and risks of continued opioid therapy with patients (recommendation category: A; evidence type: 4).

Assessing Risk and Addressing Potential Harms of Opioid Use (Recommendations 8, 9, 10, 11, and 12)

8. **Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk for opioid-related harms and discuss risk with patients.** Clinicians should work with patients to incorporate into the management plan strategies to mitigate risk, including offering naloxone (recommendation category: A; evidence type: 4).

9. When prescribing initial opioid therapy for acute, subacute, or chronic pain, and periodically during opioid therapy for chronic pain, **clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP)** data to determine whether the patient is receiving opioid dosages or combinations that put the patient at high risk for overdose (recommendation category: B; evidence type: 4).

Assessing Risk and Addressing Potential Harms of Opioid Use (Recommendations 8, 9, 10, 11, and 12)

10. When prescribing opioids for subacute or chronic pain, **clinicians should consider the benefits and risks of toxicology testing** to assess for prescribed medications as well as other prescribed and nonprescribed controlled substances (recommendation category: B; evidence type: 4).

11. **Clinicians should use particular caution when prescribing opioid pain medication and benzodiazepines concurrently** and consider whether benefits outweigh risks of concurrent prescribing of opioids and other central nervous system depressants (recommendation category: B; evidence type: 3).

12. **Clinicians should offer or arrange treatment with evidence-based medications to treat patients with opioid use disorder.** Detoxification on its own, without medications for opioid use disorder, is not recommended for opioid use disorder because of increased risks for resuming drug use, overdose, and overdose death (recommendation category: A; evidence type: 1).

Guideline in a Rural Context

Working in perspective

Guideline in a Rural Context

- Understanding the importance of what ‘rural’ is and means
- Norms, values, beliefs, traditions
- Trust, relationship
- Infrastructure, capacity
- Clinicians, specialists, accessing care

Guideline in a Rural Context

- Assess and Monitor
  - data-informed decision making, e.g., PMP, opioid dashboards
- Communicate Effectively
  - apply “Multi-directional” education to reduce stigma, build trust
- Strengthen, support, and mobilize communities and partnerships
  - connecting the dots among providers, pharmacists, specialists, healthcare and public health leadership

Guideline Integration

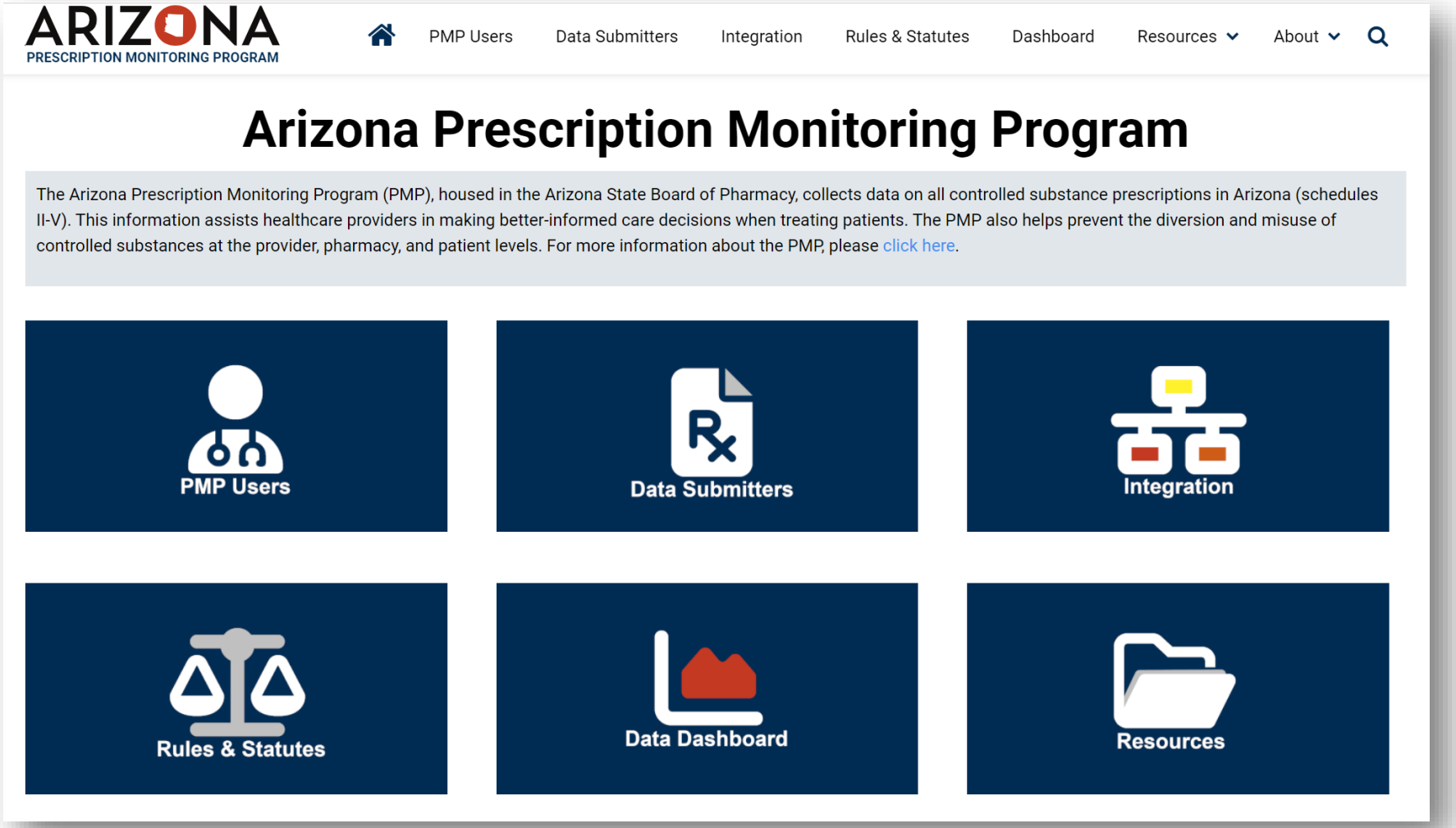
Steps and approach

Guideline Integration - EHR

Infrastructure – Workflow

- Standardize prescribing checklist
- Prioritize and update EHR
- Utilize Arizona's PMP portal
- Integrate PMP into EHR
  - 14,500 Prescribers & 3,000 Pharmacists (2024)
  - *Board of Pharmacy* has funds to create an API that connects EHR's to the PMP

Guideline Integration - EHR



Guideline Integration - Policy

Education

- Onboarding new staff
- Ongoing professional development for providers and staff
- Community outreach, marketing, forums

Guideline Integration

Build a diverse and skilled clinical, public health, and community workforce

- Recruit and support specialists
- Build transportation infrastructure
- Support local working groups, Mohave County MSTEPP, Yavapai County MATFORCE, GilaHope, others

Discussion

Questions, comments?

Thank You!

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Jason Gillette: jgillette@guildhealthgroup.com

Resources

2022 CDC Clinical Practice Guideline at a Glance

2022 CDC Clinical Practice Guideline for Prescribing Opioids Implementation Guide

Arizona Prescription Monitoring Program

CDC Hooks website

Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1–49.
DOI: http://dx.doi.org/10.15585/mmwr.rr6501e1.

Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain —United States, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95.
DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1

HealthIT Clinical Decision Support

Prescription Drug Monitoring Program Integration in the Electronic Health Record

Use and Release of Confidential Information: https://www.azleg.gov/ars/36/02604.htm

ARS 36-2606:
https://www.azleg.gov/viewDocument/?docName=http://www.azleg.gov/ars/36/02606.htm