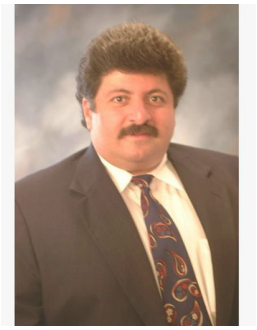
Opioid Prescribing TOOLKIT

A Message from the Commissioner of the Putnam County Department of Health

At one time opioids were touted as the "perfect" solution for pain management. Today our county's opioid-related deaths have proven this false. Unfortunately opioid overdose fatalities tell only part of the epidemic. Recent years have shown a skyrocketing number of naloxone-saved lives—potential deaths averted by this opioid-reversing medication.

By practicing these clinical guidelines developed by the Centers for Disease Control and Prevention, we can reverse this trend and end this sad epidemic.

Thank you.
Michael J. Nesheiwat, MD
Commissioner of Health



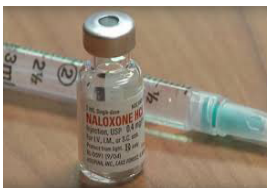
The Opioid Epidemic in Putnam County

The Opioid Prescribing Toolkit was developed by The Putnam Communities That Care (CTC) Coalition and Partnership For Success grant. The Coalition consists of over 100 community partners including non-profit agencies, local schools, government agencies, human services and health organizations, businesses, and others from all sectors of the community. The Putnam CTC coalition uses data to identify risk and protective factors related to the health and wellness of our youth and implements evidence-based environmental strategies to address these issues.

This Toolkit was created with the intention to help Putnam County providers determine when and how to prescribe opioids for chronic pain. It is also designed to show how to consider and use less risky and effective non-opioid and non-pharmacologic options. The Toolkit addresses dosage, duration, follow-up, and discontinuation as well as tips for assessing risk and potential harm.

Most 12-25 year olds who abuse or misuse prescription drugs are getting them at home or from friends/family.*

Emergency Department Visits**
2015 All Opioid Overdoses = 36
2016 All Opioid Overdoses = 39
2017 All Opioid Overdoses = 59
2018 (January to June) Opioid Overdoses = 27



Opioid Related Deaths***
2015 Opioid Overdoses Resulting in Death = 14
2016 Opioid Overdoses Resulting in Death = 15
2017 Opioid Overdoses Resulting in Death = 24
2018 Opioid Overdoses Resulting in Death = 18

**Putnam County PNA/YAS Survey Data 2015*
***NYS-County Opioid Quarterly Report 2016/2017/2018*
****Based upon Putnam County Coroners' Report 2015/2016/2017/2018*

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

PUTNAM COALITION CTC

Guideline for Prescribing Opioids for Chronic Pain

IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC's Guideline 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 Guideline is not intended for patients who are in active cancer treatment, pallilative care, or end-of-life care.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

☑ Non-pharmacologic therapy and non-opioid 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 non-pharmacologic therapy and non-opioid 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 therapy will be discontinued, if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvements in pain and function that outweigh 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. They should carefully reassess evidence of individual benefits and risks when 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 that is severe enough to require opioids. Three days or less will often be sufficient; more than 7 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 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 strategies into the management plan to mitigate risk. Naloxone should be considered when factors that increase risk for opioid overdose are present, such as: history of overdose or substance abuse, 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 PDMP data to determine whether the patient is receiving other opioids or dangerous combinations that put him/her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy, ranging from every prescription to every 3 months.

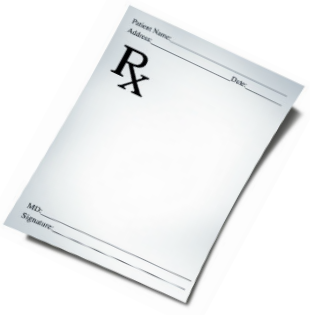
☑ When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription and illicit drugs.

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

☑ Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

Clinical Reminders

- Use immediate-release opioids when starting treatment.
- Start low and go slow.
- When opioids are needed for acute pain, prescribe no more then needed.
- Do not prescribe ER/LA opioids for acute pain.
- Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed.
- Evaluate risk factors for opioid-related harms.
- Check PDMP for high dosage and prescriptions from other providers.
- Use urine drug testing to identify prescribed substance and undisclosed use.
- Avoid concurrent benzoidiazepine and opioid prescribing.
- Arrange treatment for opioid use disorder if needed.



*Adapted from the Centers for Disease Control and Prevention

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 non-opioid therapies have been tried and optimized.
- Discuss benefits and risks (addiction and overdose)with patient. Evaluate risk of harm or misuse.
- Discuss risk factors with patient.
- Check prescription drug monitoring program (PDMP) data.
- Check urine drug screen.
- Set criteria for stopping or continuing opioids.
- Assess baseline pain and function (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

- Set criteria for stopping or continuing opioids.

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

NON-OPIOID TREATMENTS FOR CHRONIC PAIN

PRINCIPLES OF CHRONIC PAIN TREATMENT

Patients with pain should receive treatment that provides the greatest benefit. Opioids are not the first-line therapy for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. Evidence suggests that non-opioid medications and non-pharmacological therapies, can provide relief to those suffering from chronic pain, and can provide safer and effective relief.

EFFECTIVE approach to chronic pain should:

Use non-opioid therapies to the extent possible.

Identify and address co-existing mental health conditions (depression, anxiety, PTSD).

Focus on functional goals and improvements, engaging patients actively in their pain managment.

Use disease-specific treatment when available (triptans for migraines, gabapentin/pregabalin/ duloxetine for neuropathic pain).

Use first-line medications options perferentially.

Consider interventional therapies (corticosteroid injections) in patients who fail standard non-invasive therapies.

Use multimodal approaches, including interdisciplinary rehabilitation for patients who have failed standard treatments, have severe functional deficits, or psychosocial risk factors.

CTC PUTNAM COALITION

https://preventioncouncilputnam.org/coalitions

@putnamctc @putnamctc

Putnam Communities That Care Coalition
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Carmel, NY 10512
845-225-4646

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

Community Drop Box Sites

Safely dispose of medications at one of our Putnam County drop box sites.

Putnam County Sheriff's Department
3 County Center
Carmel, NY 10512
Open 24/7

Putnam Valley Town Hall
265 Oscawana Lake Road
Putnam Valley, NY 10579
Open during regular business hours

The Kern Building
(Lower Floor of Dept. of Health Building)
1 Geneva Road
Brewster, NY 10509
Open during regular business hours

Philipstown
Town Hall
238 Main Street
Cold Spring, NY 10516
M-F 8:30a.m. to 4 p.m.

Kent Police Department
25 Sybil's Crossing
Kent, NY 10512
Open 24/7

Patterson Town Hall
1142 Route 311
Patterson, NY 12563
Open during regular business hours

OASAS Approved Treatment Providers

Arms Acres
75 Seminary Hill Road
Carmel, NY 10512
Outpatient Services 845-225-5202
Inpatient and Detox 845-225-3400
Medicated-Assisted Treatment available
www.armsacres.com

CoveCare Center
1808 Route Six
Carmel, NY 10512
845-225-2700 ext.102
Mental Health and Substance Abuse Issues
www.covecarecenter.org

St. Christophers Inn
21 Franciscan Way
Garrison, NY 10524
845-335-1020
Detox, rehabilitation programs for men 18 and over.
Medicated-Assisted Treatment available
www.stchristophersinn-graymoor.org

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