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# Finding the Balance: Managing pain in primary care

*A Guide for Primary Care Providers*

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## Please Let Us Know You Participated

The HCS Educational Outreach team aims to help health care professionals implement evidence-based best practices related to pain and opioid safety.

**Please take a 2-minute survey to help us track and improve the materials we provide and to opt in or out of further participation.**

To reach HCS directly with questions or feedback please email [monica.roberts@uky.edu](mailto:monica.roberts@uky.edu)





# Key Best Practices

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## Understand and apply the 2022 CDC Guideline

### In November 2022, the CDC issued an updated clinical practice guideline for prescribing opioids.

The major concepts are consistent with the previous guideline. Key themes and notable changes in the new edition include:

**Focus on Risks and Benefits:** A foundational principle of the guideline is assessment of realistic benefits and known risks of opioids. Initiation and adjustment of opioid therapy are only appropriate when benefits outweigh risks and the clinician and patient have engaged in shared decision-making.

**Downplayed Duration and Dose Details:** The 2022 guideline still advises limiting days' supply and careful consideration before increasing opioid doses. However, the recommendations no longer provide the specific thresholds for duration or dose that were included in the 2016 guideline.

**New Guidance on Tapering:** The 2022 guideline includes a section related to patients already on opioid therapy. It recommends continuing opioids when benefits outweigh risks. Detailed advice is provided for gradual, patient-centered tapering when risks outweigh benefits.

**Call for Multimodal Pain Care:** The 2022 guideline continues to emphasize nonpharmacologic and non-opioid therapies and to call for increased reimbursement for and expanded access to multimodal care.

**Emphasis on Flexibility:** The CDC acknowledged misapplication of the 2016 guideline. The 2022 guideline emphasizes clinical judgment and cautions against rigid policy or over-application by organizations or governments.

**Expanded Scope:** The 2022 guideline is intended for clinicians providing acute, subacute, and chronic pain care to adult outpatients. It continues to exclude pain related to sickle cell disease or cancer and to palliative and end-of-life care.



### Guiding Principles

Pain needs to be appropriately assessed and treated, whether or not opioids are part of treatment.

Recommendations are **voluntary** and support individualized, person-centered care. Flexibility to meet patient needs is critical.

Pain management requires a multimodal, multidisciplinary approach.

Special attention should be given to avoid misapplying the guideline or implementing policies that unintentionally cause harm to patients.

All health care entities should attend to health inequities, provide culturally appropriate and accessible communication, and ensure access to effective pain management regimens for all persons.

*Adapted from the 2022 CDC Guideline*

Clinicians are encouraged to read the guideline using the provided QR code or reference. The remainder of this guide was developed prior to the guideline's release, but the principles presented here have been reviewed for consistency with its recommendations.

Dowell D, et al. CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022. *MMWR Recomm Rep.* 2022;71. doi:10.15585/mmwr.rr7103a1





## 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.<sup>1</sup>

Pain intensity on a 0 to 10 scale 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.<sup>1</sup>

The treatment of pain should be individualized to address suffering and functional impairment.<sup>1</sup>

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.

Successful pain management 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."*<sup>13</sup>



### Tips for Specialist Referral

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

- Referral is indicated when current treatment is not working and next steps are unclear or when the provider is uncomfortable continuing treatment.
- Pain may have no known cause despite extensive workup. A specialist can help 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.
- Consider referral when milestones such as pain duration or opioid dose 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 a specialist in addiction medicine may be appropriate when clear evidence of misuse is present.

*Adapted from The American Academy of Pain Medicine<sup>3</sup>*





## 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.**

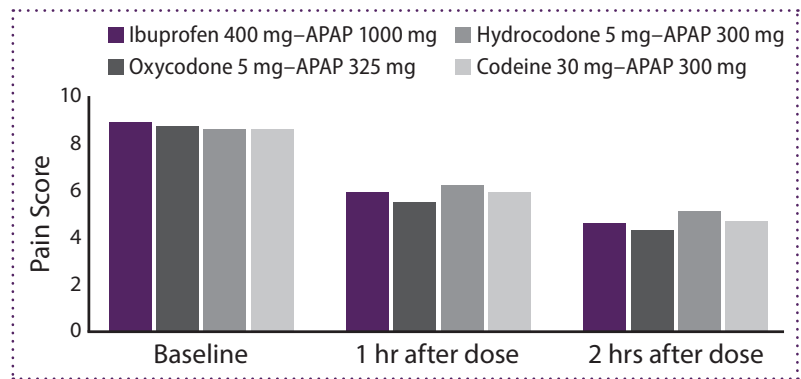
Additionally, studies show that around half of patients presenting to the emergency department with pain do not desire any analgesic.<sup>5,6</sup> In a small study of patients with acute musculoskeletal pain, only 11% expressed a preference for an opioid.<sup>6</sup>



### 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.<sup>7-9</sup>

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.<sup>9</sup>



Adapted from Chang, et al.<sup>9</sup>

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.<sup>7</sup>



### Acute Low Back Pain

Acute or subacute low back pain typically improves over time regardless of treatment.<sup>10</sup> 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.<sup>10</sup>

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.<sup>11</sup> Adverse effects were more likely among patients who received cyclobenzaprine or oxycodone/acetaminophen.<sup>11</sup> Nearly 40% of patients used the as-needed medication less than once a day, only once, or not at all.<sup>11</sup>



#### 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.<sup>12,13</sup> NSAID use is supported by the mechanism of inhibiting prostaglandin synthesis, a central factor in the development of renal colic.<sup>14</sup> Ketorolac (IM or IV) and ibuprofen (IV) are commonly used evidence-based options for severe pain from renal colic.<sup>14</sup>



#### 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.<sup>15,16</sup>

Treatment recommendations for acute migraine attacks include:

- Non-specific agents (e.g., acetaminophen, NSAIDs, caffeinated analgesic combinations) for mild to moderate migraine.
- Migraine-specific agents (e.g., triptans, gepants, lasmiditan) for moderate to severe migraine or poor response to non-specific agents.
- 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.<sup>17–19</sup>

Noninvasive neuromodulation devices are FDA-cleared for treating acute migraine. These devices have been classified as having nonsignificant risk.<sup>19</sup>

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



#### 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:** Explain test results and diagnoses, and be clear about their limitations. Chronic pain often does not correlate with physical exam or imaging findings. Establish realistic expectations for pain management.

*Adapted from Bergman et al.,  
Smith et al., and Haverfield et al.<sup>21–23</sup>*



**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.<sup>24</sup>

**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.<sup>25,26</sup>

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

**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.<sup>27</sup>

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.<sup>28</sup>

### 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](http://www.exerciseismedicine.org) for implementation tools and resources for health care professionals.

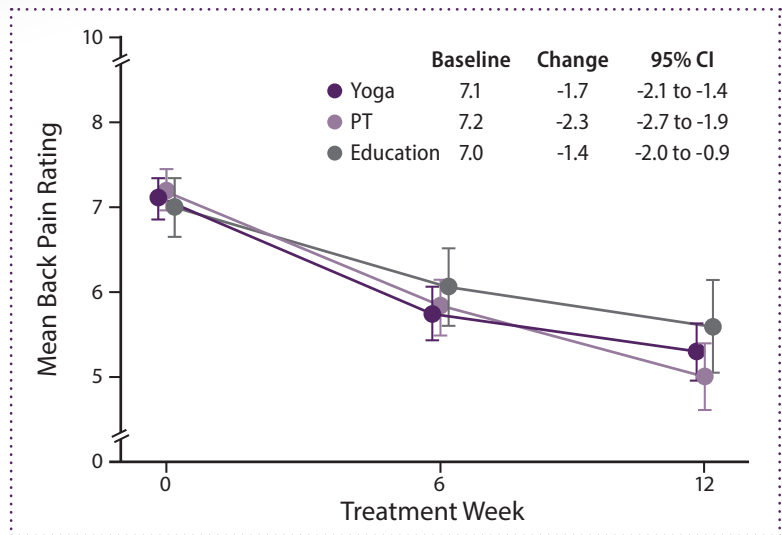
*Adapted from Booth, et al.<sup>24</sup>*



## Finding the Balance

### Managing pain in primary care

**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.<sup>29</sup>



Adapted from Saper, et al.<sup>29</sup>



### 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.”<sup>30</sup> 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.<sup>31</sup>

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.<sup>32</sup>



### Cognitive Behavioral Therapy (CBT)

CBT aims to reduce distress and improve function by helping individuals decrease maladaptive thoughts and behaviors and increase self-efficacy.<sup>33</sup> CBT can also be used to treat mood, anxiety, sleep, and other mental health disorders that often co-occur with chronic pain.<sup>33</sup> 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.<sup>34</sup>



### Massage

Massage therapy is a widely accepted treatment for musculoskeletal disorders and chronic pain conditions.<sup>35</sup> 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.<sup>35,36</sup>





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.”*<sup>37</sup>

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.<sup>37</sup>

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.<sup>38</sup>



### 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.<sup>39</sup> 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.<sup>39,40</sup>

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.<sup>41</sup> These findings were consistent with several similar European acupuncture trials.<sup>41</sup>

Adverse events are infrequent and generally mild in studies of acupuncture conducted by trained and licensed practitioners.<sup>26,39,41</sup>

### 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](http://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.<sup>42</sup> 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.<sup>43,44</sup>

### Evidence for Non-Opioid Medications for Select Chronic Pain Conditions<sup>45-52</sup>

Drug Class	Example Drugs	Low Back Pain	Osteo-arthritis	Fibro-myalgia	Diabetic Neuropathy	Proposed Mechanism
	Acetaminophen	? <sup>a</sup>	★ <sup>b</sup>	⊖		Activation of descending inhibitory pathways
Oral NSAIDs	Ibuprofen Celecoxib	★★	★★	⊖		Decreased formation of prostaglandins via inhibition of COX enzymes
Topical NSAIDs	Diclofenac		★★			
Muscle Relaxers	Cyclobenzaprine	? <sup>c</sup>		?		Reduction in tonic somatic motor activity
SNRIs	Duloxetine Venlafaxine	★★	★★	★★	★★	Inhibition of serotonin & norepinephrine reuptake
SSRIs	Paroxetine Fluoxetine	⊖		★	★ <sup>d</sup>	Inhibition of serotonin reuptake
TCA's	Desipramine Nortriptyline	? <sup>e</sup>		★★	★★	Neuromodulation of serotonin & norepinephrine
Gabapentinoids	Gabapentin	⊖		★	★★	Reduced excitability of glutamergic neurons
	Pregabalin	⊖ <sup>f</sup>		★★	★★	
	Topiramate	?			⊖	Anticonvulsant via multiple potential mechanisms
	Low-dose Naltrexone			★		Opioid receptor antagonism; reduced microglia activation
	Topical Lidocaine	⊖ <sup>g</sup>			★★	Blocked nerve conduction via reduced sodium permeability
	Topical Capsaicin	★			★ <sup>h</sup>	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.<sup>53</sup> Formal self-management programs are offered in group or individual sessions, via online or telephone courses, or by self-study toolkits.<sup>53</sup> 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.acpanow.com](http://www.acpanow.com)

Choose PT:  
[www.choosept.com](http://www.choosept.com)

Self-Management Resource Center:  
[www.selfmanagementresource.com](http://www.selfmanagementresource.com)

### Supporting Chronic Pain Self-Management

*Adapted from Mann, et al.; ACPA; and Dorflinger, et al.<sup>53-55</sup>*

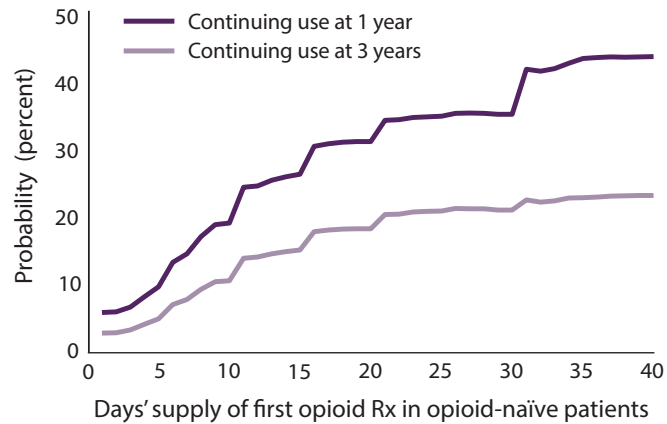
Feature	Details	Provider's Role
Acceptance	Patient shifts toward managing pain as a long-term practice rather than seeking a "cure."	Educate patients on the nature of their pain with a focus on the biopsychosocial model of chronic pain.
Working alliance	Provider and patient develop a positive bond and 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.<sup>56</sup>

The CDC Guideline recommends limiting the use of opioids to the lowest effective dose and smallest quantity needed for the expected duration of severe pain. The guideline notes that a few days' supply is sufficient for many common acute pain conditions and limits the need for tapering at the end of the course.<sup>57</sup>



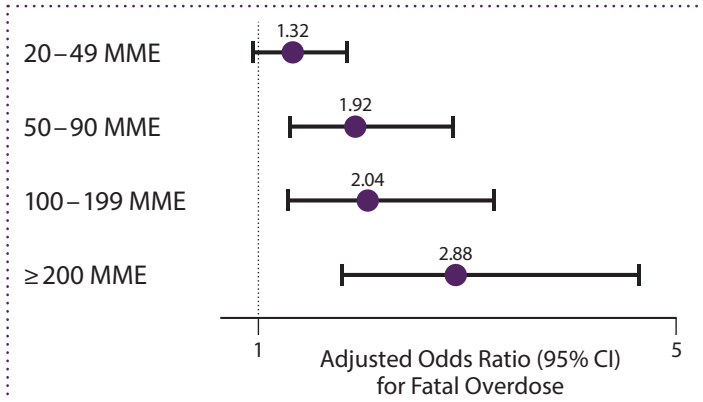
Adapted from Shah, et al.<sup>56</sup>

**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.<sup>58</sup> Additionally, patients who initiate therapy with long-acting opioids are more likely to develop chronic opioid use.<sup>56</sup>

### 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.<sup>59</sup>

Non-fatal overdoses also increase with higher doses.<sup>60</sup> 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.<sup>60</sup>



Adapted from Gomes, et al.<sup>59</sup>

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





**Methadone poses unique challenges.**

Although methadone accounted for about 1% of opioid analgesic prescriptions in 2014, methadone was involved in 22.9% of opioid-related deaths.<sup>63</sup> This imbalance prompted a reevaluation of methadone use for pain.

Methadone prescribers must consider its unique pharmacokinetic and pharmacodynamic properties and monitor for drug interactions and 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



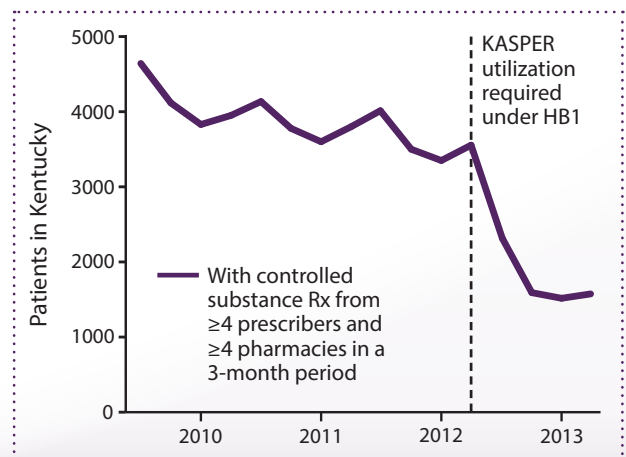
**Exposure in adolescence might lead to misuse:** Individuals who have had an opioid prescription by 12th grade are, on average, 33% more likely to misuse prescription opioids after high school than those with no opioid prescription. Risk triples in otherwise low-risk individuals.<sup>64</sup>

**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.<sup>57</sup>**

**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.<sup>65</sup>



Adapted from Freeman, et al.<sup>65</sup>

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



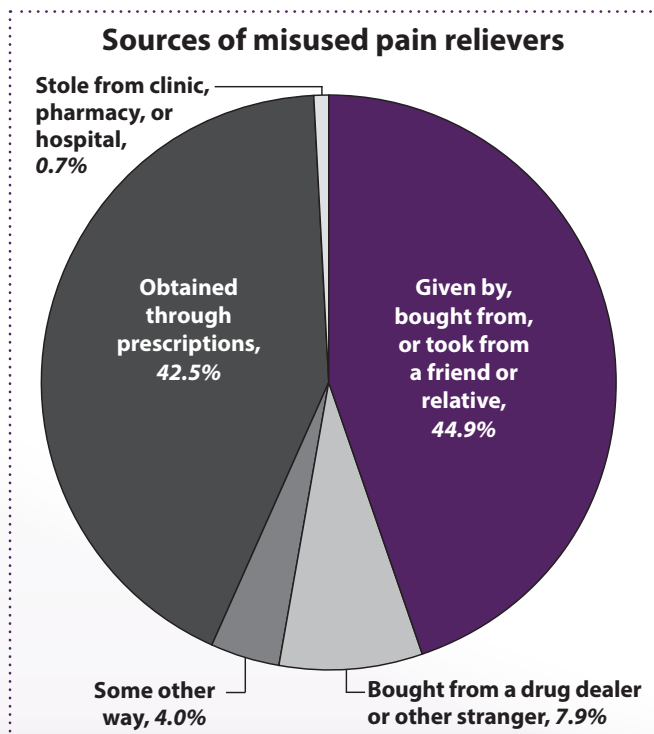
### Other Risk-Mitigation Strategies

Other frequently employed risk-mitigation strategies lack robust evidence supporting their use. When used collaboratively instead of punitively, treatment agreements can serve as a written aspect of informed consent. Urine drug testing, pill counts, and misuse screening tools provide information, but results may be misinterpreted. Successful use of risk-mitigation tools requires trust between the patient and prescriber. In some circumstances, specific strategies may be required by law. 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.<sup>66</sup>

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

Identifying OUD in patients on long-term opioid therapy for chronic pain can be difficult. Behaviors typically associated with OUD may also reflect unsatisfactory pain relief or other facets of the pain condition.<sup>67,68</sup> Recent studies of patients on opioid therapy show about 9% meet DSM-V criteria for moderate to severe OUD.<sup>68-70</sup> When assessing a patient who is taking prescribed opioids, do not consider tolerance and withdrawal as symptoms of OUD.<sup>70</sup> Patients with OUD should be referred to a provider who is experienced in managing comorbid pain and addiction for possible treatment with buprenorphine or methadone, which are associated with reductions in opioid-related morbidity and overdose mortality.<sup>71,72</sup>

### Almost half of people who misused pain relievers in the past year obtained them from a friend or relative.<sup>73</sup>



Adapted from SAMHSA<sup>73</sup>

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.<sup>74</sup>

The FDA recommends immediate disposal of unused medication and suggests the following means of disposal, in preference order:<sup>75</sup>

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.



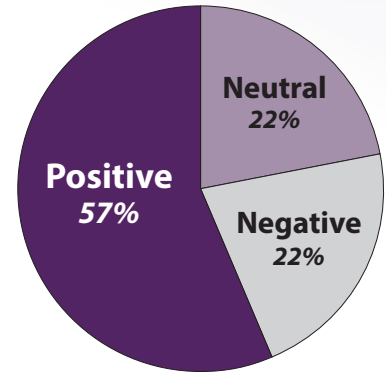
## Prescribe naloxone to patients on long-term opioid therapy

### Naloxone administration by bystanders during an overdose significantly increases the odds of survival.<sup>76</sup>

FDA recommendations encourage increased access to naloxone.<sup>78</sup>

- 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.

### 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.<sup>79</sup>

### Populations at High Risk for Overdose

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

### Naloxone Education

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

### Prescribing Naloxone

Multiple naloxone products are designed for use by trained bystanders and approved for the emergency treatment of known or suspected opioid overdose as manifested by respiratory and/or central nervous system depression.

When selecting a product, consider:

- Risk factors for overdose
- Risk of opioid withdrawal upon naloxone administration
- Patient and caregiver preferences
- Product availability and price

**The first over-the-counter naloxone product was approved in 2023. However, writing a prescription allows patients to access cost savings through insurance, Medicaid, and discount programs.**

For more information about prescribing naloxone and to access the Kentucky Naloxone Copay Program, visit [www.kphanet.org/copay](http://www.kphanet.org/copay)

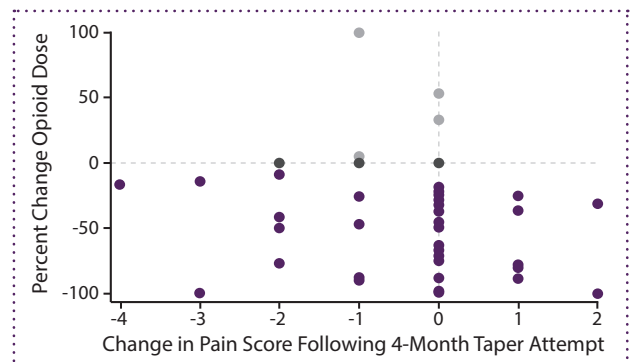


# Collaborate with patients to reduce opioid doses safely and effectively

Expert guidelines recommend tapering opioids when risks outweigh benefits, but reducing opioid doses can be challenging for patients and prescribers.<sup>57,80,81</sup>

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

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.<sup>83</sup>



Adapted from Darnall, et al.<sup>83</sup>

## Communication Recommendations

Adapted from Henry et al., Matthias et al., and Goesling et al.<sup>84-86</sup>

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 Therapy<sup>81</sup>

- 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.<sup>80</sup>**

**Use Caution: Overdose death and suicide are more common in patients whose chronic opioid therapy is discontinued than in those maintained on opioids.<sup>87,88</sup>**

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

**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.<sup>81</sup>

**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 Guide<sup>81</sup>*



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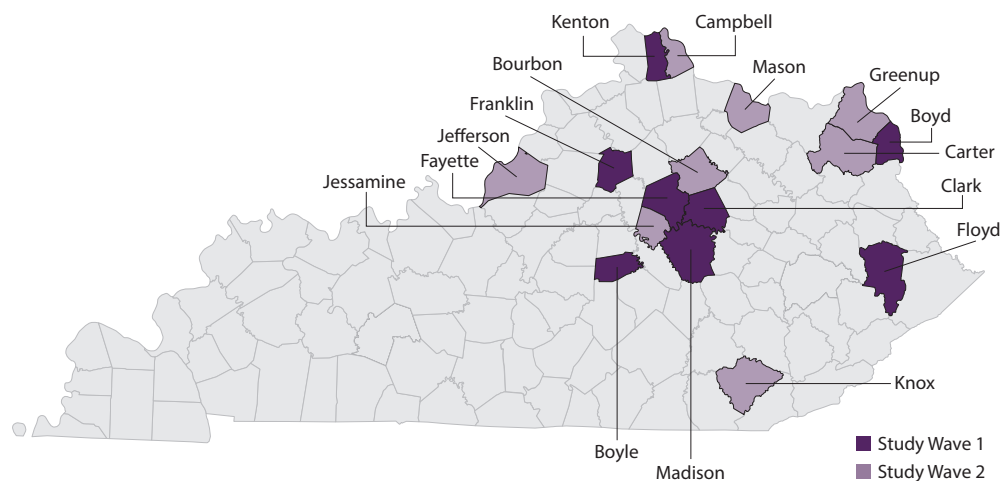
# HEALing Communities Study

**Ambitiously aiming to reduce opioid overdose deaths by 40%**

**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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*The authors wish to express our sincere gratitude to Edward Michna, MD, JD, RPh, Assistant Professor, Harvard Medical School, for his insightful and invaluable feedback during the development of these materials.*