



Ending the Opioid Epidemic — A Call to Action

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On August 24, 2016, I mailed a letter and pocket card (see figure) to 2.3 million doctors, nurses, dentists, and other clinicians asking them to help address America's escalating

opioid epidemic. It was the first time in the 145-year history of the Office of the Surgeon General that such a letter was issued specifically to medical professionals calling them to action.

The letter and pocket card are part of a larger campaign — Turn The Tide Rx — that also includes an online pledge for clinicians, educational resources, and an invitation to share experiences with colleagues about how to address opioid-use disorder, commonly referred to as addiction. The campaign is also a precursor to the first *Surgeon General's Report on Alcohol, Drugs, and Health*, released November 17, 2016.

I chose to take these actions because of the magnitude and trajectory of the opioid epidemic. The annual number of overdose

deaths involving prescription and illicit opioids has nearly quadrupled since 2000, and this increase parallels marked growth in the quantity of opioid pain relievers being prescribed.^{1,2} In addition, more than 2 million people in the United States are addicted to prescription opioids and more than 12 million report having misused these medications in 2015.³ Prescription opioid addiction and misuse are also contributing to a resurgence in heroin use and the spread of HIV and hepatitis C.⁴

As I visited communities throughout the country as part of our Turn The Tide Rx tour, I heard the heartbreaking stories behind these statistics. In Oklahoma City, a mother and father shared the tragic experience of their son, an all-American athlete, whose fatal

disease began with prescriptions he received after sports injuries. In Napaskiak, a remote fishing village in Alaska with fewer than 500 people, residents lamented that their clinic had been broken into multiple times by people seeking prescription opioids. In Knoxville, people of all ages told me they could not admit they had an opioid-use disorder for fear that they would be fired from their jobs or ostracized by their friends, their neighbors, and even their doctors. In each place I visited, I saw the complexity of causes driving an epidemic that cuts across boundaries of economic status, race, and education level.

But I also encountered many reasons to be hopeful. I saw firsthand that when given access to evidence-based treatment, people can recover and rebuild their lives. Right now, however, we estimate that more than 1 million people who need treatment lack access to it.⁵ I also saw how putting the opioid antagonist naloxone in the

TURN THE TIDE

PRESCRIBING OPIOIDS FOR CHRONIC PAIN

ADAPTED FROM CDC GUIDELINE

Opioids can provide short-term benefits for moderate to severe pain. Scientific evidence is lacking for the benefits to treat chronic pain.

IN GENERAL, DO NOT PRESCRIBE OPIOIDS AS THE FIRST-LINE TREATMENT FOR CHRONIC PAIN (for adults 18+ with chronic pain > 3 months excluding active cancer, palliative, or end-of-life care).

BEFORE PRESCRIBING

1 ASSESS PAIN & FUNCTION

Use a validated pain scale. Example: PEG scale where the score = average 3 individual question scores (30% improvement from baseline is clinically meaningful).

Q1: What number from 0 – 10 best describes your PAIN in the past week? (0 = “no pain”, 10 = “worst you can imagine”)

Q2: What number from 0 – 10 describes how, during the past week, pain has interfered with your ENJOYMENT OF LIFE? (0 = “not at all”, 10 = “complete interference”)

Q3: What number from 0 – 10 describes how, during the past week, pain has interfered with your GENERAL ACTIVITY? (0 = “not at all”, 10 = “complete interference”)

2 CONSIDER IF NON-OPIOID THERAPIES ARE APPROPRIATE

Such as: NSAIDs, TCAs, SNRIs, anti-convulsants, exercise or physical therapy, cognitive behavioral therapy.

3 TALK TO PATIENTS ABOUT TREATMENT PLAN

- Set realistic goals for pain and function
- Discuss benefits, side effects, and risks (e.g., addiction, overdose).
- Check patient understanding about treatment plan.

4 EVALUATE RISK OF HARM OR MISUSE. CHECK:

- Known risk factors: illegal drug use; prescription drug use for nonmedical reasons; history of substance use disorder or overdose; mental health conditions; sleep-disordered breathing.
- Prescription drug monitoring program data (if available) for opioids or benzodiazepines from other sources.

WHEN YOU PRESCRIBE

START LOW AND GO SLOW. IN GENERAL:

- Start with immediate-release (IR) opioids at the lowest dose for the shortest therapeutic duration. IR products when starting opioids.
- Avoid ≥ 90 MME/day; consider specialist to support management of higher doses.
- If prescribing ≥ 50 MME/day, increase follow-up frequency; consider offering naloxone for overdose risk.
- For acute pain; prescribe < 3 day supply; more than 7 days will rarely be required.
- Counsel patients about safe storage and disposal of unused opioids.

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See below for MME comparisons. For MME conversion factors and calculator, go to TurnTheTideRx.org/treatment.

50 MORPHINE MILLIGRAM EQUIVALENTS (MME)/DAY:

- 90 mg of hydrocodone (10 tablets of hydrocodone/acetaminophen 5/300)
- 33 mg of oxycodone (~2 tablets of oxycodone sustained-release 15mg)

90 MORPHINE MILLIGRAM EQUIVALENTS (MME)/DAY:

- 90 mg of hydrocodone (18 tablets of hydrocodone/acetaminophen 5/300)
- 60 mg of oxycodone (4 tablets of oxycodone sustained-release 15mg)

AFTER INITIATION OF OPIOID THERAPY

ASSESS, TAILOR & TAPER

- Reassess benefits/risks within 1-4 weeks after initial assessment.
- Assess pain and function and compare results to baseline. Schedule reassessment at regular intervals (≤ 3 months).
- Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.

TREATING OVERDOSE & ADDICTION

- Screen for opioid use disorder (e.g., difficulty controlling use; see DSM-5 criteria). If yes, treat with medication-assisted treatment (MAT). MAT combines behavioral therapy with medications like methadone, buprenorphine, and naltrexone. Refer to findtreatment.samhsa.gov. Additional resources at TurnTheTideRx.org/, resourcesat.hhs.gov/opioids.
- Learn about medication-assisted treatment (MAT) and apply to be a MAT provider at www.samhsa.gov/medication-assisted-treatment.
- Consider offering naloxone if high risk for overdose: history of overdose or substance use disorder, higher opioid dosage (≥ 50 MME/day), concurrent benzodiazepine use.

ADDITIONAL RESOURCES

CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN:
www.cdc.gov/drugoverdose/prescribing/guideline.html

SAMHSA POCKET GUIDE FOR MEDICATION-ASSISTED TREATMENT (MAT):
store.samhsa.gov/MATguide

NIDAMED: www.drugabuse.gov/nidamed-medical-health-professionals

ENROLL IN MEDICARE: go.cms.gov/pecos
Most prescribers will be required to enroll or validly opt out of Medicare for their prescriptions for Medicare patients to be covered. Delay may prevent patient access to medications.

JOIN THE MOVEMENT

and commit to ending the opioid crisis at TurnTheTideRx.org.




Turn The Tide Rx Pocket Card, Mailed to 2.3 Million Clinicians.

drug monitoring programs and starting prescriber education programs for their peers.

The Obama administration has played an important role in addressing the opioid epidemic. The Department of Health and Human Services has invested millions of dollars in treatment programs, access to naloxone, and prescription-drug monitoring programs, and the Centers for Disease Control and Prevention has developed opioid prescriber guidelines. Going forward, it will be essential for Congress to adequately fund efforts in this area. It will also be necessary to continue efforts to expand insurance coverage, which is essential for obtaining access to prevention and treatment services. Although 20 million people have secured health care coverage through the Affordable Care Act, there are still millions more who need it, particularly in states that have yet to expand Medicaid.

But the opioid epidemic cannot be solved by government alone. It will require the engagement and leadership of all segments of society, particularly clinicians. As clinicians, we have a unique responsibility to address this epidemic. We can sharpen our prescribing practices and use prescription-drug monitoring programs

 An audio interview with Dr. Murthy is available at NEJM.org

to reduce the risk of opioid misuse and overdose. We can ensure that the recognition and treatment of opioid-use disorder is a universal aspect of training and part of every clinician's toolbox. We can use our voices to call for a more effective approach to opioid-use disorder in our health care institutions, in our communities, and in our

government. And perhaps most important, we can use our position as leaders in society to help change how our country sees addiction — not as a personal failing but as a chronic disease of the brain that requires compassion and care. Eradicating the bias against addiction that too many people — including some clinicians — still harbor will be essential to creating an environment where people feel comfortable coming forward and asking for help.

Our ability to address the opioid epidemic will also depend on our willingness as a society to be clear-eyed about what is working and where gaps still exist. For example, as we urge clinicians to consider nonopioid pain-treatment alternatives in their practice, we must also acknowledge that more needs to be done to make these alternatives affordable. The pharmaceutical industry, payers, academia, and government will have to work together to develop additional safe alternatives to opioids and to ensure that they are accessible to patients.

It is also important to recognize that though the Mental Health Parity and Addiction Equity Act of 2008 was a major step forward in ensuring that health insurance plans treat substance use disorders the same way they treat other medical conditions, more accountability is required to ensure that this promise is fully reflected in payer practices. And we need to be willing to grapple openly and honestly with the fact that we have paid too little attention to the physical and emotional factors that are driving pain for millions of Americans. Among other things,

that means making prevention and emotional well-being a higher priority, not only in the clinical setting but also in our communities at large. Finally, we have to do all these things without allowing the pain-control pendulum to swing to the other extreme, where patients for whom opioids are necessary and appropriate cannot obtain them.

Society still looks to the medical profession for help and for hope during difficult times. This is one of those times. This is a moment for clinicians — who have dedicated their lives to providing compassionate care to others — to be not only caregivers but also the leaders and advocates that our communities need.

Disclosure forms provided by the author are available at NEJM.org.

From the Office of the Surgeon General, Department of Health and Human Services, Washington, DC.

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1. Paulozzi L, Jones C, Mack K, Rudd R. Vital signs: overdoses of prescription opioid pain relievers — United States, 1999–2008. *MMWR Morb Mortal Wkly Rep* 2011;60:1487–92.
2. Rudd RA, Aleshire N, Zibbell JE, Gladden RM. Increases in drug and opioid overdose deaths — United States, 2000–2014. *MMWR Morb Mortal Wkly Rep* 2016;64:1378–82.
3. Prescription drug use and misuse in the United States: results from the 2015 National Survey on Drug Use and Health. NSDUH Data Review (<http://www.samhsa.gov/data>).
4. Compton WM, Jones CM, Baldwin GT. Relationship between nonmedical prescription-opioid use and heroin use. *N Engl J Med* 2016;374:154–63.
5. Jones CM, Campopiano M, Baldwin G, McCance-Katz E. National and state treatment need and capacity for opioid agonist medication-assisted treatment. *Am J Public Health* 2015;105(8):e55–e63.

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