COURSE #95501 — 5 CONTACT HOURS/CREDITS RELEASE DATE: 10/01/25 EXPIRATION DATE: 09/30/28

Opioid Safety: Balancing Benefits and Risks

HOW TO RECEIVE CREDIT

- Read the enclosed course.
- Complete the questions at the end of the course.
- Return your completed Evaluation to NetCE by mail or fax, or complete online at www.NetCE.com. (If you are a physician or Florida nurse, please return the included Answer Sheet/Evaluation.) Your postmark or facsimile date will be used as your completion date.
- Receive your Certificate(s) of Completion by mail, fax, or email.

Faculty

Mark Rose, BS, MA, LP, is a licensed psychologist in the State of Minnesota with a private consulting practice and a medical research analyst with a biomedical communications firm. Earlier healthcare technology assessment work led to medical device and pharmaceutical sector experience in new product development involving cancer ablative devices and pain therapeutics. Along with substantial experience in addiction research, Mr. Rose has contributed to the authorship of numerous papers on CNS, oncology, and other medical disorders. He is the lead author of papers published in peer-reviewed addiction, psychiatry, and pain medicine journals and has written books on prescription opioids and alcoholism published by the Hazelden Foundation. He also serves as an Expert Advisor and Expert Witness to law firms that represent disability claimants or criminal defendants on cases related to chronic pain, psychiatric/substance use disorders, and acute pharmacologic/toxicologic effects. Mr. Rose is on the Board of Directors of the Minneapolis-based International Institute of Anti-Aging Medicine and is a member of several professional organizations.

Faculty Disclosure

Contributing faculty, Mark Rose, BS, MA, LP, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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The division planners and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This course is designed for all physicians, osteopaths, physician assistants, pharmacy professionals, and nurses who may alter prescribing and/or dispensing practices to ensure safe opioid use.

Accreditations & Approvals

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This activity was planned by and for the healthcare team, and learners will receive 5 Interprofessional Continuing Education (IPCE) credits for learning and change.

NetCE designates this continuing education activity for 6 hours for Alabama nurses.

NetCE designates this continuing education activity for 5 pharmacotherapeutic/pharmacology contact hours.

AACN Synergy CERP Category A.

NetCE designates this activity for 5 hours ACPE credit(s). ACPE Universal Activity Numbers: JA4008164-0000-25-057-H08-P and JA4008164-0000-25-057-H08-T.

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Course Objective

The purpose of this course is to provide clinicians who prescribe or distribute opioids with an appreciation for the complexities of opioid prescribing and the dual risks of litigation due to inadequate pain control and drug diversion or misuse in order to provide the best possible patient care and to prevent a growing social problem.

Learning Objectives

Upon completion of this course, you should be able to:

1. Outline the types of pain and effective approaches to managing different pain types.
2. Describe the Centers for Disease Control and Prevention's most recent guidelines for prescribing opioids.
3. Identify behaviors that are indicative of opioid seeking, diversion, addiction, and/or misuse.

4. Discuss federal and state laws pertaining to the prescription of controlled substances.
5. Create a plan to properly educate patients and families regarding safe opioid use.
6. Describe potential causes and effects of disparities in pain management, and approaches to minimize negative consequences.

Pharmacy Technician Learning Objectives

Upon completion of this course, you should be able to:

1. Discuss types of pain and the CDC's guidelines for opioid prescribing.
2. Describe factors that can affect opioid prescribing, including signs of misuse, legal parameters, and treatment disparities.

Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the course material for better application to your daily practice.

INTRODUCTION

Healthcare professionals should know the best clinical practices in opioid prescribing, including the associated risks of opioids, approaches to the assessment of pain and function, and pain management modalities. Pharmacologic and nonpharmacologic approaches should be used on the basis of current knowledge in the evidence base or best clinical practices. Patients with moderate-to-severe chronic pain who have been assessed and treated, over a period of time, with nonopioid therapy or nonpharmacologic pain therapy without adequate pain relief, are considered to be candidates for a trial of opioid therapy. Initial treatment should always be considered individually determined and as a trial of therapy, not a definitive course of treatment [1; 2].

TYPES OF PAIN AND THE ROLE OF OPIOIDS

ACUTE AND SUBACUTE PAIN

Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute (less than one month) or subacute (one to three months) pain, clinicians should prescribe the lowest effective dose of immediate-release opioids in a quantity no greater than that needed for the expected duration of severe pain [2].

With postoperative, acute, or intermittent pain, analgesia often requires frequent titration, and the two- to four-hour analgesic duration with short-acting hydrocodone, morphine, and oxycodone is more effective than extended-release formulations. Short-acting opioids are also recommended in patients who are medically unstable or with highly variable pain intensity [2].

CHRONIC NON-CANCER PAIN

Nonpharmacologic therapy and nonopioid pharmacologic therapy are the preferred first-line therapies for chronic non-cancer pain. Several nonpharmacologic approaches are therapeutic complements to pain-relieving medication, lessening the need for higher doses and perhaps minimizing side effects. These interventions can help decrease pain or distress that may be contributing to the pain sensation. Approaches include palliative radiotherapy, complementary/alternative methods, manipulative and body-based methods, and cognitive/behavioral techniques. The choice of a specific nonpharmacologic intervention is based on the patient's preference, which, in turn, is usually based on a successful experience in the past [2].

interactive activity

View the CDC's video Prescription Opioids: Back on Track at https://www.netce.com/learning.php?page=activities&courseid=3207. This video highlights the risks of opioids and offers some nonopioid options for chronic pain management.

Implantable intrathecal opioid infusion and/or spinal cord stimulation may be options for severe, intractable pain. Both options require that devices or ports be implanted, with associated risks. With intrathecal opioid infusion, the ability to deliver the drug directly into the spine provides pain relief with significantly smaller opioid doses, which can help to minimize side effects (e.g., drowsiness, dizziness, dry mouth, nausea, vomiting, and constipation) that can accompany systemic pain medications that might be delivered orally, transdermally, or through an IV [3]. However, use of opioid infusion has traditionally been limited to cancer pain. With spinal cord stimulation therapy, the most challenging aspect is patient selection. In order for patients to be considered for spinal cord stimulation, other options should have been ineffective or be contraindicated. Spinal cord stimulation is indicated for severe neuropathic pain persisting at least six months [2; 3].

If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate. Clinicians should consider opioid therapy only if expected benefits for pain and function are anticipated to outweigh risks to the patient [4].

Opioid therapy for chronic pain should not be initiated without consideration by the clinician and patient on follow-up, taper, and exit strategy if opioid therapy is unsuccessful.. The goals of treatment should be established with all patients prior to the initiation of opioid therapy, including reasonable improvements in pain, function, depression, anxiety, and avoidance of unnecessary or excessive medication use. The treatment plan should describe therapy selection, measures of progress, and other diagnostic evaluations, consultations, referrals, and therapies [1; 2].

In patients who are opioid-naïve, start at the lowest possible dose and titrate to effect. Dosages for patients who are opioid-tolerant should always be individualized and titrated by efficacy and tolerability. When starting opioid therapy for chronic pain, clinicians should prescribe short-acting instead of extended-release/long-acting (ER/LA) opioid formulations [1; 2].

The need for frequent progress and benefit/risk assessments during the trial should be included in patient education. Patients should also have full knowledge of the warning signs and symptoms of respiratory depression [2].

According to the American Society of Interventional Pain Physicians, before starting opioid therapy, clinicians must take certain basic steps to prevent opioid abuse: distinguish individual opioid abuse risk factors; screen patients' potential for addiction and abuse during their initial visit; categorize patients in accordance with their level of risk and implement an appropriate level of monitoring; and refrain from judgments before a thorough assessment. Combining the above strategies with point-of-care urine drug testing as a confirmatory tool have been shown to contribute significantly to the identification of inconsistencies.

(https://www.painphysicianjournal.com/current/pdf?article=NDIwNA%3D%3D&journal=103. Last accessed September 28, 2025.)

Level of Evidence: Expert Opinion/Consensus Statement

Prescribers should be knowledgeable of federal and state opioid prescribing regulations. Issues of equianalgesic dosing, close patient monitoring during all dose changes, and cross-tolerance with opioid conversion should be considered. If necessary, treatment may be augmented, with preference for nonopioid and immediate-release opioids over ER/LA opioids. Taper opioid dose when no longer needed [4].

PALLIATIVE CARE AND PAIN AT THE END OF LIFE

Unrelieved pain is the greatest fear among people with a life-limiting disease, and the need for an increased understanding of effective pain management is well-documented. Although experts have noted that 90% of end-of-life pain can be managed effectively, rates of pain are high, even among people receiving palliative care [5; 6; 7].

The inadequate management of pain is the result of several factors related to both patients and clinicians. In a survey of oncologists, patient reluctance to take opioids or to report pain were two of the most important barriers to effective pain relief. This reluctance is related to a variety of attitudes and beliefs [5; 8; 9]:

- Fear of addiction to opioids
- Worry that if pain is treated early, there will be no options for treatment of future pain
- Anxiety about unpleasant side effects from pain medications
- Fear that increasing pain means that the disease is getting worse
- Desire to be a "good" patient
- Concern about the high cost of medications

Education and open communication are the keys to overcoming these barriers. Every member of the healthcare team should reinforce accurate information about pain management with patients and families. The clinician should initiate conversations about pain management, especially regarding the use of opioids, as few patients will raise the issue themselves or even express their concerns unless they are specifically asked [10]. It is important to acknowledge patients' fears individually and provide information to help them differentiate fact from fiction. For example, when discussing opioids with a patient who fears addiction, the clinician should explain that the risk of addiction is low. It is also helpful to note the difference between addiction and physical dependence [1; 5].

There are several other ways clinicians can allay patients' fears about pain medication [1; 8]:

- Assure patients that the availability of pain relievers cannot be exhausted; there will always be medications if pain becomes more severe.
- Acknowledge that side effects may occur but emphasize that they can be managed promptly and safely and that some side effects will abate over time.
- Explain that pain and severity of disease are not necessarily related.

Encouraging patients to be honest about pain and other symptoms is also vital. Clinicians should ensure that patients understand that pain is multidimensional and emphasize the importance of talking to a member of the healthcare team about possible causes of pain, such as emotional or spiritual distress. The healthcare team and patient should explore psychosocial and cultural factors that may affect self-reporting of pain, such as concern about the cost of medication [1; 8].

Clinicians' attitudes, beliefs, and experiences also influence pain management, with addiction, tolerance, side effects, and regulations being the most important concerns. A lack of appropriate education and training in the assessment and management of pain has been noted to be a substantial contributor to ineffective pain management. As a result, many clinicians, especially primary care physicians, do not feel confident about their ability to manage pain in their patients [5; 8; 9].

Clinicians require a clear understanding of available medications to relieve pain, including appropriate dosing, safety profiles, and side effects. If necessary, clinicians should consult with pain specialists to develop an effective approach.

Strong opioids are used for severe pain at the end of life. Morphine, buprenorphine, oxycodone, hydromorphone, fentanyl, and methadone are the most widely used in the United States. Unlike nonopioids, opioids do not have a ceiling effect, and the dose can be titrated until pain is relieved or side effects become unmanageable. Patients who are opioid-naïve or who have been receiving low doses of a weak opioid, the initial dose should be low, and, if pain persists, the dose may be titrated up daily until pain is controlled [2; 7].

More than one route of opioid administration will be needed by many patients during end-of-life care, but in general, opioids should be given orally, as this route is the most convenient and least expensive.

The transdermal route is preferred to the parenteral route, although dosing with a transdermal patch is less flexible and so may not be appropriate for patients with unstable pain. Intramuscular injections should be avoided because injections are painful, drug absorption is unreliable, and the time to peak concentration is long [2; 7].

CENTERS FOR DISEASE CONTROL AND PREVENTION OPIOID PRESCRIBING GUIDELINE

The Centers for Disease Control and Prevention (CDC) originally published *Guideline for Prescribing Opioids for Chronic Pain–United States, 2016* in an effort to address an ongoing crisis of prescription opioid misuse, abuse, and overdose [2]. While these guidelines were based on the best available evidence at the time, there was some criticism that they were too focused on limiting opioid prescriptions—to the point of patients and prescribers complaining of stigma and reduced access to needed opioid analgesics. In response to this and to the availability of new evidence, the CDC published updates to the guideline in 2022 [2]. The updated clinical practice guideline is intended to achieve improved communication between clinicians and patients about the risks and benefits of pain treatment, including opioid therapy for pain; improved safety and effectiveness for pain treatment, resulting in improved function and quality of life for patients experiencing pain; and a reduction in the risks associated with long-term opioid therapy, including opioid use disorder, overdose, and death [2].

The 2022 clinical practice guideline includes 12 recommendations for clinicians who are prescribing opioids for outpatients 18 years of age or older with acute (duration <1 month) pain, subacute (duration of 1 to 3 months) pain, or chronic (duration of >3 months) pain outside of sickle cell disease related pain management, cancer pain treatment, palliative care, and end-of-life care. These recommendations are graded according to applicability and strength of the supporting evidence (***Table 1***) [2].

Each of the 12 recommendations is followed by considerations for implementation. These implementation considerations offer practical insights meant to further inform clinician-patient decision-making for the respective recommendation and are not meant to be rigidly or inflexibly followed. In addition, these five guiding principles should broadly inform implementation across recommendations:

- Acute, subacute, and chronic pain need to be appropriately and effectively treated independent of whether opioids are part of a treatment regimen.
- Recommendations are voluntary and are intended to support, not supplant, individualized, person-centered care. Flexibility to meet the care needs and the clinical circumstances of a specific patient are paramount.
- A multimodal and multidisciplinary approach to pain management attending to the physical health, behavioral health, long-term services and supports, and expected health outcomes and well-being of each person is critical.
- Special attention should be given to avoid misapplying this updated clinical practice guideline beyond its intended use or implementing policies purportedly derived from it that might lead to unintended consequences for patients.
- Clinicians, practices, health systems, and payers should vigilantly attend to health inequities, provide culturally and linguistically appropriate communication, including communication that is accessible to persons with disabilities, and ensure access to an appropriate, affordable, diversified, coordinated, and effective nonpharmacologic and pharmacologic pain management regimen for all persons.

The following sections are reprinted from the 2022 guideline from the CDC [2].

CDC GUIDELINE RECOMMENDATION GRADING SCHEME	
Grade/Level	**Description**
Recommendation Categories	
A	Applies to all persons; most patients should receive the recommended course of action.
B	Individual decision making needed; different choices will be appropriate for different patients. Clinicians help patients arrive at a decision consistent with patient values and preferences and specific clinical situations.
Evidence Type	
1	Randomized clinical trials or overwhelming evidence from observational studies.
2	Randomized clinical trials with important limitations, or exceptionally strong evidence from observational studies.
3	Observational studies or randomized clinical trials with notable limitations.
4	Clinical experience and observations, observational studies with important limitations, or randomized clinical trials with several major limitations.
Source: [2]	*Table 1*

DETERMINING WHETHER OR NOT TO INITIATE OPIOIDS FOR PAIN

All patients with pain should receive treatment that provides the greatest benefits relative to risks. See Recommendation 1 for determining whether to initiate opioids for acute pain (i.e., with a duration of less than one month) and Recommendation 2 for determining whether or not to initiate opioids for subacute (i.e., with a duration of at least one month and less than three months) or chronic pain (i.e., with a duration of three months or more).

Recommendation 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).

Implementation Considerations

Nonopioid therapies are at least as effective as opioids for many common acute pain conditions, including low back pain, neck pain, pain related to other musculoskeletal injuries (e.g., sprains, strains, tendonitis, and bursitis), pain related to minor surgeries typically associated with minimal tissue injury and mild postoperative pain (e.g., simple dental extraction), dental pain, kidney stone pain, and headaches including episodic migraine.

Clinicians should maximize use of nonopioid pharmacologic (e.g., topical or oral nonsteroidal anti-inflammatory drugs [NSAIDs], acetaminophen) and nonpharmacologic (e.g., ice, heat, elevation, rest, immobilization, or exercise) therapies as appropriate for the specific condition.

Opioid therapy has an important role for acute pain related to severe traumatic injuries (including crush injuries and burns), invasive surgeries typically associated with moderate-to-severe postoperative pain, and other severe acute pain when NSAIDs and other therapies are contraindicated or likely to be ineffective.

Opioids are not first-line therapy for many common acute pain conditions, including low back pain, neck pain, pain related to other musculoskeletal injuries (such as sprains, strains, tendonitis, bursitis), pain related to minor surgeries typically associated with minimal tissue injury and only mild postoperative pain (e.g., dental extraction), dental pain, kidney stone pain, and headaches, including episodic migraine.

When diagnosis and severity of acute pain warrant the use of opioids, clinicians should prescribe immediate-release opioids (see Recommendation 3) at the lowest effective dose (see Recommendation 4) and for no longer than the expected duration of pain severe enough to require opioids (see Recommendation 6).

Clinicians should prescribe and advise opioid use only as needed (e.g., hydrocodone 5 mg/acetaminophen 325 mg, one tablet not more frequently than every 4 hours as needed for moderate-to-severe pain) rather than on a scheduled basis (e.g., one tablet every 4 hours) and encourage and recommend an opioid taper if opioids are taken around the clock for more than a few days (see Recommendation 6).

If patients already receiving opioids long term require additional medication for acute pain, nonopioid medications should be used when possible, and if additional opioids are required (e.g., for superimposed severe acute pain), they should be continued only for the duration of pain severe enough to require additional opioids, returning to the patient's baseline opioid dosage as soon as possible, including a taper to baseline dosage if additional opioids were used around the clock for more than a few days (see Recommendation 6).

Clinicians should ensure that patients are aware of expected benefits of, common and serious risks of, and alternatives to opioids before starting or continuing opioid therapy and should involve patients meaningfully in decisions about whether to start opioid therapy.

Recommendation 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).

Implementation Considerations

To guide patient-specific selection of therapy, clinicians should evaluate patients and establish or confirm the diagnosis.

Clinicians should recommend appropriate noninvasive, nonpharmacologic approaches to help manage chronic pain, such as exercise (e.g., aerobic, aquatic, resistance exercises) or exercise therapy (a prominent modality in physical therapy) for back pain, fibromyalgia, and hip or knee osteoarthritis; weight loss for knee osteoarthritis; manual therapies for hip osteoarthritis; psychological therapy, spinal manipulation, low-level laser therapy, massage, mindfulness-based stress reduction, yoga, acupuncture, and multidisciplinary rehabilitation for low back pain; mind-body practices (e.g., yoga, tai chi, qigong), massage, and acupuncture for neck pain; cognitive-behavioral therapy [CBT], myofascial release massage, mindfulness practices, tai chi, qigong, acupuncture, and multidisciplinary rehabilitation for fibromyalgia; and spinal manipulation for tension headache.

Low-cost options to integrate exercise include walking in public spaces or use of public recreation facilities for group exercise. Physical therapy can be helpful, particularly for patients who have limited access to safe public spaces or public recreation facilities for exercise or whose pain has not improved with low-intensity physical exercise.

Health insurers and health systems can improve pain management and reduce medication use and associated risks by increasing reimbursement for and access to noninvasive, nonpharmacologic therapies with evidence for effectiveness.

Clinicians should review U.S. Food and Drug Administration (FDA)-approved labeling including boxed warnings and weigh benefits and risks before initiating treatment with any pharmacologic therapy.

When patients affected by osteoarthritis have an insufficient response to nonpharmacologic interventions such as exercise for arthritis pain, topical NSAIDs can be used in patients with pain in a single or few joints near the surface of the skin (e.g., knee). For patients with osteoarthritis pain in multiple joints or incompletely controlled with topical NSAIDs, duloxetine or systemic NSAIDs can be considered.

NSAIDs should be used at the lowest effective dose and shortest duration needed and should be used with caution, particularly in older adults and in patients with cardiovascular comorbidities, chronic renal failure, or previous gastrointestinal bleeding.

When patients with chronic low back pain have had an insufficient response to nonpharmacologic approaches such as exercise, clinicians can consider NSAIDs or duloxetine for patients without contraindications.

Tricyclic, tetracyclic, and serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressants, selected anticonvulsants (e.g., pregabalin, gabapentin enacarbil, oxcarbazepine), and capsaicin and lidocaine patches can be considered for neuropathic pain.

Duloxetine and pregabalin are FDA-approved for the treatment of diabetic peripheral neuropathy, and pregabalin and gabapentin are FDA-approved for treatment of post-herpetic neuralgia.

In patients with fibromyalgia, tricyclic (amitriptyline) and SNRI antidepressants (duloxetine and milnacipran), NSAIDs (topical diclofenac), and specific anticonvulsants (pregabalin and gabapentin) are used to improve pain, function, and quality of life. Duloxetine, milnacipran, and pregabalin are FDA-approved for the treatment of fibromyalgia. In older adults, decisions to use tricyclic antidepressants should be made judiciously on a case-by-case basis because of risks for confusion and falls.

Patients with co-occurring pain and depression might be especially likely to benefit from antidepressant medication (see Recommendation 8).

Opioids should not be considered first-line or routine therapy for subacute or chronic pain. This does not mean that patients should be required to sequentially fail nonpharmacologic and nonopioid pharmacologic therapy or be required to use any specific treatment before proceeding to opioid therapy. Rather, expected benefits specific to the clinical context should be weighed against risks before initiating therapy. In some clinical contexts (e.g., serious illness in a patient with poor prognosis for return to previous level of function, contraindications to other therapies, and clinician and patient agreement that the overriding goal is patient comfort), opioids might be appropriate regardless of previous therapies used. In other situations, (e.g., headache or fibromyalgia), expected benefits of initiating opioids are unlikely to outweigh risks regardless of previous nonpharmacologic and nonopioid pharmacologic therapies used.

Opioid therapy should not be initiated without consideration by the clinician and patient of an exit strategy to be used if opioid therapy is unsuccessful.

Before opioid therapy is initiated for subacute or chronic pain, clinicians should determine jointly with patients how functional benefit will be evaluated and establish specific, measurable treatment goals.

For patients with subacute pain who started opioid therapy for acute pain and have been treated with opioid therapy for ≥30 days, clinicians should ensure that potentially reversible causes of chronic pain are addressed and that opioid prescribing for acute pain does not unintentionally become long-term opioid therapy simply because medications are continued without reassessment. Continuation of opioid therapy at this point might represent initiation of long-term opioid therapy, which should occur only

as an intentional decision that benefits are likely to outweigh risks after informed discussion between the clinician and patient and as part of a comprehensive pain management approach.

Clinicians seeing new patients already receiving opioids should establish treatment goals, including functional goals, for continued opioid therapy. Clinicians should avoid rapid tapering or abrupt discontinuation of opioids (see Recommendation 5).

Patient education and discussion before starting opioid therapy are critical so that patient preferences and values can be understood and used to inform clinical decisions.

Clinicians should review available low-cost options for pain management for all patients, and particularly for patients who have low incomes, do not have health insurance, or have inadequate insurance.

Clinicians should ensure that patients are aware of expected benefits of, common and serious risks of, and alternatives to opioids before starting or continuing opioid therapy and should involve patients in decisions about whether to start opioid therapy.

OPIOID SELECTION AND DOSAGE

Recommendation 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).

Implementation Considerations

Clinicians should not treat acute pain with ER/LA opioids or initiate opioid treatment for subacute or chronic pain with ER/LA opioids, and clinicians should not prescribe ER/LA opioids for intermittent or as needed use.

ER/LA opioids should be reserved for severe, continuous pain. The FDA has noted that some ER/LA opioids should be considered only for patients who have received certain dosages of opioids of immediate-release opioids daily for at least 1 week.

When changing to an ER/LA opioid for a patient previously receiving a different immediate-release opioid, clinicians should consult product labeling and reduce total daily dosage to account for incomplete opioid cross-tolerance.

Clinicians should use additional caution with ER/LA opioids and consider a longer dosing interval when prescribing to patients with renal or hepatic dysfunction because decreased clearance of medications among these patients can lead to accumulation of drugs to toxic levels and persistence in the body for longer durations.

Methadone should not be the first choice for an ER/LA opioid. Only clinicians who are familiar with methadone's unique risk profile and who are prepared to educate and closely monitor their patients, including assessing risk for QT prolongation and considering electrocardiographic monitoring, should consider prescribing methadone for pain.

Only clinicians who are familiar with the dosing and absorption properties of the ER/LA opioid transdermal fentanyl and are prepared to educate their patients about its use should consider prescribing it.

Recommendation 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).

Implementation Considerations

The recommendations related to opioid dosages are not intended to be used as an inflexible, rigid standard of care; rather, they are intended to be guideposts to help inform clinician-patient decision-making. Risks of opioid use, including risk for

overdose and overdose death, increase continuously with dosage, and there is no single dosage threshold below which risks are eliminated. Therefore, the recommendation language emphasizes that clinicians should avoid increasing dosage above levels likely to yield diminishing returns in benefits relative to risks to patients rather than emphasizing a single specific numeric threshold. Further, these recommendations apply specifically to starting opioids or to increasing opioid dosages, and a different set of benefits and risks applies to reducing opioid dosages (see Recommendation 5).

When opioids are initiated for opioid-naïve patients with acute, subacute, or chronic pain, clinicians should prescribe the lowest effective dosage.

For patients not already taking opioids, the lowest effective dose can be determined using product labeling as a starting point with calibration as needed based on the severity of pain and other clinical factors such as renal or hepatic insufficiency (see Recommendation 8).

The lowest starting dose for opioid-naïve patients is often equivalent to a single dose of approximately 5–10 MME or a daily dosage of 20–30 MME/day.

If opioids are continued for subacute or chronic pain, clinicians should use caution when prescribing opioids at any dosage and should generally avoid dosage increases when possible.

Many patients do not experience benefit in pain or function from increasing opioid dosages to ≥50 MME/day but are exposed to progressive increases in risk as dosage increases. Therefore, before increasing total opioid dosage to ≥50 MME/day, clinicians should pause and carefully reassess evidence of individual benefits and risks. If a decision is made to increase dosage, clinicians should use caution and increase dosage by the smallest practical amount. The recommendations related to opioid dosages are not intended to be used as an inflexible, rigid standard of care; rather, they are intended to be guideposts to help inform clinician-patient decision-making.

Additional dosage increases beyond 50 MME/day are progressively more likely to yield diminishing returns in benefits for pain and function relative to risks to patients as dosage increases further. Clinicians should carefully evaluate a decision to further increase dosage based on individualized assessment of benefits and risks and weighing factors such as diagnosis, incremental benefits for pain and function relative to risks with previous dosage increases, other treatments and effectiveness, and patient values and preferences.

Again, the recommendations related to opioid dosages are not intended to be used as an inflexible, rigid standard of care; rather, they are intended to be guideposts to help inform clinician-patient decision making.

Recommendation 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, 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).

interactive activity

View the CDC's video Tapering Opioids for Chronic Pain at https://www.netce.com/learning.php?page=activities&courseid=3207. This short video describes when and how clinicians should initiate opioid tapering and outlines ways to support patients through the process.

Implementation Considerations

Clinicians should carefully weigh both the benefits and risks of continuing opioid medications and the benefits and risks of tapering opioids. If benefits outweigh risks of continued opioid therapy, clinicians should work closely with patients to optimize nonopioid therapies while continuing opioid therapy.

When benefits (including avoiding risks of tapering) do not outweigh risks of continued opioid therapy, clinicians should optimize other therapies and work closely with patients to gradually taper to a reduced opioid dosage or, if warranted based on the individual clinical circumstances of the patient, appropriately taper and discontinue opioid therapy.

In situations where benefits and risks of continuing opioids are considered to be close or unclear, shared decision-making with patients is particularly important.

At times, clinicians and patients might not be able to agree on whether or not tapering is necessary. When patients and clinicians are unable to arrive at a consensus on the assessment of benefits and risks, clinicians should acknowledge this discordance, express empathy, and seek to implement treatment changes in a patient-centered manner while avoiding patient abandonment.

Patient agreement and interest in tapering is likely to be a key component of successful tapers.

For patients agreeing to taper to lower opioid dosages and for those remaining on higher opioid dosages, clinicians should establish goals with the patient for continued opioid therapy (see Recommendations 2 and 7) and maximize pain treatment with nonpharmacologic and nonopioid pharmacologic treatments as appropriate (see Recommendation 2).

Clinicians should collaborate with the patient on the tapering plan, including patients in decisions such as how quickly tapering will occur and when pauses in the taper may be warranted.

Clinicians should follow up frequently (at least monthly) with patients engaging in opioid tapering. Team members (e.g., nurses, pharmacists, behavioral health professionals) can support the clinician and patient during the ongoing taper process through telephone contact, telehealth visits, or face-to-face visits.

When opioids are reduced or discontinued, a taper slow enough to minimize symptoms and signs of opioid withdrawal (e.g., anxiety, insomnia, abdominal pain, vomiting, diarrhea, diaphoresis, mydriasis, tremor, tachycardia, or piloerection) should be used.

Longer duration of previous opioid therapy might require a longer taper. For patients who have taken opioids long-term (e.g., for ≥1 year), tapers can be completed over several months to years depending on the opioid dosage and should be individualized based on patient goals and concerns.

When patients have been taking opioids for longer durations (e.g., for ≥1 year), tapers of 10% per month or slower are likely to be better tolerated than more rapid tapers.

For patients struggling to tolerate a taper, clinicians should maximize nonopioid treatments for pain and should address behavioral distress. Clinically significant opioid withdrawal symptoms can signal the need to further slow the taper rate.

At times, tapers might have to be paused and restarted again when the patient is ready and might have to be slowed as patients reach low dosages.

Before reversing a taper, clinicians should carefully assess and discuss with the patient the benefits and risks of increasing opioid dosage.

Goals of the taper may vary (e.g., some patients might achieve discontinuation; others might attain a reduced dosage). If the clinician has determined with the patient that the ultimate goal of tapering is discontinuing opioids, after the smallest available dose is reached the interval between doses can be extended and opioids can be stopped when taken less frequently than once a day.

Clinicians should access appropriate expertise if considering tapering opioids during pregnancy because of possible risk to the pregnant patient and to the fetus if the patient goes into withdrawal.

Clinicians should advise patients of an increased risk for overdose on abrupt return to a previously prescribed higher dose, because of loss of opioid tolerance, provide opioid overdose education, and offer naloxone.

Clinicians should remain alert to signs of and screen for anxiety, depression, and opioid misuse or opioid use disorder (see Recommendations 8 and 12) that might be revealed by an opioid taper and provide treatment or arrange for management of these comorbidities.

Clinicians should closely monitor patients who are unable to taper and who continue on high-dose or otherwise high-risk opioid regimens (e.g., opioids prescribed concurrently with benzodiazepines) and should work with patients to mitigate overdose risk (e.g., by providing overdose education and naloxone—see Recommendation 8).

Clinicians can use periodic and strategic motivational questions and statements to encourage movement toward appropriate therapeutic changes and functional goals.

Clinicians have a responsibility to provide or arrange for coordinated management of patients' pain and opioid-related problems, including opioid use disorder.

Payers, health systems, and state medical boards should not use this clinical practice guideline to set rigid standards or performance incentives related to dose or duration of opioid therapy; should ensure that policies based on cautionary dosage thresholds do not result in rapid tapers or abrupt discontinuation of opioids; and should ensure that policies do not penalize clinicians for accepting new patients who are using prescribed opioids for chronic pain, including those receiving high dosages of opioids, or for refraining from rapidly tapering patients prescribed long-term opioid medications.

Although Recommendation 5 specifically refers to patients using long-term opioid therapy for subacute or chronic pain, many of the principles in these implementation considerations and supporting rationale, including communication with patients, pain management and behavioral support, and slower taper rates, are also relevant when discontinuing opioids in patients who have received them for shorter durations (see also Recommendations 6 and 7).

OPIOID DURATION AND FOLLOW-UP

Recommendation 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).

Implementation Considerations

Nontraumatic, nonsurgical acute pain can often be managed without opioids (see Recommendation 1).

Opioids are sometimes needed for treatment of acute pain (see Recommendation 1). When the diagnosis and severity of acute pain warrant use of opioids, clinicians should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. For many common causes of nontraumatic, nonsurgical pain, when opioids are needed, a few days or less are often sufficient, and shorter courses can minimize the need to taper opioids to prevent withdrawal symptoms at the end of a course of opioids. However, durations should be individualized to the patients' clinical circumstances.

Clinicians should generally avoid prescribing additional opioids to patients "just in case" pain continues longer than expected.

For postoperative pain related to major surgery, procedure-specific opioid prescribing recommendations are available with ranges for amounts of opioids needed (on the basis of actual use and refills and on consensus).

To minimize unintended effects on patients, clinicians, practices, and health systems should have mechanisms in place for the subset of patients who experience severe acute pain that continues longer than the expected duration. These mechanisms should allow for timely re-evaluation to confirm or revise the initial diagnosis and to adjust management accordingly. Clinicians, practices, and health systems can help minimize disparities in access to and affordability of care and refills by ensuring all patients can obtain and afford additional evaluation and treatment, as needed.

Longer durations of opioid therapy are more likely to be needed when the mechanism of injury is expected to result in prolonged severe pain (e.g., severe traumatic injuries).

Patients should be evaluated at least every 2 weeks if they continue to receive opioids for acute pain.

If opioids are continued for ≥1 month, clinicians should ensure that potentially reversible causes of chronic pain are addressed and that opioid prescribing for acute pain does not unintentionally become long-term opioid therapy simply because medications are continued without reassessment. Continuation of opioid therapy at this point might represent initiation of long-term opioid therapy, which should occur only as an intentional decision that benefits are likely to outweigh risks after discussion between the clinician and patient and as part of a comprehensive pain management approach. Clinicians should refer to recommendations on subacute and chronic pain for initiation (Recommendation 2), follow-up (Recommendation 7), and tapering (Recommendation 5) of ongoing opioid therapy.

If patients already receiving long-term opioid therapy require additional opioids for superimposed severe acute pain (e.g., major surgery), opioids should be continued only for the duration of pain severe enough to require additional opioids, returning to the patient's baseline opioid dosage as soon as possible, including a taper to baseline dosage if additional opioids were used around the clock for more than a few days.

If opioids are used continuously (around the clock) for more than a few days for acute pain, clinicians should prescribe a brief taper to minimize withdrawal symptoms on discontinuation of opioids.

If a taper is needed, taper durations might need to be adjusted depending on the duration of the initial opioid prescription (see supporting rationale for this recommendation for additional details).

Tapering plans should be discussed with the patient prior to hospital discharge and with clinicians coordinating the patient's care as an outpatient. (See Recommendation 5 for tapering considerations when patients have taken opioids continuously for longer than one month.)

Recommendation 7

Clinicians should evaluate benefits and risks with patients within one to four weeks of starting opioid therapy for subacute or chronic pain or of dosage escalation. Clinicians should regularly re-evaluate benefits and risks of continued opioid therapy with patients (recommendation category: A, evidence type: 4).

Implementation Considerations

In addition to evaluating benefits and risks of opioids before starting opioid therapy (see Recommendation 2), clinicians should evaluate patients to assess benefits and risks of opioids within 1 to 4 weeks of starting long-term opioid therapy or of dosage escalation.

Clinicians should consider follow-up intervals within the lower end of this range when ER/LA opioids are started or increased, given increased risk for overdose within the first 2 weeks of treatment, or when total daily opioid dosage is ≥50 MME/day. (Overdose risk is doubled across multiple studies for dosages of 50 to <100 MME/day relative to <20 MME/day. See Recommendation 4.)

Shorter follow-up intervals (every two to three days for the first week) should be strongly considered when starting or increasing the dosage of methadone, given the variable half-life of this drug (see Recommendation 3) and the potential for drug accumulation during initiation and during upward titration of dosage.

An initial follow-up interval closer to 4 weeks can be considered when starting immediate-release opioids at a dosage of <50 MME/day.

Clinicians should follow up with and evaluate patients with subacute pain who started opioid therapy for acute pain and have been treated with opioid therapy for 30 days to reassess the patient's pain, function, and treatment course; ensure that potentially reversible causes of chronic pain are addressed; and prevent unintentional initiation of long-term opioid therapy. Continuation of opioid therapy at this point might represent initiation of long-term opioid therapy, which should occur only as an intentional decision that benefits are likely to outweigh risks after discussion between the clinician and patient and as part of a comprehensive pain management approach (see Recommendation 2).

Clinicians should regularly reassess all patients receiving long-term opioid therapy, including patients who are new to the clinician but on long-term opioid therapy, with a suggested interval of every three months or more frequently for most patients.

Clinicians seeing new patients already receiving opioids should establish treatment goals, including functional goals, for continued opioid therapy (see Recommendation 2).

Clinicians should re-evaluate patients who are at higher risk for opioid use disorder or overdose (e.g., patients with depression or other mental health conditions, a history of substance use disorder, a history of overdose, taking ≥50 MME/day, or taking other central nervous system depressants with opioids) more frequently than every 3 months. Clinicians should regularly screen all patients for these conditions, which can change during the course of treatment (see Recommendation 8).

Clinicians, practices, and health systems can help minimize unintended effects on patients by ensuring all patients can access and afford follow-up evaluation.

In practice contexts where virtual visits are part of standard care (e.g., in remote areas where distance or other context makes follow-up visits challenging), or for patients for whom in-person follow-up visits are challenging (e.g., frail patients), follow-up assessments that allow the clinician to communicate with and observe the patient through telehealth modalities may be conducted.

At follow-up, clinicians should review patient perspectives and goals, determine whether opioids continue to meet treatment goals, including sustained improvement in pain and function and determine whether the patient has experienced common or serious adverse events or early warning signs of serious adverse events or has signs of opioid use disorder.

Clinicians should ensure that treatment for depression, anxiety, or other psychological comorbidities is optimized.

Clinicians should ask patients about their preferences for continuing opioids, considering their effects on pain and function relative to any adverse effects experienced. If risks outweigh benefits of continued opioid therapy (e.g., if patients do not experience meaningful, sustained improvements in pain and function compared with prior to initiation of opioid therapy; if patients are taking higher-risk regimens [e.g., dosages of ≥50 MME/day or opioids combined with benzodiazepines] without evidence of benefit; if patients believe benefits no longer outweigh risks; if patients request dosage reduction or discontinuation; or if patients experience overdose or other serious adverse events), clinicians should work with patients to taper and reduce opioid dosage or taper and discontinue opioids when possible, using principles from Recommendation 5.

Clinicians should maximize pain treatment with nonpharmacologic and nonopioid pharmacologic treatments as appropriate (see Recommendation 2).

ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

Recommendation 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).

Implementation Considerations

Clinicians should ask patients about their drug and alcohol use and use validated tools or consult with behavioral specialists to screen for and assess mental health and substance use disorders.

When considering initiating long-term opioid therapy, clinicians should ensure that treatment for depression and other mental health conditions is optimized, consulting with behavioral health specialists when needed.

Clinicians should offer naloxone when prescribing opioids, particularly to patients at increased risk for overdose, including patients with a history of overdose, patients with a history of substance use disorder, patients with sleep-disordered breathing, patients taking higher dosages of opioids (e.g., ≥50 MME/day), patients taking benzodiazepines with opioids (see Recommendation 11), and patients at risk for returning to a high dose to which they have lost tolerance (e.g., patients undergoing tapering or recently released from prison).

Practices should educate patients on overdose prevention and naloxone use and offer to provide education to members of their households.

Naloxone co-prescribing can be facilitated by clinics or practices with resources to provide naloxone training and by collaborative practice models with pharmacists or through statewide protocols or standing orders for naloxone at pharmacies.

Resources for prescribing naloxone in primary care and emergency department settings can be found through Prescribe to Prevent at https://prescribetoprevent.org; additional resources are at https://samhsa.gov.

In part because of concerns about cost of naloxone and access for some patients and reports that purchasing of naloxone has in some cases been required to fill opioid prescriptions, including for patients without a way to afford naloxone, this recommendation specifies that naloxone should be offered to patients. To that end, clinicians, health systems, and payers can work to ensure patients can obtain naloxone, a potentially lifesaving treatment.

Clinicians should avoid prescribing opioids to patients with moderate or severe sleep-disordered breathing when possible to minimize risk for respiratory depression.

When making decisions about whether to initiate opioid therapy for pain during pregnancy, clinicians and patients together should carefully weigh benefits and risks. For pregnant people already receiving opioids, clinicians should access appropriate expertise if tapering is being considered because of possible risk to the pregnant patient and to the fetus if the patient goes into withdrawal (see Recommendation 5).

For pregnant people with opioid use disorder, medication for opioid use disorder (buprenorphine or methadone) is the recommended therapy and should be offered as early as possible in pregnancy to prevent harms to both the patient and the fetus (see Recommendation 12).

Clinicians should use additional caution and increased monitoring (see Recommendation 7) to minimize risks of opioids prescribed for patients with renal or hepatic insufficiency and for patients aged ≥65 years. Clinicians should implement interventions to mitigate common risks of opioid therapy among older adults, such as exercise or bowel regimens to prevent constipation, risk assessment for falls, and patient monitoring for cognitive impairment.

For patients with jobs that involve potentially hazardous tasks and who are receiving opioids or other medications that can negatively affect sleep, cognition, balance, or coordination, clinicians should assess patients' abilities to safely perform the potentially hazardous tasks (e.g., driving, use of heavy equipment, climbing ladders, working at heights or around moving machinery, or working with high-voltage equipment).

Clinicians should use prescription drug monitoring program (PDMP) data (see Recommendation 9) and toxicology screening (see Recommendation 10) as appropriate to assess for concurrent substance use that might place patients at higher risk for opioid use disorder and overdose.

Clinicians should provide specific counseling on increased risks for overdose when opioids are combined with other drugs or alcohol (see Recommendation 2) and ensure that patients are provided or receive effective treatment for substance use disorders when needed (see Recommendation 12).

Although substance use disorder can alter the expected benefits and risks of opioid therapy for pain, patients with co-occurring pain and substance use disorder require ongoing pain management that maximizes benefits relative to risks. (See Recommendation 12 Pain Management for Patients with Opioid Use Disorder for additional considerations specific to these patients.)

If clinicians consider opioid therapy for chronic pain for patients with substance use disorder, they should discuss increased risks for opioid use disorder and overdose with patients, carefully consider whether benefits of opioids outweigh increased risks, and incorporate strategies to mitigate risk into the management plan, such as offering naloxone and increasing frequency of monitoring (see Recommendation 7).

If patients experience nonfatal opioid overdose, clinicians should evaluate for opioid use disorder and treat or arrange treatment if needed. Clinicians should work with patients to reduce opioid dosage and to discontinue opioids when indicated (see Recommendation 5) and should ensure continued close monitoring and support for patients prescribed or not prescribed opioids. If clinicians continue opioid therapy in patients with prior opioid overdose, they should discuss increased risks for overdose with patients, carefully consider whether benefits of opioids outweigh substantial risks, and incorporate strategies to mitigate risk into the management plan, such as considering offering naloxone and increasing frequency of monitoring (see Recommendation 7).

Recommendation 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 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).

Implementation Considerations

Ideally, PDMP data should be reviewed before every opioid prescription for acute, subacute, or chronic pain. This practice is recommended in all jurisdictions where PDMP availability and access policies, as well as clinical practice settings, make it practicable (e.g., clinician and delegate access permitted).

At a minimum, during long-term opioid therapy, PDMP data should be reviewed before an initial opioid prescription and then every three months or more frequently. Recommendation category B acknowledges variation in PDMP availability and circumstances. However, because PDMP information can be most helpful when results are unexpected, and to minimize bias in application, clinicians should apply this recommendation when feasible to all patients rather than differentially based on assumptions about what they will learn about specific patients.

Clinicians should use specific PDMP information about medications prescribed to their patient in the context of other clinical information, including their patient's history, physical findings, and other relevant testing, to help them communicate with and protect their patient.

Clinicians should review PDMP data specifically for prescription opioids and other controlled medications patients have received from additional prescribers to determine whether a patient is receiving total opioid dosages or combinations (e.g., opioids combined with benzodiazepines) that put the patient at risk for overdose.

PDMP-generated risk scores have not been validated against clinical outcomes such as overdose and should not take the place of clinical judgment. Clinicians should not dismiss patients from their practice on the basis of PDMP information. Doing so can adversely affect patient safety and could result in missed opportunities to provide potentially lifesaving information (e.g., about risks of prescription opioids and about overdose prevention) and interventions (e.g., safer prescriptions, nonopioid pain treatment [see Recommendations 1 and 2], naloxone [see Recommendation 8], and effective treatment for substance use disorder [see Recommendations 8 and 12]).

Clinicians should take actions to improve patient safety:

- Discuss information from the PDMP with their patient and confirm that their patient is aware of any additional prescriptions. Because clinicians often work as part of teams, prescriptions might appropriately be written by more than one clinician coordinating the patient's care. Occasionally, PDMP information can be incorrect (e.g., if the wrong name or birthdate has been entered, the patient uses a nickname or maiden name, or another person has used the patient's identity to obtain prescriptions).
- Discuss safety concerns, including increased risk for respiratory depression and overdose, with patients found to be receiving overlapping prescription opioids from multiple clinicians who are not coordinating the patient's care or patients who are receiving medications that increase risk when combined with opioids (e.g., benzodiazepines; see Recommendation 11) and offer naloxone (see Recommendation 8).
- Use particular caution when prescribing opioid pain medication and benzodiazepines concurrently, understanding that some patient circumstances warrant prescribing of these medications concomitantly. Clinicians should communicate with others managing the patient to discuss the patient's needs, prioritize patient goals, weigh risks of concurrent benzodiazepine and opioid exposure, and coordinate care (see Recommendation 11).
- Consider the total MME/day for concurrent opioid prescriptions to help assess the patient's overdose risk (see Recommendation 4). Buprenorphine should not be counted in the total MME/day in calculations given its partial agonist properties at opioid receptors that confer a ceiling effect on respiratory depression. If patients are found to be receiving total daily dosages of opioids that put them at risk for overdose, discuss safety concerns with the patient, consider in collaboration with the patient whether or not benefits of tapering outweigh risks of tapering (see Recommendation 5), and offer naloxone (see Recommendation 8).
- Discuss safety concerns with other clinicians who are prescribing controlled substances for their patient. Ideally, clinicians should first discuss concerns with their patient and inform him or her that they plan to coordinate care with the patient's other clinicians to improve the patient's safety.

- Screen for substance use and discuss concerns with their patient in a nonjudgmental manner (see Recommendations 8 and 12).
- When diverting (sharing or selling prescription opioids and not taking them) might be likely, consider toxicology testing to assist in determining whether prescription opioids can be discontinued without causing withdrawal (see Recommendations 5 and 10). A negative toxicology test for prescribed opioids might indicate the patient is not taking prescribed opioids, although clinicians should consider other possible reasons for this test result, such as false negative results or misinterpretation of results (see Recommendation 10).

Recommendation 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).

Implementation Considerations

Toxicology testing should not be used in a punitive manner but should be used in the context of other clinical information to inform and improve patient care.

Clinicians should not dismiss patients from care based on a toxicology test result. Dismissal could have adverse consequences for patient safety, potentially including the patient obtaining opioids or other drugs from alternative sources and the clinician missing opportunities to facilitate treatment for substance use disorder.

Prior to starting opioids and periodically (at least annually) during opioid therapy, clinicians should consider the benefits and risks of toxicology testing to assess for prescribed opioids as well as other prescription and nonprescription controlled substances that increase risk for overdose when combined with opioids, including nonprescribed and illicit opioids and benzodiazepines.

Clinicians, practices, and health systems should aim to minimize bias in testing and should not apply this recommendation differentially based on assumptions about patients.

Predicting risk is challenging, and currently available tools do not allow clinicians to reliably identify patients who are at low risk for substance use or substance use disorder. Clinicians should consider toxicology screening results as potentially useful data, in the context of other clinical information, for all patients, and consider toxicology screening whenever its potential limitations can be addressed.

Clinicians should explain to patients that toxicology testing will not be used to dismiss patients from care and is intended to improve their safety.

Clinicians should explain expected results (e.g., presence of prescribed medication and absence of drugs, including non-prescribed controlled substances, not reported by the patient) and ask patients in a nonjudgmental manner about use of prescribed and other drugs and whether there might be unexpected results.

Limited toxicology screening can be performed with a relatively inexpensive presumptive immunoassay panel that tests for opiates as a class, benzodiazepines as a class, and several non-prescribed substances. Toxicology screening for a class of drugs might not detect all drugs in that class. For example, fentanyl testing is not included in widely used toxicology assays that screen for opiates as a class.

Clinicians should be familiar with the drugs included in toxicology screening panels used in their practice and should understand how to interpret results for these drugs. For example, a positive "opiates" immunoassay detects morphine, which might reflect patient use of morphine, codeine, or heroin, but does not detect synthetic opioids and might not detect semisynthetic opioids. In some cases, positive results for specific opioids might reflect metabolites from opioids the patient is taking and might not mean the patient is taking the specific opioid that resulted in the positive test. Confirmatory testing should be used when:

- Toxicology results will inform decisions with major clinical or nonclinical implications for the patient
- A need exists to detect specific opioids or other drugs within a class, such as those that are being prescribed, or those that cannot be identified on standard immunoassays
- A need exists to confirm unexpected screening toxicology test results

Restricting confirmatory testing to situations and substances for which results can reasonably be expected to affect patient management can reduce costs of toxicology testing.

Clinicians might want to discuss unexpected results with the local laboratory or toxicologist and should discuss unexpected results with the patient. Clinicians should discuss unexpected results with patients in a nonjudgmental manner, avoiding use of potentially stigmatizing language (e.g., avoid describing a specimen as testing "clean" or "dirty").

Discussion with patients prior to specific confirmatory testing can sometimes yield a candid explanation of why a particular substance is present or absent and remove the need for confirmatory testing during that visit. For example, a patient might explain that the test is negative for prescribed opioids because they felt opioids were no longer helping and discontinued them. If unexpected results from toxicology screening are not explained, a confirmatory test on the same sample using a method selective enough to differentiate specific opioids and metabolites (e.g., gas or liquid chromatography/mass spectrometry) might be warranted.

Clinicians should use unexpected results to improve patient safety (e.g., optimize pain management strategy [see Recommendation 2], carefully weigh benefits and risks of reducing or continuing opioid dosage [see Recommendation 5], re-evaluate more frequently [see Recommendation 7], offer naloxone [see Recommendation 8], and offer treatment or refer the patient treatment with medications for opioid use disorder [see Recommendation 12], all as appropriate).

Recommendation 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).

Implementation Considerations

Although in some circumstances it might be appropriate to prescribe opioids to a patient who is also prescribed benzodiazepines (e.g., severe acute pain in a patient taking long-term, stable low-dose benzodiazepine therapy), clinicians should use particular caution when prescribing opioid pain medication and benzodiazepines concurrently. In addition, clinicians should consider whether benefits outweigh risks of concurrent use of opioids with other central nervous system depressants (e.g., muscle relaxants, non-benzodiazepine sedative hypnotics, potentially sedating anticonvulsant medications such as gabapentin and pregabalin).

Buprenorphine or methadone for opioid use disorder should not be withheld from patients taking benzodiazepines or other medications that depress the central nervous system.

Clinicians should check the PDMP for concurrent controlled medications prescribed by other clinicians (see Recommendation 9) and should consider involving pharmacists as part of the management team when opioids are co-prescribed with other central nervous system depressants.

In patients receiving opioids and benzodiazepines long-term, clinicians should carefully weigh the benefits and risks of continuing therapy with opioids and benzodiazepines and discuss with patients and other members of the patient's care team.

Risks of concurrent opioid and benzodiazepine use are likely to be greater with unpredictable use of either medication, with use of higher-dosage opioids and higher-dosage benzodiazepines in combination, or with use with other substances including alcohol (compared with long-term stable use of lower-dosage opioids and lower-dosage benzodiazepines without other substances).

In specific situations, benzodiazepines can be beneficial, and stopping benzodiazepines can be destabilizing.

If risks are determined to outweigh benefits of continuing opioid and benzodiazepine therapy at current dosages and a decision is made to taper, it might be safer and more practical to taper opioids first. There can be greater risks of benzodiazepine withdrawal relative to opioid withdrawal, and tapering opioids can be associated with anxiety (see Recommendation 5).

Clinicians should taper benzodiazepines gradually prior to discontinuation because abrupt withdrawal can be associated with rebound anxiety, hallucinations, seizures, delirium tremens, and, rarely, death. The rate of tapering should be individualized.

If benzodiazepines prescribed for anxiety are tapered or discontinued, or if patients receiving opioids require treatment for anxiety, evidence-based psychotherapies (e.g., CBT) and/or specific antidepressants or other nonbenzodiazepine medications, or both, approved for anxiety should be offered.

Clinicians should communicate with other clinicians managing the patient to discuss the patient's needs, prioritize patient goals, weigh risks of concurrent benzodiazepine and opioid exposure, and coordinate care.

Recommendation 12

Clinicians should offer or arrange treatment 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).

Implementation Considerations

Although stigma can reduce the willingness of individuals with opioid use disorder to seek treatment, opioid use disorder is a chronic, treatable disease from which people can recover and continue to lead healthy lives.

If clinicians suspect opioid use disorder, they should discuss their concern with their patient in a nonjudgmental manner and provide an opportunity for the patient to disclose related concerns or problems.

Clinicians should assess for the presence of opioid use disorder using criteria from the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders*.

For patients meeting criteria for opioid use disorder, particularly if moderate or severe, clinicians should offer or arrange for patients to receive evidence-based treatment with medications for opioid use disorder.

Clinicians should not dismiss patients from their practice because of opioid use disorder because this can adversely affect patient safety.

Medication treatment of opioid use disorder has been associated with reduced risk for overdose and overall deaths. Identification of opioid use disorder represents an opportunity for a clinician to initiate potentially life-saving interventions, and should the clinician collaborate with the patient regarding their safety to increase the likelihood of successful treatment.

For pregnant persons with opioid use disorder, medication for opioid use disorder (buprenorphine or methadone) is the recommended therapy and should be offered as early as possible in pregnancy to prevent harms to both the patient and the fetus.

Clinicians unable to provide treatment themselves should arrange for patients with opioid use disorder to receive care from a substance use disorder treatment specialist, such as an office-based buprenorphine or naltrexone treatment provider, or from an opioid treatment program certified by Substance Abuse and Mental Health Services Administration to provide methadone or buprenorphine for patients with opioid use disorder.

All clinicians, and particularly clinicians prescribing opioids in communities without sufficient treatment capacity for opioid use disorder, should obtain a waiver to prescribe buprenorphine for opioid use disorder.

Clinicians prescribing opioids should identify treatment resources for opioid use disorder in the community, establish a network of referral options that span the levels of care that patients might need to enable rapid collaboration and referral, when needed, and work together to ensure sufficient treatment capacity for opioid use disorder at the practice level.

Although identification of an opioid use disorder can alter the expected benefits and risks of opioid therapy for pain, patients with co-occurring pain and opioid use disorder require ongoing pain management that maximizes benefits relative to risks.

Management of Opioid Misuse that Does Not Meet Criteria for Opioid Use Disorder

Clinicians can have challenges distinguishing between opioid misuse behaviors without opioid use disorder and mild or moderate opioid use disorder. For patients with opioid misuse that does not meet criteria for opioid use disorder (e.g., taking opioids in larger amounts than intended without meeting other criteria for opioid use disorder), clinicians should reassess the patient's pain, ensure that therapies for pain management have been optimized (see Recommendation 2), discuss with patients, and carefully weigh benefits and risks of continuing opioids at the current dosage (see Recommendation 5). For patients who choose to but are unable to taper, clinicians may reassess for opioid use disorder and offer buprenorphine treatment or refer for buprenorphine or methadone treatment if criteria for opioid use disorder are met. Even without a diagnosis of opioid use disorder, transitioning to buprenorphine for pain can also be considered given reduced overdose risk with buprenorphine compared with risk associated with full agonist opioids (see Recommendation 5).

Pain Management for Patients with Opioid Use Disorder

Although identification of an opioid use disorder can alter the expected benefits and risks of opioid therapy for pain, patients with co-occurring pain and substance use disorder require ongoing pain management that maximizes benefits relative to risks. Clinicians should use nonpharmacologic and nonopioid pharmacologic pain treatments as appropriate (see Recommendations 1 and 2) to provide optimal pain management [11]. For patients with pain who have an active opioid use disorder but are not in treatment, clinicians should consider buprenorphine or methadone treatment for opioid use disorder, which can also help with concurrent management of pain [11]. For patients who are treated with buprenorphine for opioid use disorder and experience acute pain, clinicians can consider temporarily increasing the buprenorphine dosing frequency (e.g., to twice a day) to help manage pain, given the duration of effects of buprenorphine is shorter for pain than for suppression of withdrawal [11; 12]. For severe acute pain (e.g., from trauma or unplanned major surgery) in patients receiving buprenorphine for opioid use disorder, clinicians can consider additional as-needed doses of buprenorphine. In supervised settings, adding a short-acting full agonist opioid to the patient's regular dosage of buprenorphine can be considered without discontinuing the patient's regular buprenorphine dosage; however, if a deci-

sion is made to discontinue buprenorphine to allow for more mu-opioid receptor availability, patients should be monitored closely because high doses of a full agonist opioid might be required, potentially leading to oversedation and respiratory depression as buprenorphine's partial agonist effect lessens. For patients receiving naltrexone for opioid use disorder, short-term use of higher-potency nonopioid analgesics (e.g., NSAIDs) can be considered to manage severe acute pain. Patients receiving methadone for opioid use disorder who require additional opioids as treatment for severe acute pain management should be carefully monitored, and when feasible should optimally be treated by a clinician experienced in the treatment of pain in consultation with their opioid treatment program. [11]. The American Society of Addiction Medicine National Practice Guideline for the Treatment of Opioid Use Disorder (2020 Focused Update) provides additional recommendations for the management of patients receiving medications for opioid use disorder who have planned surgeries for which nonopioid therapies are not anticipated to provide sufficient pain relief [11].

RESPONSE TO THE CDC'S OPIOID PRESCRIBING GUIDELINE UPDATE

It is important to note that the CDC's guidelines are voluntary, and the changes may not result in changes to state laws and rules established to restrict opioid prescribing and help curb opioid misuse following publication of the 2016 guideline. The 2022 draft guideline emphasizes prescriber decision-making and access to necessary opioid analgesics to address unrelenting pain. The guideline states that some policies have extended even beyond the 2016 recommendations, contributing to patient harm, including untreated and undertreated pain, serious withdrawal symptoms, worsening pain outcomes, psychological distress, overdose, and suicidal ideation and behavior [2]. However, state governments seem reluctant to make similar changes, especially as opioid overdose deaths have increased [13].

The American Academy of Pain Medicine, which had expressed dismay with the 2016 CDC guideline and how it was misapplied by insurance companies, state governments, and healthcare organizations, indicated general support for the 2022 revision [14].

IDENTIFICATION OF DRUG DIVERSION/SEEKING BEHAVIORS

Urine drug tests can give insight into patients who are misusing opioids. A random sample of urine drug test results from 800 pain patients treated at a Veterans Affairs facility found that 25.2% were negative for the prescribed opioid while 19.5% were positive for an illicit drug/unreported opioid [15]. Negative urine drug test results for the prescribed opioid do not necessarily indicate diversion but may indicate the patient halted his/her use due to side effects, lack of efficacy, or pain remission. The concern arises over the increasingly stringent climate surrounding clinical decision-making regarding aberrant urine drug test results and that a negative result for the prescribed opioid or a positive urine drug test may serve as the pretense to terminate a patient rather than guide him/her into addiction treatment or an alternative pain management program; the CDC states that "clinicians should not dismiss patients from care on the basis of a toxicology test result. Dismissal could have adverse consequences for patient safety, potentially including the patient obtaining opioids from alternative sources and the clinician missing opportunities to facilitate treatment for a substance use disorder" [2].

In addition to aberrant urine screens, there are certain behaviors that are suggestive of an emerging opioid use disorder. The most suggestive behaviors are [4; 16; 17]:

- Selling medications
- Prescription forgery or alteration
- Injecting medications meant for oral use
- Obtaining medications from nonmedical sources

- Resisting medication change despite worsening function or significant negative effects
- Loss of control over alcohol use
- Using illegal drugs or non-prescribed controlled substances
- Recurrent episodes of:
  - Prescription loss or theft
  - Obtaining opioids from other providers in violation of a treatment agreement
  - Unsanctioned dose escalation
  - Running out of medication and requesting early refills

Behaviors with a lower level of evidence for their association with opioid misuse include [4; 16; 17]:

- Aggressive demands for more drug
- Asking for specific medications
- Stockpiling medications during times when pain is less severe
- Using pain medications to treat other symptoms
- Reluctance to decrease opioid dosing once stable
- In the earlier stages of treatment:
  - Increasing medication dosing without provider permission
  - Obtaining prescriptions from sources other than the pain provider
  - Sharing or borrowing similar medications from friends/family

interactive activity

View the CDC's video Risk Factors in Opioid Prescribing at https://www.netce.com/learning.php?page=activities&courseid=3207. This video addresses the various risk factors likely to increase susceptibility to opioid-associated harms and suggests strategies for mitigating these risks.

FEDERAL AND STATE LAW

In response to the rising incidence in prescription opioid misuse, dependence, diversion, and overdose, in 2018 the FDA mandated opioid-specific REMS (i.e., Opioid Analgesic REMS or OA REMS) to reduce the potential negative patient and societal effects of prescribed opioids. Other elements of opioid risk mitigation include the FDA partnering with other governmental agencies, state professional licensing boards, and societies of healthcare professionals to help improve prescriber knowledge of appropriate and safe opioid prescribing and safe home storage and disposal of unused medication [18].

Several regulations and programs at the state level have been enacted in an effort to reduce prescription opioid abuse, diversion, and overdose, including [19]:

- Physical examination required prior to prescribing
- Tamper-resistant prescription forms
- Pain clinic regulatory oversight
- Prescription limits
- Prohibition from obtaining controlled substance prescriptions from multiple providers
- Patient identification required before dispensing
- Immunity from prosecution or mitigation at sentencing for individuals seeking assistance during an overdose

CONTROLLED SUBSTANCES LAWS/RULES

The U.S. Drug Enforcement Administration (DEA) is responsible for formulating federal standards for the handling of controlled substances. In 2011, the DEA began requiring every state to implement electronic databases that track prescribing habits, referred to as PDMPs. Specific policies regarding controlled substances are administered at the state level [19].

According to the DEA, drugs, substances, and certain chemicals used to make drugs are classified into five distinct categories or schedules depending upon the drug's acceptable medical use and the drug's abuse or dependency potential [20]. The abuse rate is a determinate factor in the scheduling of the drug; for example, Schedule I drugs are considered the most dangerous class of drugs with a high potential for abuse and potentially severe psychologic and/or physical dependence.

STATE-SPECIFIC LAWS AND RULES

Most states have established laws and rules governing the prescribing and dispensing of opioid analgesics. It is each prescriber's responsibility to have knowledge of and adhere to the laws and rules of the state in which he or she prescribes.

interactive activity

Visit the NetCE website to view excerpts from specific state rules and regulations relating to the regulation of controlled substances, electronic PDMPs, enacted state legislation, and prescribing guidelines. https://www.netce.com/learning.php?page=activities&courseid=3207.

PATIENT EDUCATION ON THE USE AND DISPOSAL OF OPIOIDS

Patients and caregivers should be counseled regarding the safe use and disposal of opioids. As part of its mandatory OA REMS for extended-release/long-acting opioids (discussed later in this course), the FDA requires a patient counseling document with information on the patient's specific medications, instructions for emergency situations and incomplete pain control, and warnings not to share medications or take them unprescribed. A copy of this form may be accessed online at https://www.opioidanalgesicrems.com/Resources/Docs/patient_counseling_document.pdf [21].

When prescribing opioids, clinicians should counsel patients on the following [18]:

- Importance of adherence to prescribed dosing regimen
- Patients should use the least amount of medication necessary to treat pain and for the shortest amount of time
- The risk of serious adverse events that can lead to death
- The risk of addiction that can occur even when product is used as recommended
- Known risk factors for serious adverse events, including signs and symptoms of overdose and opioid-induced respiratory depression, GI obstruction, and allergic reactions, among others
- The most common side effects, along with the risk of falls, working with heavy machinery, and driving
- When to call the prescriber (e.g., managing adverse events, ongoing pain)
- How to handle missed doses
- The importance of full disclosure of all medications and supplements to all healthcare professionals and the risks associated with the use of alcohol and other opioids/benzodiazepines
- Product-specific concerns, such as not to crush or chew ER products; transdermal systems and buccal films should not be cut, torn, or damaged before use, etc.
- How to safely taper dose to avoid withdrawal symptoms
- Safe storage and disposal, risks of theft by family members and household visitors
- Never share any opioid analgesic with another person
- How and when to use naloxone products and their various means of administration
- Seeking emergency medical treatment if an opioid overdose occurs
- How to report adverse events and medication errors to FDA

In addition, in July 2025, the FDA announced that all opioid manufacturers must change safety labels (within 30 days) with new evidence regarding long-term use of opioids. The change is intended to assist healthcare professionals and patients to make fully informed treatment decisions when considering or already taking opioids for an extended period of time. The labeling changes must include the following [22]:

- Clearer risk information: A summary of study results showing the estimated risks of addiction, misuse, and overdose during long-term use.
- Dosing warnings: Stronger warnings that higher doses come with greater risks and that those risks remain over time.
- Clarified use limits: Removing language which could be misinterpreted to support using opioid pain medications over indefinitely long duration
- Treatment guidance: Labels will reinforce that long-acting or extended-release opioids should only be considered when other treatments, including shorter-acting opioids, are inadequate.
- Safe discontinuation: A reminder not to stop opioids suddenly in patients who may be physically dependent, as it can cause serious harm.
- Overdose reversal agents: Additional information on medications that can reverse an opioid overdose.
- Drug interactions: Enhanced warning about combining opioids with other drugs that slow down the nervous system—now including gabapentinoids.
- More risks with overdose: New information about toxic leukoencephalopathy—a serious brain condition that may occur after an overdose.
- Digestive health: Updates about opioid-related problems with the esophagus.

There are no universal recommendations for the proper disposal of unused opioids, although efforts toward patient education on what to do with unused or expired medications have increased in recent years. According to the FDA, the best way to dispose of most types of unused or expired medications (both prescription and over-the-counter) is to immediately use a take-back option, such as a designated take-back location or by mailing medications back using a prepaid drug mail-back envelope. As of April 2025, the FDA began requiring OA REMS Program Companies to provide prepaid mail-back envelopes upon request to pharmacies and other dispensers of opioid analgesics to improve proper and equitable disposal of this class of drugs [23].

If these options are not available, it is recommended to consult the list of medications recommended for disposal by flushing down the toilet. For example, the FDA recommends that certain medications, including oxycodone/acetaminophen (Percocet), oxycodone (OxyContin tablets), and transdermal fentanyl patches (Duragesic Transdermal System), be flushed down the toilet instead of thrown in the trash. Patients should be advised to flush prescription drugs down the toilet only if the label or accompanying patient information specifically instructs doing so. If medication is not on the flush list, it is recommended to mix the medication with an undesirable substance (e.g., cat litter, dirt, used coffee grounds), and put it into an impermeable, nondescript container (e.g., disposable container with a lid or a sealed bag) before throwing in trash at home. Any personal information should be obscured or destroyed [23; 24].

CONSIDERATIONS FOR NON-ENGLISH-PROFICIENT PATIENTS

For patients who are not proficient in English, it is important that information regarding the risks associated with the use of opioids and available resources be provided in their native language, if possible. When there is an obvious disconnect in the communication process between the practitioner and patient due to the patient's lack of proficiency in the

English language, an interpreter is required. Interpreters can be a valuable resource to help bridge the communication and cultural gap between patients and practitioners. Interpreters are more than passive agents who translate and transmit information back and forth from party to party. When they are enlisted and treated as part of the interdisciplinary clinical team, they serve as cultural brokers who ultimately enhance the clinical encounter. In any case in which information regarding treatment options and medication/treatment measures are being provided, the use of an interpreter should be considered. Print materials are also available in many languages, and these should be offered whenever necessary.

DISPARITIES IN PAIN MANAGEMENT

At greatest risk of unrelieved pain from stigma and bias are children, the elderly, racial and ethnic minorities, active duty or military veterans, and those with cancer, HIV, or sickle cell disease. Pain undertreatment in Black patients is especially widespread, from prevalent misperceptions (often unconscious) that this group has higher pain tolerance and is more likely to abuse their opioid prescription [25]. As a result, prescribers, dispensers, and administrators would benefit from considering both the tenets of appropriate opioid prescribing and the impact of culture on experiences of pain and effective pain management.

It is clear that health disparities exist among racial and ethnic minority groups, and this is true for pain management services and medications. A large-scale national study in the United States found racial differences in the prescription of analgesics for patients with migraine, low back pain, and bone fractures [26]. Specifically, Black Americans were less likely to be prescribed analgesics for their pain compared with their White counterparts. Racial minority patients are also more likely to experience longer wait times for medication compared with White patients [27].

Analysis of a national dataset found that Black Americans were less likely to be prescribed opioids for back pain and abdominal pain compared with non-Hispanic White Americans [28]. The authors speculate that racial biases may influence prescribing behaviors. An examination of Medicaid patients who received epidural analgesia during vaginal childbirth also found statistically significant racial/ethnic differences [29]. In this study, 59.6% of the White patients received epidural analgesia, compared with 49.5% of Black Americans, 48.2% of Asians, and 35.2% of Hispanics. Even after the researchers controlled for age, urban/rural residence, and the availability of anesthesiologists, race and ethnicity still predicted epidural analgesia prescribing trends [29].

In a meta-analysis of ethnicity and pain management researchers found that professionals under-rated ethnic minority patients' levels of pain and were less likely to indicate their pain scores on their charts compared with their White counterparts [30]. In addition, Black American and Hispanic patients were less likely to have been given analgesics than White patients.

Studies have not definitively isolated the factors that contribute to these disparities. One of the challenges in understanding health disparities, and particularly pain management disparities, is the fact that racial and ethnic minority groups are heterogeneous [31; 32]. Healthcare professional barriers may include professionals' beliefs about appropriate pain management; lack of training and knowledge about the intersection of pain and culture, race, and ethnicity; lack of culturally sensitive assessment for pain; and expectations about racial and ethnic minority pain patients based on stereotypes [33]. Consequently, practitioners may underestimate and minimize racial minority patients' pain experiences. In a qualitative study, Native American individuals described their complaints of pain being dismissed, receiving inadequate care, and neglected aftercare [34].

Studies have also shown that the language and race/ethnicity of the healthcare professional influences pain management. For example, the ratings of pain tend to be comparable when the patient and healthcare provider speak the same language. When there is a native language, pain ratings tend to diverge. When literacy and language barriers are eliminated, assessment and treatment improve and racial and ethnic minority patients with pain fare better [35]. In addition, healthcare professionals' level of empathy appears to increase when the patient and healthcare professional share the same skin color or are of the same ethnic group [36; 37].

It is important to note that disparities in pain management are not typically intentional. Instead, they are the result of a myriad of issues, including healthcare system, socioeconomic, and cultural factors. However, prescriber and dispenser unconscious bias can contribute to the undertreatment of pain in certain groups. Promoting positive emotions such as empathy and compassion can help reduce implicit biases. This can involve strategies like perspective taking and role playing [38]. In a study examining analgesic prescription disparities, nurses were shown photos of White or Black American patients exhibiting pain and were asked to recommend how much pain medication was needed; a control group was not shown photos. Those who were shown images of patients in pain displayed no differences in recommended dosage along racial lines; however, those who did not see the images averaged higher recommended dosages for White patients compared with Black patients [39]. This suggests that professionals' level of empathy (enhanced by seeing the patient in pain) affected prescription recommendations.

CONCLUSION

Opioid analgesics are approved by the FDA for the treatment of moderate or severe pain. However, individual patients differ greatly in clinical response to different opioid analgesics, and patient populations show widely variable response to the same opioid and dose. These response variations make opioid prescribing challenging. Further, the important role of opioid analgesics is broadly accepted in acute pain, cancer pain, and palliative and end-of-life care, but it is controversial for the management of chronic noncancer pain. Previous opioid prescribing guidelines have been criticized for lacking a patient-centered approach and failing to emphasize individualization of therapy. This prompted the 2022 revision of the CDC's opioid prescribing guidelines, which is outlined in this course.

Opioids are not a panacea for pain, nor are they safe and effective for every patient. However, they can be a useful tool, and knowledge of medical advances can give clinicians greater confidence to safely and effectively prescribe these drugs.

Implicit Bias in Health Care

The role of implicit biases on healthcare outcomes has become a concern, as there is some evidence that implicit biases contribute to health disparities, professionals' attitudes toward and interactions with patients, quality of care, diagnoses, and treatment decisions. This may produce differences in help-seeking, diagnoses, and ultimately treatments and interventions. Implicit biases may also unwittingly produce professional behaviors, attitudes, and interactions that reduce patients' trust and comfort with their provider, leading to earlier termination of visits and/or reduced adherence and follow-up. Disadvantaged groups are marginalized in the healthcare system and vulnerable on multiple levels; health professionals' implicit biases can further exacerbate these existing disadvantages.

Interventions or strategies designed to reduce implicit bias may be categorized as change-based or control-based. Change-based interventions focus on reducing or changing cognitive associations underlying implicit biases. These interventions might include challenging stereotypes. Conversely, control-based interventions involve reducing the effects of the implicit bias on the individual's behaviors. These strategies include increasing awareness of biased thoughts and responses. The two types of interventions are not mutually exclusive and may be used synergistically.

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