Virginia Mason™

Pain Management

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What's New in Medicine: Internal Medicine & Infectious Disease Conference
September 7th, 2019

Disclosures

There are no relevant financial relationships with commercial interests to disclose

Goals and Objectives

- Discuss medications to improve chronic pain, including opiates and the safe approach to prescribing.

- Review risk assessment for opiate use and means to safely and effectively discontinue opiates.

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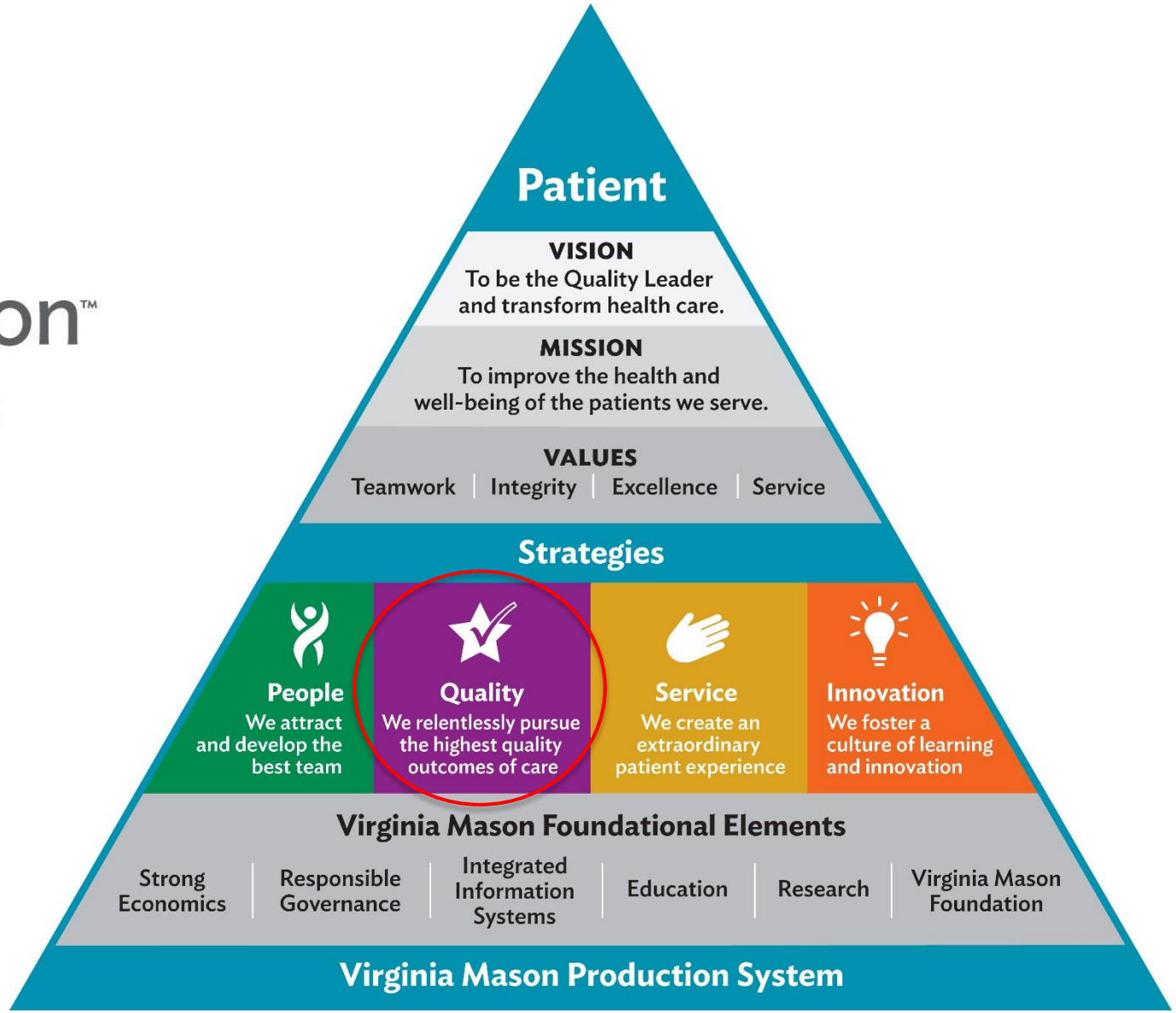
OUR STRATEGIC PLAN



2019 Organizational Goals

Quality and Safety

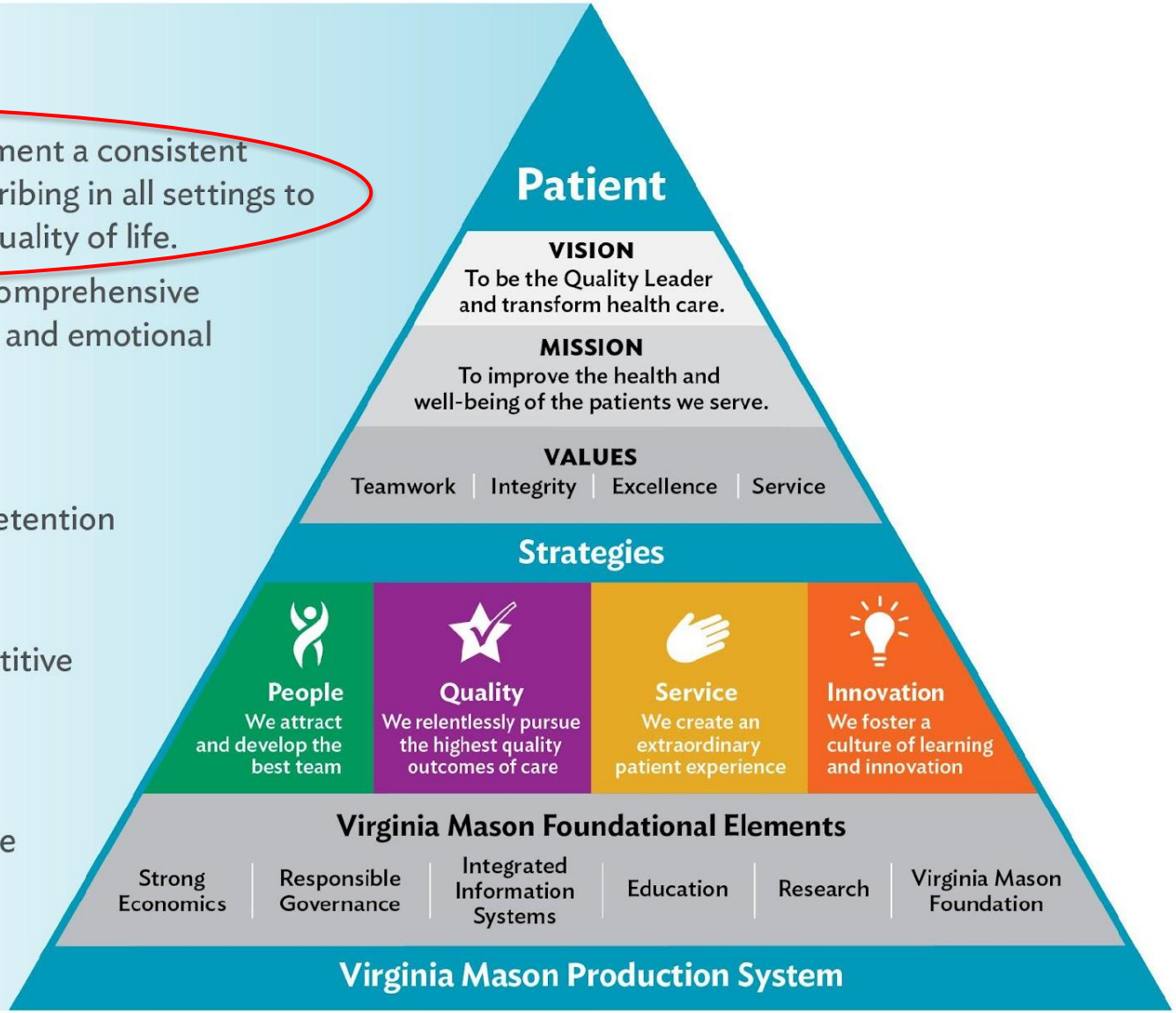
- **Pain Management: Taking on Opioids.** Implement a consistent approach to pain management and opioid prescribing in all settings to improve quality of care, patient outcomes and quality of life.
- **Workplace Safety.** Develop and implement a comprehensive workplace safety program that prevents physical and emotional harm to our team members.

Growth

- **Growth Initiatives.** Implement multi-faceted retention and growth strategies.
- **Patient Centered Access.** Provide access and convenience as key differentiators in our competitive health care market.

The Virginia Mason Experience

- Increase team member engagement and improve patient experiences in an environment where people feel valued, included and respected.



Non-Opioid Treatments for Chronic Pain

- Pharmacological Treatment
  - First line (acetaminophen, NSAIDs, Gabapentin/pregabalin, TCAs/SNRIs, topical agents)
- Non-pharmacological treatment
  - Exercise, cognitive behavioral therapy, interdisciplinary rehabilitation, patient education, weight loss, smoking cessation
- Interventional Treatment

Nonopioid Medications

Medication	Magnitude of benefits	Harms	Comments
Acetaminophen (APAP)	Small	Hepatotoxic, particularly at higher doses	First-line analgesic
NSAIDs	Small-moderate	Cardiac, GI, Renal	First-line analgesic, COX-2 selective NSAIDs less GI toxicity
Gabapentin/pregabalin	Small-moderate	Sedation, dizziness, ataxia	First-line agent for neuropathic pain; pregabalin approved for fibromyalgia
Tricyclic antidepressants, serotonin/norepinephrine reuptake inhibitors	Small-moderate	TCAs have anticholinergic and cardiac toxicities, SNRIs safer and better tolerated	First-line for neuropathic pain; TCAs and SNRIs for fibromyalgia, TCAs for headaches
Topical agents (lidocaine, capsaicin, NSAIDs, ketamine compounded)	Small-moderate	Capsaicin initial flare/burning, irritation of mucus membraines	Consider as alternative first-line, thought to be safer than systemic medications. Lidocaine/ketamine for neuropathic pain, topical NSAIDs for localized osteoarthritis, topical capsaicin for musculoskeletal and neuropathic pain
Anti-nerve growth factor (NGF) monoclonal antibodies???	Moderate	Rapidly progressive osteoarthritis (RPOA)	Development on hold due to findings of RPOA during phase 3 trials

Modified from CDC.gov Nonopioid Treatments for Chronic Pain

Opioid therapy for Chronic Pain

- Only consider opioid therapy if expected benefits for both pain and function are anticipated to outweigh risks
- If opioids used, they should be combined with non-pharmacologic therapy and non-opioid therapy
- Prior to initiating, establish treatment goals with all patients, including realistic goals for pain and function, and discuss how therapy will be discontinued if benefits do not outweigh the risks
- Prior to initiating and periodically during therapy, discuss with patients the known risks and realistic benefits of opioid therapy, along with patient/clinician responsibilities

A Public Health Crisis

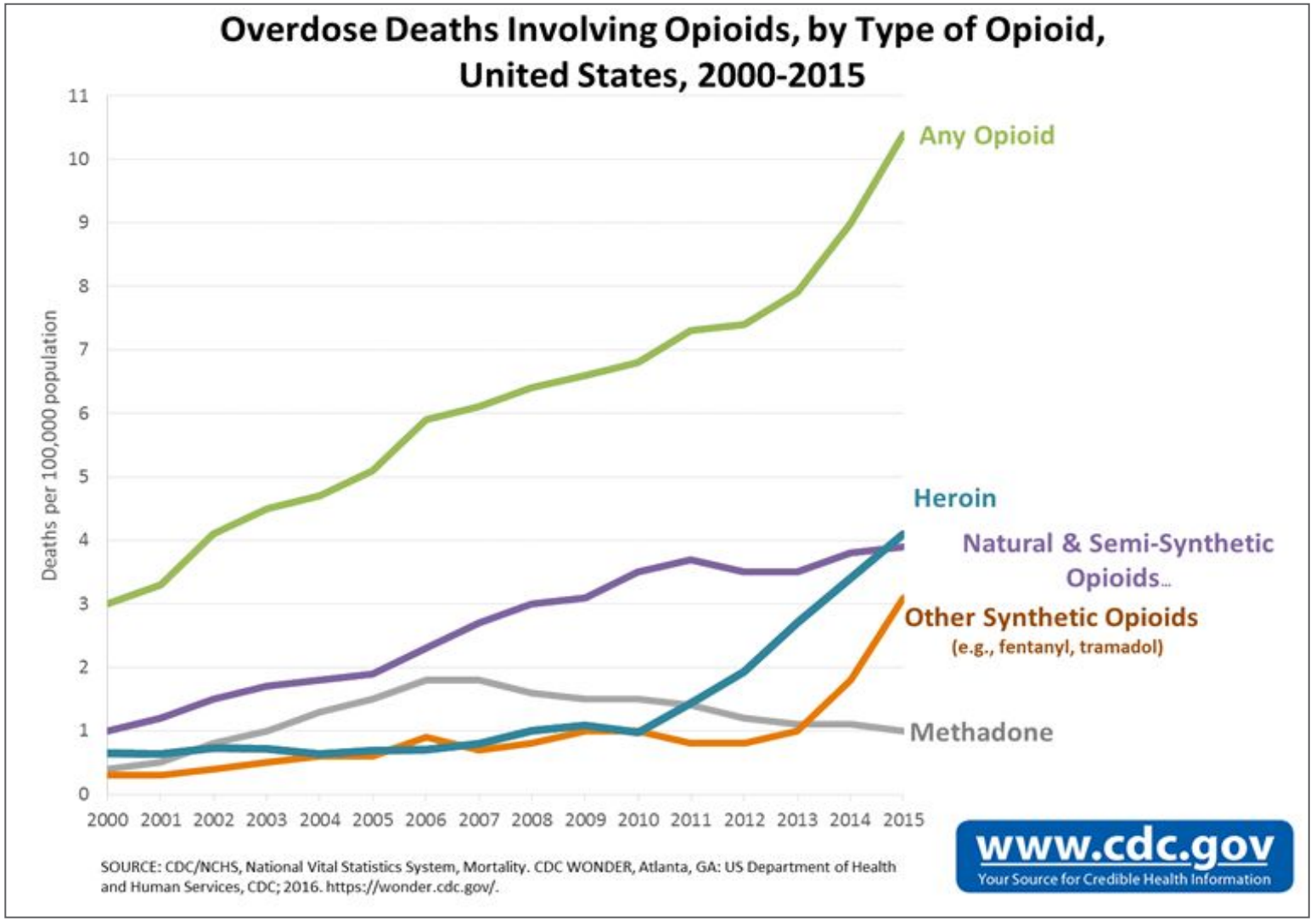
130+ Americans die every day from an opioid overdose.

Leading cause of injury related death in the United States.

Leading cause of death in the United States, age <50 years.

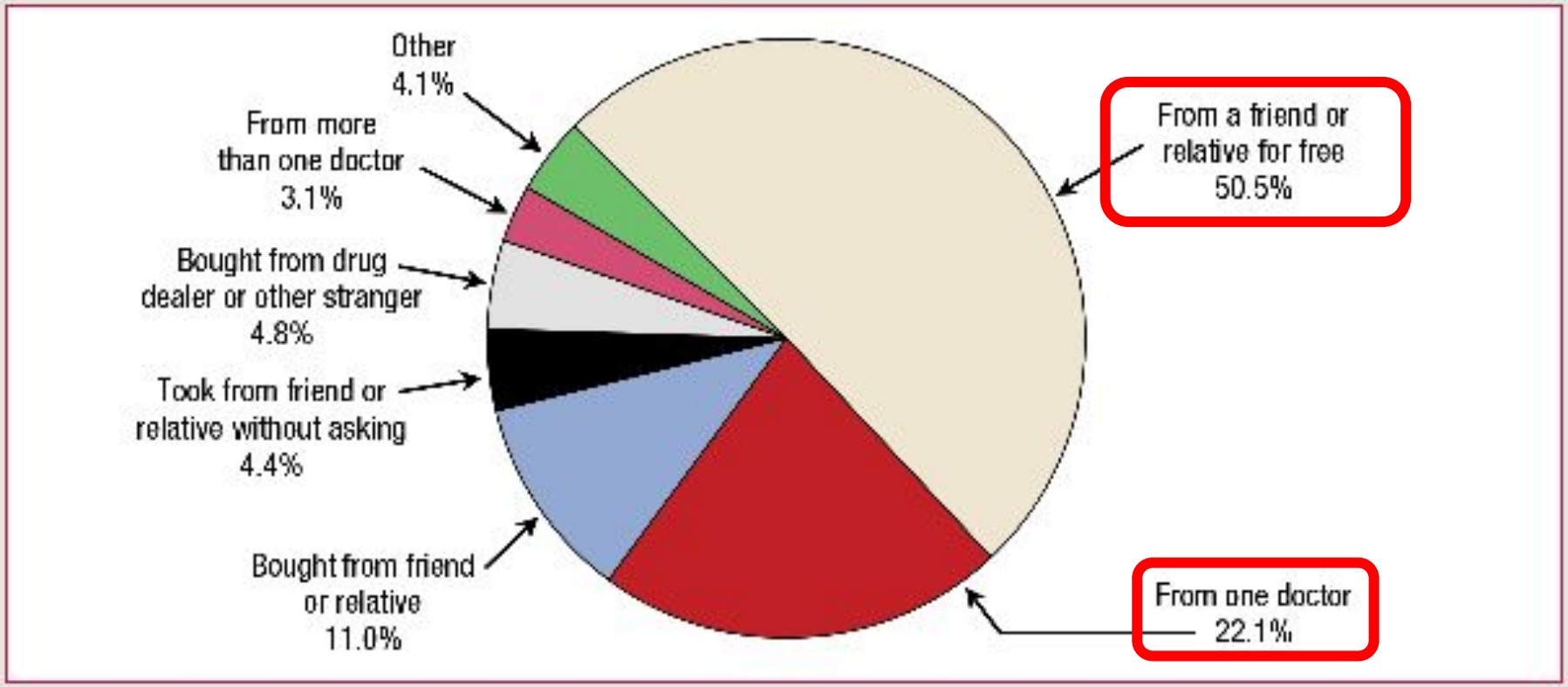
4 out of 5 heroin users started with misusing prescription opioids.

More than **40%** of all US **opioid overdose deaths** in 2016 involved a **prescription opioid**



Opioid Use Disorder: source of opiates

Figure 1. Source of prescription pain relievers for the most recent nonmedical use among past year users aged 12 or older: annual averages, 2013 and 2014



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health (NSDUHs), 2013 and 2014.

The CBHSQ Report: January 12, 2017

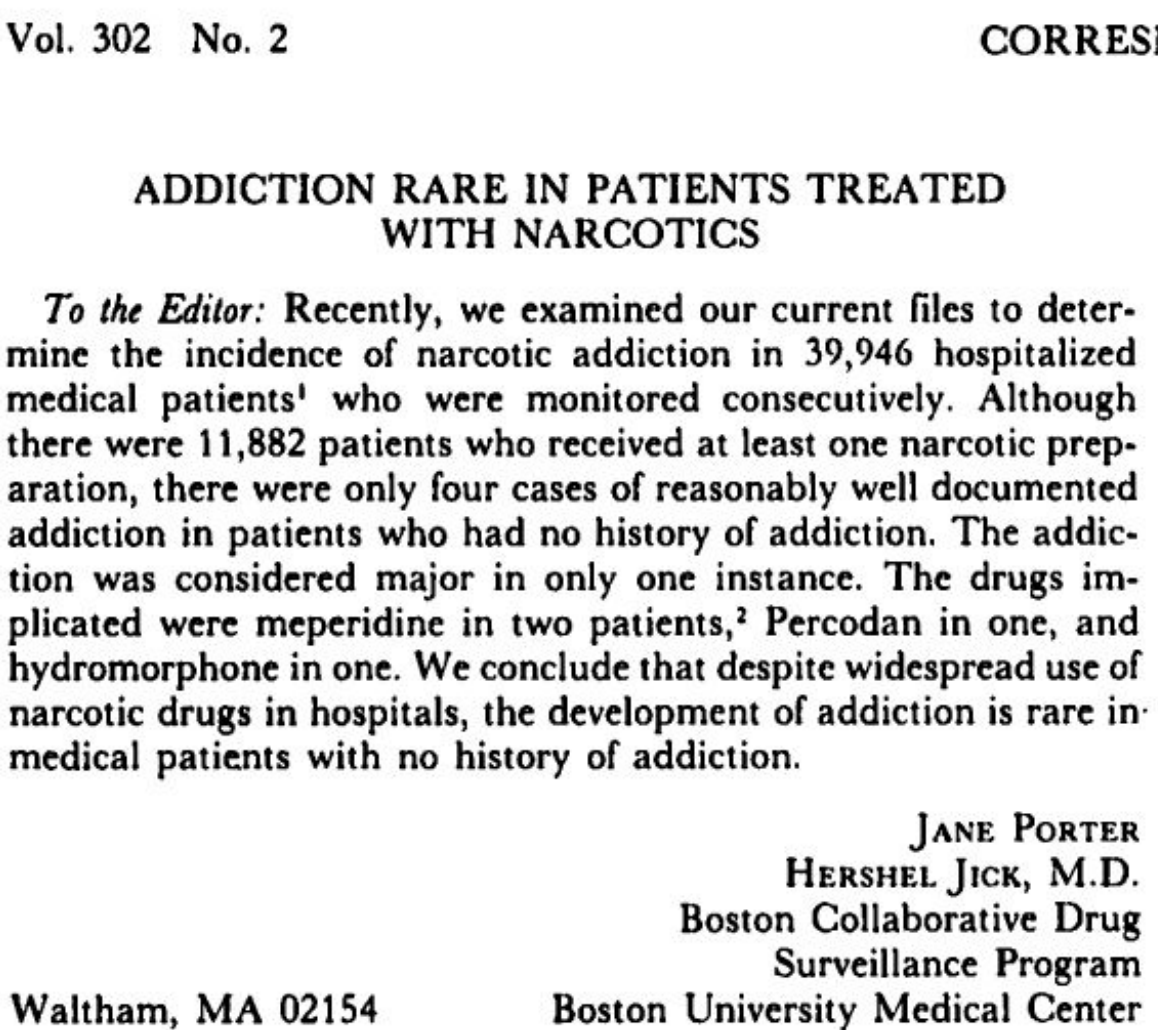
1887

Bayer Heroin Hydrochloride Advertisement from 1901, https://prescriptiondrugs.procon.org/view.resource.php?resourceID=005839

"Landmark Article"

"We conclude that despite widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of"

- Porter & Jick



Vol. 302 No. 2 CORRES

ADDICTION RARE IN PATIENTS TREATED WITH NARCOTICS

To the Editor: Recently, we examined our current files to determine the incidence of narcotic addiction in 39,946 hospitalized medical patients[1] who were monitored consecutively. Although there were 11,882 patients who received at least one narcotic preparation, there were only four cases of reasonably well documented addiction in patients who had no history of addiction. The addiction was considered major in only one instance. The drugs implicated were meperidine in two patients,[2] Percodan in one, and hydromorphone in one. We conclude that despite widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of addiction.

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Boston University Medical Center
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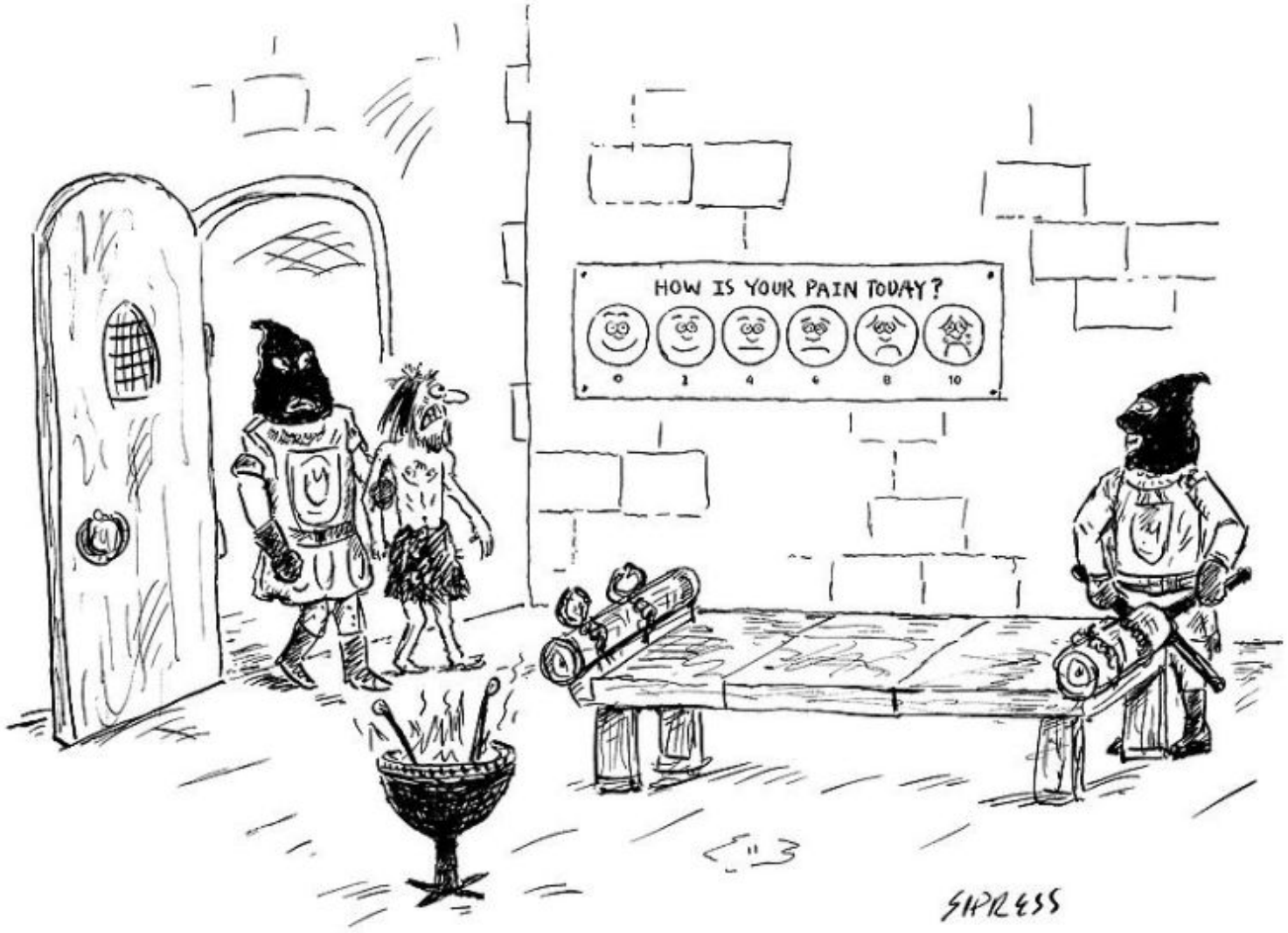
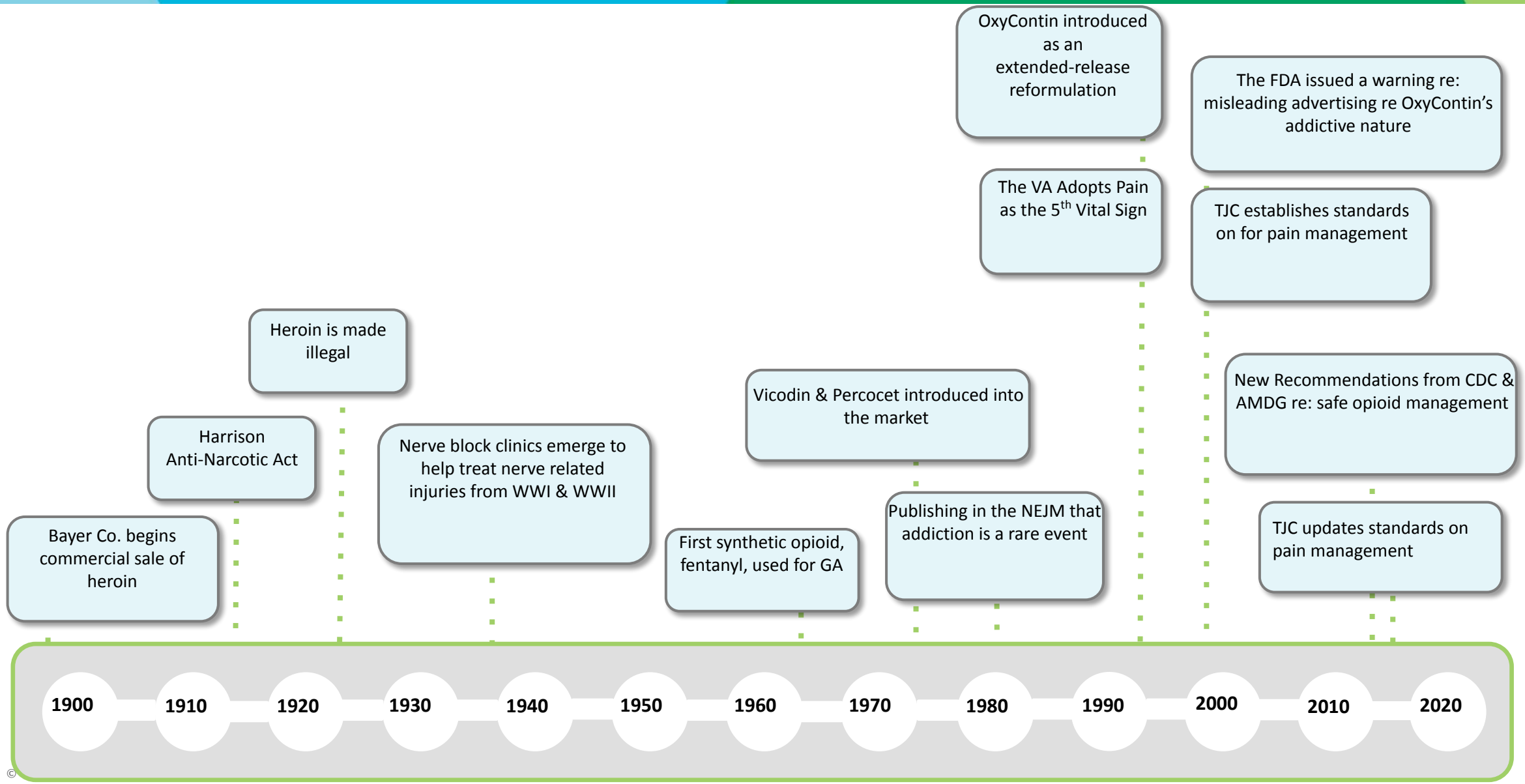
Porter, J., & Jick, H. (1980). Addiction Rare in Patients Treated with Narcotics. *New England Journal of Medicine, 302*(2), 123-123. doi:10.1056/nejm198001103020221
Screen grab from the New England Journal of Medicine

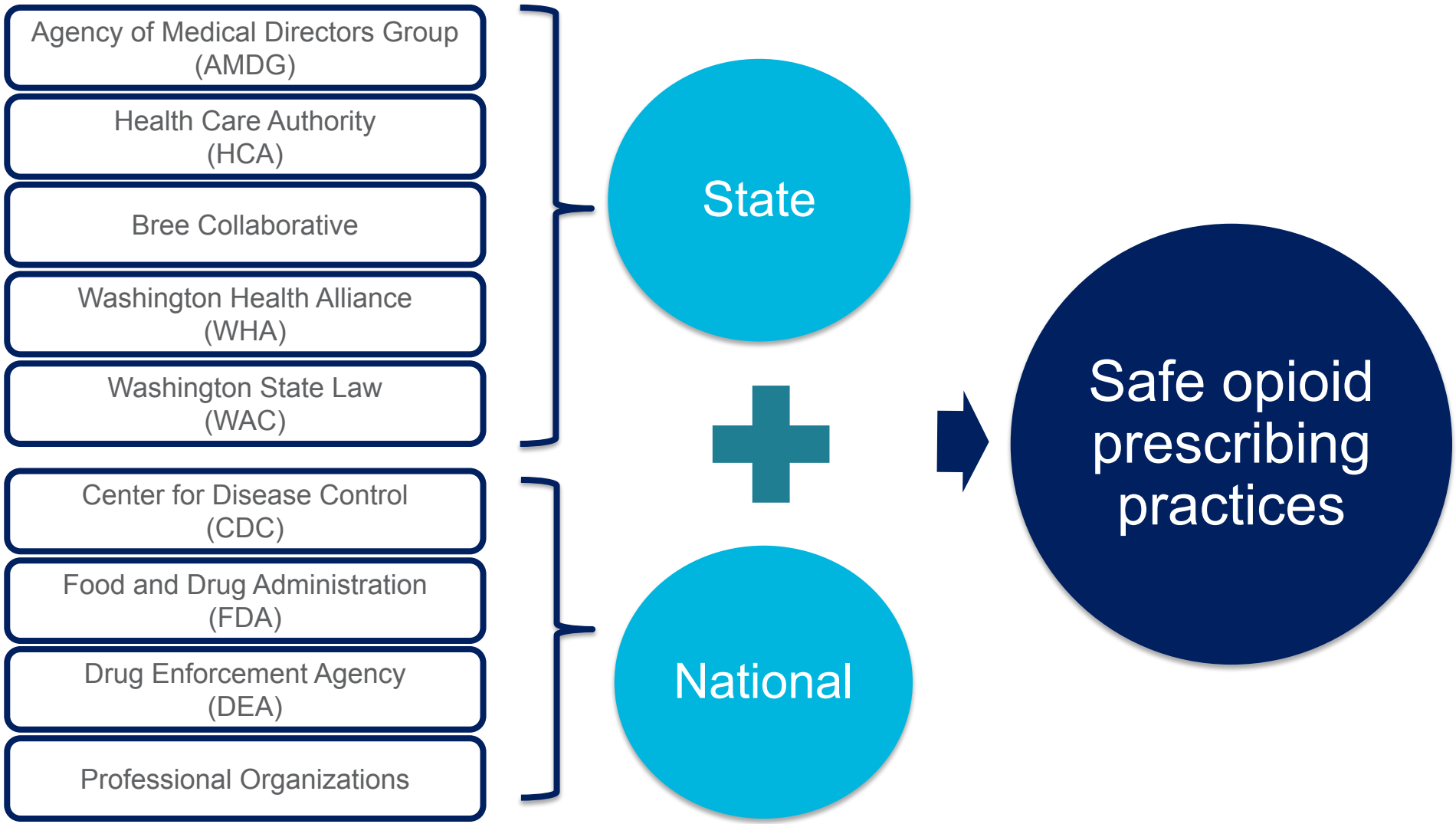
Joint Commission - the 5th Vital Sign



Sipress, David. “A Man Enters A Medieval Torture Chamber To See." Cartoon. The New Yorker, 6 Apr. 2015. Web.

How did we get here?




Agency of Medical Directors Group (AMDG)
Health Care Authority (HCA)
Bree Collaborative
Washington Health Alliance (WHA)
Washington State Law (WAC)
State
Center for Disease Control (CDC)
Food and Drug Administration (FDA)
Drug Enforcement Agency (DEA)
Professional Organizations
National
Safe opioid prescribing practices

Agency of Medical Directors Group (AMDG)

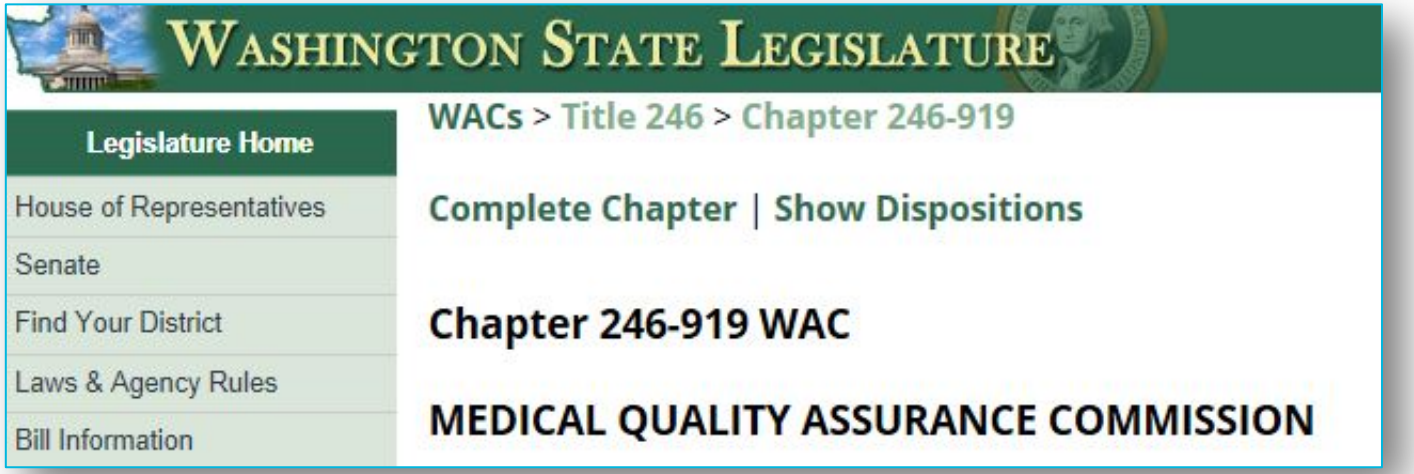
All pain phases	Opioids for chronic non-cancer pain	Reducing or discontinuing therapy	Opioid Use Disorder (OUD)
• Clinically meaningful improvement • Accurate diagnosis and expectations • Start with non-opioid treatment • Expanded discussion on dosing threshold	• Must of functional improvement • Assess comorbidities • Do not combine with benzos • Utilize effective monitoring strategies to minimize potential adverse outcomes	• Taper if patient experiences an adverse outcomes or overdose • Taper if patient exhibits aberrant behaviors • Worsening pain while tapering is not uncommon	•Assess using DSM-V criteria •1 in 5 patients on chronic opioid therapy will develop OUD as defined by DSM-V •Likelihood of developing OUD increases 122-fold for chronic use ≥120mg

Interagency Guideline on Prescribing Opioids for Pain. June 2015

Washington State Legislation

ESHB 1427

- Requires implementation of safe opioid prescribing practices
- Goal to minimize potential for misuse and abuse
- Does not recommend avoiding use of opioids



Chapter 246-919 WAC

Washington State Legislation

Acute Prescribing

- Give instructions for pain expectations
- Taper instructions

Chronic Prescribing

- State objectives of treatment
- Provide patient agreement/consent
- Ensure naloxone available for high risk patients
- Consultation with pain specialists for MED ≥120mg/day
- Assess for opioid use disorder

- Check Prescription Monitoring Program (PMP)
- Assess pain and function
- Assess risk of opioid use

- Communicate expectations
- Engage in multimodal therapy, not opioids only
- Provide non-pharmacologic therapy

Chapter 246-919

Washington State Legislation

Co-prescribing

Provider shall not knowingly prescribed opioids in combination with any of the below w/out documentation of clinical judgement:

- Benzodiazepines
- Barbiturates
- Sedatives
- Carisoprodol
- Sleeping medications

If a patient receiving an opioid prescription is known to be receiving one or more of the above medications, the opioid prescribing provider shall consult w/ the other prescribers to establish a plan

Tapering requirements

- Patient request
- Deterioration in function or pain
- Non-compliant with written agreement
- Other treatments indicated
- Severe adverse event or overdose
- Unauthorized escalation in dose
- No improvement in pain, function, or quality of life with dose increase
- Evidence of misuse, abuse, substance use disorder, or diversion

Chapter 246-919

Changes to Opioid Prescribing and Monitoring

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Purpose: The Washington Medical Commission has revised and updated opioid prescribing rules. This one sheet provides high level information regarding these changes that will assist you in providing appropriate medical care for patients.

Important Terms:

For the purpose of these rules:

- Inappropriate treatment of pain includes non-treatment, under treatment, overtreatment and the continued use of ineffective treatments.
- Pain includes: acute, perioperative, subacute and chronic. These rules do not apply to palliative, in-patient hospital care, procedural medications and cancer related treatments.
- Children and adolescent patients should be treated based on weight of the patient and adjust the dosage accordingly.

What you need to know:

- These rules will be effective January 1, 2019.
- Prescriptions must not be written for more than is needed for effective pain control. The rules provide specific timelines for each phase of pain, you must document the justification for such a quantity.
- PMP checks are required at first refill/renewal, during a pain phase transition and periodically based on the patients risk level.
- Prescribing opioids must be based on clear documentation of unrelieved pain.

What you need to do to prescribe opioids:

- Give the patient resources regarding the risks associated with opioids as well as the safe storage and disposal of opioids, at the first issuance of an opioid prescription and when the patient transitions to another pain phase.
- Complete 1 hour of opioid prescribing CME by the end of your next full CME reporting period after January 1, 2019.

Additional resources:

Agency Medical Director's Group
The Centers for Disease Control and Prevention
Bree Collaborative
WMC Pain Info

Rumor Busting

Rumor: You will no longer be able to prescribe opioids for chronic pain patients.
Fact: These rules do not change your ability to prescribe opioids to chronic pain patients. These rules do not impose a prescribing limit. In fact, you can prescribe up to 120 MED without the need to consult a pain management specialist. As in the 2012 Pain Management Rules, when prescribing in excess of 120 MED first consult with a pain management specialist and document such in the patient record.

PO Box 47866 | Olympia, Washington 98504-7866 | Medical.Commission@doh.wa.gov | WMC.wa.gov

Health Care Authority

- Major driver in state initiatives and collaboration to change policies around opioid prescribing
- Largest purchaser of health care in state of Washington
- Limits acute prescribing:
  - Age ≤ 20 years: 18 pills or 90mL of liquid per prescription (3 day supply)
  - Age ≥ 21 years: **42 pills** or 210mL of liquid per prescription (7 day supply)

CMS – Medicare 2019 Policy

- Part D plans to limit initial opioid scripts to ≤7 day supply
- Prescription above 90mg morphine equivalents will trigger a "safety edit" requiring pharmacists to speak with prescribing doctor regarding appropriateness before completing prescription fill
- Prescription above 200mg morphine equivalents, insurers are able to place a "safety edit" allowing only the insurer the ability to override and approve filling of the prescription

SUPPORT Act for Opioid Recovery (HR6)

Medicare 2020 changes:

- **ePrescribing for controlled substances.** Section 2003 of HR6 mandates that prescriptions for all controlled substances covered under Medicare Part D must be transmitted electronically beginning on January 1, 2021, with a few exceptions.

- Medicare enrollees must undergo an initial examination which includes screening for an opioid use disorder

What else can I do to keep my patients safe?

VM Dept of Primary Care Policy

PURPOSE: standardize safe opioid prescribing by Primary Care Providers

SCOPE: from determination that opioid prescription may be indicated to patient receives prescription

POLICY:

- Opioid prescribing:
  - Must occur at visit only (except Hospice / Palliative Care)
  - Should not occur at initial visit
  - Must include records review before prescribing
  - Must include Prescription Monitoring Program (PMP) review before prescribing
  - Refills: no early, weekday after 5 PM, weekend, holiday or non-visit refills will be offered
  - Naloxone: all patients with MED >50mg or on an opioid + benzodiazepine are education and provided a prescription
- Chronic opioid prescribing:
  - Must include completion of VMMC standard pain and risk assessment tools (including Pain Scale, Opioid Risk Tool score, PEG score) before initiation, then minimum once yearly
  - Must include Persistent Pain Provider-Patient Compact review, signature, save to chart
  - Must include urine drug screen at initiation then should be performed routinely every 12 months minimum
  - Morphine equivalent dose (MED): taper to 90mg MED, or lower if appropriate. If unable to taper to 90mg MED, obtain consultation from a pain specialist.
  - Should not be prescribed in conjunction with chronic benzodiazepine use. If necessary, must document patient was educated regarding risk and why one of the medications cannot be discontinued
  - Documentation must include:
    - Pain and risk tool scores, functional goals, assessment and treatment plan
    - Opioid prescription(s) information (with dose, schedule, # tabs, # refills and MED)
    - Medication Management Note (MMN), completed at initiation then every 12 to 18 months
  - Visit frequency must occur:
    - Opioid alone: every 3 months with PCP. Every other visit may occur with Clinical Pharmacist only
    - Opioid + benzodiazepine: every month with PCP
    - All patients must complete a COT Annual visit yearly with pharmacist, or in the setting of a Shared Medical Appointment or linked appointment as needed

When to prescribe intranasal naloxone

Patients prescribed opioids who:

- Receive opioids at a dosage ≥ 50 morphine milligram equivalents (MME) per day
- Have respiratory conditions such as chronic obstructive pulmonary disease (COPD) or obstructive sleep apnea (**regardless of opioid dose**);
- Have been co-prescribed benzodiazepines (**regardless of opioid dose**).
- Have a non-opioid substance use disorder, report excessive alcohol use, or have a mental health disorder (**regardless of opioid dose**).

Are you Safe?

Chronic pain is complicated. We are here to partner with you.
1 in 10 people using chronic opioid therapy develop opioid use disorder.
Unsafe opioid use increases the risk of harm which may include:

Increased Pain | Relationship conflicts | Fear | Loneliness | Despair | Loss of life

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- No early refills
- Engaged with activities & loved ones
- Engaged in non-opioid treatment for pain
- Consistent urine screen results

- Falls
- Work or school difficulties related to opioids
- Emergency department visits to request opioids
- Concerns raised by family or friends
- Opioid are becoming more important to me than my pain

- Unexpected urine screen results
- Uncontrolled behavior/anger toward staff or loved ones related to opioids
- Not being open to other options to treat pain
- Using opioids to relieve stress/anxiety
- Taking more than prescribed, or requesting early refills

- Self- identified unsafe use
- Any overdose on opioids
- Driving under the influence
- **Taking other people's** prescriptions or outdated prescriptions
- Buying, selling or trading opioids

If you, your family, or your healthcare team have concerns,
we will work together to identify safe options.

- Medically assisted therapies work and can be managed by your primary care provider. These medications include:
  - buprenorphine/naloxone, naltrexone, and methadone
- Tapering off your opioids in consultation with your health care providers.
- Consultation with specialists to offer other options to treat pain.

Five "A"s of Opioid Treatment

1. Analgesia
2. Activities of daily living/Function
3. Adverse Events
4. Aberrant Behavior
5. Affect

To be assessed at all visits and documented

Risk assessment prior to prescribing opioids

Male gender, nicotine use, higher prescribed opioid dosages, inappropriate prescribing procedures, and a substance abuse history are associated with risk of opioid-related overdose(1)

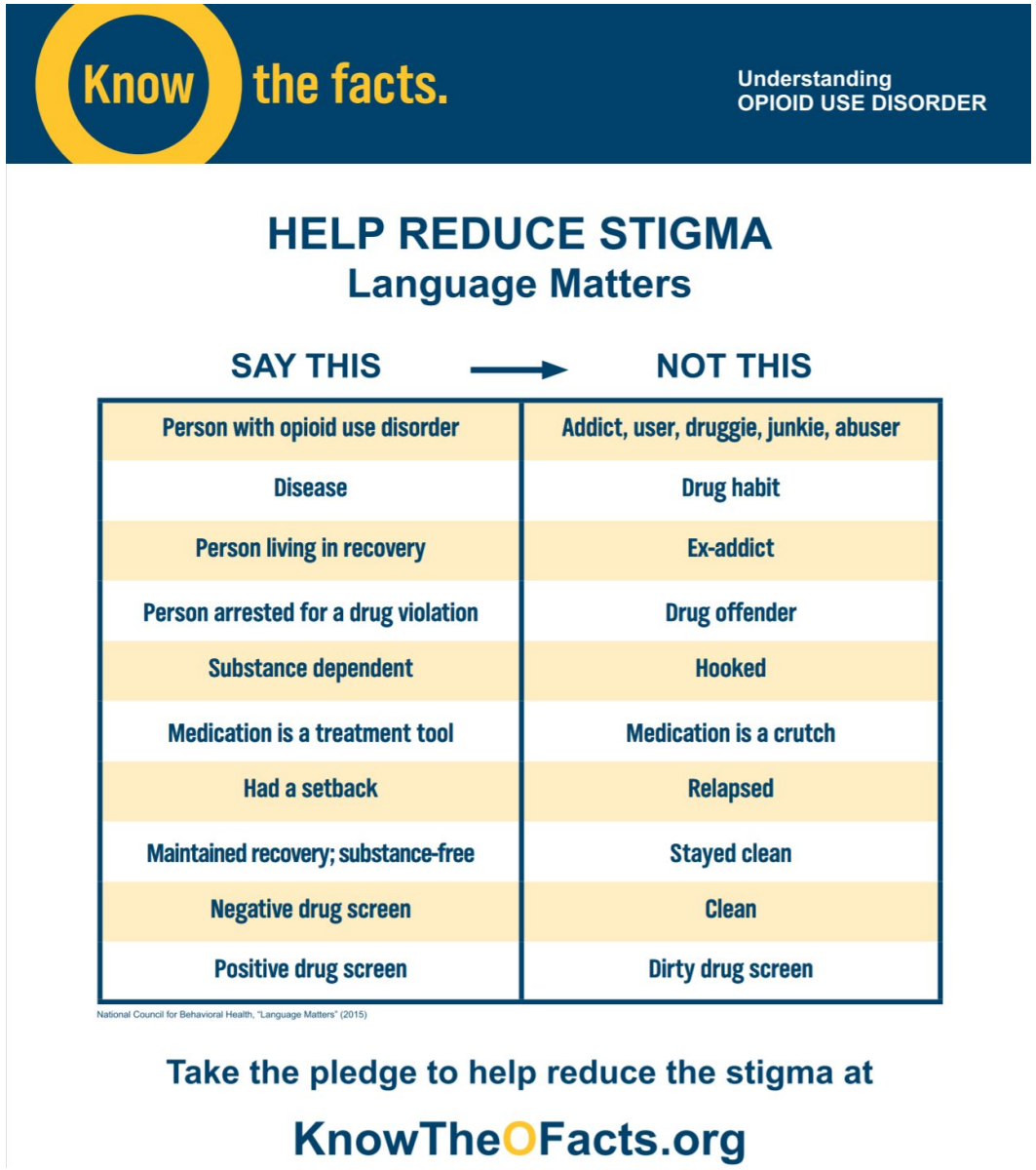
Standardized screening tools have been developed in attempt to predict likelihood of opioid misuse (2)

- Screener and Opioid Assessment for Patients with Pain (SOAPP)
- Opioid Risk Tool (ORT)
- Diagnosis, Intractability, Risk, Efficacy (DIRE)

1. Brady KT et al. 2016. Prescription opioid abuse in the US: An update. Am J of Psychiatry 173(1):18-26
2. Moore TM, Jones T, Browder JH, et al. A comparison of common screening methods for predicting aberrant drug- related behavior among patients receiving opioids for chronic pain management. Pain Med. 2009;10:1426–1433

Education = Reducing Stigma

- Substance use disorder, including OUD, is a chronic relapsing disease
- Attitudes in the community and healthcare setting directly impact a patient's ability to receive adequate treatment
- Help reduce stigma by using positive, patient-centered language



Next Level Recovery – Indiana. https://www.in.gov/recovery/know-the-o/tools-resources.html. Access February 17, 2019.

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Opioid Risk Tool (ORT)

OPIOID RISK TOOL (ORT)

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Prescription drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Prescription drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

A score of 3 or lower indicates low risk for future opioid abuse
A score of 4 to 7 indicates moderate risk for opioid abuse
A score of 8 or higher indicates a high risk for opioid abuse

Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk too. Pain Med. 2005; 6 (6) : 432

PEG Screening Tool

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PEG PAIN SCREENING TOOL

Circle number that best describes your <u>pain on average</u> in the past week:												
No pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Pain as bad as you can imagine
Circle number that best describes how, during the past week, pain has interfered with your <u>enjoyment of life</u>:												
Does not interfere	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Interferes completely
Circle number that best describes how, during the past week, pain has interfered with your <u>general activity</u>:												
Does not interfere	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Interferes completely

Name: _____

Date of birth: _____

Development and Initial Validation of the PEG, a Three-item Scale Assessing Pain Intensity and Interference Erin E. Krebs, MD, MPH et al J Gen Intern Med 24(6):733–8 DOI: 10.1007/s11606-009-0981-1 © Society of General Internal Medicine 2009

5/11/2017

Taper/Discontinue

Risks Outweigh Benefits--Constantly Reassess

- benefit
- pain and function
- risk

Clear Indications of Misuse (Red Flags)

- Consistent aberrant behavior
- disruptive or threatening in clinic
- positive UA
- multiple missed appts
- using illicit substances
- diversion of medication

One approach: ***decrease total dose by 10% every two weeks***

- Patients may vary
- can taper faster or slower
- Consider Medication Assisted Treatment (MAT) – Methadone, Buprenorphine, Naltrexone

OPIOID TAPER PATHWAY

STEP 1

CONSIDER TAPER

- **Lack of improvement** in clinical meaningful improvement in function using validated instruments:
  Goal of 30% improvement after 3 months of treatment initiation or medication change.
  1. Pain score
  2. Functional score
- **Morphine Equivalent Dose (MED) > 90 mg**
- **Aberrant Behaviors**
- **Significant behavioral and physical risks that outweigh benefit** such as:
  1. Decreased function
  2. Substance use disorder (except tobacco)
  3. Risk for opioid-related toxicity
  4. Comorbid medical conditions (e.g. Sleep Apnea, Pulmonary disease, Prolonged QT)
- **Patient Request**
- **Violations of Controlled Medication Agreement**

STEP 2

- **Review expectations** with patient (Review *Oregon Pain Guidance* Recommendations for Potentially Challenging Patient Interactions)
- **Set date** for taper to begin
- Consider **referral** to buprenorphine treatment or methadone maintenance when opioid use disorder suspected (http://buprenorphine.samhsa.gov/bwns_locator/index.html; http://dpt2.samhsa.gov/treatment/directory.aspx)
- **Considerations** for tapering;

Slow Taper	Fast Taper	Benzodiazepine Taper
No significant aberrant behavior, but need for taper identified	Aberrant behavior Toxicity Change in medical condition	Discuss and decide with patient which medication to taper first (benzo vs. opioid)

- **Define goal of taper:**
  1. Discontinue opioid medication completely
  2. Taper to a lower dose; recommended goal of ≤ 90mg MED
  3. Establish rate of taper based on safety considerations:

Determine Amount of Daily Dose Decrease	Determine How to Decrease Dose	Determine Frequency of Dose Decrease	Determine Follow-up Plan
5-15% of total daily dose	- Decrease tablet strength - Decrease frequency of daily dosing	- Decrease weekly - Decrease monthly	- Frequency of visits - Care team provider will patient follow-up with

STEP 3

REASSESS

Do not reverse the taper, it must be unidirectional. Rate may be slowed or paused while managing withdrawal
With each follow up visit during taper, consider urine drug screen and review of PMP
Watch for signs of unmasked mental health disorders during taper
After ¼ to ½ of the dose has been reached, may consider slowing down the taper for patient tolerance
Provide adjuvant medications for pain management and withdrawal symptom management (see page 2)

Source: Oregon Pain Guidance, Opioid Prescribing Guidelines, pages 35-39
http://www.southernoregonopioidmanagement.org/app/content/uploads/2014/04/OPG_Guidelines.pdf

CDC Taper Recommendations

Go Slow

A decrease of 10% of the original dose per week is a reasonable starting point. Some patients who have taken opioids for a long time might find even slower tapers (e.g., 10% per month) easier.

Discuss the increased risk for overdose if patients quickly return to a previously prescribed higher dose.

Consult

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

Let patients know that most people have improved function without worse pain after tapering opioids. Some patients even have improved pain after a taper, even though pain might briefly get worse at first.

Tell patients "I know you can do this" or "I'll stick by you through this."

Withdrawal

- Unpleasant, but not life threatening
- Onset depends on medication half-life that was discontinued
  - Short-acting: symptoms within 3-6 hours
  - Long-acting: symptoms within 12-24 hours
- Most intense in the first 3-5 days
- May last for months if patient has been on chronic opioid therapy for a number of years

Symptom	Management Medication	Dose	Duration	Side Effects / Contraindications
Nausea Diarrhea Muscle Pain Hypertension Sweating Anxiety	Clonidine	0.1-0.2mg q 6 hours 0.1mg-0.2mg/24hr patch weekly (TT-1 or TT-2)	Throughout taper as needed	• Hypotension • Anticholinergic effects
	Tizanidine	2mg q8 hours (max 36mg/day)		• Hypotension • Dizziness • Somnolence
Anxiety Restlessness	Hydroxyzine*	25mg q 6 hours prn		• Drowsiness • Rash • Hypotension
Irritability Insomnia	Trazodone	50-100mg qHS		• Drowsiness • Suicidal Thoughts • Prolonged QTc • Dry Mouth
	Hydroxyzine*	25-50mg qHS		• Drowsiness • Rash • Hypotension
Pain Fever	Acetaminophen	325mg q 4 hours		• Max 3g / 24 hours
	NSAID*	Package Instructions		• GI bleeds
Nausea	Promethazine*	25mg q 6 hours prn		• Dizziness • Prolonged QTc

**Agents may be high-risk in individuals >65 years of age, may consider alternatives*

CDC website and TurnTheTideRx.org

- https://www.cdc.gov/drugoverdose/prescribing/clinical-tools.html

Quick Reference for Healthcare Providers

Quick Reference for Healthcare Providers

Urine Drug Testing

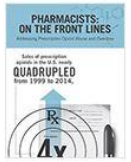
Urine Drug Testing

Mobile App

Opioid Prescribing Guideline Mobile App [PDF – 637K]

Guideline Resources: Mobile App ›

Pharmacists' Brochure



Pharmacists: On the Front Lines [PDF – 1M]

Pocket Guide: Tapering

Pocket Guide: Tapering Opioids for Chronic Pain [PDF – 2M]

Fact Sheet

Guideline for Prescribing Opioids for Chronic Pain: Recommendations [PDF – 674K]

Checklist*

Checklist for Prescribing Opioids for Chronic Pain [PDF – 81K]

Nonopioid Treatments

Nonopioid Treatments for Chronic Pain [PDF – 2 MB]

Assessing Benefits and Harms

Assessing Benefits and Harms of Opioid Therapy [PDF – 2M]

Calculating Dosage

Calculating Total Daily Dose of Opioids for Safer Dosage [PDF – 1M]

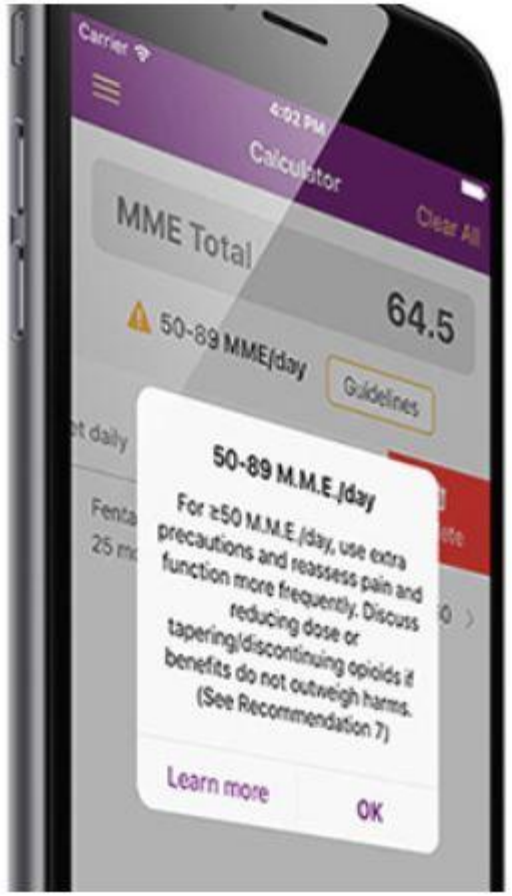
PDMPs

Prescription Drug Monitoring Programs (PDMPs) [PDF – 8M]

Infographic

Infographic: Why Guidelines for Primary Care Providers? [PDF – 2M]

CDC Opioid Guideline App: Prescribe with Confidence



Additional Resources

- Michigan OPEN (Opioid Prescribing Engagement Network) https://michigan-open.org/
- Substance Abuse and Mental Health Services Administration https://www.samhsa.gov/medication-assisted-treatment
- Washington State Department of Health – Opioid Prescribing www.doh.wa.gov
- Health and Human Services https://www.hss.gov/opioids/

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