JULY 2017

CDC Vitalsigns™

Opioid Prescribing

Where you live matters

The amount of opioids prescribed in the US peaked in 2010 and then decreased each year through 2015. However, prescribing remains high and vary widely from county to county. Healthcare providers began using opioids in the late 1990s to treat chronic pain (not related to cancer), such as arthritis and back pain. As this continued, more opioid prescriptions were written, for more days per prescription, in higher doses. Taking opioids for longer periods of time or in higher doses increases the risk of addiction, overdose, and death. In 2015, six times more opioids per resident were dispensed in the highest-prescribing counties than in the lowest-prescribing counties. County-level characteristics, such as rural versus urban, income level, and demographics, only explained about a third of the differences. This suggests that people receive different care depending on where they live. Healthcare providers have an important role in offering safer and more effective pain treatment.

Healthcare providers can:

- Follow the *CDC Guideline for Prescribing Opioids for Chronic Pain*, which includes recommendations such as:
  - Use opioids only when benefits are likely to outweigh risks.
  - Start with the lowest effective dose of immediate-release opioids. For acute pain, prescribe only the number of days that the pain is expected to be severe enough to require opioids.
  - Reassess benefits and risks if considering dose increases.
- Use state-based prescription drug monitoring programs (PDMPs) which help identify patients at risk of addiction or overdose.

6x

Providers in the highest prescribing counties prescribed 6 times more opioids per person than the lowest prescribing counties in 2015.

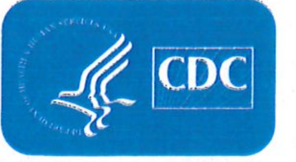
50%

Half of US counties had a decrease in the amount of opioids (MME*) prescribed per person from 2010 to 2015.

3x

The MME prescribed per person in 2015 was still more than 3 times as high as in 1999.

Want to learn more? www.cdc.gov/vitalsigns/opioids



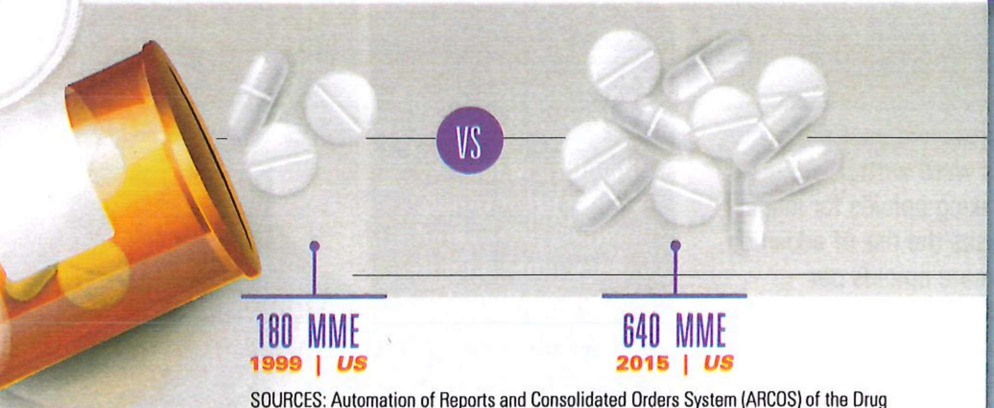
Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

* MME, morphine milligram equivalents, is a way to calculate the total amount of opioids, accounting for differences in opioid drug type and strength.

Problem:

Despite recent declines, opioid prescribing is still high and inconsistent across the US.

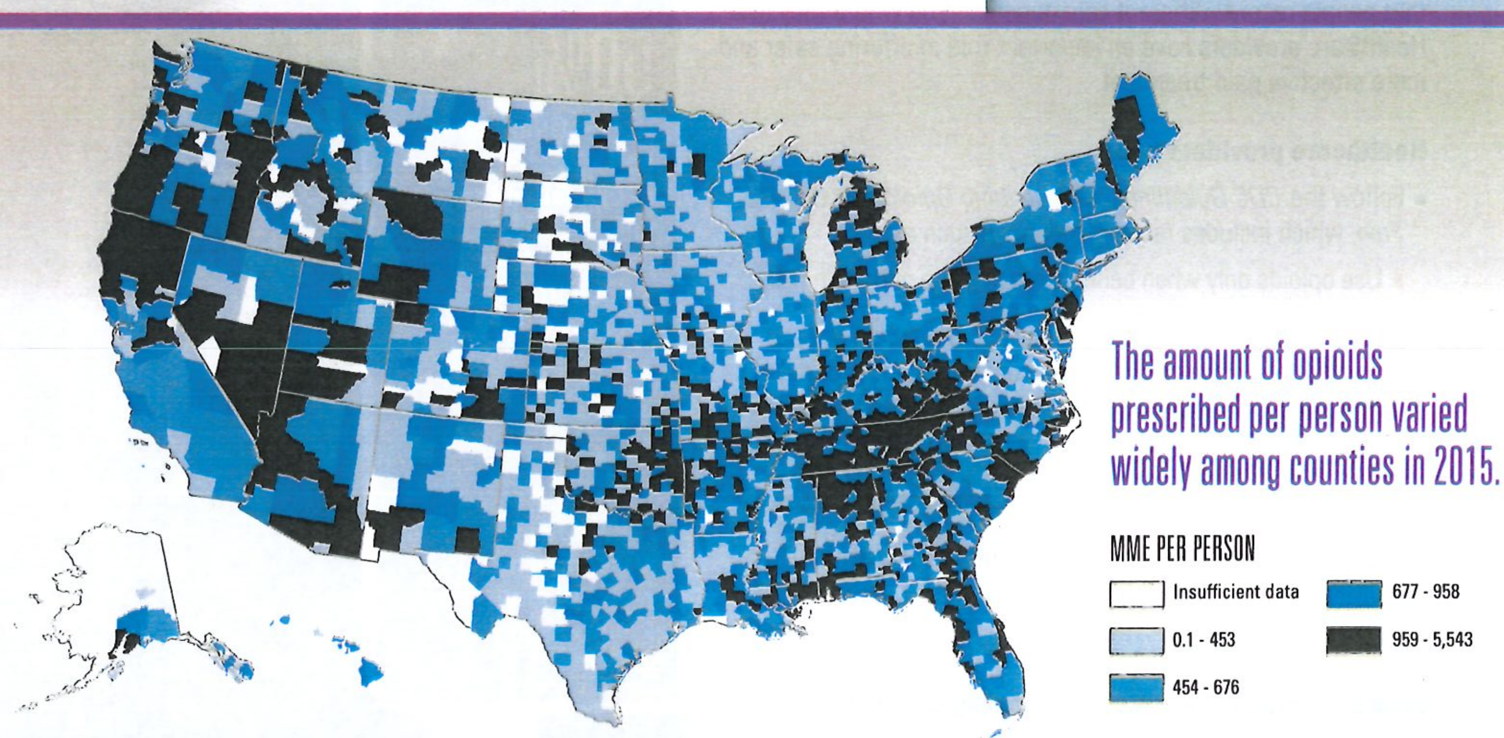
The amount of opioids prescribed per person was three times higher in 2015 than in 1999.



SOURCES: Automation of Reports and Consolidated Orders System (ARCOS) of the Drug Enforcement Administration; 1999. QuintilesIMS Transactional Data Warehouse; 2015.

Some characteristics of counties with higher opioid prescribing:

- Small cities or large towns
- Higher percent of white residents
- More dentists and primary care physicians
- More people who are uninsured or unemployed
- More people who have diabetes, arthritis, or disability



Higher opioid prescribing puts patients at risk for addiction and overdose. The wide variation among counties suggests a lack of consistency among providers when prescribing opioids. The 2016 ***CDC Guideline for Prescribing Opioids for Chronic Pain*** offers recommendations that may help to improve prescribing practices and ensure all patients receive safer, more effective pain treatment.

SOURCE: CDC Vital Signs, July 2017

Promising actions for safer opioid prescribing

Problem: High prescribing
Solution: Safer prescribing practices

Problem: Too many prescriptions

In 2015, the amount of opioids prescribed was enough for every American to be medicated **around the clock for 3 weeks.**

(640 MME per person, which equals 5 mg of hydrocodone every 4 hours)

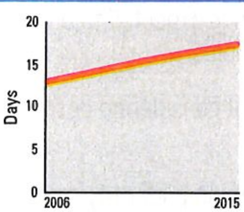
Solution: Fewer prescriptions

Use opioids **only** when benefits are likely to outweigh risks. Options other than opioids include:

- Pain medicines like acetaminophen, ibuprofen, and naproxen
- Physical therapy and exercise
- Cognitive behavioral therapy

Therapies that don't involve opioids may work better and have fewer risks and side effects.

Problem: Too many days



Even at low doses, taking an opioid for more than 3 months increases the risk of addiction by **15 times.**

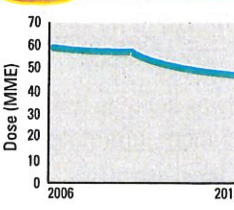
Average days supply per prescription increased from 2006 to 2015.

Solution: Fewer days

For acute pain, prescriptions should only be for the expected duration of pain severe enough to need opioids. **Three days or less** is often enough; more than seven days is rarely needed.

If continuing opioids, ask whether benefits continue to outweigh risks. If not, use other treatments and taper opioids gradually.

Problem: Too high a dose



A dose of 50 MME or more per day **doubles** the risk of opioid overdose death, compared to 20 MME or less per day. At 90 MME or more, the risk increases **10 times.**

Average daily MME per prescription declined both nationwide and in most counties, but it is still too high.

Solution: Lower doses

Use the lowest effective dose of immediate-release opioids when starting, and reassess benefits and risks when considering dose increases.

Avoid a daily dose of 90 MME or more. If already taking high doses, offer the opportunity to gradually taper to safer doses.

For more recommendations when considering opioids for chronic pain outside of end-of-life care, see ***The CDC Guideline for Prescribing Opioids for Chronic Pain.*** The Guideline can also be used to inform health systems, states, and insurers to ensure appropriate prescribing and improve care for all people.

www.cdc.gov/drugoverdose/prescribing/guideline.html

SOURCE: CDC Vital Signs, July 2017

What Can Be Done?

The Federal Government is

- Educating healthcare providers and the public about pain management, addiction, and opioid overdose and providing guidance on safe and effective pain management.
- Equipping states with resources to implement and evaluate safe prescribing practices.
- Improving access to addiction treatment and recovery services.
- Increasing access to overdose-reversing drugs, such as naloxone.
- Tracking opioid-related trends to better understand and respond to the epidemic.
- Supporting cutting-edge research about pain management and addiction.

States can

- Maximize prescription drug monitoring programs (PDMPs) by using near real-time data reporting, integrating with electronic health records, and promoting routine provider use.
- Implement and evaluate programs to improve prescribing practices.
- Use data to identify and address high-risk prescribing.
- Enhance the use of prescribing guidelines based on the best available science.
- Increase access to medication-assisted treatment for addiction and naloxone for opioid overdose.

Health insurers can

- Refer to the Guideline in setting up prescription claims review programs to identify and address improper prescribing and use of opioids.
- Increase coverage for other proven treatments to reduce pain, such as physical therapy and non-opioid pain medicines.
- Cover clinicians' time when they are conducting activities that improve quality and safety of pain management and addressing addiction. These can include patient counseling, coordination of care, and checking the patient's prescription history in the PDMP.
- Reduce barriers (such as prior authorization) to use of nonopioid pain medications and medication-assisted treatment for addiction.

Healthcare providers can:

- Follow the *CDC Guideline for Prescribing Opioids for Chronic Pain*, which includes recommendations such as:
  - Use opioids only when benefits are likely to outweigh risks.
  - Start with the lowest effective dose of immediate-release opioids. For acute pain, prescribe only the number of days that the pain is expected to be severe enough to require opioids.
  - Reassess benefits and risks if considering dose increases.
- Use state-based PDMPs which help identify patients at risk of addiction or overdose.

Everyone can

- Consider non-opioid options for pain management.
- Store prescription opioids in a secure place, out of reach of others (including children, family, friends, and visitors).
- Dispose of medications properly as soon as the course of treatment is done. For more information, visit FDA at: www.fda.gov/Drugs/ResourcesForYou.
- Get help if you're having trouble controlling your opioid use, SAMHSA's National Helpline: 1-800-662-HELP.

1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348
www.cdc.gov

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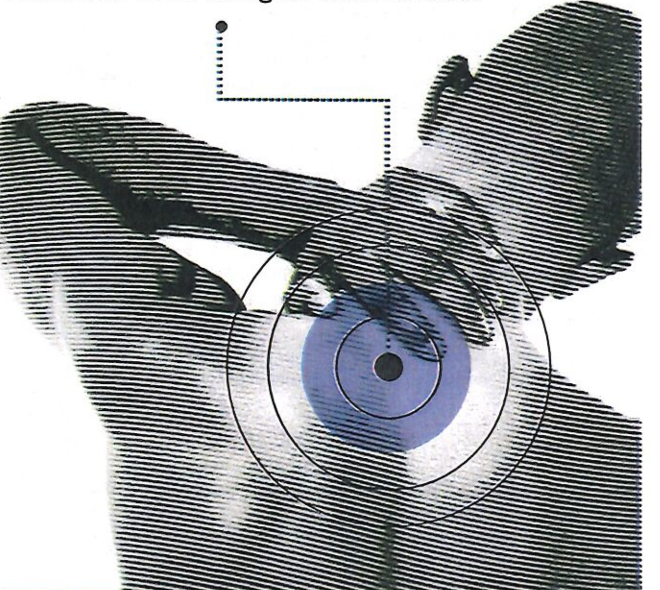
POCKET GUIDE: TAPERING OPIOIDS FOR CHRONIC PAIN*

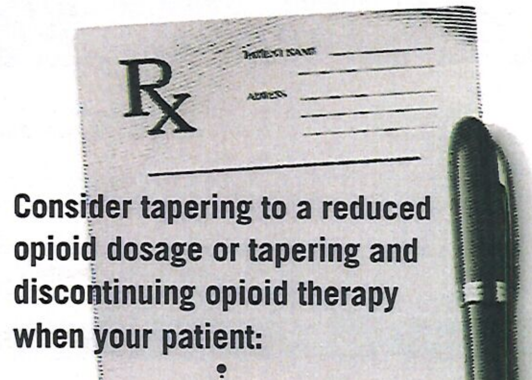
Follow up regularly with patients to determine whether opioids are meeting treatment goals and whether opioids can be reduced to lower dosage or discontinued.

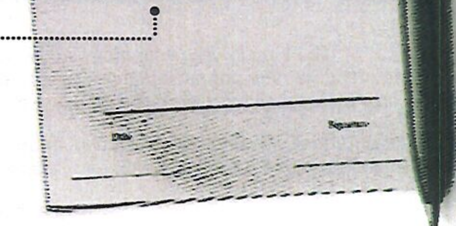


GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

*Recommendations focus on pain lasting longer than 3 months or past the time of normal tissue healing, outside of active cancer treatment, palliative care, and end-of-life care.

WHEN TO TAPER





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

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

*morphine milligram equivalents

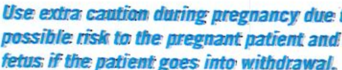
HOW TO TAPER

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

Go Slow

A decrease of 10% 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.

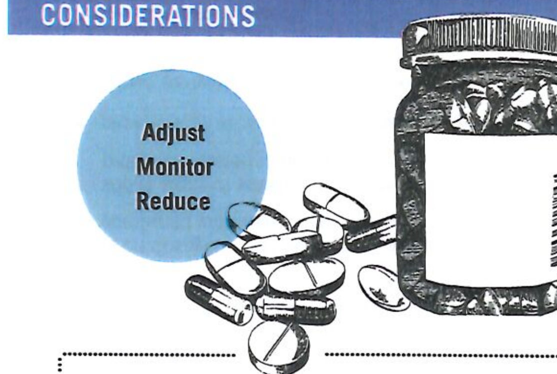
Watch for signs of anxiety, depression, and opioid use disorder during the taper and offer support or referral as needed.

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."

CONSIDERATIONS



Adjust
Monitor
Reduce

1. Adjust the rate and duration of the taper according to the patient's response.
2. Don't reverse the taper; however, the rate may be slowed or paused while monitoring and managing withdrawal symptoms.
3. Once the smallest available dose is reached, the interval between doses can be extended and opioids may be stopped when taken less than once a day.

RESOURCES:

CDC Guideline for Prescribing Opioids for Chronic Pain
www.cdc.gov/drugoverdose/prescribing/guideline.html

Washington State Opioid Taper Plan Calculator
www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf

Tapering Long-Term Opioid Therapy in Chronic Noncancer Pain
www.mayoclinicproceedings.org/article/S0025-6196(15)00303-1/fulltext

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

www.cdc.gov/drugoverdose