Welcome to the inaugural newsletter of your Pain Advisory Council. It is the intent of this newsletter to provide timely tips and tools for safe and rational opioid prescribing, deprescribing of high risk opioid pain relievers, multimodal treatment options for acute and chronic pain management, and substance use disorder recognition and treatment. The articles will be short and targeted to current initiatives with links to more resources. These will be archived with our existing Opioid Guideline Toolkit. It will also recognize the accomplishments of providers and their staff who are making progress in implementing the guidelines and helping us to achieve the aims of better health care at a lower cost with good patient and provider satisfaction.

This newsletter and the Pain Advisory Council are needed because of the current opioid crisis. The latest CDC report tells us that 200 people die each day due to opioid overdoses. The causes of this opioid crisis include overzealous and misleading advertising by pharmaceutical companies; overprescribing of opioid pain relievers without adequate evidence about the risks, benefits, and alternatives; and a legacy of drug control policies that relied on law enforcement rather than health care providers to address substance use disorders. Knowing the causes offers us opportunities to intervene for our patients and our system.

There now exist mountains of data on effective options for managing both acute and chronic pain. Guidelines from this data emphasize a holistic approach with patient function as the focal point of the treatment plan and the use of multimodal treatment options that do not rely exclusively on opioid pain relievers. This evidence tells us there is little benefit and many harms to long term use of opioid pain relievers for chronic pain, moving us toward those other treatment options. Providers with an understanding of the underlying pathophysiology of pain and the treatment options available can manage chronic pain like other chronic illnesses, such as diabetes or hypertension. We will work with providers to make such knowledge available to implement in your busy practices.

Prior overprescribing has put many patients on high doses of opioid pain relievers and suffering from serious side effects including memory loss, worsening pain sensations, and even death. While it is important to work toward lower doses, simply cutting these patients off or too rapidly weaning them can provoke aberrant behaviors, lead to illicit substance use, and unmask a latent substance use disorder. We have tools to help providers inform patients of the risks and work with those patients to gradually wean down to safer doses and alternatives to opioids for their pains.

Finally, because as many as 1 in 4 patients on chronic opioid pain relievers have an opioid use disorder, providers need to recognize, diagnose, and be able to treat substance use disorders. Providers writing for opioid pain relievers should consider becoming certified for medication assisted therapies (MAT) such as buprenorphine (Suboxone®, Subutex®), and naltrexone (Vivitrol®) to treat opioid use disorders. We will share such opportunities as they become available.
**Medication Highlight - Naloxone**

Naloxone is an opioid antagonist indicated for the emergency treatment of known or suspected opioid overdose, including heroin overdose. Naloxone can be prescribed for the individual at risk for overdose or to a family member or person who is in a position to assist the individual at risk in the event of an overdose. Naloxone is not a controlled substance; it can be prescribed by any clinician with prescriptive authority. Any patient can purchase naloxone without a prescription directly from the pharmacy under the WI HOPE laws.

The CDC and the Wisconsin Medical Examining Board Opioid Prescribing Guidelines recommend prescribing naloxone for patients at higher risk for overdose, including:

- History of overdose (a relative contraindication to chronic opioid therapy)
- Opioid doses over 50 MME per day
- History of substance use disorder
- Concurrent benzodiazepine or sedative-hypnotic use
- Clinical depression
- Evidence of increased risk by other measures (behaviors, family history, PDMP, UDS, risk questionnaires, etc.)
- Increased risk due to comorbid renal disease, sleep apnea, COPD

Naloxone products available for outpatient use include nasal spray via a mucosal atomizer device, Narcan® Nasal Spray, and Evzio® Auto-Injector. Cost, insurance coverage, and product availability can influence which product to prescribe. [Naloxone Products for Outpatient Prescribing](#)

**Patient Education:**

- Review risk factors for opioid overdose and actions to prevent overdose
- Teach family and friends to recognize the signs of overdose, activation of emergency medical services, and how to administer naloxone
- Advise all patients to go the ED after use.

[Additional information](#) on prescribing naloxone can be found on the Opioid Guideline Toolkit.

**Ascension Medical Group Establishes New Opioid Guidelines**

The AMG [Outpatient Opioid Guidelines](#) promote the latest evidence for safe and effective treatment of acute and chronic pain while helping providers understand a new paradigm when treating pain and prescribing opioids. The guidelines support use of opioids when other treatment options have been exhausted and where the potential benefit outweighs the risk of harm to the patient.

Resources and tools can be found on the [AMG Opioid Guideline Share Point site](#). Each edition of this newsletter will detail a different component of the opioid guidelines.

For questions, contact a member of the Pain Advisory Council leadership team.

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