ACADEMIC DETAILING FOR OPIOID PRESCRIBING

7-15-2025

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The term “ACADEMIC DETAILING” was coined in the 1970s
by Jerry Avorn MD, Harvard Medical School

Compared to traditional didactic prescriber education (articles, lectures), pharmaceutical “detailing” used *marketing methods* that were *more engaging*, *more persuasive*, *possibly more effective*.

Has also been defined as *interactive*, *evidence-based* *medication education* ***outreach*** to prescribers.

Rome 2025

Rome BN, et al. Academic Detailing Interventions and Evidence-Based Prescribing A Systematic Review
JAMA Network Open | Vol. 8, No. 1 2025;8;(1):e2453684.

AD IS EFFECTIVE FOR INCREASING NALOXONE PRESCRIPTION

Academic detailing by the SF Dept of Health to opioid-prescribing primary care providers.

83% accepted. Average of 2.6 AD contacts each. Focused on naloxone.

With custom, visually stimulating educational materials.

Eleven-fold increase in naloxone prescribing within 4 months
vs. those who did not receive the intervention. (Behar 2017)

There was a **five-fold increase in naloxone prescribing** in a retrospective VA trial. (Bounthavong 2019)

Behar E, et al. Academic Detailing Pilot for Naloxone Prescribing Among Primary Care Providers in San Francisco. Fam Med 2017;49(2):122-126.

Bounthavong M, et al. Implementation evaluation of academic detailing on naloxone prescribing trends at the United States Veterans Health Administration. Health Serv Res. 2019; 54: 1055– 1064.

In an 1983 RCT, >400 high-prescribing MDs were randomized to. **(1) no intervention,**
(2) mailed printed material only, or **(3) in-person sessions w printed material.**

Educational Content: **encouraged reduced prescribing**
of **propoxyphene for pain**, **cephalexin**, and **papaverine for cognitive impairment**.

Discussion of patient cases were encouraged; published evidence was reviewed.

Both sides of any controversial issues were presented before making recommendations.

Detailers were knowledgeable pharmacists, trained in communication techniques.

Of physicians randomized to in-person visits, 90% completed at least 1 of 2 visits; 80% completed both.

RESULTS:

14% reduction in prescribing of target drugs vs. no intervention. (P = 0.0001).

No effect of the printed materials alone vs. no intervention.

Avorn J, e al. Improving drug-therapy decisions through educational outreach: a randomized controlled trial of academically based "detailing." N Engl J Med. 1983;308(24):1457-1463.

In an RCT, for doctors randomized to education sessions by the hospital analgesic-stewardship pharmacist on discharge opioids after surgery:

Patients were discharged on **slow-release opioids half as often** as control
adjusted OR: 0.52 (95% CI, 0.35-0.77)

Patients were **discharged without any opioids 70% more often** (aOR 1.69; 95% CI, 1.24-2.30).

(Hopkins 2020)

Hopkins RE, et al. Educating junior doctors and pharmacists to reduce discharge prescribing of opioids for surgical patients: a cluster randomised controlled trial. Med J Aust. 2020;213(9):417-423. Randomized Controlled Trial Med J Aust. 2020 Nov;213(9):417-423.

In a January 2025 review of AD 118 studies that measuring ***changes in prescribing.***

36 studies had the lowest risk of bias.

Of those, 70% had significant reduction in prescribing, as recommended.

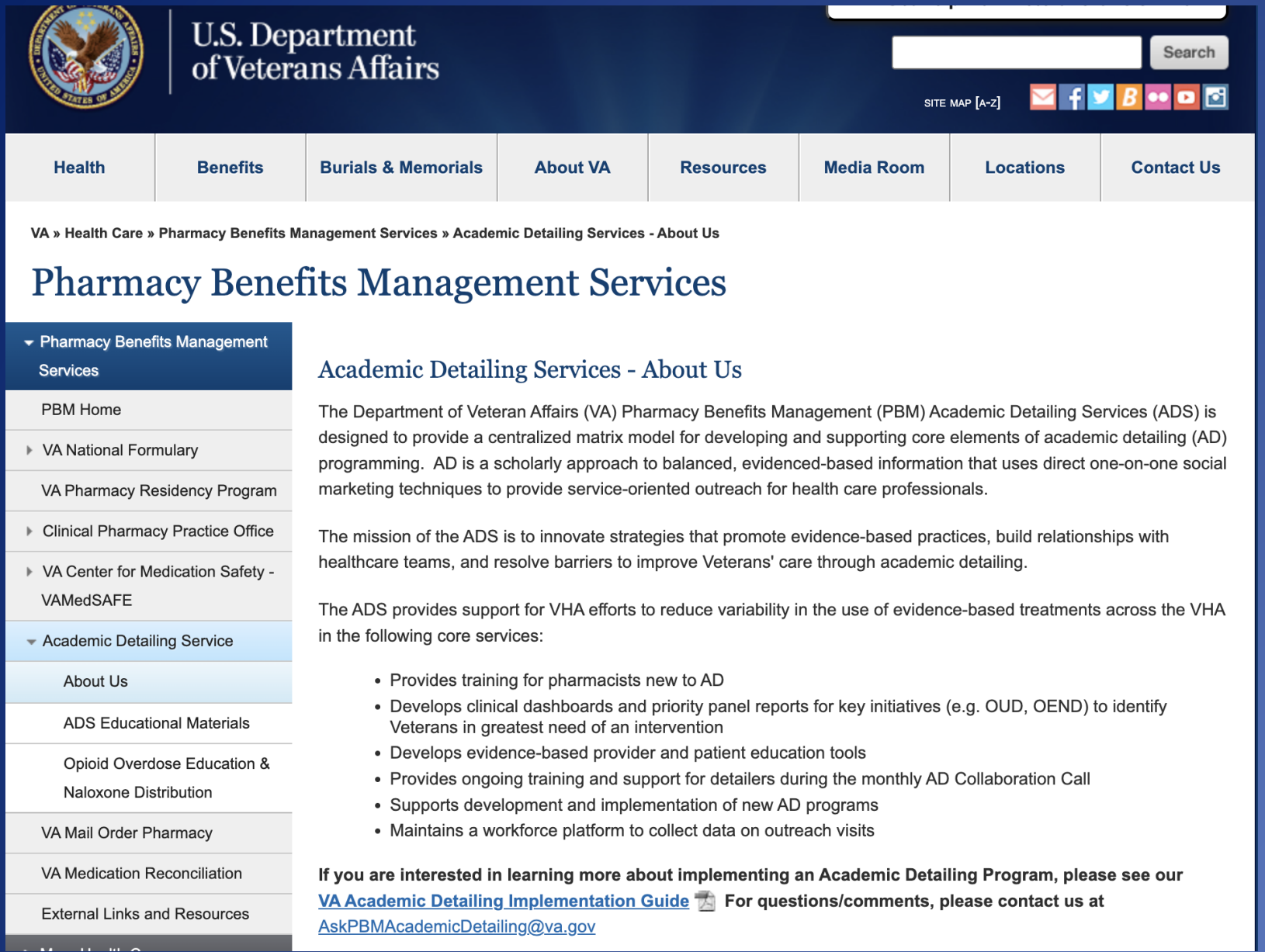
Combining AD with interventions, such as Audit & Feedback, was beneficial.

Rome 2025

Rome BN, et al. Academic Detailing Interventions and Evidence-Based Prescribing A Systematic Review
JAMA Network Open | Vol. 8, No. 1 2025;8;(1):e2453684.

VA Academic Detailing Services

https://www.pbm.va.gov/PBM/academicdetailingservice/AboutUs.asp



U.S. Department of Veterans Affairs

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Pharmacy Benefits Management Services

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Academic Detailing Services - About Us

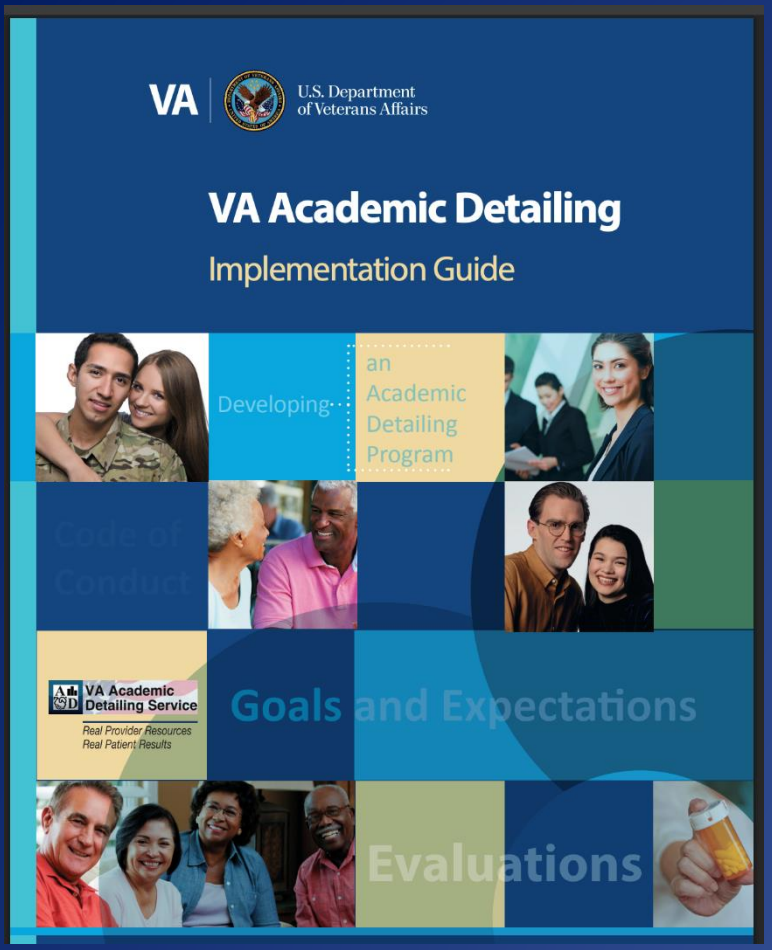
The Department of Veteran Affairs (VA) Pharmacy Benefits Management (PBM) Academic Detailing Services (ADS) is designed to provide a centralized matrix model for developing and supporting core elements of academic detailing (AD) programming. AD is a scholarly approach to balanced, evidenced-based information that uses direct one-on-one social marketing techniques to provide service-oriented outreach for health care professionals.

The mission of the ADS is to innovate strategies that promote evidence-based practices, build relationships with healthcare teams, and resolve barriers to improve Veterans' care through academic detailing.

The ADS provides support for VHA efforts to reduce variability in the use of evidence-based treatments across the VHA in the following core services:

- Provides training for pharmacists new to AD
- Develops clinical dashboards and priority panel reports for key initiatives (e.g. OUD, OEND) to identify Veterans in greatest need of an intervention
- Develops evidence-based provider and patient education tools
- Provides ongoing training and support for detailers during the monthly AD Collaboration Call
- Supports development and implementation of new AD programs
- Maintains a workforce platform to collect data on outreach visits

If you are interested in learning more about implementing an Academic Detailing Program, please see our VA Academic Detailing Implementation Guide For questions/comments, please contact us at AskPBMAcademicDetailing@va.gov



60 pgs, 2016

The VA recommends limiting the number of key messages to between 4 and 6 per campaign

can be divided among more than one visit . . .

"An example of a possible key message:
Consider tapering patients on opioids at >= 100 MEDD to reduce the risk of overdose."

VA Academic Detailing Services

SAMPLE OF PUBLIC DOMAIN RESOURSES

Resources For Providers:

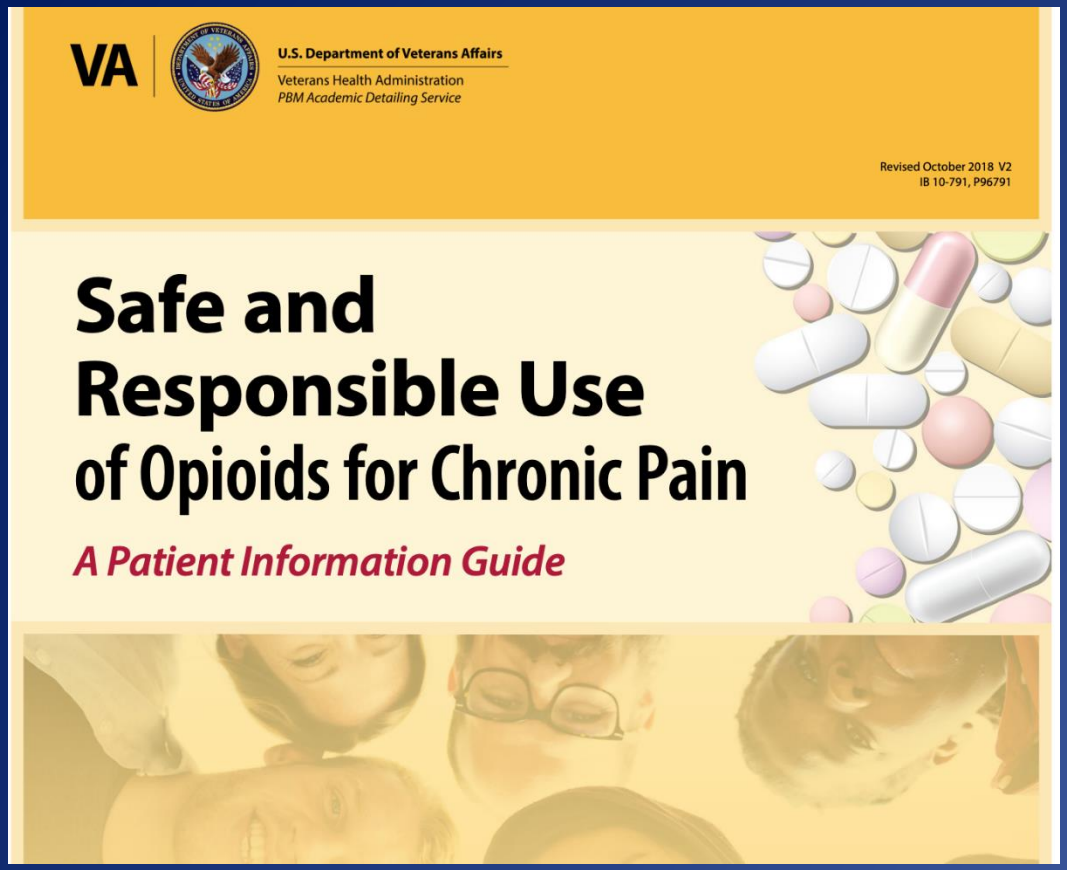
'Opioid Medication Risks' (2 pgs)

Resources For Patients:

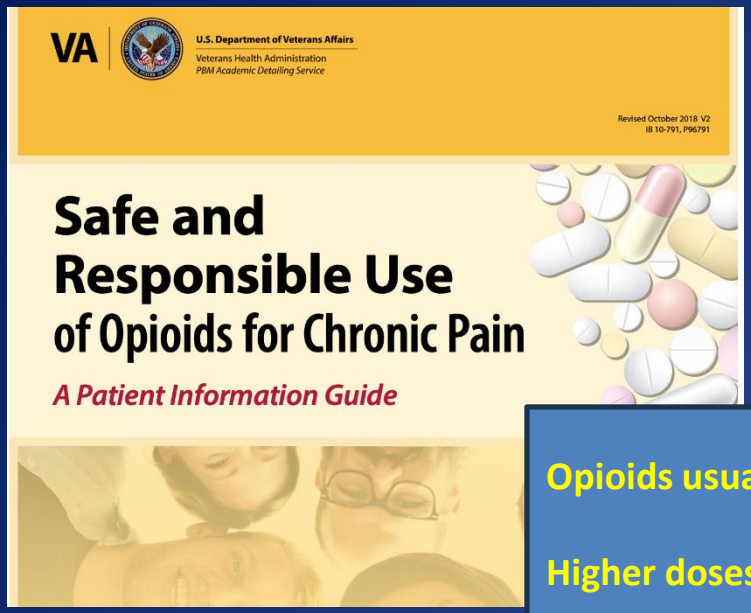
'Slowly Stopping Opioid Medications' (2 pgs)

'Use of Opioids for Chronic Pain' (2 pgs)

'Safe and Responsible Use of Opioids for Chronic Pain' (9 pgs)



9 pgs, revised 2018



9 pgs, revised 2018

Excerpt:

Opioids usually only "take the edge off" chronic pain for a short time.

Higher doses usually cause more side effects, without reducing your pain.

Daily use of opioids can actually make your pain worse over time.

When carefully assessed, 25% to 40% of patients on long-term opioid therapy (more than 90 days) have an opioid use disorder.

If you and your provider decide to reduce your opioids, your provider will try to prevent or lessen any withdrawal symptoms.

Decreasing slowly makes it easier to stop opioid medicines.

Tips to Reduce Your Risks:

Talk to your provider about decreasing your opioid medication. . .

CIAO: **C**enter for **I**nnovation in **A**cademic detailing on **O**pioids and stimulants

at the San Francisco Dept. of Public Health,
funded by the **CA Dept of Public Health**, with grant funding from **CDC**.

- Provides trainings & technical assistance to detailers
- Develops public-domain resources.

CENTER FOR INNOVATIVE
ACADEMIC DETAILING
ON OPIOIDS & STIMULANTS

‘Opioids and Chronic Pain: A Guide for Primary Care Providers’

‘Toolkit for Inheriting Patients on Long-term Opioids.’

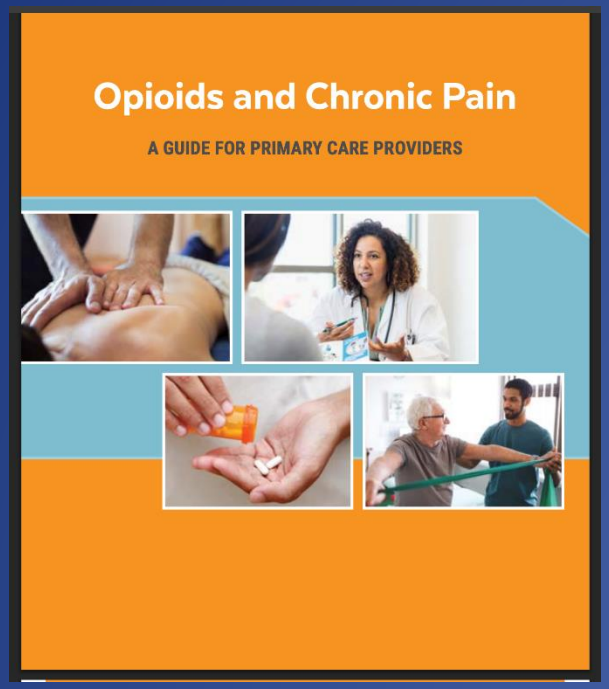
‘Patient Abandonment: The Impact of Losing Access to Long-Term Opioid Therapy’

5 minute video by CIAO Medical Director Phillip Coffin on supporting patients who have lost their provider.

(Opioid Stewardship, etc., etc.)

CENTER FOR INNOVATIVE
ACADEMIC DETAILING
ON OPIOIDS & STIMULANTS

Opioids and Chronic Pain
A Guide for Primary Care Providers



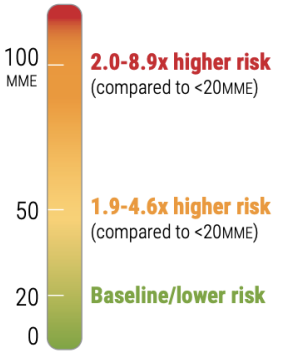
40 pgs. Updated Feb 2023

Opioid dose considerations

CALCULATING MORPHINE MILLIGRAM EQUIVALENTS (MME)

Opioid (doses in mg/day except where noted)	Conversion factor
Codeine	0.15
Morphine	1
Hydrocodone	1
Oxycodone	1.5
Fentanyl transdermal (in mcg/hr)	2.4
Oxymorphone	3
Hydromorphone	5
Methadone	
1-20 mg/day	4
21-40 mg/day	8
41-60 mg/day	10
≥61 mg/day	12

Higher opioid dose = higher risk of overdose[4]



These dose conversions are estimated and cannot account for all individual differences in genetics and pharmacokinetics. Some opioids, including methadone and fentanyl, have complex conversion factors and require expertise to manage.

CDC recommends

If opioids *are* appropriate, consider using episodic, short-acting opioids and keep at the lowest effective dose—***low and slow.***

Starting opioids:

Starting dose for opioid-naive patients is generally 5-30 MME/day

Exercise caution:

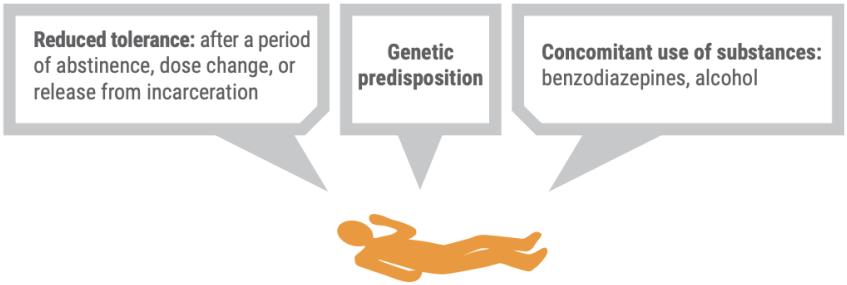
- Doses ≥ **50 MME**
- Concurrent use of a benzodiazepine, alcohol, or methadone for pain

Overdose prevention

Prior opioid overdose is a major risk for future overdose.

A patient who has previously overdosed is greater than **seven times more likely** to overdose in the subsequent year.[21]

OTHER FACTORS THAT INCREASE RISK OF OVERDOSE



Some patients have overdosed and don't realize it.

In one study, out of 60 patients on opioid therapy for pain, 37% had stopped breathing or required help to be woken up due to opioids.[22]

45% of those patients denied overdosing, calling it a bad reaction.

The word "overdose" may have negative connotations and people who use prescription opioids may not relate to it. Instead of using the word "overdose", consider language like "accidental overdose" or "bad reaction", or talk about "opioid safety".

Managing patients on opioids

INHERITING PATIENTS ALREADY ON OPIOID THERAPY CAN BE COMPLEX

1. **Review case with former provider if possible.**
   Develop a treatment plan that slowly adjusts to your style of management to avoid a radical divergence from the prior plan of care.

2. **Consider bridging the patient until a plan of care is determined.**
   Abruptly tapering or stopping opioids can be dangerous:
   a. Opioids may be crucial to the patient's condition
   b. Patient may be at risk of other harms (see next page)

3. **Develop a patient-centered care plan.**

4. **Screen for opioid use disorder; start discussing medication options right away.**
   The patient may struggle with an opioid use disorder diagnosis—give them time.

5. **Document opioid stewardship and rationale for treatment plan.**
   Investigations into opioid prescribing often focus on insufficient documentation.

PATIENT ENGAGEMENT

- Recognize external factors that can make any patient-provider conversation challenging, especially **patient stressors** (e.g. psychological stressors) and **provider stressors** (e.g. time pressure, clinic/health system policies).
- Use motivational interviewing techniques.

For more information, go to: motivationalinterviewing.org

Shared decision-making for opioid therapy

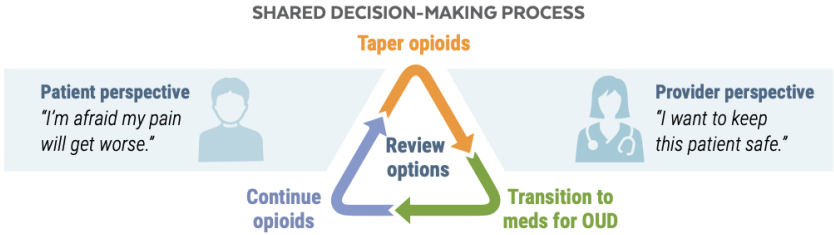
Avoid making a decision without an individualized conversation with the patient.

1 Ask the patient to describe perceived risks and benefits.

Patients may identify scenarios with limited benefit or increasing risk such as:

- On opioids after pain condition addressed
- No evidence of pain/function improvement
- Very high dose of opioids
- Other risky medications (e.g. benzodiazepines)
- Adverse effects (constipation, overdose, etc.)
- Worsening comorbidities
- Active opioid use disorder

2 Develop a plan with the patient.



Communication techniques:

- Validate patient's pain and experience
- Recognize power dynamics
- Empower patient to participate in treatment planning
- Don't judge
- Be flexible
- Prepare for emotion

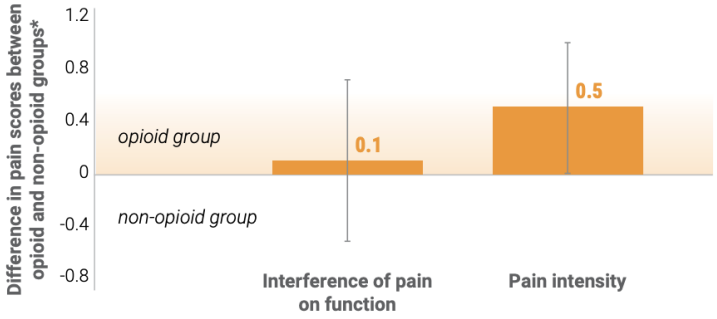
3 Before implementing change, review and develop a plan for:

- Social issues (e.g. housing, finances, intimate partner violence)
- Alternative pain management strategy (other medication and non-medication strategies)
- Mental health services
- Social support
- Withdrawal medications
- Changes in tolerance and overdose risk

Considering opioids for pain management

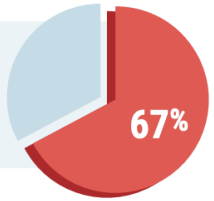
Avoid opioids as first-line therapy for chronic, non-cancer pain.

Patients randomized to opioids had **similar pain-related function and greater pain intensity** compared to those randomized to non-opioid medications.[2]



*Pain scores measured by Brief Pain Inventory (BPI) Interference and Severity Scales. Patients had no contraindications to acetaminophen or NSAIDs.

Make sure to evaluate risks and benefits—67% of patients prescribed opioids for 90 days are still using opioids at 2 years.[3]



When *should* a provider consider opioids for chronic conditions?

- When other therapies are contraindicated
- When other therapy trials were implemented and unsuccessful
- After a full assessment and discussion of risks and benefits

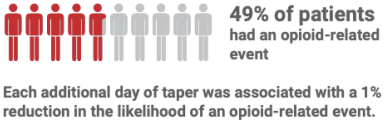
Risks of reducing opioid dose

INCREASED ILLICIT SUBSTANCE USE:

Stopping prescribed opioids increased the chance of more frequent heroin and illicit opioid pain reliever use.[5]

OPIOID-RELATED ADVERSE EVENTS:

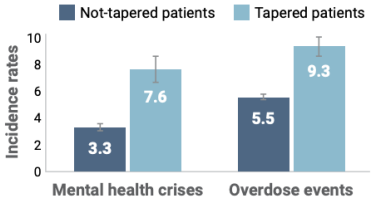
Approximately half of Medicaid patients in Vermont had an opioid-related ED visit or hospitalization following discontinuation of high-dose opioids. Speed of taper and substance use disorder diagnosis were the strongest predictors.[6]



Each additional day of taper was associated with a 1% reduction in the likelihood of an opioid-related event.

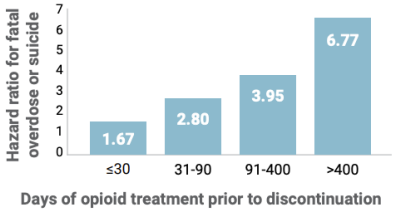
INCREASED MENTAL HEALTH CRISES AND OVERDOSE EVENTS:

Among 113,618 patients on high-dose stable opioid therapy, tapering was associated with significant increases in mental health crises and overdose.[7]



MORTALITY:

Among 1,394,102 VA patients, risk for fatal overdose or suicide rose after stopping opioid therapy, with increasing risk the longer patients had been treated before stopping.[8] Other studies have shown similar findings.[9]



Mechanics of a taper

BUILD THE CASE

1. Get to know the patient's stressors, needs, and pain:
   - don't rush to start a taper immediately: patient buy-in is important
   - individualize the taper plan (see "Example tapers for opioids")
2. Discuss the risks of tapering.
3. Involve patient in the selection of a taper speed and frequency of dose reduction (see "Example tapers for opioids").
4. Tapering should **not** result in withdrawal. However, in some circumstances, you may prescribe adjunctive medications to treat withdrawal symptoms.

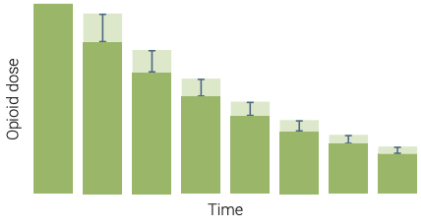
TIP

If a taper is needed, empower the patient—successful tapers may take years, but can be associated with less or similar pain.[10] Any reduction is a success.

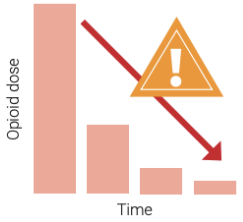
Symptom	Medication
Cold sweats, chills, feeling "jittery"	Clonidine: 0.1 mg tablet
Anxiety, problems sleeping	Hydroxyzine: 50 mg tablet
Nausea or vomiting	Ondansetron: 4 mg tablet
Diarrhea	Loperamide: 2 mg tablet
Body aches or muscle pain	NSAIDS or Acetaminophen

TAPER GOALS

Most commonly, opioid tapers will involve **dose reduction of 5-20%** of original dose every 4 weeks



Abrupt tapers (>20% of original dose) **should be avoided whenever possible**



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Example tapers for opioids[11]

Slowest taper (over years)	
Reduce by 2% to 10% every 4 to 8 weeks with pauses in taper as needed. Consider for patients taking high doses of long-acting opioids for many years.	**Ex: morphine SR 90 mg q8h = 270 MED*** **Month 1**: 90 mg SR qAM, 75 mg noon, 90 mg qPM [5% reduction][a] **Month 2**: 75 mg SR qAM, 75 mg noon, 90 mg qPM **Month 3**: 75 mg SR (60 mg+15 mg) q8h **Month 4**: 75 mg SR qAM, 60 mg noon, 75 mg qPM **Month 5**: 60 mg SR qAM, 60 mg noon, 75 mg qPM **Month 6**: 60 mg SR q8h **Month 7**: 60 mg SR qAM, 45 mg noon, 60 mg qPM **Month 8**: 45 mg SR qAM, 45 mg noon, 60 mg qPM **Month 9**: 45 mg SR q8h[b]
Standard taper (over months or years) — MOST COMMON	
Reduce by 5% to 20% every 4 weeks with pauses in taper as needed.	**Ex: morphine SR 90 mg q8h = 270 MED** **Month 1**: 75 mg (60 mg+15 mg) SR q8h [16% reduction] **Month 2**: 60 mg SR q8h; **Month 3**: 45 mg SR q8h **Month 4**: 30 mg SR q8h; **Month 5**: 15 mg SR q8h **Month 6**: 15 mg SR q12h; **Month 7**: 15mg SR qhs, then stop
Faster taper (over weeks)	
Reduce by 10% to 20% every week.	**Ex: morphine SR 90 mg q8h = 270 MED** **Week 1**: 75 mg SR q8h [16% reduction] **Week 2**: 60 mg SR (15 mg x 4) q8h; **Week 3**: 45 mg SR (15 mg x 3) q8h **Week 4**: 30 mg SR (15 mg x 2) q8h; **Week 5**: 15 mg SR q8h **Week 6**: 15 mg SR q12h; **Week 7**: 15 mg SR qhs x 7 days, then stop
Rapid taper (over days) — RARELY INDICATED	
Reduce by 20% to 50% of first dose if needed, then reduce by 10% to 20% every day.	**Ex: morphine SR 90 mg q8h = 270 MED** **Day 1**: 60 mg SR (15 mg x 4) q8h [33% reduction] **Day 2**: 45 mg SR (15 mg x 3) q8h; **Day 3**: 30 mg SR (15 mg x 2) q8h **Day 4**: 15 mg SR q8h; Days 5-7: 15 mg SR q12h **Days 8-11**: 15 mg SR qhs, then stop

[a]Continue the taper based on patient response.

[b]Continue following this rate of taper until off the morphine or the desired dose of opioid is reached.

***MED** = morphine equivalent dose

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Buprenorphine overlap initiation

Extremely high tolerance to opioids increases the risk of **precipitated withdrawal.** **An alternative is buprenorphine overlap initiation** which avoids this risk.

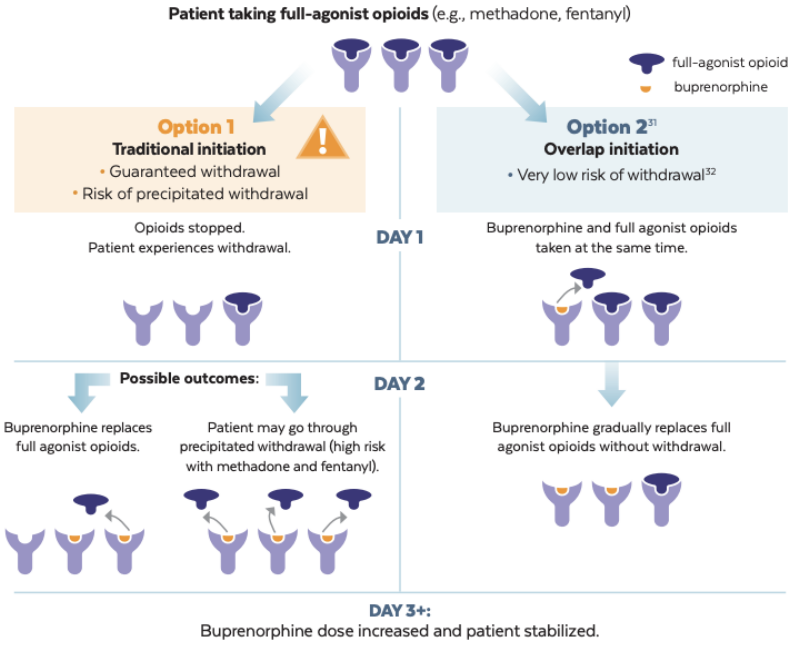
CONSIDER WHEN PATIENT:

- Doesn't want to experience withdrawal
- Had prior difficulty starting buprenorphine
- Uses fentanyl
- Wants to switch from methadone

AVOID WHEN PATIENT:

- ✗ Prefers a rapid start or is already in significant withdrawal
- ✗ Is unable to take buprenorphine multiple times a day

TRADITIONAL VS. OVERLAP INITIATION OF BUPRENORPHINE:



For overlap initiation protocols, go to:
https://cabridge.org/resource/starting-buprenorphine-with-microdosing

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Another useful resource for prescriber education:

HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics

This *HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics* provides advice to clinicians who are contemplating or initiating a reduction in opioid dosage or discontinuation of long-term opioid therapy for chronic pain. In each case the clinician should review the risks and benefits of the current therapy with the patient, and decide if tapering is appropriate based on individual circumstances.

After increasing every year for more than a decade, annual opioid prescriptions in the United States peaked at 255 million in 2012 and then decreased to 191 million in 2017.[i] More judicious opioid analgesic prescribing can benefit individual patients as well as public health when opioid analgesic use is limited to situations where benefits of opioids are likely to outweigh risks. At the same time opioid analgesic prescribing changes, such as dose escalation, dose reduction or discontinuation of long-term opioid analgesics, have potential to harm or put patients at risk if not made in a thoughtful, deliberative, collaborative, and measured manner.

Risks of rapid opioid taper

- Opioids should not be tapered rapidly or discontinued suddenly due to the risks of significant opioid withdrawal.
- Risks of rapid tapering or sudden discontinuation of opioids in physically dependent[ii] patients include acute withdrawal symptoms, exacerbation of pain, serious psychological distress, and thoughts of suicide.[1] Patients may seek other sources of opioids, potentially including illicit opioids, as a way to treat their pain or withdrawal symptoms.[1]
- Unless there are indications of a life-threatening issue, such as warning signs of impending overdose, HHS does not recommend abrupt opioid dose reduction or discontinuation.

needs.[2,3,4] Coordination across the health care team is critical. Clinicians have a responsibility to provide or arrange for coordinated management of patients' pain and opioid-related problems, and they should never abandon patients.[2] More specific guidance follows, compiled from published guidelines (the *CDC Guideline for Prescribing Opioids for Chronic Pain*[2] and the *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*[3]) and from practices endorsed in the peer-reviewed literature.

Consider[iii] tapering to a reduced opioid dosage, or tapering and discontinuing opioid therapy, when

- Pain improves[3]
- The patient requests dosage reduction or discontinuation[2,3,5]
- Pain and function are not meaningfully improved[2,3,5]
- The patient is receiving higher opioid doses without evidence of benefit from the higher dose[2,3]
- The patient has current evidence of opioid misuse[3,5]
- The patient experiences side effects[iv] that diminish quality of life or impair function[3]
- The patient experiences an overdose or other serious event (e.g., hospitalization, injury),[2,5] or has warning signs for an impending event such as confusion, sedation, or slurred speech[2,6]
- The patient is receiving medications (e.g., benzodiazepines) or has medical conditions (e.g., lung disease, sleep apnea, liver disease, kidney disease, fall risk, advanced age) that increase

CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022

https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm

CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022

Recommendations 1 – 5:

BOX 3. Recommendations for prescribing opioids for outpatients with pain, excluding pain management related to sickle cell disease, cancer-related pain treatment, palliative care, and end-of-life care; recommendation categories; and evidence types — CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022

Return

Determining Whether or Not to Initiate Opioids for Pain (Recommendations 1 and 2)

1. Nonopioid therapies are at least as effective as opioids for many common types of acute pain. Clinicians should maximize use of nonpharmacologic and nonopioid pharmacologic therapies as appropriate for the specific condition and patient and only consider opioid therapy for acute pain if benefits are anticipated to outweigh risks to the patient. Before prescribing opioid therapy for acute pain, clinicians should discuss with patients the realistic benefits and known risks of opioid therapy (recommendation category: B; evidence type: 3).
2. Nonopioid therapies are preferred for subacute and chronic pain. Clinicians should maximize use of nonpharmacologic and nonopioid pharmacologic therapies as appropriate for the specific condition and patient and only consider initiating opioid therapy if expected benefits for pain and function are anticipated to outweigh risks to the patient. Before starting opioid therapy for subacute or chronic pain, clinicians should discuss with patients the realistic benefits and known risks of opioid therapy, should work with patients to establish treatment goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks (recommendation category: A; evidence type: 2).

Selecting Opioids and Determining Opioid Dosages (Recommendations 3, 4, and 5)

3. When starting opioid therapy for acute, subacute, or chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release and long-acting (ER/LA) opioids (recommendation category: A; evidence type: 4).
4. When opioids are initiated for opioid-naïve patients with acute, subacute, or chronic pain, clinicians should prescribe the lowest effective dosage. If opioids are continued for subacute or chronic pain, clinicians should use caution when prescribing opioids at any dosage, should carefully evaluate individual benefits and risks when considering increasing dosage, and should avoid increasing dosage above levels likely to yield diminishing returns in benefits relative to risks to patients (recommendation category: A; evidence type: 3).
5. For patients already receiving opioid therapy, clinicians should carefully weigh benefits and risks and exercise care when changing opioid dosage. If benefits outweigh risks of continued opioid therapy, clinicians should work closely with patients to optimize nonopioid therapies while continuing opioid therapy. If benefits do not outweigh risks of continued opioid therapy, clinicians should optimize other therapies and work closely with patients to gradually taper to lower dosages or, if warranted based on the individual circumstances of the patient, appropriately taper and discontinue opioids. Unless there are indications of a life-threatening issue such as warning signs of impending overdose (e.g., confusion, sedation, or slurred speech), opioid therapy should not be discontinued abruptly, and clinicians should not rapidly reduce opioid dosages from higher dosages (recommendation category: B; evidence type: 4).

CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022

Recommendations 6 - 12:

Deciding Duration of Initial Opioid Prescription and Conducting Follow-Up (Recommendations 6 and 7)

6. When opioids are needed for acute pain, clinicians should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids (recommendation category: A; evidence type: 4).
7. Clinicians should evaluate benefits and risks with patients within 1–4 weeks of starting opioid therapy for subacute or chronic pain or of dosage escalation. Clinicians should regularly reevaluate benefits and risks of continued opioid therapy with patients (recommendation category: A; evidence type: 4).

Assessing Risk and Addressing Potential Harms of Opioid Use (Recommendations 8, 9, 10, 11, and 12)

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk for opioid-related harms and discuss risk with patients. Clinicians should work with patients to incorporate into the management plan strategies to mitigate risk, including offering naloxone (recommendation category: A; evidence type: 4).
9. When prescribing initial opioid therapy for acute, subacute, or chronic pain, and periodically during opioid therapy for chronic pain, clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or combinations that put the patient at high risk for overdose (recommendation category: B; evidence type: 4).
10. When prescribing opioids for subacute or chronic pain, clinicians should consider the benefits and risks of toxicology testing to assess for prescribed medications as well as other prescribed and nonprescribed controlled substances (recommendation category: B; evidence type: 4).
11. Clinicians should use particular caution when prescribing opioid pain medication and benzodiazepines concurrently and consider whether benefits outweigh risks of concurrent prescribing of opioids and other central nervous system depressants (recommendation category: B; evidence type: 3).
12. Clinicians should offer or arrange treatment with evidence-based medications to treat patients with opioid use disorder. Detoxification on its own, without medications for opioid use disorder, is not recommended for opioid use disorder because of increased risks for resuming drug use, overdose, and overdose death (recommendation category: A; evidence type: 1).

2022 CDC RECOMMENDATIONS RE-WRITTEN FOR BREVITY:

1. Only consider opioid therapy for acute pain if benefits are anticipated to outweigh risks.
2. Nonopioid therapies are preferred for subacute and chronic pain.
   Consider initiating opioid therapy only if expected benefits are anticipated to outweigh risks.
3. When starting opioid therapy, use immediate-release opioids.
4. When opioids are initiated, use the lowest effective dosage.
   Evaluate benefits and risks when considering a dose increase, and avoid increasing if diminishing returns are likely.
5. Weigh benefits and risks and exercise care when changing opioid dosage.
   If opioid benefits outweigh risks, work with patients to optimize nonopioid therapies.
   If opioid benefits do not outweigh risks, optimize other therapies and work with patients to gradually taper to lower dosages
   or, if circumstances warrant, appropriately taper and discontinue opioids.
   Except for possible life-threatening issues, do not abruptly discontinue, nor rapidly reduced opioids from higher dosages.
6. When opioids are needed for acute pain, clinicians should prescribe no greater quantity than needed.
7. Regularly reevaluate benefits and risks of opioids with patients, including within 1–4 weeks of starting opioids or increasing dose.
8. Before starting opioids, and periodically, evaluate risks with patients and strategies to mitigate risk, including naloxone.
9. When starting opioids, and periodically, review controlled substance prescriptions on the PDMP.
10. For patients on opioids for subacute or chronic pain, consider benefits and risks of toxicology testing.
11. Use particular caution when prescribing opioids with CNS depressants, e.g. benzodiazepines, and weigh benefits and risks.
12. Offer or arrange treatment with MOUD to treat OUD.

2022 CDC RECOMMENDATIONS re-written for brevity, **WITH VAGUE AND/OR OBVIOUS PORTIONS HIGHLIGHTED.**

1. Only consider opioid therapy for acute pain ***if benefits are anticipated to outweigh risks.***
2. ***Nonopioid therapies are preferred*** (for subacute and chronic pain)

   Consider initiating opioid therapy ***only if expected benefits are anticipated to outweigh risks***.
3. When starting opioid therapy, use immediate-release opioids.
4. When opioids are initiated, ***use the lowest effective dosage***.

   Evaluate benefits and risks when considering a dose increase, and ***avoid increasing if diminishing returns*** are likely.
5. ***Weigh benefits and risks*** and ***exercise care*** when changing opioid dosage.

   If opioid benefits outweigh risks, work with patients to optimize nonopioid therapies.

   If opioid benefits do not outweigh risks, optimize other therapies and *work with patients to gradually taper to lower dosages*

   or, if circumstances warrant, appropriately taper and discontinue opioids.

   Except for possible life-threatening issues, do not abruptly discontinue, nor rapidly reduced opioids from higher dosages.
6. When opioids are needed for acute pain, clinicians should ***prescribe no greater quantity than needed.***
7. ***Regularly reevaluate benefits and risks*** of opioids with patients, including within 1–4 weeks of starting opioids or increasing dose.
8. Before starting opioids, and periodically, ***evaluate risks*** with patients and ***strategies to mitigate risk***, including naloxone.
9. When starting opioids, and periodically, review controlled substance prescriptions on the PDMP.
10. For patients on opioids for subacute or chronic pain, ***consider benefits and risks of toxicology testing***.
11. ***Use particular caution*** when prescribing opioids with CNS depressants, e.g. benzodiazepines, ***and weigh benefits and risks***.
12. Offer or arrange treatment with MOUD to treat OUD.

MANY GUIDELINE RECOMMENDATIONS ARE NOT STRICTLY EVIDENCE-BASED

According to the AHRQ :

"**No instrument** was shown to be associated with high accuracy for **predicting opioid overdose, addiction, abuse, or misuse**."

EVIDENCE-BASED RISK MITIGATION STRATEGIES:

CO-PRESCRIBING NALOXONE: Reduced ED visits, and a trend (RR 0.77) in reduced all-cause mortality

AVOIDANCE OF CO-PRESCRIPTION OF BENZODIAZEPINES OR GABAPENTINOIDS: Reduced overdose risk.

USE OF SHORT-ACTING VS. LONG-ACTING OPIOIDS: Reduced overdose risk.

OTHERWISE, no study has evaluated the effectiveness of risk mitigation strategies on misuse, OUD and overdose INCLUDING:

- patient education
- urine drug screening
- monitoring instruments
- more frequent monitoring intervals
- pill counts
- abuse-deterrent formulations
- Or opioid dosing strategies, e.g. scheduled vs. PRN, or opioid rotation.

Agency for Healthcare Research & Quality AHRQ Publication No. 20-EHC011. April 2020
https://effectivehealthcare.ahrq.gov/sites/default/files/related_files/opioids-chronic-pain.pdf (search for "risk mitigation" or "risk reduction")

SHOULD CONTENT/GOALS OF AD EDUCATION EMPHASIZE GUIDELINE-CONCORDANT CARE?

Liebschutz, et al.: 53 primary care opioid prescribers randomized to . . .

(1) AD WITH AUDIT & FEEDBACK.

AN **AD SESSION** with an expert physician

where each aspect of guideline concordant care was reviewed.

Including **AUDIT & FEEDBACK OF A PATIENT REGISTRY, specifically:**

% with a patient-agreement, with at least one UDS/yr

% with a mental health dx, other risk factors, early refills (misuse), & % with MME>100.

(2) NURSE CARE MANAGER

(3) "ELECTRONIC DECISION TOOLS" (online risk factor screening instruments, etc.)

vs. CONTROLS:

ELECTRONIC DECISION TOOLS ONLY.

Liebschutz JM, et al. Improving adherence to long-term opioid therapy guidelines to reduce opioid misuse in primary care: a cluster-randomized clinical trial. JAMA Intern Med. 2017;177(9):1265-1272.

Continued . . .

. . . Continued: Liebschutz JM, et al. 2017

RESULTS:

Improved adherence to guideline-recommended monitoring:

% with a provider-patient agreement;

% with at least one urine drug screen within a year

But no improvement in early opioid refills

vs. electronic decision tools alone.

Liebschutz JM, et al. Improving adherence to long-term opioid therapy guidelines to reduce opioid misuse in primary care: a cluster-randomized clinical trial. JAMA Intern Med. 2017;177(9):1265-1272

EMPHSASIZING REDUCED PRESCRIBING IN AD:

In Staten Island, NYC Health Dept representatives visited prescribers with the following recommendations, based on the NYC Dept of Health & Mental Hygiene's judicious opioid prescribing guidelines:

(1) A 3-day supply of opioids is usually sufficient for acute pain,
(2) Avoid prescribing opioids for chronic noncancer pain, and
(3) Avoid high-dose opioid prescriptions (i.e., ≥ 100 total daily MMEs)

RESULTS: A decrease in high-dose prescribing (>100 MME) in Staten Island vs. other boroughs ($P < .01$), although there were concurrent media interventions as well.

Kattan 2016

An emphasis on reducing prescribing is often seen in AD interventions.
(Presented earlier: Avorn, et al; Rome, et al. reviewed only trials that reported prescribing changes)

Kattan JA et al. Public Health Detailing-A Successful Strategy to Promote Judicious Opioid Analgesic Prescribing. Am J Public Health. 2016 Aug;106(8):1430-8.

CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022

https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm

Per the CDC Guidelines,

"Clinical evidence reviews found insufficient evidence to determine long-term benefits of opioid therapy for chronic pain ...[7] "

7. Chou R, Hartung D, Turner J, et al. Opioid treatments for chronic pain. Comparative effectiveness review no. 229. Agency for Healthcare Research and Quality; 2020.

WHAT IS THE EVIDENCE OF EFFECTIVENESS OF LONG-TERM OPIOIDS FOR CHRONIC PAIN?

Review of 71 RCTs , AHRQ, 2022

AHRQ: Agency for Healthcare, Research & Quality

(1)

For opioids ***compared to non-opioid pharmacotherapy:***

No evidence of effectiveness for chronic pain 6-<12 months

Evidence of lack of effectiveness at 1 – <6 months, and at 12 months.

(2)

For opioids ***compared to placebo:***

No-evidence of effectiveness at 6-<12 months, or at 12 months.

Slight effectiveness for pain reduction: avg reduction of 0.8 points* out of 10 at 1 – <6 months.

*** This is below the threshold for a clinically meaningful change in pain scores.**

*** Next slide**

AHRQ: Systematic Review: Opioid Treatments for Chronic Pain. 2022. Agency for Healthcare Research and Quality. https://effectivehealthcare.ahrq.gov/products/opioids-chronic-pain/research.

Chou, Roger: Presentation: ASAM Pain and Addiction: Common Threads Course XXV - April 2024 Session 2: The State of Evidence-based Pain Care, accessed 7-29-2024 https://elearning.asam.org/products/asam-pain-and-addiction-common-threads-course-xxv-2024#tab- product_tab_contents__18

Feb;12(1):12-20.

THRESHOLD FOR CLINICALLY MEANINGFUL IMPROVEMENT IN PAIN SCORES:

Dworkin et. al. 2008 proposed a **1 point threshold** as a meaningful improvement (on a scale from 1 – 10).

The review by Noble et. al., 2022, noted **2 points** as a minimum meaningful change in pain scores (10 point scale), citing Farrar 2000, Salafi 2004, and Hagg 2003.

The 2022 CDC Guidelines noted **30%** as a meaningful improvement for pain and function, citing the review by Ostello 2008.

Approximately two thirds of the 44 studies in the 2022 AHRQ review that defined a meaningful improvement in pain scores used **30%** as the threshold.

(Pain intensity is a limited measure of burden, tolerability, pain interference, & quality of life, which are also affected by confidence in managing pain, psychological factors, etc.). Sullivan &Ballantyne 2023, Adams 2018

Dworkin RH, et. al. Interpreting the clinical importance of treatment outcomes in chronic pain clinical trials: IMMPACT recommendations. J Pain. 2008;9(2):105-121.

Noble, M. Long-term opioid management for chronic noncancer pain. Review Cochrane Database Syst Rev. 2010 Jan 20;2010(1):CD006605.

Farrar JT. What is clinically meaningful: outcome measures in pain clinical trials. *Clinical Journal of Pain* 2000;16(2 Supplement):S106-12.

Salaffi F, et al. Minimal clinically important changes in chronic musculoskeletal pain intensity measured on a numerical rating scale. *European Journal of Pain* 2004 Aug;8(4):283-91.

Hagg O, et al. The clinical importance of changes in outcome scores after treatment for chronic low back pain. *European Spine Journal* 2003 Feb;12(1):12-20.

CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022

Ostello RWJG, et al. Interpreting change scores for pain and functional status in low back pain: towards international consensus regarding minimal important change. Spine 2008; 33:90–4

AHRQ: Systematic Review: Opioid Treatments for Chronic Pain. 2022. Agency for Healthcare Research and Quality. https://effectivehealthcare.ahrq.gov/products/opioids-chronic-pain/research

Sullivan, Mark and Ballantyne, Jane, The Right to Pain Relief and other Deep Roots of the Opioid Epidemic. Oxford University Press 2023, New York, NY. pg 99 – 100.

Adams MH, et al. Prevalence and correlates of low pain interference among patients with high pain intensity who are prescribed long-term opioid therapy. J Pain. 2018; 19:1074-1081.

VA/DoD Clinical Practice Guidelines Use of Opioids in the Management of Chronic Pain (2022)

"Recommendation #1:

We recommend against initiation of long-term opioid therapy for chronic pain

Strength of recommendation: (Strong evidence)"

(VA/DoD Chronic Pain 2022)

National Institute for Health and Care Excellence:

"Do not initiate opioids to manage chronic primary pain.

in people aged 16 years and over." (NICE 2021)

"…**we have little if any evidence** that long-term opioids improve outcomes for chronic pain. **It should be a rare patient** where we start long-term opioids."

'ASAM Pain & Addiction: Essentials Online,' American Society of Addiction Medicine.

VA/DoD Clinical Practice Guidelines Use of Opioids in the Management of Chronic Pain (2022)
https://www.healthquality.va.gov/guidelines/pain/cot/

NICE: Nat'l. Inst for Health and Care Excellence. Chronic Pain (Primary and Secondary) in Over 16s: Assessment of all Chronic Pain and Management of Chronic Primary Pain. https://www.nice.org.uk/guidance/NG193

Modules presented by Donald Teater, MD, MPH ('Pain & Addiction: Essentials,' ASAM)

'ASAM Pain & Addiction: Essentials Online,' American Society of Addiction Medicine; modules presented by Donald Teater, MD, MPH, ASAM.org - 'education' - 'e-learning center'
https://elearning.asam.org/products/the-asam-pain-addiction-essentials-online-module-4-treatment-pharmacological-approaches

CONCLUSIONS:

- Helpful Academic Detailing (AD) implementation resources are available, as well as practical resources for prescribers & patients that are engaging & appealing.

- AD can be effective at reducing opioid prescribing for chronic non-cancer pain, which, in turn, is associated with reduced rates of OUD and OD.

- Resources presented here do not address buprenorphine as a relatively safe alternative for pain treatment when full opioids would otherwise be prescribed.
  (VA Guidelines: bup-for-ch. pain preferred over full opioids)

- AD educational goals & content emphasizing judicious opioid prescribing may be most effective, vs. process-measures such as guideline-concordant care.

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Please contact me for questions, comments

THE END