

PROVIDER/CLINICIAN RESOURCES

1. American Society of Addiction Medicine (ASAM) www.asam.org
2. Apply for DATA 2000 Waiver. www.samhsa.gov/medication-assisted-treatment/training-materials-resources/apply-for-practitioner-waiver
3. Calculating Total Daily Dose of Opioids for Safer Dosage Brochure www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf
4. CDC Opioid Guideline Mobile App. www.cdc.gov/drugoverdose/prescribing/app.html
5. Checklist for prescribing opioids for chronic pain. www.cdc.gov/drugoverdose/pdf/pdo_checklist-a.pdf
6. DC Health PDMP. <https://dchealth.dc.gov/service/prescription-drug-monitoring-program>
7. DC PMP AWARDx™ Platform <https://districtofcolumbia.pmpaware.net/login>
8. Development and initial validation of the PEG, a three-item scale assessing pain intensity and interference. Krebs, Erin E et al. Journal of general internal medicine vol. 24,6 (2009): 733-8. doi:10.1007/s11606-009-0981-1. <https://link.springer.com/article/10.1007/s11606-009-0981-1>
9. Foundation for Opioid Response Efforts (FORE). Committed to convening and supporting partners advancing patient-centered, innovative, evidence-based solutions addressing the opioid crisis. <https://forefdn.org/news-updates/>
10. Guideline for Prescribing Opioids for Chronic Pain (Brochure/Fact Sheet) www.cdc.gov/drugoverdose/pdf/prescribing/Guidelines_Factsheet-a.pdf
11. List of CDC-Developed Clinical Tools and Resources. www.cdc.gov/drugoverdose/pdf/guidelines_factsheet-a.pdf
12. Opioid Data Analysis and Resources. www.cdc.gov/drugoverdose/data/analysis.html
13. Pocket Guide: Tapering Opioids for Chronic Pain (Brochure) www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf
14. Urine Drug Testing: A Reference Guide for Clinicians <https://ciswh.org/wp-content/uploads/2017/06/Urine-Drug-Testing-Guide-2013.pdf>
15. White patients far more likely to get popular addiction treatment prescription, study finds. www.inquirer.com/health/buprenorphine-suboxone-prescription-race-disparity-20190508.html

PATIENT SERVICE RESOURCES

Prevention Services focuses on deterring the onset or first use of alcohol, tobacco, and other drugs (ATOD) among youth and reducing substance abuse risk factors for adolescents, families and communities.

1. Buprenorphine Drug Assistance Program. <https://dchealth.dc.gov/bup-dap>
2. DC Prevention Center Locations. <https://dchealth.dc.gov/page/dc-area-addiction-treatment-locations>
3. "LiveLongDC" Text to 888-111 to get a map of naloxone locations <https://livelong.dc.gov/>
4. Medication-Assisted Treatment, Substance Abuse Treatment, and Syringe Service Program locations. <https://dchealth.dc.gov/node/1459696>
5. Opioids for Acute Pain (Brochure) www.cdc.gov/drugoverdose/pdf/patients/Opioids-for-Acute-Pain-a.pdf
6. SAMHSA Behavioral Health Treatment Services Locator. <https://findtreatment.samhsa.gov/>
7. Where Can I Get Narcan in DC? <https://dchealth.dc.gov/node/1450461>

GENERAL OPIOID RESOURCES

1. Department of Health and Human Services (DHHS). www.hhs.gov/opioids/prevention/index.html
2. Food and Drug Administration (FDA). www.fda.gov/drugs/information-drug-class/opioid-medications
3. National Institution of Health (NIH). www.drugabuse.gov/drug-topics/opioids
4. Opioid Basics. www.cdc.gov/drugoverdose/opioids/index.html
5. Substance Abuse and Mental Health Services Administration (SAMHSA). www.drugabuse.gov/drug-topics/opioids

OPIOID TREATMENT PROGRAMS IN THE DISTRICT OF COLUMBIA

BHG XL VI, LLC — Phone: (202) 610-1886 — bhgrecovery.com
1320 Good Hope Road SE, Washington DC, 20020

Department of Veterans Affairs Community Clinic —
Phone: (202) 745-8000 x8336 — washingtondc.va.gov
50 Irving Street N.W., Washington DC, 20037

DOC Central Detention Facility Methadone Program —
Phone: (202) 671-2066 — methadonecenters.com
1900 D Street SE, Washington DC, 20003

PIDARC — Phone: (202) 296-4455 — pidarcdc.org
2112 F Street, Northwest, Suite 102, Washington DC, 20037

UPO Comprehensive Treatment Center —
Phone: (202) 682-6586 — upo.org/ctc/
1900 Massachusetts Ave., S.E. Bldg. 13, Washington DC, 20037

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POCKET GUIDE

FOR SAFE OPIOID PRESCRIBING



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DC MURIEL BOWSER, MAYOR

GUIDELINES FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

The Center for Disease Control's Guidelines for Prescribing Opioids for Chronic Pain is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guidelines are not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long acting (ER/LA) opioids.

When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥ 50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥ 90 MME/day or carefully justify a decision to titrate dosage to ≥ 90 MME/day.

Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥ 50 MME/day), or concurrent benzodiazepine use, are present.

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 dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

Clinicians should assess for and offer/arrange evidence-based treatment for patients with Opioid Use Disorder (OUD). Typically, this would be Medication-Assisted Treatment (MAT) with buprenorphine or methadone in combination with behavioral therapies.

According to CDC guidelines, "Experts agreed that clinicians should not dismiss patients from their practice on the basis of PDMP information. Doing so can adversely affect patient safety, could represent patient abandonment, and could result in missed opportunities to provide potentially lifesaving information (eg. opioid risks and overdose prevention) and interventions (eg. safer prescriptions, nonopioid pain treatment, see Recommendation 1); naloxone, see Recommendation 8; and effective treatment for substance use disorder, see Recommendation 12)."

CHECKLIST FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

When CONSIDERING long-term opioid therapy

- Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- Check that nonopioid therapies tried and optimized.
- Discuss benefits and risks (eg, addiction, overdose) with patient.
- Evaluate risk of harm or misuse.
 - Discuss risk factors (eg, history of substance use, younger age, depression, use of psychotropic medications) 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 Scale Score); 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 nonopioid 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 naloxone.
 - Avoid ≥ 90 MME/day total (≥ 90 mg hydrocodone; ≥ 60 mg oxycodone), if necessary to proceed with ≥ 90 MME, document dosing justification and/or consider specialist referral.
- Schedule reassessment at regular intervals (≤ 3 months).

Consider tapering to a reduced opioid dosage or tapering and discontinuing opioid therapy when your patient:

- Requests dosage reduction
- Does not have clinically meaningful improvement in pain and function (eg, at least 30% improvement on the 3-item PEG scale)
- Is on dosages ≥ 50 MME*/day without benefit or opioids are combined with benzodiazepines
- Shows signs of substance use disorder (eg, work or family problems related to opioid use; difficulty controlling use)
- Experiences overdose or other serious adverse event(s)
- Shows early warning signs for overdose risk such as confusion, sedation, or slurred speech led reassessment.

Tapering plans should be individualized and should minimize symptoms of opioid withdrawal while maximizing pain treatment with nonpharmacologic therapies and nonopioid medications. In general:

Go Slow: A decrease of 10% per month is a reasonable starting point if patients have taken opioids for more than a year. A decrease of 10% per week may work for patients who have taken opioids for a shorter time (weeks to months).

Consult: Discuss the increased risk for overdose if patients quickly return to a previously prescribed higher dose. Coordinate with specialists and treatment experts as needed—especially for patients at high risk of harm such as pregnant women or patients with an opioid use disorder. Use extra caution during pregnancy due to possible risk to the pregnant patient and to the fetus if the patient goes into withdrawal.

Support: Make sure patients receive appropriate psychosocial support. If needed, work with mental health providers, arrange for treatment of opioid use disorder, and offer naloxone for overdose prevention. Watch for signs of anxiety, depression, and opioid use disorder during the taper and offer support or referral as needed.

Encourage: Patient collaboration and buy-in are important to successful tapering. Tell patients that improved function and decreased pain after a taper can be expected, even though pain may initially get worse.

Assessing Pain and Function Using PEG Scale

1. What number best describes your pain on average in the past week?										
0	1	2	3	4	5	6	7	8	9	10
no pain								worst you can imagine		
2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?										
0	1	2	3	4	5	6	7	8	9	10
not at all								complete interference		
3. What number best describes how, during the past week, pain has interfered with your general activity?										
0	1	2	3	4	5	6	7	8	9	10
not at all								complete interference		

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

HOW SHOULD PROVIDERS USE THE TOTAL DAILY OPIOID DOSE IN CLINICAL PRACTICE?

Use caution when prescribing opioids at any dosage and prescribe the lowest effective dose. *Use extra precautions when increasing to ≥ 50 MME per day* such as:-

- Monitor and assess pain and function more frequently.
- Discuss reducing dose or tapering and discontinuing opioids if benefits do not outweigh harms.- Consider offering naloxone.
- Avoid or carefully justify increasing dosage to ≥ 90 MME/day.*

Higher Dosage, Higher Risk.

Higher dosages of opioids are associated with higher risk of overdose and death—even relatively low dosages (20-50 morphine milligram equivalents (MME) per day) increase risk. Higher dosages haven't been shown to reduce pain over the long term. One randomized trial¹ found no difference in pain or function between a more liberal opioid dose escalation strategy (with average final dosage 52 MME) and maintenance of current dosage (average final dosage 40 MME).

* https://www.cdc.gov/drugoverdose/pdf/prescribing/Guidelines_Factsheet-a.pdf

WHY IS IT IMPORTANT TO CALCULATE THE TOTAL DAILY DOSAGE OF OPIOIDS?

Calculating the total daily dose of opioids helps identify patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose.

Patients prescribed higher opioid dosages are at higher risk of overdose death. In a national sample of Veterans Health Administration (VHA) patients with chronic pain receiving opioids from 2004–2009, patients who died of opioid overdose were prescribed an average of 98 MME/day, while other patients were prescribed an average of 48 MME/day.

How should the total dose of opioids be calculated?

Calculating morphine milligram equivalents (MME)

OPIOID OR OPIOID ANTAGONIST*	CONVERSION FACTOR
Codeine	0.15
Fentanyl transdermal (in mcg/hr)	2.4
Hydrocodone	1
Hydromorphone	4
Methadone: 1-20 mg/day	4
Methadone: 21-40 mg/day	8
Methadone: 41-60 mg/day	10
Methadone: ≥ 61 -80 mg/day	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3
Tapentadol	0.4
Naltrexone*	N/A

HOW MUCH IS 50 OR 90 MME/DAY FOR COMMONLY PRESCRIBED OPIOIDS?

50MME/DAY	90MME/DAY
50 mg of hydrocodone (10 tablets of hydrocodone/acetaminophen 5/300)	90 mg of hydrocodone (9 tablets of hydrocodone/acetaminophen 10/325)
33 mg of oxycodone (~ 2 tablets of 15 mg strength sustained-release dosage form)	60 mg of oxycodone (When dosed twice daily, 2 tablets of 15 mg strength oxycodone sustained-release dosage form)
12 mg of methadone (12 mg of methadone as oral liquid dosage form or ~half 5mg tablet and one 10mg tablet)	~20 mg of methadone (4 tablets of methadone 5 mg)

KEY DIFFERENCES IN MEDICATIONS *

	METHADONE	BUPRENORPHINE	NALTREXONE
FDA approval	1972	2002	2010
Mechanism	FULL agonist	PARTIAL agonist	Antagonist
Receptors	μ opioid receptor		
Receptor affinity	Moderate	VERY HIGH	VERY HIGH
Administration	Oral liquid	Sublingual tab/film injection, implant	Injection Oral
Co-formulation	--	NALOXONE	--
Duration of effect	24-36 hrs	Sublingual: 24 - 36 hrs injection: 28 days implant: 6 months	Injection: 28 days Oral 24-48 hrs

MEDICATION ASSISTED THERAPY

Medication-Assisted Treatment (MAT), including Opioid Treatment Programs (OTPs), combines behavioral therapy and medications to treat substance use disorders. Despite overwhelming evidence-based reports and research, however, the treatment of OUD has been driven along racial/ethnic lines. Consequently, the effective but more expensive use of Buprenorphine is more accessible in high-income, non-minority neighborhoods as substantiated by Hansen et al *Drug Alcohol Depend* 2016 publication.

BUP DAP is DC Health's newest approach to encourage DC residents experiencing substance use or misuse to start and stay in medicated assisted treatment. BUP DAP which stands for Buprenorphine Drug Assistance Program, is designed to increase access to drugs used primarily in medication assisted substance misuse treatment (Buprenorphine, Naltrexone, Suboxone, and Naloxone). Please visit our website for more details: <https://dchealth.dc.gov/bupdap>

Treatment of Opioid Use Disorder is typically classified as Pharmacologic and Nonpharmacologic. For pharmacologic treatment, clinicians turn to two major medication categories: Full (methadone) or Partial (buprenorphine) Opioid Agonists and Opioid Antagonists such as naltrexone. Nonpharmacologic approaches traditionally include treatment measures such as detoxification, rehabilitation, and outpatient treatment. Although there is widespread consensus amongst addiction healthcare providers/clinicians that the data regarding the effectiveness of opioid use disorder is robust, unfortunately this sentiment does not extend to nonpharmacologic treatment. Research and data pertaining to the effectiveness of non-pharmacologic treatment measures tend to be limited and/or do not exist. An illustrative summary of OUD treatment is depicted below.

TREATMENT OF OPIOID USE DISORDER *

- Pharmacologic treatment
 - Medications:
 - Opioid agonist: methadone & buprenorphine
 - Opioid antagonist: naltrexone
 - Robust data regarding effectiveness of maintenance treatment
- Nonpharmacologic treatment
 - Detoxification, rehabilitation, residential treatment, outpatient treatment, self-help, etc
 - Limited or no data regarding effectiveness

EFFECTIVENESS OF MEDICATION TREATMENT FOR OPIOID USE DISORDER *

- ▲ Retention in treatment (relieves opioid withdrawal and cravings)
- ▲ Opioid relapse by $>50\%$
- ▲ Opioid overdose deaths by $\sim 75\%$
- ▲ Health complications (HIV, Hepatitis C)
- ▲ Criminal justice costs

HOW CAN WE REDUCE STIGMA?

Changing the Language of Addiction

Terms that stigmatize addiction can affect the perspective and behavior of patients, clients, scientists and clinicians. Clinicians especially need to be aware of person-first language and avoid more stigmatizing terms.

TERMS NOT TO USE

- Addict, abuser, user, junkie, druggie
- Alcoholic, drunk
- Ex-addict, former alcoholic
- Clean/dirty (drug test)
- Addictions, addictive disorders

TERMS TO USE

- Person with a substance use disorder
- Person with an alcohol use disorder
- Person with an opioid use disorder
- Person in recovery
- Addiction, substance use disorder