

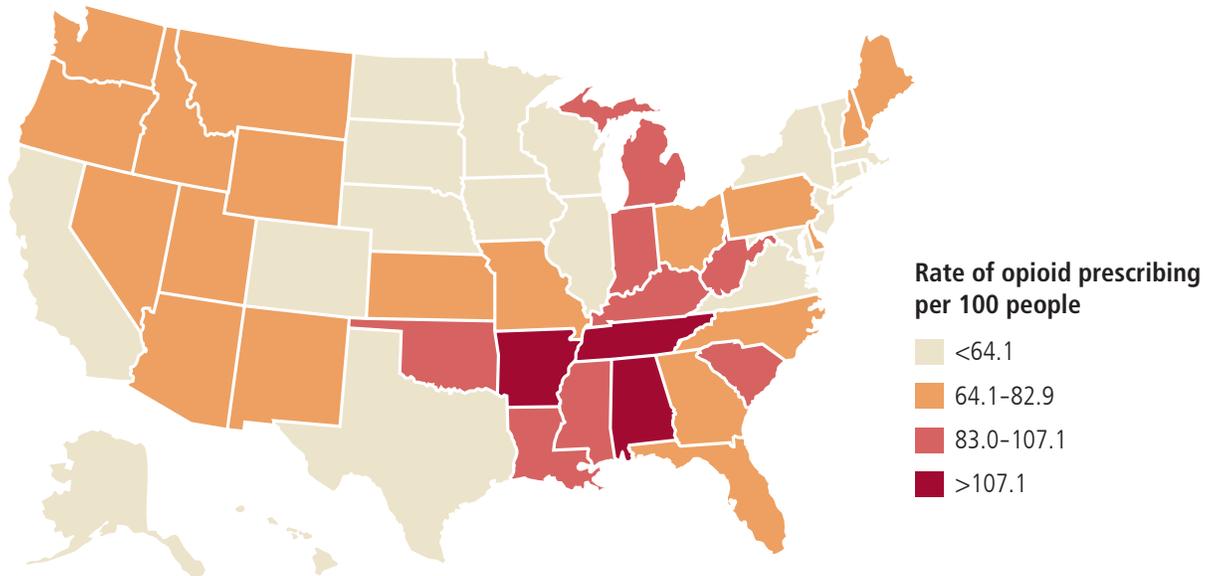


Pain and opioid management in primary care

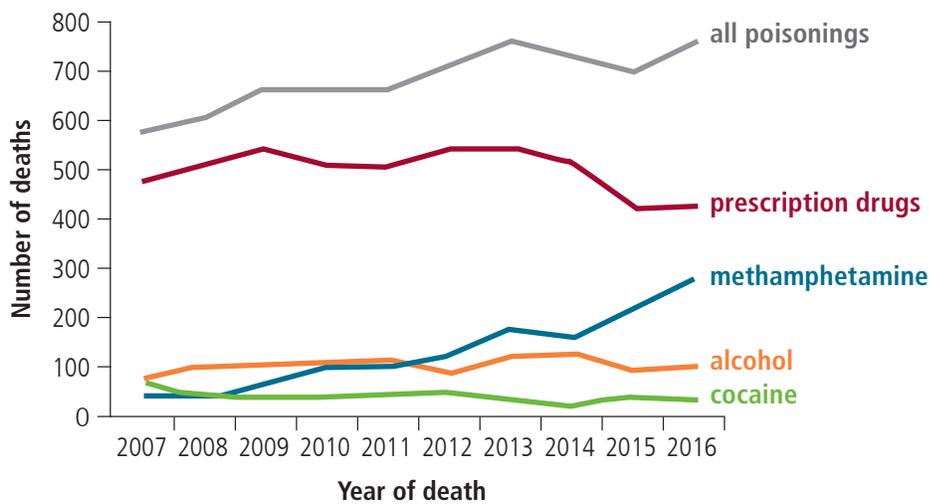


The opioid epidemic in Oklahoma

Oklahoma ranked 5th nationally in rates of opioid prescribing in 2016, with 97.9 opioid prescriptions per 100 people.¹



Over half of deaths related to unintentional poisonings involved prescription drugs in 2016.²



Opioids account for the majority of prescription drug-related overdose deaths.

Despite recent declines, deaths from opioids remain common.

Opioid prescriptions written for acute pain conditions frequently result in unused medication.

Leftover prescribed opioids increase the risk of addiction, accidental overdose, and diversion.

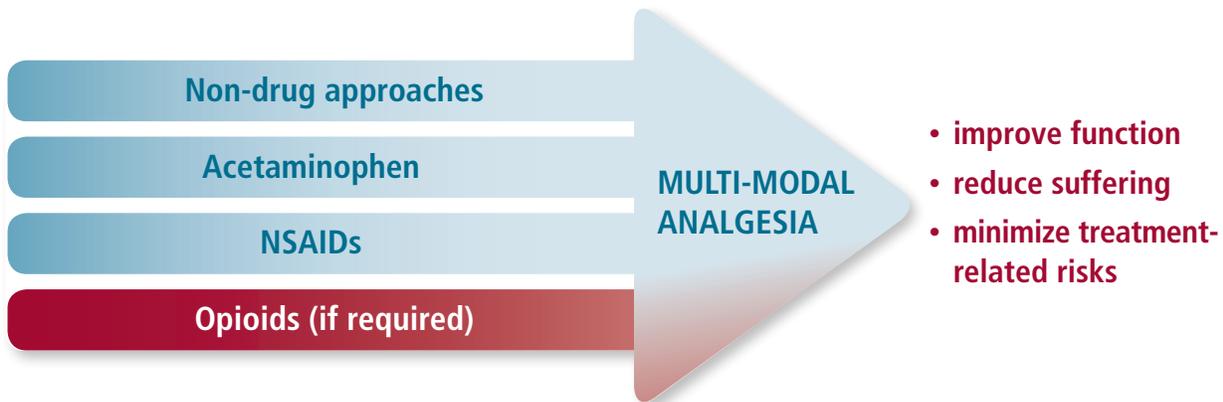
For post-op pain, 4 pills are typically used but 30 are prescribed.



Limit opioid prescribing for acute pain

Patients often first receive opioids for acute pain conditions, such as wisdom tooth extractions, minor surgery, or musculoskeletal injuries. These short-term pain conditions typically resolve over time, usually in no more than 30 days.

When pain treatment is needed, use multiple options to get patients back to regular activities.



DO NO HARM if newly prescribing opioids for acute pain.

- ✓ **Prescribe short courses of immediate release opioids at low doses**, ideally three days or fewer. Each refill or additional week of opioid prescribed increases the risk of misuse by 20%.³
- ✓ **Continue non-opioid treatments.** Emphasize to patients that non-opioid modalities can have a greater effect on functional improvement than opioids.
- ✓ **Check the Oklahoma Prescription Monitoring Program** prior to prescribing.
- ✓ **Avoid co-prescribing with benzodiazepines**, as this doubles the risk of overdose death.⁴

If prescribing opioids for acute pain in patients on long-term opioids:

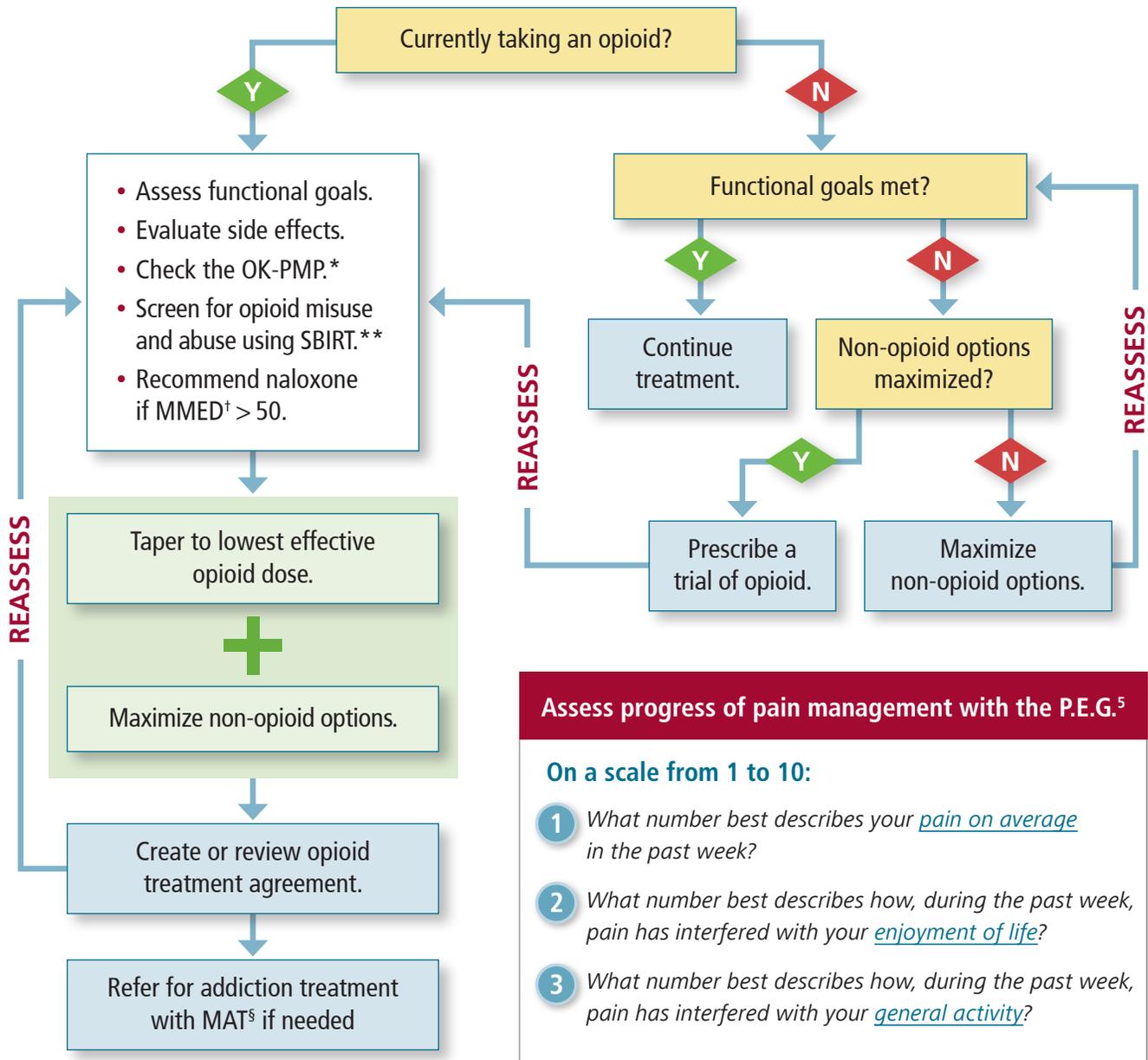
- Use lowest effective dose of additional immediate release opioid for the shortest time.
- Continue to emphasize multi-modal approaches, including non-opioid medications and non-drug options.
- Recommend naloxone, it is free in Oklahoma, and counsel patients on risk of opioid overdose.
- Taper acute pain opioid as pain resolves.

For patients with acute pain requiring opioids who have OUD or substance use disorder, collaborate with an addiction treatment provider to develop a safe care plan.

Transitioning from acute to chronic pain

When pain lasts beyond 90 days of expected healing, the focus of care shifts to chronic pain management. This includes closely assessing functional goals, optimizing additional non-drug and drug treatment options, and reduce risk if prescribing opioids.

An algorithm for managing chronic pain



Assess progress of pain management with the P.E.G.⁵

On a scale from 1 to 10:

- 1 What number best describes your *pain on average* in the past week?
- 2 What number best describes how, during the past week, pain has interfered with your *enjoyment of life*?
- 3 What number best describes how, during the past week, pain has interfered with your *general activity*?

* **OK-PMP:** Oklahoma Prescription Monitoring Program

****SBIRT:** Screening, Brief Intervention, and Referral to Treatment

† **MMED:** Morphine Milligram Equivalents per Day

§ **MAT:** Medication Assisted Treatment

Evidence for non-opioid chronic pain management options

TREATMENT OPTIONS		Neuropathic pain	Nociceptive pain
DRUG OPTIONS	acetaminophen (Tylenol, generics)	○	●
	NSAIDs—oral (ibuprofen, naproxen)	○	●
	NSAIDs—topical (diclofenac gel)	○	●
	lidocaine patch (Lidoderm, generics)	●	○
	selective serotonin reuptake inhibitors (SSRIs)	○	○
	tricyclic antidepressants (amitriptyline, nortriptyline)	●	○
	serotonin-norepinephrine reuptake inhibitors (SNRIs) duloxetine (Cymbalta, generics)	●	●
	milnacipran (Savella)	●	○
	venlafaxine (Effexor, generics)	●	○
	anticonvulsants (gabapentin, pregabalin)	●	○
NON-DRUG OPTIONS	exercise (physical therapy, tai chi)	○	●
	acupuncture	○	●
	massage	○	●
	transcutaneous electrical nerve stimulation	●	○
	cognitive behavioral therapy	○	●
	self-management	○	●
	mindfulness meditation	○	●

Coding based on quality of data for use in the elderly:

- = data from at least 1 randomized controlled trial (RCT) or meta-analysis of RCTs, with consistent efficacy
- = data from non-experimental studies or inconsistent efficacy
- = inadequate data or not effective

Implement structured visits for chronic pain

Initial visit

- ✓ **Complete comprehensive exam** and confirm diagnosis.
- ✓ **Evaluate for medical conditions** (e.g., sleep apnea).
- ✓ **Screen for behavioral health risks** such as depression (PHQ 9), anxiety (GAD 7), drug abuse (DAST-10), alcohol use (AUDIT).
- ✓ **Check OK-PMP.**
- ✓ **Establish goals for better function.**
- ✓ **Create a multi-modal pain plan and a signed treatment agreement.**

If using an opioid:

- **Advise on the risks of opioids:**
 - Constipation, low testosterone, fractures
 - Dependence, abuse, overdose, and death
- **Monitor for appropriate opioid use:**
 - OK-PMP check at least every three months
 - Urine screens (see mytopcare.org)
- **Discuss management of opioids:**
 - Store in locked place, refill policies
 - Taper opioids if not achieving goals
- **Refer or discuss co-management with appropriate specialists, as needed.**
- **Sign informed consent.**

Follow-up visits for chronic pain

- ✓ **Monitor progress** toward functional goals using a standard assessment like P.E.G.
- ✓ **Review responses to SBIRT questions.**
- ✓ **Check OK-PMP.**
- ✓ **Screen for side effects of pain medications.**
- ✓ **Monitor opioid use**, if prescribing, through urine drug screens, pill counts, and asking patients about how they are using their opioids.
- ✓ **Review the multi-modal pain plan.**
- ✓ **Schedule follow up in 1-3 months** and review pain plan at least annually.

Ensuring safer pain care

DO	<ul style="list-style-type: none"> • assess pain • create a pain management plan • set goal for improved function • recommend naloxone
NO	<ul style="list-style-type: none"> • opioid prescription without assessment and plan • sedating medications with opioids • overdose deaths and zero suicides
H	<p>HARM REDUCTION by avoiding or tapering opioids if:</p> <ul style="list-style-type: none"> • ineffective • side-effects • opioid use disorder (OUD) • behavioral health problems
A	<p>AGREE in writing on:</p> <ul style="list-style-type: none"> • opioid risks and benefits • 1 prescriber, 1 pharmacy • no early refills • monitoring visits • urine drug testing • OK-PMP checks
R	<p>RX opioids using:</p> <ul style="list-style-type: none"> • lowest effective dose • immediate release formulations • acute pain <3 days, rarely 7 • chronic pain <50 MMED
M	<p>MONITOR:</p> <ul style="list-style-type: none"> • progress toward functional goal • for misuse • for side-effects • for treating or referring OUD or behavioral health problems

Key messages

- Optimize non-opioid treatments for acute pain.
- For patients with severe pain requiring opioids, prescribe lowest dose, shortest course.
- Understand efficacy of non-opioid management options for chronic pain.
- Establish a process of identifying and monitoring patients with chronic pain, especially if opioids are prescribed.
- Remember to **DO NO HARM** for patients prescribed opioids.

Counsel patients on safe storage and disposal of opioids and other controlled substances.



- Store all controlled substances in a locked place.
- Throw out any unused prescriptions:
 - Crush and mix with kitty litter or used coffee grounds.
 - Fold patches in half, adhesive side together, and discard.
 - Bring meds to take-back bins or flush down the toilet.



RPR Exchange (Research to Practice to Research Exchange): A convenient way for clinicians and researchers to communicate about information relevant to clinical practice. Learn more at: rpr.lib.ok.us.



DO NO HARM is a practice improvement program helping primary care practices implement delivery system changes, technology, clinical decision support, and patient self-management to adopt guidelines for safer pain and opioid management.

Partnering organizations



NaRCAD is a national resource center that supports clinical outreach education programs across the United States. With NaRCAD's trainings and ongoing program support, clinical educators have a greater impact when visiting front line clinicians, helping those clinicians to make the best, evidence-based decisions. Learn more at narcad.org.



This material was produced by Alosa Health, a nonprofit organization that produces educational content and manages and provides consulting for clinical outreach education initiatives. Alosa Health is not affiliated with any pharmaceutical company. For more information, visit AlosaHealth.org.



Located in the Oklahoma Clinical and Translational Science Institute at The University of Oklahoma Health Sciences Center, the Oklahoma Primary Healthcare Improvement Cooperative (OPHIC) is the academic research arm of a community-engaged system with a mission to facilitate the diffusion of research innovations into community clinical delivery systems. OPHIC partners include our state's County Health Improvement Organizations and other entities critical for translational research in community settings.



The Oklahoma Department of Mental Health and Substance Abuse Services provides educational resources and clinical services to improve the mental health of the citizens of Oklahoma.

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