CDC Guideline for Prescribing Opioids for Chronic Pain

Clinician Outreach and Communication Activity (COCA) Call

June 22, 2016

Office of Public Health Preparedness and Response
Division of Emergency Operations

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Planners have reviewed content to ensure there is no bias.

This presentation will include discussion of the off-label use of medications with evidence-based indications for pain.

Objectives

At the conclusion of this session, the participant will be able to:

- **Describe what is known about effectiveness and risks of long-term opioid therapy for chronic pain.**
- **Discuss how to determine when opioids should be initiated or continued for chronic pain, and when they should be discontinued.**
- **Discuss recommendations for opioid selection and dosage for chronic pain.**
- **Describe strategies that can be used to assess risk and address harms associated with opioid use.**

Save-the-Dates

Mark your calendar for the upcoming opioid prescribing calls

Call No.	Date	Topic
1	June 22	Guideline for Prescribing Opioids for Chronic Pain
2	July 27	Non-Opioid Treatments
3	August 3	Assessing Benefits and Harms of Opioid Therapy
4	August 17	Dosing and Titration of Opioids

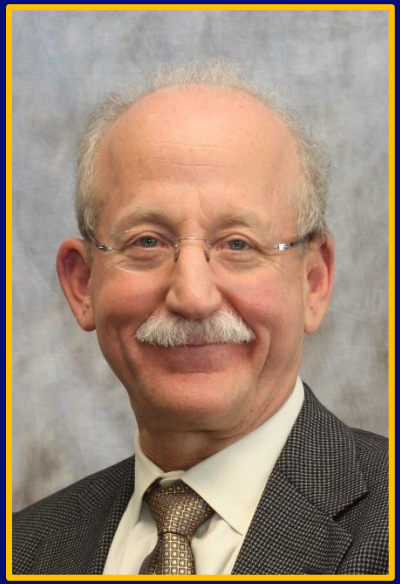
TODAY'S PRESENTER

Tamara Haegerich, PhD
Deputy Associate Director for Science
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

TODAY'S PRESENTER

Deborah Dowell, MD, MPH
Senior Medical Advisor
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

TODAY'S PRESENTER



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Disclaimer

The findings and conclusions in this presentation are those of the author(s) and do not necessarily represent the views of the Centers for Disease Control and Prevention/the Agency for Toxic Substances and Disease Registry

CDC Guideline for Prescribing Opioids for Chronic Pain

Tamara Haegerich, PhD
Deborah Dowell, MD, MPH

June 22, 2016

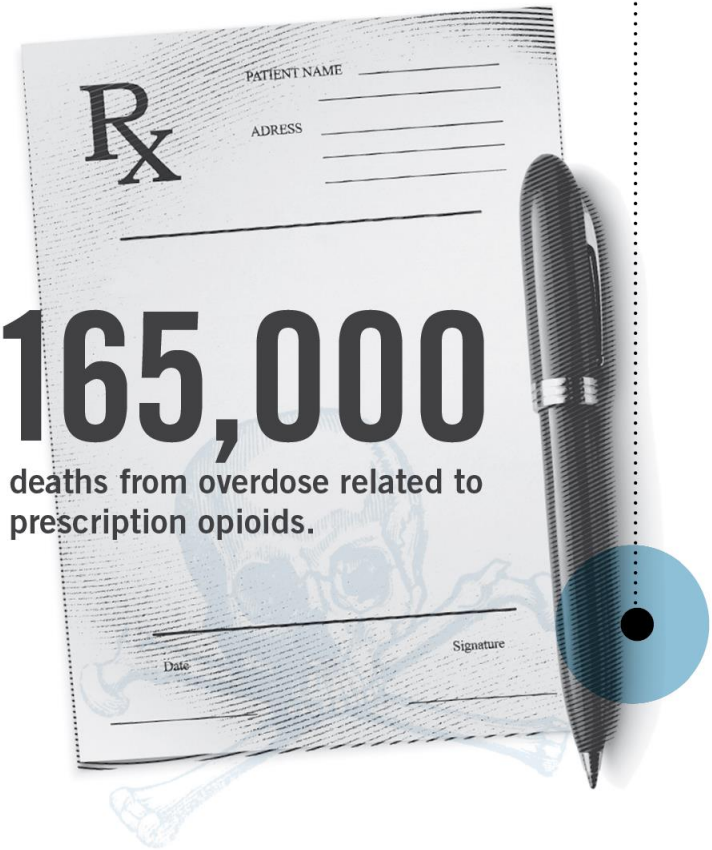
Chronic Pain and Prescription Opioids

- 11% of Americans experience daily (chronic) pain
- Opioids frequently prescribed for chronic pain
- Primary care providers commonly treat chronic, non-cancer pain
  - account for ~50% of opioid pain medications dispensed
  - report concern about opioids and insufficient training

The amount
of opioids prescribed has
QUADRUPLED
from 1999-2014,

but the pain that
Americans report remains
UNCHANGED

Since 1999, there have been more than



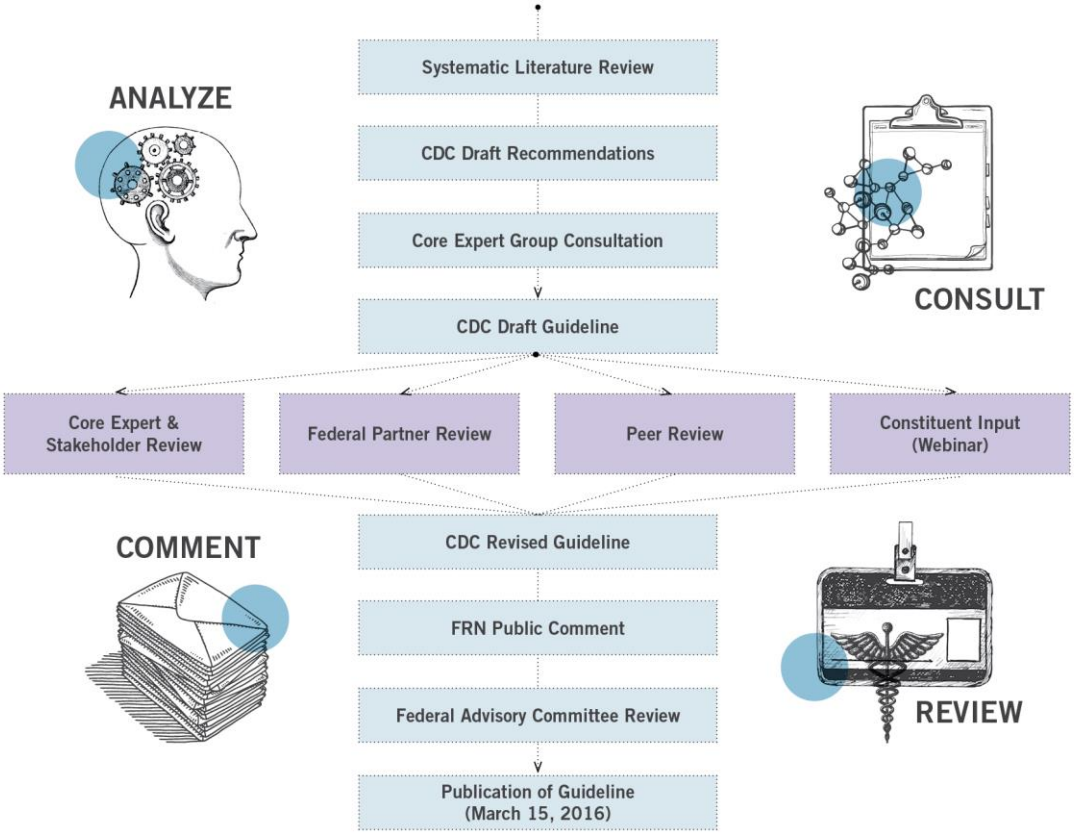
165,000

deaths from overdose related to prescription opioids.

Purpose, Use, and Primary Audience

- Primary Care Providers
  - Family medicine, Internal medicine
  - Physicians, nurse practitioners, physician assistants
- Treating patients ≥18 years with chronic pain
  - Pain longer than 3 months or past time of normal tissue healing
- Outpatient settings
- Does not include active cancer treatment, palliative care, and end-of-life care

Guideline Development Process



GRADE Method

- Standard for guideline development
- Transparent approach for conducting systematic review, rating quality of evidence, and determining strength of recommendations
- Used by > 100 organizations
- Recommendations based on:
  - Quality of evidence
  - Balance between benefits and harms
  - Values and preferences
  - Cost

GRADE Evidence Types

- Evidence Types:
  - Type 1: Randomized controlled trials (RCTs); overwhelming observational studies
  - Type 2: RCTs (limitations); strong observational
  - Type 3: RCTs (notable limitations); observational
  - Type 4: RCTs (major limitations); observational (notable limitations) clinical experience

GRADE Recommendation Categories

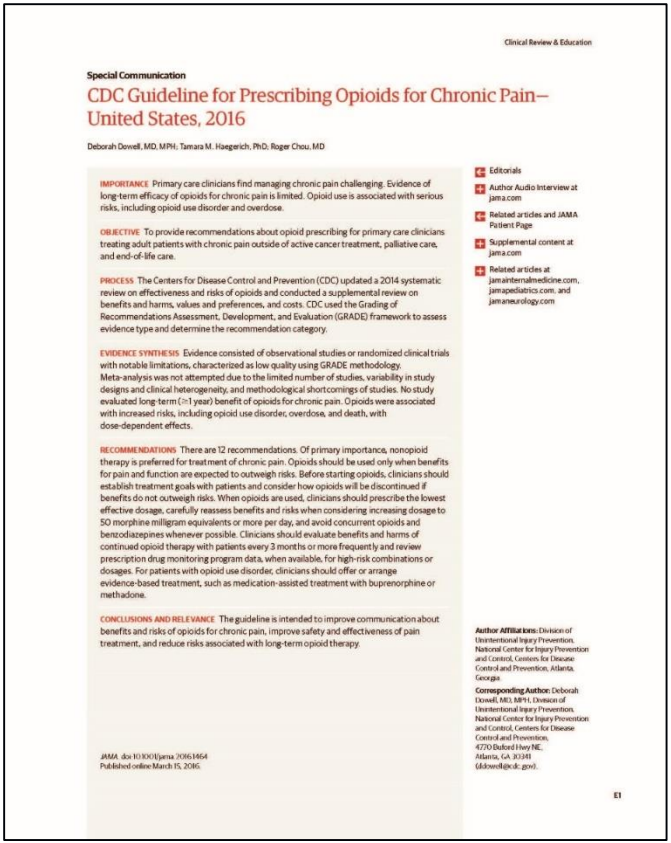
- Recommendation categories:
  - Category A: applies to all patients; most patients should receive recommended course of action
  - Category B: individual decision making required; providers help patients arrive at decision consistent with values/preferences and clinical situation

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Recommendations and Reports / Vol. 65 / No. 1
March 18, 2016

CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016

Continuing Education Examination available at http://www.cdc.gov/mmwr/cme/conted.html.

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



Clinical Review & Education

Special Communication

CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016

Deborah Dowell, MD, MPH; Tamara M. Haegerich, PhD; Roger Chou, MD

IMPORTANCE Primary care clinicians find managing chronic pain challenging. Evidence of long-term efficacy of opioids for chronic pain is limited. Opioid use is associated with serious risks, including opioid use disorder and overdose.

OBJECTIVE To provide recommendations about opioid prescribing for primary care clinicians treating adult patients with chronic pain outside of active cancer treatment, palliative care, and end-of-life care.

PROCESS The Centers for Disease Control and Prevention (CDC) updated a 2014 systematic review on effectiveness and risks of opioids and conducted a supplemental review on benefits and harms, values and preferences, and costs. CDC used the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) framework to assess evidence type and determine the recommendation category.

EVIDENCE SYNTHESIS Evidence consisted of observational studies or randomized clinical trials with notable limitations, characterized as low quality using GRADE methodology. Meta-analysis was not attempted due to the limited number of studies, variability in study designs and clinical heterogeneity, and methodological shortcomings of studies. No study evaluated long-term (≥1 year) benefit of opioids for chronic pain. Opioids were associated with increased risks, including opioid use disorder, overdose, and death, with dose-dependent effects.

RECOMMENDATIONS There are 12 recommendations. Of primary importance, nonopioid therapy is preferred for treatment of chronic pain. Opioids should be used only when benefits for pain and function are expected to outweigh risks. Before starting opioids, clinicians should establish treatment goals with patients and consider how opioids will be discontinued if benefits do not outweigh risks. When opioids are used, clinicians should prescribe the lowest effective dosage, carefully reassess benefits and risks when considering increasing dosage to 50 morphine milligram equivalents or more per day, and avoid concurrent opioids and benzodiazepines whenever possible. Clinicians should evaluate benefits and harms of continued opioid therapy with patients every 3 months or more frequently and review prescription drug monitoring program data, when available, for high-risk combinations or dosages. For patients with opioid use disorder, clinicians should offer or arrange evidence-based treatment, such as medication-assisted treatment with buprenorphine or methadone.

CONCLUSIONS AND RELEVANCE The guideline is intended to improve communication about benefits and risks of opioids for chronic pain, improve safety and effectiveness of pain treatment, and reduce risks associated with long-term opioid therapy.

Editorials
Author Audio Interview at jama.com
Related articles and JAMA Patient Page
Supplemental content at jama.com
Related articles at jamainternalmedicine.com, jamapediatrics.com, and jamaneurology.com

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JAMA: The Journal of American Medical Association

Deborah Dowell, Tamara Haegerich, and Roger Chou

CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016

Published online March 15, 2016

JAMA®
The Journal of the American Medical Association

Clinical Evidence Summary

- No long-term (≥ 1 year) outcomes in pain/function; most placebo-controlled trials ≤ 6 weeks
- Opioid dependence in primary care: 3%-26%
- Dose-dependent association with risk of overdose/harms
- Inconsistent results for different dosing protocols; initiation with LA/ER increased risk of overdose
- Methadone associated with higher mortality risk
- No differences in pain/function with dose escalation
- Risk prediction instruments have insufficient accuracy for classification of patients
- Increased likelihood of long-term use when opioids used for acute pain

Contextual Evidence Summary

- Effective nonpharmacologic therapies: exercise, cognitive behavioral therapy (CBT), interventional procedures
- Effective nonopioid medications: acetaminophen, nonsteroidal anti-inflammatory drugs (NSAIDs), anticonvulsants, antidepressants
- Opioid-related overdose risk is dose-dependent
- Factors that increase risk for harm: pregnancy, older age, mental health disorder, substance use disorder, sleep-disordered breathing
- Providers lack confidence in ability to prescribe safely and are concerned about opioid use disorder
- Patients are ambivalent about risks/benefits and associate opioids with addiction

Organization of Recommendations

- **The 12 recommendations are grouped into three conceptual areas:**
  - Determining when to initiate or continue opioids for chronic pain
  - Opioid selection, dosage, duration, follow-up, and discontinuation
  - Assessing risk and addressing harms of opioid use

Determine when to initiate or continue opioids for chronic pain

Opioids not first-line or routine therapy for chronic pain

1

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

(Recommendation category A: Evidence type: 3)

Establish and measure progress toward goals

2

- Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks.
- Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

(Recommendation category A: Evidence type: 4)

Discuss benefits and risks with patients

3

- Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

(Recommendation category A: Evidence type: 3)

Opioid selection, dosage, duration, follow-up, and discontinuation

Use immediate-release opioids when starting

4

- When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

(Recommendation category A: Evidence type: 4)

Additional cautions for

- *Methadone*
- *Transdermal fentanyl*
- *Immediate-release opioids combined with ER/LA opioids*

Use caution at any dose and avoid increasing to high dosages

5

- When opioids are started, clinicians should prescribe the lowest effective dosage.
- Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

(Recommendation category A: Evidence type: 3)

6

Prescribe no more than needed

- Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids.
- 3 days or less will often be sufficient; more than 7 days will rarely be needed.

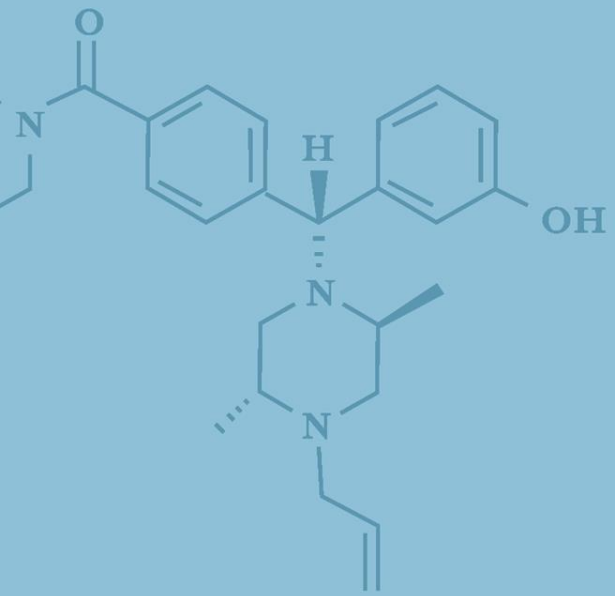
(Recommendation category A: Evidence type: 4)

Offer a taper if opioids cause harm or are not helping

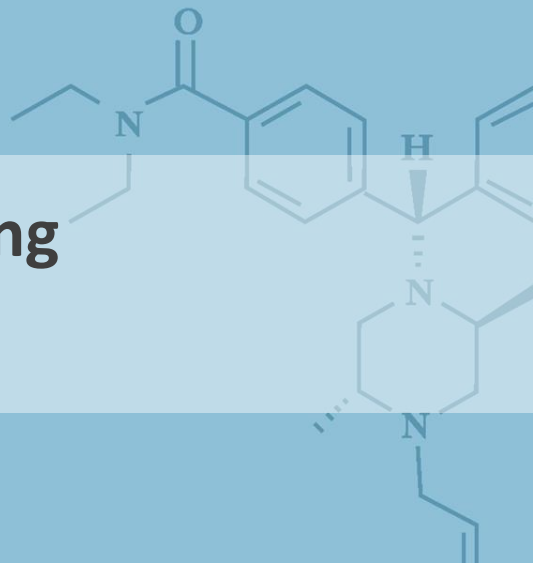
7

- Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation.
- Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently.
- If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

(Recommendation category A: Evidence type: 4)



Assessing risk and addressing harms of opioid use



Evaluate and address risks for opioid-related harms

8

- Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms.
- Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

(Recommendation category A: Evidence type: 4)

Check PDMP for high dosages and dangerous combinations

9

- 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 dangerous combinations that put him/her at high risk for overdose.
- Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

(Recommendation category A: Evidence type: 4)

Test urine for prescribed opioids and other drugs

10

- When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

(Recommendation category B: Evidence type: 4)

Avoid concurrent opioid and benzodiazepine prescribing

11

- Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

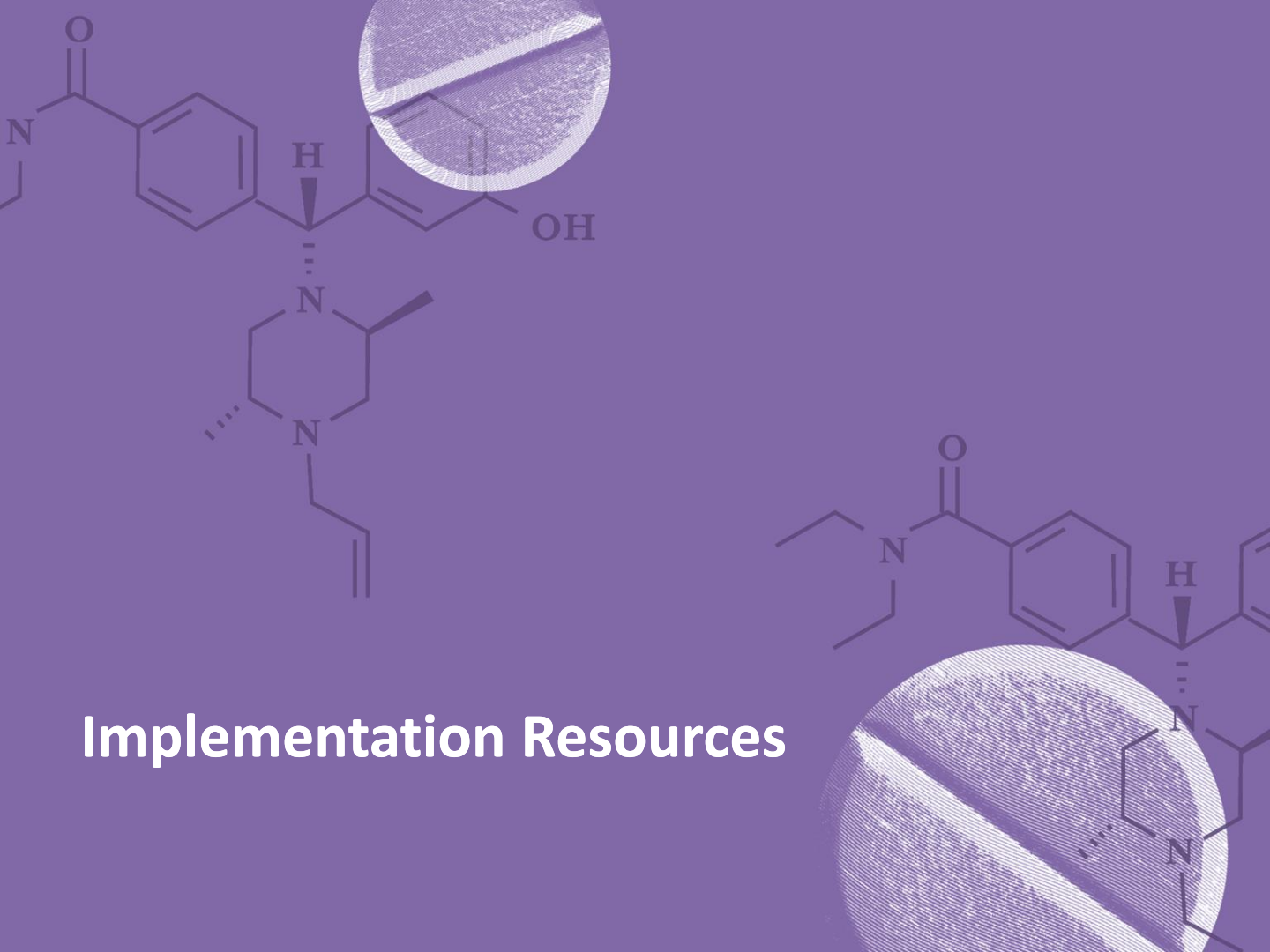
(Recommendation category A: Evidence type: 3)

Treat patients for opioid use disorder (OUD) if needed

12

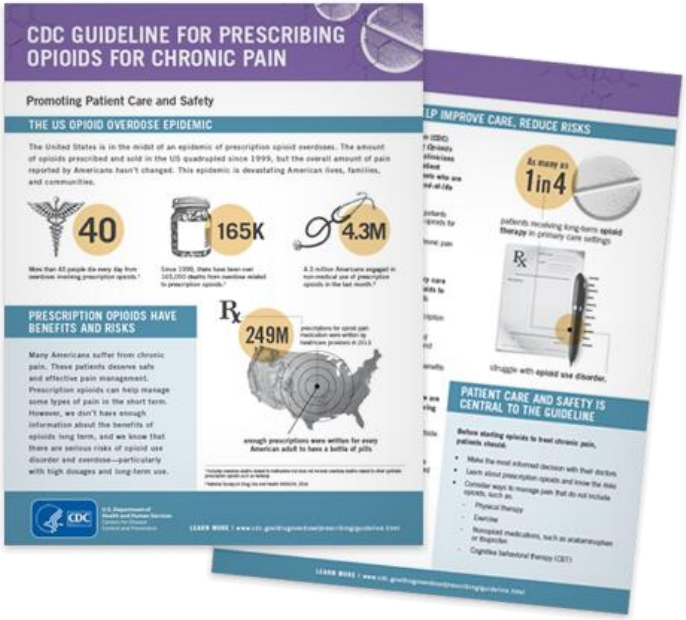
- Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

(Recommendation category A: Evidence type: 2)



Implementation Resources

Resources



- Fact sheets
  - New Opioid Prescribing Guideline
  - Assessing Benefits and Harms of Opioid Therapy
  - Prescription Drug Monitoring Programs
  - Calculating Total Daily Dose of Opioids for Safer Prescribing
  - Pregnancy and Opioid Pain Medications

Checklist for prescribing opioids for chronic pain

Checklist for prescribing opioids for chronic pain

For primary care providers treating adults (18+) with chronic pain ≥3 months, excluding cancer, palliative, and end-of-life care

CHECKLIST

When CONSIDERING long-term opioid therapy

- ☐ Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- ☐ Check that non-opioid therapies tried and optimized.
- ☐ Discuss benefits and risks (eg, addiction, overdose) with patient.
- ☐ Evaluate risk of harm or misuse.
  - Discuss risk factors with patient.
  - Check prescription drug monitoring program (PDMP) data.
  - Check urine drug screen.
- ☐ Set criteria for stopping or continuing opioids.
- ☐ Assess baseline pain and function (eg, PEG scale).
- ☐ Schedule initial reassessment within 1–4 weeks.
- ☐ Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

If RENEWING without patient visit

- ☐ Check that return visit is scheduled <3 months from last visit.

When REASSESSING at return visit

Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.

- ☐ Assess pain and function (eg, PEG); compare results to baseline.
- ☐ Evaluate risk of harm or misuse:
  - Observe patient for signs of over-sedation or overdose risk.
    - If yes: Taper dose.
  - Check PDMP.
  - Check for opioid use disorder if indicated (eg, difficulty controlling use).
    - If yes: Refer for treatment.
- ☐ Check that non-opioid therapies optimized.
- ☐ Determine whether to continue, adjust, taper, or stop opioids.
- ☐ Calculate opioid dosage morphine milligram equivalent (MME).
  - If ≥50 MME/day total (≥50 mg hydrocodone; ≥33 mg oxycodone), increase frequency of follow-up; consider offering naloxone.
  - Avoid ≥90 MME/day total (≥90 mg hydrocodone; ≥60 mg oxycodone), or carefully justify; consider specialist referral.
- ☐ Schedule reassessment at regular intervals (≤3 months).

REFERENCE

EVIDENCE ABOUT OPIOID THERAPY

- *Benefits of long-term opioid therapy for chronic pain not well supported by evidence.*
- *Short-term benefits small to moderate for pain; inconsistent for function.*
- *Insufficient evidence for long term benefits in low back pain, headache, and fibromyalgia.*

NON-OPIOID THERAPIES

Use alone or combined with opioids, as indicated:

- Non-opioid medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants).
- Physical treatments (eg, exercise therapy, weight loss).
- Behavioral treatment (eg, CBT).
- Procedures (eg, intra-articular corticosteroids).

EVALUATING RISK OF HARM OR MISUSE

Known risk factors include:

- Illegal drug use; prescription drug use for nonmedical reasons.
- History of substance use disorder or overdose.
- Mental health conditions (eg, depression, anxiety).
- Sleep-disordered breathing.
- Concurrent benzodiazepine use.

Urine drug testing: Check to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.

Prescription drug monitoring program (PDMP): Check for opioids or benzodiazepines from other sources.

ASSESSING PAIN & FUNCTION USING PEG SCALE

PEG 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"

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TO LEARN MORE
www.cdc.gov/drugoverdose/prescribing/guideline.html

March 2016

Connect With Us

Find more information on drug overdose and the Guideline:

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

Are you on Twitter?

- Follow **@DebHouryCDC** and **@CDCInjury** for useful information and important Guideline updates.

Find out more about Injury Center social media:

- www.cdc.gov/injury/socialmedia

CDC Guideline for Prescribing Opioids
for Chronic Pain

FEASIBILITY for PRIMARY CARE PROVIDERS

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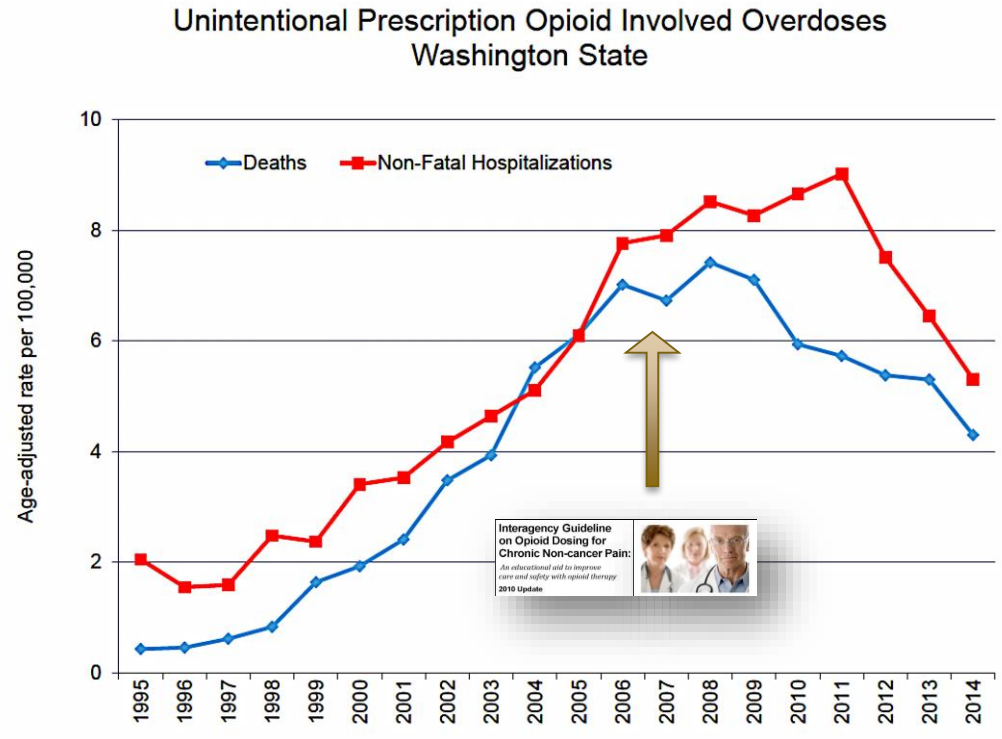
IS IT POSSIBLE TO CHANGE YOUR PRACTICE?

- **Feasible**
  - Capable of being done or carried out;
  - Capable of being used or dealt with successfully;
  - Reasonable
  - Likely
    - – Merriam Webster Dictionary

- **Imperative**
  - "Above all, do no harm" – Hippocrates

- **Practical**
  - "Vision without execution is hallucination" –Thomas Edison

WASHINGTON STATE'S SUCCESS



Source: Jennifer Sabel PhD Epidemiologist, WA State Department of Health, May 2016

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KEY ELEMENTS

Guideline Compliant Care

- Team approach with pain champion(s)
- Shared clinic policies and assessment tools
  - Consensus for a pain “standard of care”
  - Focus on functional gains
  - Address opioid safety and efficacy
- Emphasis on a multimodal treatment approach
- Address substance use disorders and have referral options with a defined referral process
- Patient self-management classes and support
- Longer visits
- After visit care with Case or Care managers
- Web-based program with Tele-mentoring and E-consults

Courtesy of Dr. Melissa Weimer, OHSU

IMPLEMENTING BEST PRACTICES

1. Highstreet Medical Center, Springfield, MA
2. Boston Medical Center's TOPCARE, MA
3. Community Hospital of the Monterey Peninsula, CA
4. Duke University Health System, NC
5. Group Health (Seattle) Learning Health Systems, WA
6. Kaiser Permanente's Southern California Medical Group
7. Lancaster General Health/Penn Medicine, PA
8. Medford Oregon's Opioid Prescribing Group, OR
9. Oregon Health & Science University's PROPEL clinic, OR
10. Priority Health (HMO), Lansing, MI
11. Rhode Island/Miriam Hospitals
12. Temple University Hospital Systems, PA
13. VA/DoD Health systems nationwide: Connecticut, Minneapolis, Indianapolis, Seattle/Puget Sound
14. University of Washington and its UW Neighborhood Clinics

***Will you add your clinical practice here**: _____?*

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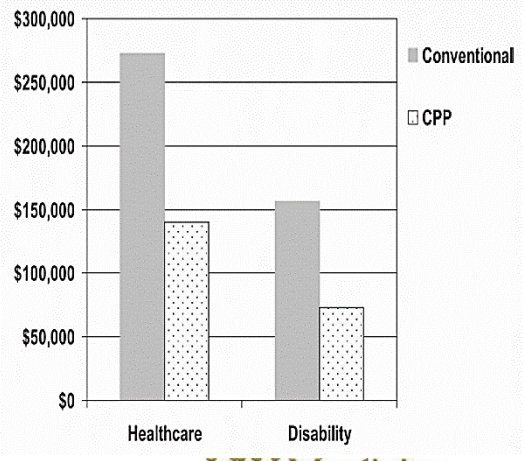
AN URGENCY

Guideline Compliant Care

- Epidemic in America
  - Influenza Pandemic (1918: 500,000)
  - HIV (1981-2005: 550,000)
  - Prescription Opioid ODs (1999-2014: 165,000, and counting)
- Families and communities are suffering from opioid-related accidental deaths and addictions
- Health care expenses can be reduced with multidisciplinary chronic pain care:
  - Reduce direct costs 70%
  - Reduce disability costs 40%



[1]Gatchel 2006

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HOW?

Guideline Compliant Care

Understand Safe & Effective Chronic Pain Treatments

1. For Clinicians

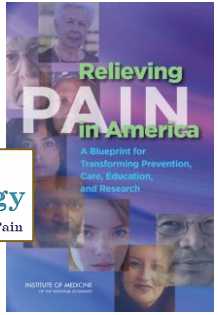
- **CDC Guidelines**, & your state's guidelines
- UW's "COPE REMS" www.coperems.org

AMDG agency medical directors' group

A collaboration of state agencies, working together to improve health care quality for Washington State citizens.

2. For Patients and Families

- YouTube: "Understand Pain", "Brainman Stops His Opioids"
- Stanford's: Chronic Pain Self Management Program
- U. Michigan's: fibroguide.com
- American Chronic Pain Association



3. For Policymakers and Payers

- National Pain Strategy
- IOM 2011 Report: Relieving Pain in America

National Pain Strategy

A Comprehensive Population Health-Level Strategy for Pain

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HOW?

Step 2: Assess

✓ *Does your practice:*

- ❑ Use registries and regular review based on dose (MME)
- ❑ Measure and track function (e.g. PEG) and mood (e.g. PHQ's, GAD, PC-PTSD) when prescribing chronic opioids
- ❑ Screen for Misuse/Addiction Risks (e.g. ORT, SOAPP, DIRE)*
- ❑ Adhere to monitoring policies and procedures: PDMP, UDT
- ❑ Enter Care Agreements & Informed Consent re benefits & harms
- ❑ Screen for Medical Risks: e.g. sleep apnea, benzodiazepine use
- ❑ Follow protocols for OD high risk/naloxone prescribing
- ❑ Have Buprenorphine licensees? And actually prescribe?
- ❑ Process for interprofessional referrals? (CBT, PT/OT, Rehab, Addiction)

*widely used, though poor predictive validity

WHO?

- **You**, confident of your care provider relational skills, compassion, and capacity to learn and deliver best-practice pain care.
- **Your multidisciplinary/interprofessional pain care team…**
- …Enabled and enlarged by policies and processes that **your organization's medical and administrative leadership** will need to support.
- Your **patients and families**, since successful chronic pain treatment requires patient engagement and self-management.

WHEN?

Transformation is a process, it doesn't happen all at once

- **Start** with a *sense of urgency*
- **Identify** your team and its champions
- **Engage & communicate** goals within your group and throughout the larger organization
- **Prioritize** internal and external obstacles, and introduce steps that overcome initial barriers
- **Get** quick wins
- **Build** IT and other resources needed to support change
- Regularly **review** and **sustain** processes

SELECTED REFERENCES

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2. Washington State Interagency Guideline on Prescribing Opioids for Pain 2015. www.agencymeddirectors.wa.gov

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5. National Pain Strategy: A Comprehensive Population Health-Level Strategy for Pain https://iprcc.nih.gov/docs/HHSNational_Pain_Strategy.pdf

6. Dowell D, Haegerich TM, Chou R. CDC guideline for prescribing opioids for chronic pain—United States, 2016. JAMA. 2016 315(15):1624-1645.

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- **Using the Webinar System**
  - “Click” the Q&A tab at the top left of the webinar tool bar
  - “Click” in the white space
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  - “Click” ask

- **On the Phone**
  - Press Star (*) 1 to enter the queue
  - State your name
  - Listen for the operator to call your name
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Thank you for joining!

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When: A few days after the live call

What: All call recordings (audio, webinar, and transcript)

Where: On the COCA Call webpage

http://emergency.cdc.gov/coca/calls/2016/callinfo_062216.asp

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Save-the-Dates

Mark your calendar for the upcoming opioid prescribing calls

Call No.	Date	Topic
1	June 22	Guideline for Prescribing Opioids for Chronic Pain
2	July 27	Non-Opioid Treatments
3	August 3	Assessing Benefits and Harms of Opioid Therapy
4	August 17	Dosing and Titration of Opioids

Upcoming COCA Call
registration is not required

Identification and Care of Patients with Hantavirus Disease

- **Date: Thursday, June 30, 2016**
- **Time: 2:00 – 3:00 pm (Eastern)**
- **Presenters:**
  - Dr. Barbara Knust – CDC
  - Dr. Gregory Mertz – University of New Mexico
  - Dr. Michelle Harkins – University of New Mexico

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