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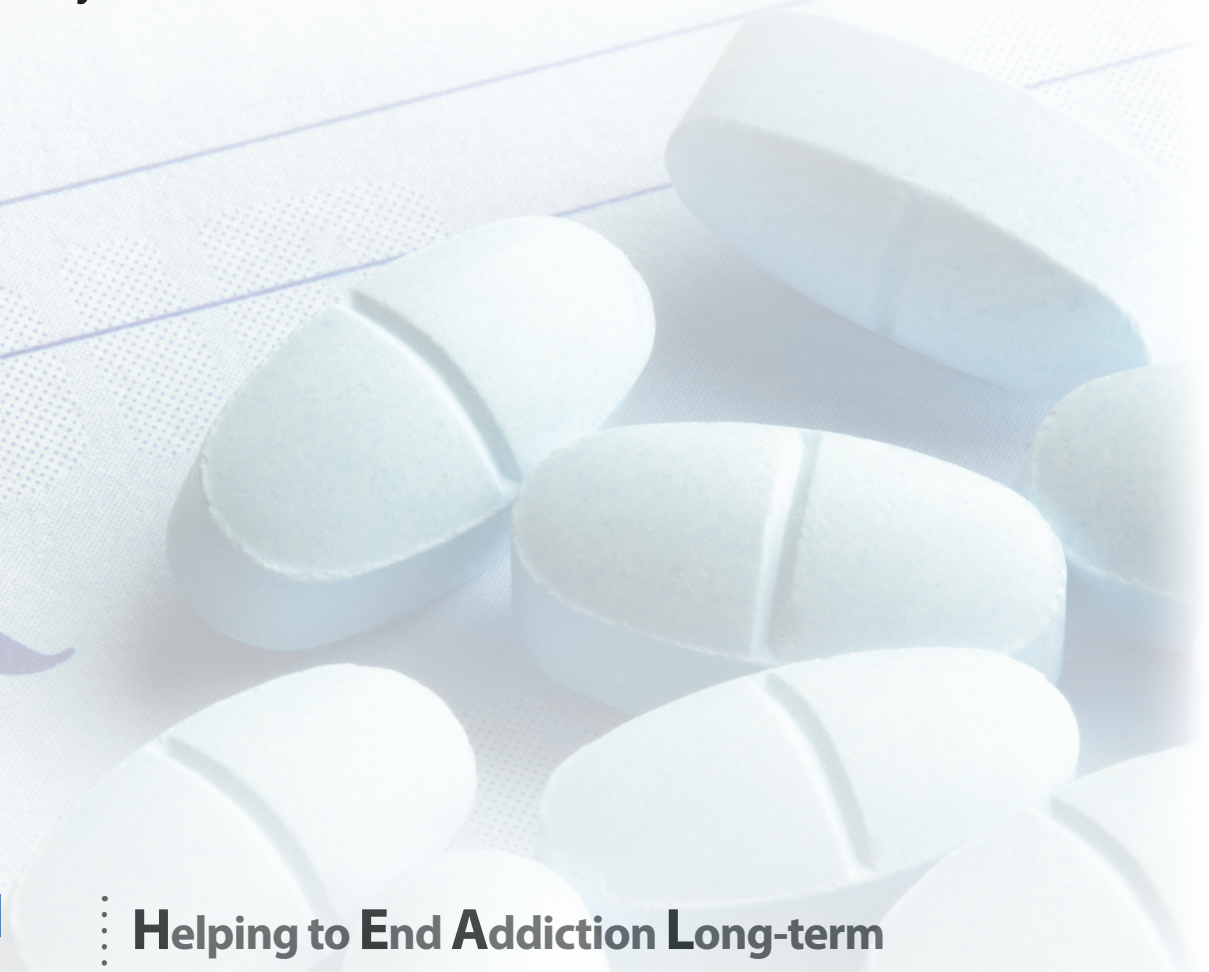
HEALing Communities Study
Kentucky



Finding the Balance: Managing pain in primary care

A Guide for Primary Care Providers

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Helping to End Addiction Long-term

The HEALing Communities Study utilizes a community engaged process to develop a comprehensive, data-driven community response plan to deploy evidence-based practices across multiple sectors and reduce opioid overdose deaths within highly affected communities by 40% over 3 years.



Key Best Practices

- pg 1:** Individualize the pain management plan for every patient
 - pg 3:** Use non-opioid therapy first line for acute pain
 - pg 5:** Treat chronic non-cancer pain with a biopsychosocial approach that maximizes non-opioid therapies
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 - pg 11:** Keep patients and communities safe with risk mitigation, OUD treatment, and disposal education
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Individualize the pain management plan for every patient

There is no one-size-fits-all approach to treating pain.

The experience of pain is complex, and pain conditions have a wide variety of features, pathologies, and effects. This variation makes it impossible to develop a treatment algorithm for pain management.¹

Pain intensity on a 0 to 10 scale is commonly used to assess pain, but intensity does not capture the entirety of the pain experience or the impact of pain on daily life. Overdependence on the intensity scale can lead to unnecessary opioid use.¹

The assessment and treatment of pain should be individualized to address the suffering and functional impairment experienced by the patient.¹

Regardless of diagnosis or etiology, every pain management plan should:

- Be developed in collaboration with the patient.
- Address the biopsychosocial nature of pain.
- Include multiple evidence-based modalities and patient education.
- Focus on the patient's goals for function and daily living.
- Avoid emphasizing cure or complete pain relief.
- Balance the risks of each intervention with the potential benefits.



Quick Review: Pain

Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.

Nociceptive pain arises from stimulation of nerve endings by noxious stimuli or tissue damage. It can be *somatic* (arising from skin, bone, joint, muscle, or connective tissue) or *visceral* (arising from internal organs).

Neuropathic pain is a result of damage to or abnormal functioning of the nervous system and often does not correlate with physical exam findings or imaging results.

Acute pain is usually nociceptive. Common causes are surgery, acute illness, trauma, labor, and medical procedures. Acute pain generally resolves with the healing process.

Chronic non-cancer pain persists for months to years and often reflects a pathophysiologic pain state. Chronic pain can be difficult to treat due to changes in nerve function and transmission.

Cancer pain requires unique treatment strategies, which are not addressed in this guide.

Assessment of pain includes:

- Physical functioning
- Pain intensity
- Psychological functioning
- Social aspects
- Fear-avoidance behavior
- Pain catastrophizing
- Self-efficacy
- Coexisting conditions

Adapted from Finnerup¹, DiPiro²



Successful pain management, with or without the adjunctive use of opioids, often requires trials of many different treatments and persistent effort on the part of both patient and provider. However, the American Academy of Pain Medicine notes that “Patients do best when they adopt a new lifestyle not solely dictated by the pain. The provider does best by offering support and encouragement; not necessarily by more testing, more medication, more referrals, or more procedures.”³

Many pain conditions can be managed in primary care, but referral to a pain specialist is often beneficial.³

A key element in effectively treating pain, especially chronic pain, is knowing when a pain specialist can help and what services each specialist offers. Establishing relationships with specialists is crucial to effective communication and collaboration.³

The following tips can help primary care providers decide on and navigate referral to a specialist:

- Referral is indicated when current treatment is not working and next steps are unclear or when the provider is uncomfortable continuing current treatment. Never feel compelled to provide treatment beyond your level of expertise.
- Chronic pain may have no known cause despite extensive workup. A specialist can help confirm or establish a diagnosis and offer suggestions on management.
- Early referral can help break the cycle of chronicity and deconditioning that may occur with chronic pain conditions.
- Pause and consider referral when milestones such as pain duration or opioid milligram thresholds are reached.
- Referral to behavioral health services may facilitate the management of pain, particularly when it co-exists with anxiety, depression, bipolar disorder, PTSD, or other psychiatric conditions.
- Referral to an addiction specialist may be more appropriate when clear evidence of misuse is present.³

Interventional Pain Management

Specialists in interventional pain management use minimally invasive procedures to relieve pain when more conservative treatments are ineffective. For some conditions, these procedures precede or replace surgery. Procedures that may be available at an interventional pain management clinic include:

- Epidural steroid injections
- Medial branch blocks/facet joint injections
- Occipital nerve blocks for headaches
- Other nerve blocks targeted at specific anatomic regions
- Radiofrequency nerve ablations
- Kyphoplasty for spine fracture
- Anesthetic and/or steroid injections in muscles and joints, including trigger point injections

Adapted from Mount Sinai⁴



Use **non-opioid therapy** first line for acute pain

Across a variety of conditions, non-opioid analgesics can effectively treat pain with fewer adverse effects than opioids.

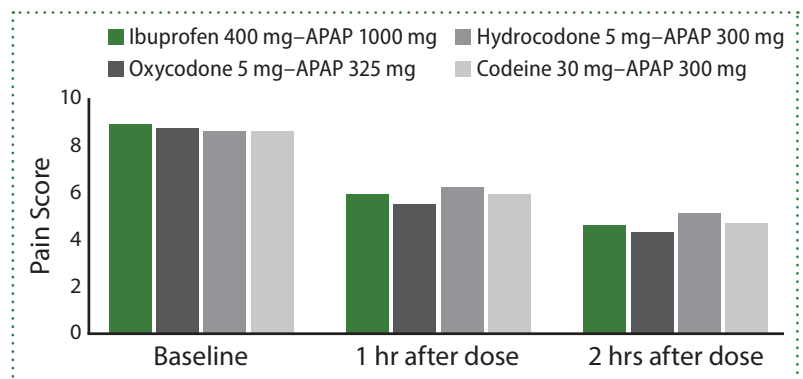
Additionally, studies show that around half of patients presenting to the emergency department with pain do not desire any analgesic.^{5,6} In a small study of patients with acute musculoskeletal pain, only 11% expressed a preference for an opioid.⁶



Musculoskeletal Injury

Multiple studies show no difference in efficacy between opioid-containing regimens and NSAID regimens (with or without acetaminophen) when single doses are administered in emergency care settings for moderate to severe acute pain from musculoskeletal injury.⁷⁻⁹

A double-blind, randomized clinical trial of more than 400 patients with acute extremity pain severe enough to warrant imaging found no difference in pain scores or rescue analgesic use in patients who received a single dose of an opioid-acetaminophen combination and patients who received a single dose of an ibuprofen-acetaminophen combination.⁹



Adapted from Chang, et al.⁹

Adverse effects are more common with opioid-containing regimens. In one study, 36% of patients receiving a dose of oxycodone 10 mg for soft tissue injury reported an adverse reaction compared to only 8% of patients receiving naproxen 250 mg, despite no statistical difference in pain scores.⁷



Acute Low Back Pain

Acute or subacute low back pain typically improves over time regardless of treatment.¹⁰ The American College of Physicians recommends nonpharmacologic treatment with superficial heat, massage, acupuncture, or spinal manipulation and recommends a short course of an NSAID or skeletal muscle relaxant if pharmacologic treatment is desired.¹⁰

A 10-day course of naproxen 500 mg twice a day with as-needed cyclobenzaprine 5 mg or oxycodone 5 mg/acetaminophen 325 mg was not superior to naproxen plus placebo for pain relief or functional outcomes at 7 days or 3 months following an ED visit for acute low back pain.¹¹ Adverse effects were more likely among patients who received cyclobenzaprine or oxycodone/acetaminophen.¹¹ Nearly 40% of patients used the as-needed medication less than once a day, only once, or not at all.¹¹



Renal Colic

For kidney stones, NSAIDs provide pain relief equal to or marginally better than opioids with lower vomiting rates and less frequent need for rescue analgesics.^{12,13} NSAID use is supported by the mechanism of inhibiting prostaglandin synthesis, a central factor in the development of renal colic.¹⁴ Ketorolac (IM or IV) and ibuprofen (IV) are commonly used evidence-based options for severe pain from renal colic.¹⁴



Migraine

The use of opioids to treat migraines has been associated with increased headache-related disability scores, headache frequency, transformation to chronic migraine, and health-care utilization, as well as high rates of opioid dependence.^{15,16}

Treatment recommendations for acute migraine attacks include:

- NSAIDs first-line for mild to moderate migraine.
- Triptans first-line for moderate to severe migraine. Failure to respond to one triptan warrants trials of different triptans in subsequent attacks.
- Individualization of pharmacotherapy based on migraine and patient characteristics.
- Medication administration early in an attack.
- Avoidance of opioid- or butalbital-containing products or use only as a last resort.¹⁷⁻¹⁹

Several noninvasive neuromodulation devices are FDA-cleared for treating acute migraine. These devices have been classified as having nonsignificant risk.¹⁹

Preventative treatments for episodic and chronic migraines are available but are beyond the scope of this guide.²⁰



Talking About Pain

Communicating about pain can be challenging for patients and providers. Several common themes for improving pain management communication appear in the literature.

Empathy and understanding: Use reflective listening, acknowledge the subjectivity of pain, and reassure patients that their concerns are heard and their descriptions of pain are believed.

Patient-centered care: Encourage patients to share their goals and preferences and to engage in shared decision-making. Ask about function and the effect of pain on patients' daily lives. Offer the patient treatment options whenever possible.

Prioritization: Inquire about patients' goals for appointments. Remember that patients may be unable or unwilling to focus on other health needs until pain has been addressed. Planning extra time for pain management may be necessary.

Realistic expectations: Communicate and explain diagnoses, test results, and other medical information. Be clear about the limitations of tests and imaging. Establish realistic expectations for pain management.

*Adapted from Bergman et al.,
Smith et al., and Haverfield et al.²¹⁻²³*



As pain becomes chronic, it is less connected to an underlying pathology of tissue damage.

Nociceptive pathways transmitting pain signals become more sensitive, and the contributions from psychosocial factors or secondary pathology can increase.²⁴

Treat chronic non-cancer pain with a *biopsychosocial approach* that maximizes non-opioid therapies

Effectively treating chronic pain requires a biopsychosocial approach that acknowledges the complex interactions between physical health, emotion and perception, and social factors. Multimodal pain management should incorporate medications, nonpharmacologic interventions, and self-management education.

Nonpharmacologic Pain Management



Physical Activity

Increasing physical activity improves pain severity, physical function, and quality of life across a variety of chronic pain conditions. Exercise has been shown to cause no actual harm, with temporary soreness or muscle pain the primary adverse event.^{25,26}

No single exercise modality is superior, and most available evidence supports both land- or water-based aerobic and resistance exercise.²⁴

Tai Chi: For fibromyalgia, tai chi regimens outperformed aerobic exercise classes. Tai chi showed a larger clinically important effect compared to aerobic exercise of the same intensity (twice weekly for 24 weeks). Patients were also more likely to attend the tai chi classes.²⁷

For knee osteoarthritis, tai chi was non-inferior to physical therapy, with both groups showing clinically significant improvements in pain. Tai chi also showed significantly greater improvements in depression.²⁸

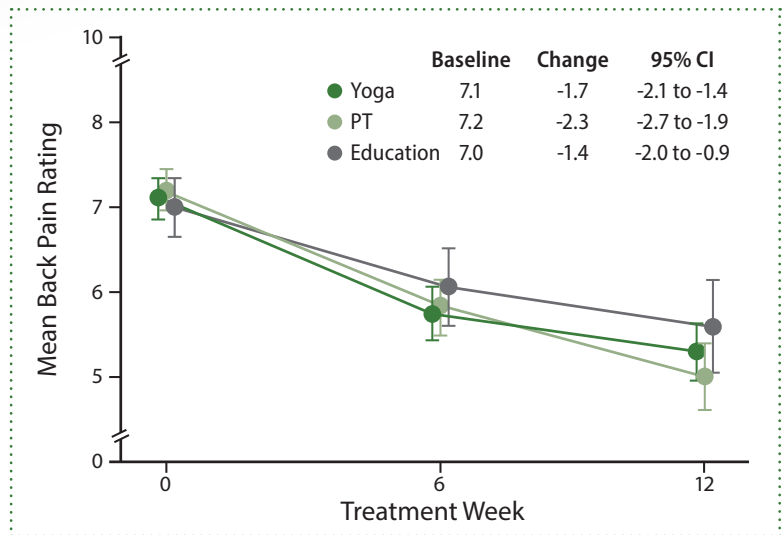
Build a Patient-Specific Exercise Prescription

- Select a modality that the patient enjoys; ensure the patient perceives the activity as affordable, safe, and meaningful.
- Dose activity based on time, allowing the patient to pause and restart as tolerated.
- Build confidence with gradual pacing and avoid early pain exacerbations.
- Emphasize a goal of improved function and quality of life.
- Address fear, anxiety and maladaptive beliefs about the link between activity and pain.
- Remind the patient that reversing biological adaptations of chronic pain will take time.
- Combine supervised exercise programs with home exercise and education to improve adherence.
- Encourage patients to keep a record of their activities.
- Visit www.exerciseismedicine.org for implementation tools and resources for health care professionals.

Adapted from Booth, et al.²⁴



Yoga: For chronic low back pain, yoga classes were non-inferior to individual physical therapy for decreased pain and improvement in disability after 12 weeks. While yoga and physical therapy were not superior to education with a self-care book and newsletters, participants in yoga and physical therapy were more likely to show clinically meaningful improvements in function. Additionally, participants in yoga and physical therapy were more likely to discontinue pain medication than those who received the educational intervention.²⁹



Adapted from Saper, et al.²⁹



Mindfulness-Based Stress Reduction (MBSR)

MBSR is a structured group program using meditation and exercise techniques aimed at helping participants develop “nonjudgmental awareness of moment-to-moment experience.”³⁰ Mindfulness-based interventions have been shown to improve outcomes related to quality of life, well-being, and psychological distress as well to reduce pain intensity in both the short- and long-term.³¹

In a randomized, wait-list controlled trial of MBSR, more than 100 patients with stable chronic pain received weekly group training in MBSR for 8 weeks in addition to standard care and were asked to practice meditation for 45 minutes each day. While changes in pain-scale measures between the groups were not significant, significant improvements with MBSR were shown in measures of vitality, pain acceptance, control over pain, general anxiety, and mental health quality of life.³²



Cognitive Behavioral Therapy (CBT)

CBT aims to reduce distress and improve function by helping individuals decrease maladaptive thoughts and behaviors and increase self-efficacy.³³ CBT can also be used to treat mood, anxiety, sleep, and other mental health disorders that often co-occur with chronic pain.³³ The use of CBT as an adjunctive therapy for chronic pain has a long history. A 2012 systematic review of more than 30 trials concluded that CBT has a small to moderate effect on pain, disability, psychological distress and catastrophic ways of thinking about pain.³⁴



Massage

Massage therapy is a widely accepted treatment for musculoskeletal disorders and chronic pain conditions.³⁵ Systematic reviews have shown high heterogeneity and mixed results, with some evidence for improved pain and function in the short-term compared to no treatment or inactive controls.^{35,36}



A real-world cohort study of Kentucky patients with chronic low back pain found that around half of patients referred from their PCP to a local massage therapist experienced improvement after up to 10 weekly massage treatments in 12 weeks. Including participants who did not have clinically meaningful improvement, 80% reported overall satisfaction with the massage therapy they received and 74% agreed or strongly agreed with the statement, *“I would want massage again if my back pain returns or gets worse.”*³⁷

Proportion of patients with clinically meaningful improvement after 12 weeks of massage for chronic low back pain

LOW BACK PAIN DISABILITY **54%**

QUALITY OF LIFE, PHYSICAL **55%**

QUALITY OF LIFE, MENTAL **43%**

QUALITY OF LIFE, BODILY PAIN **49%**

Adapted from Elder, et al.³⁷

For patients with knee osteoarthritis, a randomized clinical trial showed that 8 weekly 1-hour sessions of whole-body massage provided statistically and clinically significant improvement in osteoarthritis symptoms compared to light touch or usual care.³⁸



Acupuncture

Acupuncture is a traditional Chinese medicine technique that uses the insertion of needles at specific points throughout the body to promote healing and improve function.³⁹ Although it is gaining popularity and acceptance among patients and practitioners, the specific mechanism of action is unclear and there are methodological limitations in clinical trials.^{39,40}

In a trial of more than 600 patients with chronic low back pain, participants in acupuncture groups were treated twice weekly for three weeks, and then weekly for four weeks. Results showed a clinically and statistically significant improvement in disability scores and symptom bothersomeness scores for individualized, standardized, and simulated acupuncture compared to usual care, but did not show a difference between sham acupuncture and real acupuncture.⁴¹ These findings were consistent with several similar European acupuncture trials.⁴¹

Adverse events are infrequent and generally mild in studies of acupuncture conducted by trained and licensed practitioners.^{26,39,41}

Acupuncture & Medicare

Medicare Part B covers acupuncture for chronic low back pain

- Initial coverage for up to 12 sessions in 90 days; additional coverage for 8 sessions if patient shows improvement.
- Must be provided by a doctor, nurse practitioner or PA with an advanced degree in acupuncture or Oriental Medicine and a license to practice acupuncture.
- Only covered condition is chronic low back pain lasting 12 weeks or longer.

www.medicare.gov/coverage/acupuncture



Non-Opioid Pharmacotherapy

The landmark SPACE trial found that treatment of chronic back pain and hip or knee osteoarthritis with opioids was *not* superior to treatment with non-opioid medications for improving pain-related function. Pain intensity was significantly lower in the non-opioid group, and adverse medication-related symptoms were significantly more common in the opioid group.⁴² Similarly, other clinical trials have not shown evidence to support the efficacy and safety of opioids in fibromyalgia, and there is only very low-quality evidence that oxycodone has value in the treatment of painful diabetic neuropathy.^{43,44}

Evidence for Non-Opioid Medications for Select Chronic Pain Conditions⁴⁵⁻⁵²

Drug Class	Example Drugs	Low Back Pain	Osteo-arthritis	Fibro-myalgia	Diabetic Neuropathy	Proposed Mechanism
	Acetaminophen	? ^a	★ ^b	⊖		Activation of descending inhibitory pathways
Oral NSAIDs	Ibuprofen Celecoxib	★★	★★	⊖		Decreased formation of prostaglandins via inhibition of COX enzymes
Topical NSAIDs	Diclofenac		★★			
Muscle Relaxers	Cyclobenzaprine	? ^c		?		Reduction in tonic somatic motor activity
SNRIs	Duloxetine Venlafaxine	★★	★★	★★	★★	Inhibition of serotonin & norepinephrine reuptake
SSRIs	Paroxetine Fluoxetine	⊖		★	★ ^d	Inhibition of serotonin reuptake
TCA's	Desipramine Nortriptyline	? ^e		★★	★★	Neuromodulation of serotonin & norepinephrine
Gabapentinoids	Gabapentin	⊖		★	★★	Reduced excitability of glutamergic neurons
	Pregabalin	⊖ ^f		★★	★★	
	Topiramate	?			⊖	Anticonvulsant via multiple potential mechanisms
	Low-dose Naltrexone			★		Opioid receptor antagonism; reduced microglia activation
	Topical Lidocaine	⊖ ^g			★★	Blocked nerve conduction via reduced sodium permeability
	Topical Capsaicin	★			★ ^h	Reduced pain signaling via depletion of substance P

Table Key:

- ⊖ Trial showed no difference or negative effect
- ? Evidence is mixed
- ★ Evidence of superiority to placebo or comparator
- ★★ Multiple trials show superiority to placebo or comparator
- blank No evidence identified

Table Notes:

- a** In two trials, acetaminophen reduced pain scores, but NSAID comparators were superior.
- b** Meta-analysis showed very small effect size compared to placebo.
- c** Inconsistent effects in placebo-controlled trials and in trials of muscle relaxant plus NSAID.
- d** Paroxetine has been shown effective, but fluoxetine has not.
- e** Systematic review found no difference in pain compared to placebo.
- f** Pregabalin was not superior to opioids or celecoxib, but celecoxib plus pregabalin was superior to monotherapy.
- g** Both lidocaine and placebo groups reported greater than 50% pain reduction, suggesting large placebo effect.
- h** Doses between 0.025% and 0.075% applied 4 times daily were effective within 8 weeks.



Prescribing Pearls: Focus on patient-centered care, regimen personalization and rational polypharmacy. Establish realistic expectations for pain relief and set goals based on function and quality of life. Reduce patient frustration by explaining that multiple medication trials and dose adjustments may be necessary to find an effective regimen.

Chronic Pain Self-Management

Chronic pain self-management interventions have shown small but significant improvements in pain intensity, pain disability, catastrophizing, and health-related quality of life.⁵³ Formal self-management programs can be offered in group or individual sessions, via online or telephone courses, or by self-study toolkits.⁵³ Primary care providers can encourage and support self-management skills with or without a formal program.

Help Patients Learn More

American Chronic Pain Association:
www.theacpa.org

National Fibromyalgia & Chronic Pain Association:
www.fibroandpain.org

Choose PT: www.choosept.com

painACTION: www.painaction.com

Supporting Chronic Pain Self-Management

Adapted from Mann, et al.; ACPA; and Dorflinger, et al.⁵³⁻⁵⁵

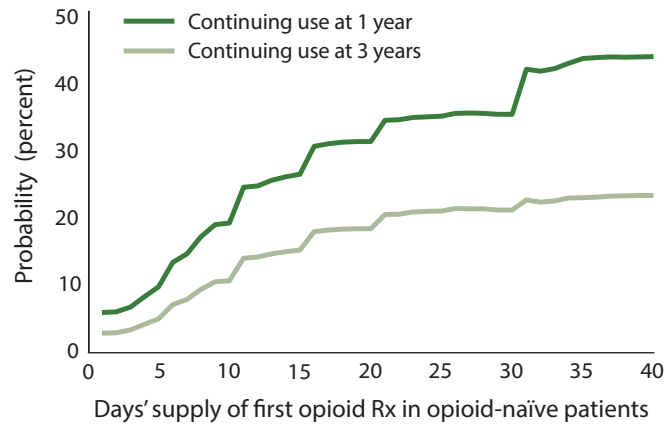
Feature	Details	Provider's Role
Acceptance	Patient shifts toward managing pain as a long-term practice rather than seeking a "cure."	Educate patients on the nature of their pain with a focus on the biopsychosocial model of chronic pain.
Working alliance	Provider and patient develop a positive bond and work collaboratively toward goals.	Treat patients as valued partners in care. Provide clear information, offer empathetic and encouraging responses, and support patient autonomy and self-efficacy.
Continued activity	Patient performs activities of daily living and engages in physical activity that supports function and quality of life.	Encourage safe activity and discuss referral to physical therapy. Reduce fear by disconnecting chronic pain from tissue injury and distinguishing "good" discomfort from new pain symptoms.
Coping and mental health	Patient understands role of psychology in pain and finds ways to thrive and enjoy life despite chronic pain condition.	Discuss referral to mental health providers with an emphasis on the success of interdisciplinary care. Allow patients to consider the referral, ask questions, and discuss preferences.
Goals and action planning	Patient and provider collaborate on specific, measurable, and action-oriented goals.	Help patients create an action plan for self-management, including barriers and facilitators. Monitor goals at each visit and assist with problem-solving.
Social support	Patient reaches out to others, avoids isolation, and maintains healthy relationships.	Assess and monitor patients' existing support structure and connect patients with live or online resources such as support groups, health coaches, or peer support.



Carefully consider risk factors for overdose and opioid use disorder when prescribing opioids

Longer duration of initial opioid therapy correlates to increased probability of long-term opioid use.⁵⁶

CDC Guidelines recommend that prescribers limit the use of opioids for acute pain to the lowest effective dose and smallest quantity needed for the expected duration of severe pain. The guidelines note that “3 days or less will often be sufficient; more than 7 days will rarely be needed.”⁵⁷



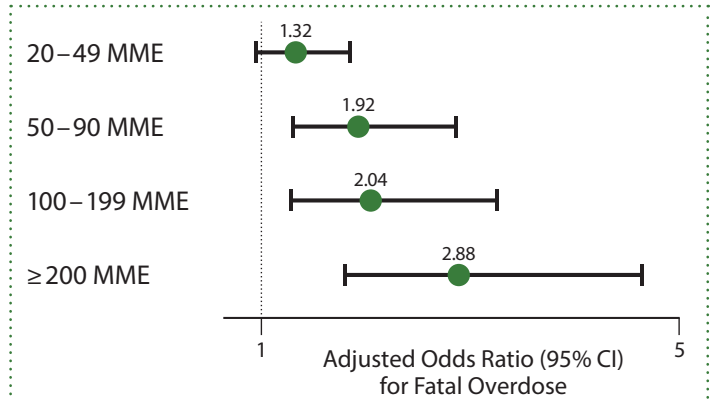
Adapted from Shah, et al.⁵⁶

Short-acting opioids are safer for initial therapy: A study in veterans showed that initiating therapy with long-acting agents (e.g., fentanyl, methadone, oxycodone ER) puts patients at significantly higher risk of unintentional overdose compared to short-acting agents.⁵⁸ Additionally, patients who initiate therapy with long-acting opioids are more likely to develop chronic opioid use.⁵⁶

Overdose risk is dose-dependent.

Compared to daily doses less than 20 MME, the odds of a fatal overdose double with a daily dose greater than 50 MME and nearly triple with a daily dose greater than 200 MME.⁵⁹

Non-fatal overdoses also increase with higher doses.⁶⁰ Patients taking more than 100 MME daily had a 1.8% annual overdose rate, nearly 9 times the rate of patients taking less than 20 MME daily.⁶⁰



Adapted from Gomes, et al.⁵⁹

Combining sedatives increases overdose risk: Studies of fatal opioid overdoses found evidence of concurrent benzodiazepine use in 31 to 61% of decedents.⁵⁷ Rates of overdose death are 10 times higher in patients prescribed both a benzodiazepine and an opioid than in those prescribed only an opioid.⁶¹ Concomitant gabapentin and opioid exposure has been associated with a 49% higher risk of fatal opioid overdose compared to opioid exposure alone.⁶²



Methadone poses unique challenges.

Although methadone accounted for about 1% of all opioid analgesic prescriptions in 2014, methadone-related deaths accounted for 22.9% of opioid-related mortality.⁶³

Methadone prescribers must consider the drug’s unique pharmacokinetic and pharmacodynamic properties and monitor for drug interactions and respiratory or cardiac adverse effects. Referral to pain management is recommended for patients on methadone for pain.

Key patient factors warrant extra caution with opioids.

- Age ≥65 years
- Sleep-disordered breathing (sleep apnea, heart failure, obesity)
- Pregnancy
- Renal or hepatic insufficiency
- Mental health conditions (anxiety, depression, post-traumatic stress disorder)
- Substance use disorder
- Prior overdose



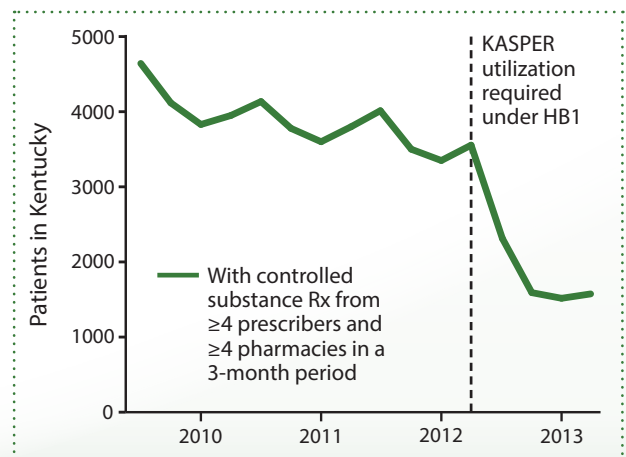
Exposure in adolescence might lead to misuse: Individuals who have had an opioid prescription by 12th grade are, on average, 33% more likely to misuse prescription opioids after high school than those with no opioid prescription. Risk triples in otherwise low-risk individuals.⁶⁴

Keep patients and communities safe with risk mitigation, OUD treatment & disposal education

CDC recommends screening all patients for current medications, illicit drug and alcohol use, and substance use disorder history prior to prescribing opioids.⁵⁷

Best practice: Check KASPER with every opioid prescription.

- Offers timely clinical information about medications patients receive from other prescribers.
- Protects patients from taking dangerous drug combinations.
- Ensures compliance with state regulatory requirements.
- Helps detect and prevent doctor shopping.⁶⁵



Adapted from Freeman, et al.⁶⁵

Need help with KASPER? Call 502-564-2703 or visit <https://ekasper.chfs.ky.gov>



Other Risk-Mitigation Strategies

Other frequently employed risk-mitigation strategies lack robust evidence supporting their use. Before adopting any strategy in an opioid risk-reduction protocol, develop a detailed plan for how to confirm findings and address unexpected results or aberrant behavior.

Potential Opioid Risk-Reduction Strategies

Adapted from Dowell, et al. and Kaye, et al.^{57,66}

Strategy	Details	Benefits	Risks
Urine drug testing*†	Provider conducts routine UDT to assess for prescribed medications as well as other prescription or illicit drugs	<ul style="list-style-type: none"> Clinical information beyond patient report May detect diversion or high-risk behavior 	<ul style="list-style-type: none"> Cost or time burden for patients or providers Unexpected or misinterpreted results lead to difficult decisions
Treatment agreements as written aspect of informed consent*†	Provider and patient develop, discuss and sign plan for prescribing and monitoring, how decisions will be made, and when opioids might be discontinued or tapered	<ul style="list-style-type: none"> Clarifies expectations for opioid prescribing Records patient's consent Serves as starting point for treatment plan and risk-benefit discussion 	<ul style="list-style-type: none"> Requires trust between prescriber and patient May be viewed as coercive or punitive May lead to attempts to mislead prescriber
Pill counts†	Pills counted in front of patient at scheduled or random times to ensure quantity matches or exceeds quantity filled minus maximum daily dose	<ul style="list-style-type: none"> Compliance information beyond patient report May detect diversion, misuse, undertreated pain, or stockpiling 	<ul style="list-style-type: none"> May create stress and time or transportation burden for patients Results may be misinterpreted
Misuse screening tools	Patient or provider completes instrument to detect potential aberrant behavior	<ul style="list-style-type: none"> Easy to administer Starting point to discuss risks and benefits 	<ul style="list-style-type: none"> Low diagnostic accuracy Patients may attempt to manipulate results
Universal precautions approach	Risk-mitigation strategies implemented for all patients rather than only for those deemed high risk	<ul style="list-style-type: none"> Focuses on risky drugs rather than risky patients Reduces stigma and avoids demographic targeting 	<ul style="list-style-type: none"> Cost or time burden for patients and providers False positives interfere with therapy and trust

* Strategy included in the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain.⁵⁷

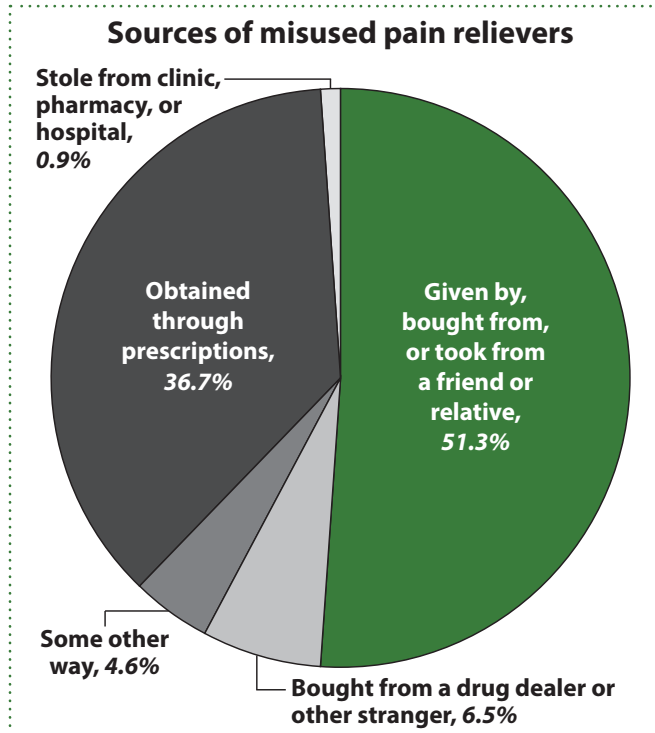
† Strategy required in some circumstances by 201 KAR 9:260.

Opioid Use Disorder (OUD) in Long-Term Opioid Therapy

Studies of addiction in patients on long-term opioid therapy show dramatically varied results, from less than 5% to nearly 50% of patients developing a use disorder as a result of treatment for chronic pain.⁶⁷⁻⁶⁹ When aberrant behavior or opioid misuse is suspected, assess patients for OUD using DSM-5 criteria.⁷⁰ Patients diagnosed with OUD should be referred to a provider who is experienced in managing comorbid pain and OUD and who is able to initiate treatment with buprenorphine or methadone, which have been repeatedly associated with reductions in opioid-related morbidity and overdose mortality.^{71,72}



More than half of people who misused pain relievers in the past year obtained them from a friend or relative.⁷³



Adapted from SAMHSA⁷³

A survey of patients with an opioid prescription found that only one-third had disposed of unused medication. An important driver of disposal was instruction from a healthcare provider.⁷⁴

The FDA recommends immediate disposal of unused medication and suggests the following means of disposal, in preference order.⁷⁵

1. Drop off the medicine promptly at a drug take-back event or permanent disposal kiosk in a pharmacy or law enforcement agency.
2. Review the FDA Flush List for medications that are appropriate to dispose of in the toilet. The FDA Flush List includes all oral opioids.
3. Discard medications in the household trash:
 - Mix medication with an unpalatable substance (e.g., cat litter, coffee grounds).
 - Place the mixture in a sealed container.
 - Throw the container in household trash.
 - Destroy or disguise personal information and dispose of prescription vial.

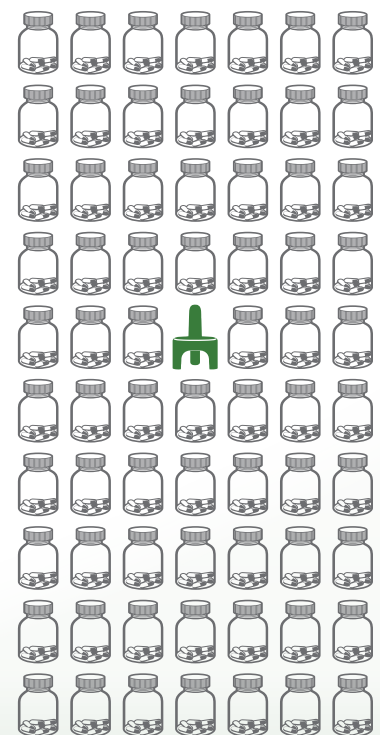
Prescribe naloxone to all patients on long-term opioid therapy

Naloxone administration by bystanders during an overdose significantly increases the odds of survival.⁷⁶

Nationally, only 1 naloxone prescription was dispensed for every 69 high-dose (≥ 50 MME) opioid prescriptions dispensed in 2018.⁷⁷

FDA recommendations encourage increased access to naloxone:⁷⁸

- Discuss the availability of naloxone with all patients who are prescribed opioid analgesics.
- Consider prescribing naloxone to patients at increased risk of opioid overdose.
- Consider prescribing naloxone to patients with household members or close contacts at risk for accidental ingestion or opioid overdose.

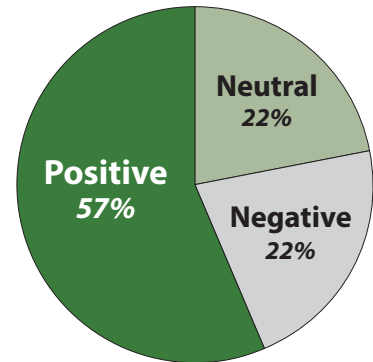




CDC guidelines suggest prescribing naloxone to high-risk populations.⁵⁷

- Total daily opioid dose ≥ 50 MME
- Concomitant opioid and benzodiazepine prescriptions
- History of opioid overdose
- History of substance use disorder
- Decreased tolerance (e.g., gap in opioid therapy, taper, incarceration)
- Other high-risk patient factors:
 - ≥65 years old
 - Sleep-disordered breathing (e.g., sleep apnea, CHF, obesity)
 - Mental health conditions (e.g., depression, anxiety, PTSD)
 - Renal or hepatic insufficiency

Reaction of patients taking a prescription opioid to a naloxone prescription offer



After education, 95% said they would want naloxone in the future

Adapted from Behar, et al.⁷⁹

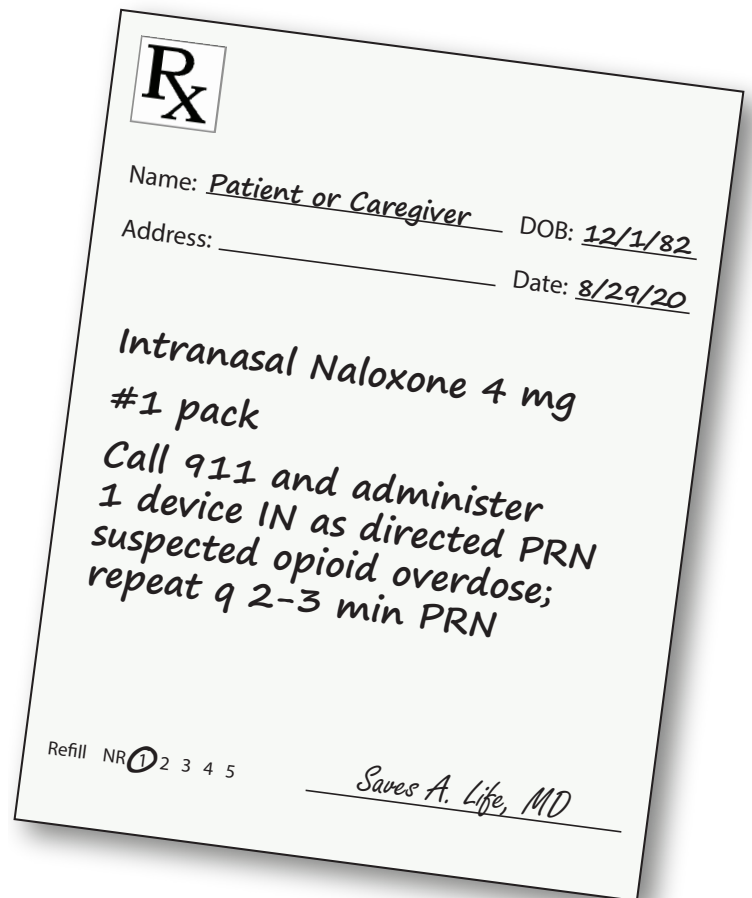
Prescribing Naloxone

Naloxone nasal spray is approved for emergency treatment of opioid overdose. The product is a single-use device that does not require assembly or priming. It is dispensed in a pack of two to allow for re-administration if needed.

Naloxone Education

Overdose response training for patients and caregivers helps ensure naloxone is used correctly in an emergency. Plan extra time or designate a trained staff member to provide this crucial education. Key elements of naloxone education include:

- How to identify an opioid overdose.
- How to respond to a suspected opioid overdose.
- How to administer naloxone nasal spray.
- How naloxone works to reverse an overdose, including anticipated effects and duration.



KY Medicaid covers Narcan Nasal Spray at no cost. To find community organizations offering free doses of naloxone, visit healthtogetherky.org and select your county.

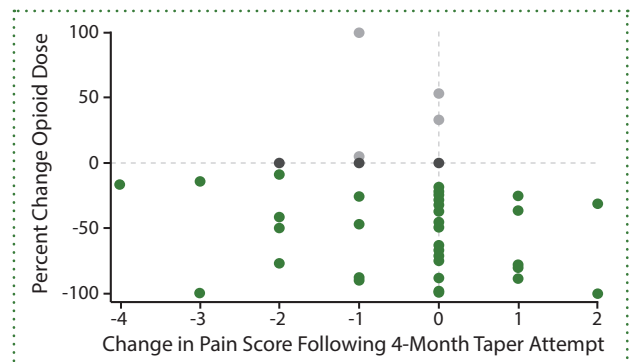


Collaborate with patients to **reduce opioid doses safely and effectively**

Expert guidelines recommend tapering opioids when risks outweigh benefits, but reducing opioid doses can be challenging for patients and prescribers.^{57,80,81}

Pain, function, and quality of life may improve with voluntary opioid dose reduction for patients on long-term opioid therapy for chronic pain.⁸² In most trials, patients receive multimodal, multidisciplinary care with close follow-up.⁸²

In one study, pain clinic patients were educated on the benefits of reducing opioid doses and offered a slow taper over 4 months. Among 82 participants, 51 completed the study. For completers, the median opioid dose was reduced from 288 MME to 150 MME, and neither pain intensity nor pain interference increased. Reaching a 50% dose reduction was not predicted by starting dose, baseline pain intensity, or years prescribed opioids.⁸³



Adapted from Darnall, et al.⁸³

Communication Recommendations

Adapted from Henry et al., Matthias et al., and Goesling et al.⁸⁴⁻⁸⁶

Recommendation	Rationale
Be specific about tapering purpose	Many patients say they do not understand why tapering is needed and may not believe that opioid risks apply to their circumstances.
Avoid blaming policies	Patients report being suspicious of providers who justify tapering by citing a governmental or institutional policy, undermining the patient-provider relationship.
Explore all factors affecting a patient	Tapering affects daily life. Identifying responsibilities and perceived trade-offs between opioid use and activities can increase patient engagement and adherence.
Discuss fear and anxiety	Fear of uncontrolled pain, withdrawal, and negative effects on mood are major barriers to opioid tapering. Addressing these fears can help establish trust.
Commit to non-abandonment	Many patients report fear of abandonment by their providers during or after tapering. Successful tapering may require frequent reassurance.
Share decision-making	Patients express a desire to have some control. Providers can offer options such as how quickly tapering will occur or which medication to taper first.
Avoid stigmatizing language	Patients report distress at “being seen as an addict,” reflecting persistent stigma around opioids. Using clinical, person-first, and nonjudgmental language can help reduce stigma and improve communication.



When to Discuss Tapering or Discontinuing Chronic Opioid Therapy⁸¹

- Patient request
- Resolution of pain
- Inadequate analgesia or lack of meaningful improvement in function
- Intolerable side effects or poor quality of life
- Unclear benefit-harm balance
- Evidence of opioid misuse or OUD
- Overdose or other warning sign related to opioids (e.g., hospitalization, injury, confusion, sedation, slurred speech)
- Concomitant medications or medical conditions that increase risk of overdose

Opioid discontinuation is not recommended when benefits of opioids outweigh risks.⁸⁰

Use Caution: Overdose death and suicide are more common in patients whose chronic opioid therapy is discontinued than in those maintained on opioids.^{87,88}

FDA has warned that rapid tapering or abrupt discontinuation of opioids can cause significant distress and harm.⁸⁹ The risk of death after stopping opioids increases with longer treatment duration and is highest immediately after discontinuation.⁸⁸

Tapering should be collaborative, patient-centered, and individualized:

- Plan extra time for tapering discussion and support.
- Obtain patient buy-in; noncollaborative tapering carries serious risks.
- Treat comorbid mental health conditions. If warranted, assess for OUD and arrange treatment.
- Establish realistic expectations for onset, duration, and severity of withdrawal symptoms. Monitor closely and follow up frequently.
- Educate the patient that while pain might worsen at first, tapering typically results in improved function and unchanged or decreased pain.
- Ensure the patient has psychosocial support.
- Avoid dismissing patients from care, which can increase the risk of overdose.⁸¹

Referral may be warranted if the provider or patient becomes uncomfortable with the taper.

Taper slowly to minimize withdrawal symptoms

- A dose reduction of 5% to 20% every 4 weeks is common.
- Long durations of opioid therapy generally require longer tapers.
 - Reduction of 10% a month or slower for patients on opioids for more than a year.
 - Reduction of 10% a week may work for patients on opioids for weeks to months.
 - Consider rapid taper after a serious adverse event such as overdose.
- Significant withdrawal symptoms signal need to slow or pause taper.
 - Short-term oral medications may alleviate some symptoms.
- Pause and restart a taper if the patient needs time to adjust.
- Extend dosing interval when smallest available dosage form is reached.
- Progress toward a safer dose is a success, no matter how slowly the taper occurs.

Adapted from HHS Guide⁸¹



Kentucky law places specific requirements on prescribing controlled substances for pain.

While regulations vary for physicians, nurse practitioners, and PAs*, the following guidelines are generally applicable:

- Prescribers must hold a valid DEA permit and be registered to use KASPER.
- Prior to initial prescribing, prescribers must:
 - Obtain and review a KASPER report for the previous 12 months.
 - Obtain and document a medical history and conduct a physical or mental health exam.
 - Make a deliberate decision that it is medically appropriate to prescribe the medication.
 - Make a written plan, including objectives of treatment and plan for medication discontinuation.
 - Educate the patient regarding the risks, benefits, and limitations of the medication, including the effect on the ability to drive and how to safely use and dispose of the medication.
 - Obtain written consent for the treatment.
- When prescribing for acute pain:†
 - Prescriptions for Schedule II controlled substances‡ are limited to a 3-day supply unless the prescriber documents medical necessity for and justification of the amount prescribed.
 - Long-acting or controlled-release opioids cannot be prescribed unless the acute pain is directly related to and close in time to a specific surgical procedure.
 - Prescribers must explain to the patient that the medication is for time-limited use and that the patient should discontinue use when the relevant condition has resolved.
- When prescribing for pain lasting longer than 3 months, prescribers must:
 - Formulate an appropriate treatment plan with a schedule for periodic evaluation.
 - Ensure the patient is seen at least once a month, reducing frequency only after:
 - Medication has been titrated to the appropriate and necessary level.
 - Medication is not causing unacceptable side effects.
 - Sufficient monitoring is in place to minimize the likelihood of misuse or diversion.
 - Ensure the patient has had a preventative health screening and appropriate physical exam at least once a year.
 - Obtain and review a current KASPER report at least once every 3 months.
 - Utilize drug screens in a random and unannounced manner at appropriate times.
- **Effective January 1, 2021 all controlled substances must be prescribed via electronic prescription, with limited exceptions.**

Follow state laws & regulations when prescribing opioids

201 KAR 9:230, 201 KAR 9:260, 201 KAR 20:057, KRS 218A.182

*Controlled substance prescriptive authority for PAs is limited to medications on Schedules III, IV, and V.

†Exceptions include major surgery, significant trauma, cancer pain, and end-of-life care; review 201 KAR 9:260 for details.

‡All prescription opioids are on Schedule II except tramadol, pentazocine, butorphanol, buprenorphine, and codeine combinations.



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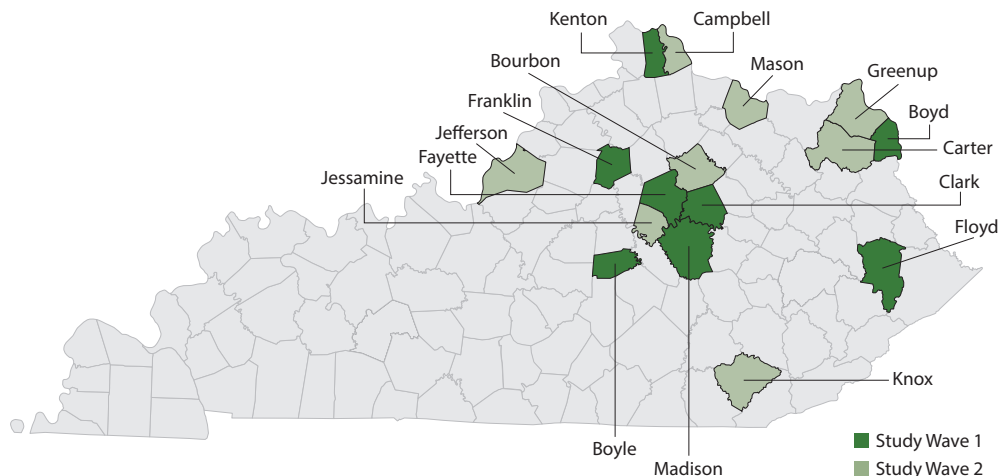
HEALing Communities Study

Ambitiously aiming to reduce opioid overdose deaths by 40% over 3 years

The HEALing Communities Study at the University of Kentucky is a 4-year, \$87 million project funded by the National Institute on Drug Abuse.

Researchers will work with 16 Kentucky counties to leverage existing resources and develop a collaborative model for ending the opioid overdose crisis. Intervention strategies focus on expanding treatment for opioid use disorder, ensuring naloxone availability, and improving prescription opioid safety.

As we implement an integrated set of evidence-based practices, we seek to better understand the unique needs of each community. What we learn will help guide efforts to increase support for patients and families and improve lives throughout Kentucky and across the country.



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