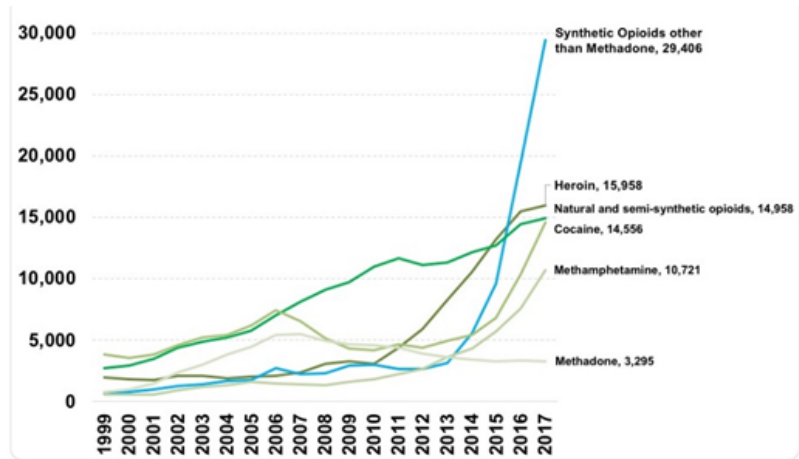


OPIOID USE IN MISSOURI: Opioid Prescribing Guidelines

Despite attention and action, the opioid epidemic continues a devastating march across every community. Between 1999 and 2016, more than 350,000 people died from an overdose involving an opioid.ⁱ Preliminary Centers for Disease Control and Prevention [data](#) from the National Institute on Drug Abuse suggests that deaths in 2017 from drugs, including prescribed opioid and illicit drugs, are the highest yet at more than 72,000.ⁱⁱ This two-fold increase in one decade is attributed solely to the opioid epidemic. While the majority of deaths are from illicit opioids, most people initiate drug use with prescription opioids.

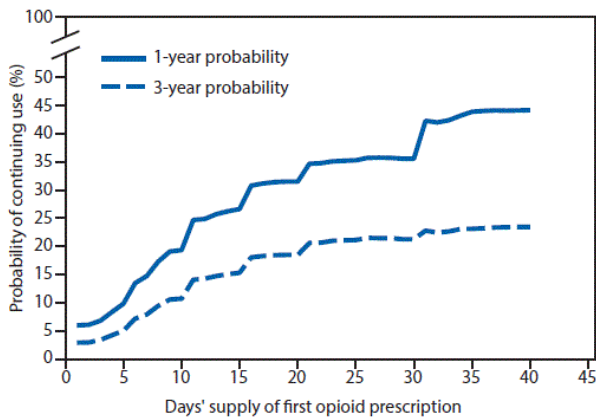
Drugs Involved in U.S. Overdose Deaths, 1999 to 2017



Source: <https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates>

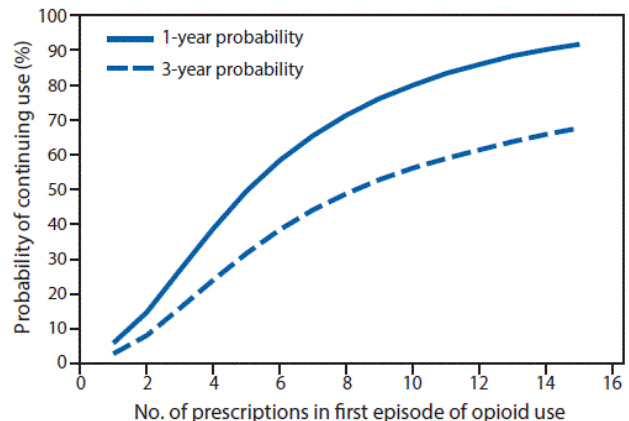
[Research](#) continues to suggest that the risk of long-term use of opioids, especially among opioid-naïve patients, increases based on the type and duration of opioid prescribed.ⁱⁱⁱ

FIGURE 1. One- and 3-year probabilities of continued opioid use among opioid-naïve patients, by number of days' supply* of the first opioid prescription — U.S., 2006–2015



*Days' supply of the first prescription is expressed in days (1–40) in 1-day increments. If a patient had multiple prescriptions on the first day, the prescription with the longest days' supply was considered the first prescription.

FIGURE 2. One- and 3-year probabilities of continued opioid use among opioid-naïve patients, by number of prescriptions* in the first episode of opioid use — U.S., 2006–2015



*Number of prescriptions is expressed as 1–15, in increments of one prescription.

Source: <https://www.cdc.gov/mmwr/volumes/66/wr/pdfs/mm6610a1.pdf>

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It is evident additional research and practice changes must include alternatives to opioids for pain management. The Alternatives to Opiates Program (ALTO) was launched in 2016 by St. Joseph’s University Medical Center in Paterson, N.J. This program offers multimodal pain management for five conditions: low-back pain, acute headaches, migraines, kidney stones and broken bones.^{iv} Programs such as this now serve as innovative models to advance clinical practice for pain management. ALTO must be aligned with policy and payment changes to support increased options to alleviate and manage pain. For example, increased access for noninsured or underinsured patients to dental resources should be encouraged in an effort to alleviate the need to manage nontraumatic tooth pain in the emergency department.

If opiates are deemed appropriate clinical treatment for pain management, established prescribing policies and assessment for risk behavior and treatment referral should be coordinated with primary care providers to ensure comprehensive clinical care and reduce opioid use disorder. As defined by the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, OUD is a problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two of 11 criteria.^v

TABLE 1: DSM-5 Diagnostic Criteria for Opioid Use Disorder^{xvii}

To confirm a diagnosis of OUD, at least two (2) of the following should be observed within a 12-month period		
DSM-5 Criteria		Example Behaviors
1	Tolerance*	Needing to take more and more to achieve the same effect, asking for increased dose without worsened pain
2	Withdrawal* (or opioids are taken to relieve or avoid withdrawal)	Feeling ill if opioid is not taken on time or exhibiting withdrawal effects
3	Craving or strong desire or urge to use opioids	Describes constantly thinking about and/or needing the opioid
4	Recurrent use in situations that are physically hazardous	Repeatedly driving under the influence
5	Using larger amounts of opioids or over a longer period than initially intended	Taking more opioid than prescribed. Repeated requests for early refills
6	Persisting desire or unable to cut down on or control opioid use	Has tried to reduce dose or quit opioid because of family’s concerns about use but has been unable to
7	Spending a lot of time to obtain, use, or recovery from opioids	Driving to different doctor’s offices every month to get renewals for various opioids prescriptions
8	Continued opioid use despite persistent or recurrent social or interpersonal problems related to opioids	Spouse or family member worried that patient’s opioid use could lead to divorce, loss of employment, death
9	Continued use despite physical or psychological problems related to opioids	Unwilling to discontinue or reduce opioid use despite non-fatal accidental overdose
10	Failure to fulfill obligations at work, school, or home due to use	Not finishing tasks at work due to taking frequent breaks to take opioid and/or recover from affects
11	Activities are given up or reduced because of use	No longer participating in weekly softball league despite no additional injury or reason for additional pain

*These diagnostic criteria not considered to be met for those individuals taking opioids solely under appropriate medical supervision.



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In 2015, clinicians and leaders from The Missouri Academy of Family Physicians, the Missouri Association of Osteopathic Physicians and Surgeons, the Missouri College of Emergency Physicians, the Missouri Dental Association, the Missouri Hospital Association, and the Missouri State Medical Association implemented consensus and evidence-based opioid prescribing guidelines for ED prescribers. This is one component of a multifaceted approach addressing the opioid crisis in Missouri. The most recent survey among hospital quality staff in 2017 suggests the majority of these guidelines were adopted in 73 percent of responding hospitals (66 percent response rate).

Since releasing the ED opioid prescribing guidelines, a multitude of additional policy and practice changes have been implemented, including the CDC Guideline for Prescribing Opioids for Chronic Pain (March 2016).^{vi}

The Centers for Medicare & Medicaid Services [proposed](#), through call letter procedures, to implement in 2019 the 2016 Comprehensive Addiction and Recovery Act (CARA) drug management program issued rules and payment change to establish safety edits for opioid prescribing, which include the following.^{vii, viii}

- Limit prescriptions for opioid naïve patients to seven days.
- Implement care coordination edits at 90 morphine milligram equivalent (MME) per day.

- Establish a threshold of 200 MME per day.

In Missouri, [Senate Bill 826](#) was passed into law on Aug. 28, 2018, and also includes a seven-day supply of opioids for first time diagnosis and treatment of acute pain for most conditions.^{ix}

Positive federal policy changes have been made in evaluating patient satisfaction, specifically related to pain management in the ED. Hospitals and providers no longer receive payment penalties for low Hospital Consumer Assessment of Healthcare Providers and Systems. HCAHPS survey questions comprising Pain Management Composite 4 have been removed from the HCAHPS Survey, as noted in the FY 2018 IPPS/LTCH PPS Final Rule (81 FR 38342). Effective July 2018, this survey question no longer is reported on Hospital Compare.^x As a result, ED providers should not feel compelled to provide controlled substances to patients to improve patient satisfaction ratings. Hospitals should not fault ED providers for not prescribing narcotics if the provider determines that they are not indicated.

USE OF PRESCRIPTION DRUG MONITORING PROGRAM

Prescribing guidelines and practice changes must be based on a complete and accurate patient assessment. Clinicians practicing in Missouri are limited in their assessment by the lack of a

statewide prescription drug monitoring program. The St. Louis County Department of Public Health created a [PDMP system](#) that currently includes jurisdictions that account for more than 80 percent of Missouri's population and 90 percent of providers.

Without a statewide PDMP, the consensus is that, while checking a PDMP is essential to assessing a patient with a complex or ambiguous pain diagnosis, a PDMP query should not be included as a specific prescribing guideline. Just as importantly, the PDMP should be used as a tool to initiate discussion about the risks of opioid use and not a method of abrupt termination of opioids, which could lead to more dangerous drug use for the patient.

MEDICATION-ASSISTED TREATMENT

As noted in a recent MHA [Trajectories](#) focused on medication-assisted treatment, with effective and ongoing treatment, individuals suffering from OUD can reach long-term remission. However, the Substance Abuse and Mental Health Services Administration estimates that nearly 80 percent of individuals with an OUD do not receive treatment.^{xi}

A systematic approach is required to reduce the toll of OUD. An emerging model of care that adopts a “medication first” approach already has produced



results in Missouri and nationally.^{xiii} This evidence-based system is expanding throughout Missouri as a component of a three-faceted OUD care, harm reduction and avoidance strategy. The model includes: adopting a medication first model, incorporating both naloxone as a rescue medicine and buprenorphine to treat OUD, leveraging existing community resources to ensure patient access to treatments through transitions of care, and improving opioid prescribing practices to reduce OUD and overdose prevalence.

Similar to the PDMP, although research and early models of care in Missouri are encouraging, the consensus among clinicians was to encourage MAT, but not to include as a guideline.

2018 REVISED MISSOURI OPIOID PRESCRIBING GUIDELINES

Hospital and Hospital Emergency Department Prescribing Guidelines for Reduced Opioid Misuse and Abuse

- A focused pain assessment prior to determination of treatment plan should be conducted. If the patient's pain prohibits a comprehensive assessment, then judicious use of opioids to alleviate pain is suggested. While the pain assessment should include risk factors for addiction and the incorporation of non-narcotic analgesics, a specific written, comprehensive assessment is not required.^{xiii}
- The Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain should serve as a primary resource. The clinical decision to prescribe opioids in excess of, or for longer duration than the guidelines suggest, should be documented.ⁱⁱⁱ
- Diagnoses based on evidence-based guidelines and appropriate diagnostics whenever possible.^{xiv}
- Non-narcotic treatment of symptomatic, non-traumatic tooth pain should be utilized when possible.^{xiv}
- Treatment of patients with acute exacerbation of existing chronic pain should begin with an attempt to contact the primary opioid prescriber or primary care provider, if circumstances are conducive.^{xiii, xiv}
- In the ED, opioid analgesic prescriptions for chronic conditions, including acute exacerbation of existing chronic pain management, should be limited to no more than 72 hours, if clinically appropriate and after assessing the feasibility of timely access for follow-up care.^{vii, viii}
- For new conditions requiring narcotics, the length of the opioid prescription should be limited to the shortest duration needed, but not to exceed seven days. Outpatient access to follow-up care should be taken into consideration regarding the length of the prescription.^{iv, vi, vii}
- ED physicians and providers should not provide prescriptions for controlled substances that are claimed to be lost or destroyed.^{xiv}
- Unless otherwise clinically indicated, ED physicians and providers should not prescribe long-acting or controlled release opioids. If indicated, prescribers should provide tamper-resistant, or abuse deterrent, forms of opioids.^{xiv, xvi}
- When narcotics are prescribed, ED staff should counsel patients on proper use, storage, and disposal of narcotic medications.^x
- Health care providers should evaluate and consider discharging patients at risk of overdose with prescriptions for naloxone.^{xvi}



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ENDNOTES

- i Centers for Disease Control and Prevention (n.d.) Understanding the epidemic. Retrieved September 13, 2018, from <https://www.cdc.gov/drugoverdose/epidemic/index.html>
- ii National Institute on Drug Abuse (2018, August). Overdose death rates. Retrieved September 13, 2018 from <https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates>
- iii Shah, A., Hayes, C. J. & Martin, B. C. (2017). Characteristics of initial prescription episodes and likelihood on long-term opioid use – United States, 2006-1015. *Morbidity and Mortality Weekly Report*, 66(10), 265-269. doi: <http://dx.doi.org/10.15585/mmwr.mm6610a1>
- iv Rodriguez, T. (2018, March 16). Non-opioid therapies for pain management in the ED. *Clinical Pain Advisor*. Retrieved from <https://www.clinicalpainadvisor.com/acute-pain/emergency-department-pain-management-non-opioid-alternatives-ketamine-regional-anesthesia/article/751223/>
- v American Psychiatric Association (n.d.) *Diagnosis and statistical manual of mental disorders V; opioid use disorder and diagnostic criteria*.
- vi Dowell, D., Haegerich, T. M. & Chou, R. (2016, March 15). CDC guideline for prescribing opioids for chronic pain – United States, 2016. *Morbidity and Mortality Weekly Report*, 65(1), 1-49. doi: <http://dx.doi.org/10.15585/mmwr.rr6501e1>
- vii Centers for Medicare & Medicaid Services. (2018, April 2). *Announcement of calendar year 2019 Medicare Advantage capitation rates and Medicare Advantage and Part D payment policies and final call letter*. Retrieved September 13, 2018, from <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2019.pdf>
- viii American Society of Addictive Medicine (n.d.) Summary of the comprehensive addiction and recovery act. Retrieved September 13, 2018, from <https://www.asam.org/advocacy/advocacy-principles/teach-it/opioids/summary-of-the-comprehensive-addiction-and-recovery-act>
- ix Missouri 99th General Assembly. (2018). *Senate Bill No. 826*. Retrieved September 13, 2018, from <https://www.senate.mo.gov/18info/pdf-bill/tat/SB826.pdf>
- x HCAHPS Online (n.d.) Retrieved October 17, 2018, from <https://www.hcahpsonline.org/en/whats-new/>
- xi CDC, National Center for Vital Statistics (2018, October 18). Provisional drug overdose death counts. Retrieved September 13, 2018, from <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>
- xii D’Onofrio, G., O’Connor, P. G., Pantalon, M. V., et al. (2015). Emergency department-initiated buprenorphine/naloxone treatment for opioid dependence: A randomized clinical trial. *Journal of the American Medical Association*, 313(16), 1636-1644.
- xiii Cantrill, S., et al. (2012). Clinical policy: Critical issues in the prescribing of opioids for adult patients in the emergency department. *Annals of Emergency Medicine*, 60(4), 499-525. doi: <http://dx.doi.org/10.1016/j.annemergmed.2012.06.013>
- xiv Agency for Healthcare Research and Quality Health Care Innovations Exchange (2016, January). Interagency guideline on prescribing Opioids for pain. Retrieved September 13, 2018, from <https://innovations.ahrq.gov/qualitytools/interagency-guideline-prescribing-opioids-pain>
- xv United States Food and Drug Administration (2018, October). Disposal of unused medicines: What you should know. Retrieved September 13, 2018, from <https://www.fda.gov/drugs/resourcesforyou/consumers/buyingusingmedicinesafely/ensuringsafeuseofmedicine/safedisposalofmedicines/ucm186187.htm>
- xvi American Society of Addictive Medicine (n.d.) *Public policy statement on the use of naloxone for the prevention of opioid overdose deaths*. Retrieved September 13, 2018, from https://www.asam.org/docs/default-source/public-policy-statements/use-of-naloxone-for-the-prevention-of-opioid-overdose-deaths-final.pdf?sfvrsn=f7c177c2_4
- xvii American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (5th ed.)*. Washington, D.C.: Author.