TRIBAL CLINIC PROVIDER GUIDE:

Using the CDC Guideline for
Prescribing Opioids for Chronic Pain

May 2020
Overview

ABOUT THIS GUIDE

The Tribal Clinic Provider Guide is designed to help Tribal clinics adopt and integrate the evidence-based CDC Guideline for Prescribing Opioids for Chronic Pain (also referred to as CDC Guideline or the Guideline) for safer and more effective prescribing. Tribal healthcare providers should read the full CDC Guideline before using this Guide. Tribal clinics may also use this Guide to expand outreach and education to patients and other stakeholders on prescription opioids, how they affect the body, and the risk of opioid misuse, abuse, and overdose.

This Guide was created to package and translate existing supporting materials developed by CDC to meet the needs of Tribal communities. Additional opioid-related materials, including shareable graphics and videos, data resources, and U.S. Department of Health and Human Services (HHS) resources, can be found at CDC’s Resource Center website, available here: https://www.cdc.gov/drugoverdose/resources/index.html.

While this Guide is primarily intended for Tribal clinics and healthcare providers, its content is relevant to the work of the Indian Health Service (IHS), and state and local health departments collaborating with Tribes. Tribal clinics are outpatient healthcare facilities operated by Tribes or Tribal organizations, pursuant to Title I and Title V of the Indian Self Determination and Education Assistance Act.¹

This guide is comprised of three sections with embedded implementation considerations, resources, and tools:

SECTION 1: BACKGROUND ON THE OPIOID OVERDOSE EPIDEMIC
This section provides a background for healthcare providers and program staff who are new to addressing prescription opioid misuse, abuse, and overdose. It includes information to help orient providers and staff to the healthcare infrastructure in Tribal communities, and social determinants of health and health inequity.

SECTION 2: OVERVIEW OF THE CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN
This section summarizes the CDC Guideline and all twelve recommendations and includes a checklist for prescribing opioids for chronic pain.

SECTION 3: CONSIDERATIONS FOR IMPLEMENTING THE CDC GUIDELINE IN TRIBAL CLINICS
This section provides additional Tribal clinic-specific considerations for using the CDC Guideline recommendation statements and implementing the Guideline in Tribal health systems. This section also highlights the work of the Eastern Band of Cherokee Indians who successfully operationalized CDC Guideline.
ADDITIONAL INFORMATION AND RESOURCES

The final section of the Guide provides background information on the history of the opioid overdose epidemic in Tribal communities and basic information on opioids to share with interested audiences. Tools and resources for providers and informative resources for patients are provided.

National Indian Health Board (NIHB) created this Guide through funding received from the Centers for Disease Control and Prevention (CDC) entitled “Reducing Opioid Overdose in Tribal Communities” (CDC-RFA-OT18-1802 DU-318). Embedded within NIHB’s mission is a goal to improve health outcomes and promote health equity within Tribal communities.

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The findings and conclusions in this article are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.
Section 1. Background: Opioid Overdose Epidemic

1.1 OPIOID OVERDOSE AND MISUSE IN TRIBAL POPULATIONS

The opioid overdose epidemic has particularly impacted American Indian and Alaska Native (AI/AN) Tribes. The drug overdose death rate among AI/AN was higher than all other reported groups every year from 2003 to 2015, with the exception of 2007. AI/AN also had the highest overall increase over that time period at 519%. Analysis of National Vital Statistics data suggested AI/ANs had an age-adjusted death rate of drug overdose deaths involving opioids of 15.7 deaths per 1000,000 in 2017.

An analysis of death certificate data from 1999 to 2009 found AI/ANs had the highest rate of unintentional prescription opioid overdose deaths at 13.06 per 100,000.

American Indian and Alaska Native populations experienced higher drug overdose death rates than all other groups between 2003 and 2014, with the exception of 2007.
Drug misuse among AI/AN youth is especially high. The Substance Abuse and Mental Health Services Administration (SAMHSA) reported in 2018 that substance dependence or abuse among those aged 12 or older was high among AI/ANs but decreased from 7.1% in 2017 to 4.0% in 2018. In addition, AI/AN 8th, 10th and 12th graders living on or near reservations from 2009-2012 were reported to have significantly higher rates of annual heroin and prescription opioid use compared to all 8th, 10th, and 12th graders.

### 1.2 HEALTH INFLUENCES AND HEALTHCARE INFRASTRUCTURE IN TRIBAL COMMUNITIES

The United States has a unique legal and political relationship with AI/AN Tribal governments established through treaties and confirmed by Supreme Court case law, federal statutes, and executive orders. Central to this relationship is the federal government’s trust responsibility to protect the interests of Indian Tribes and communities, including the provision of healthcare and public health services to AI/ANs.

Nevertheless, Tribes remain behind many other communities in their public health infrastructure, capacity, and workforce capabilities as a result of being largely left behind when the United States was modernizing its public health infrastructure. These obstacles have made it particularly difficult for Tribal communities to assemble a coordinated and comprehensive response to major health emergencies, including the opioid overdose epidemic.

Numerous socioeconomic factors contribute to the higher rates of health inequities in rates of substance use disorder and overdose among AI/ANs. These include social determinants of health such as poverty and low access to preventative and treatment-based health services. According to the 2017 American Community Survey estimates, poverty rates for all AI/AN individuals was 25.4% compared to a national average of 12.3%. Compounding the higher rates of poverty in Indian Country is the chronic underfunding of the Indian health system. In Fiscal Year 2017, congressional appropriations for medical care within IHS amounted to just $4,078 compared to $9,726 nationwide. Low health spending overall has further exacerbated substance use related health outcomes for Tribal communities by

- reducing capacity in developing a strong public health workforce;
- implementing prevention programs and strategies;
- responding to overdoses; and
- linking and retaining clients in substance use treatment and recovery care.

Tribal communities also face high rates of exposure to violence and crime. The 2016 National Intimate Partner and Sexual Violence Survey reported over 80% of AI/AN women and men experienced violence in their lifetime. Nearly 40% of Native women reported experiencing violence within the past year. In addition, for many Tribal communities, historical experiences of forced assimilation and relocation, loss of cultural practices, and malfeasance from federal agencies and officials have contributed to experiences of historical and intergenerational trauma.

See appendix for more information on the history of the opioid crisis and basic information on opioids.
Section 2. Overview of the CDC Guideline for Prescribing Opioids for Chronic Pain

2.1 BACKGROUND

Providers are encouraged to read the full CDC Guideline for Prescribing Opioids for Chronic Pain. The Guideline provides recommendations for the prescribing of opioid pain medications for patients 18 and older in primary care settings. The 12 recommendations are organized into three areas: (1) determining when to initiate or continue opioids for chronic pain; (2) opioid selection, dosage, duration, follow-up, and discontinuation; and (3) assessing risk and addressing harms of opioid use.

Recommendations focus on the use of opioids in treating chronic pain (pain lasting longer than 3 months or past the time of normal tissue healing) outside of active cancer treatment, palliative care, and end-of-life care. The full recommendations include tailored recommendations for specific populations such as pregnant women and older adults, and additional guidance on tapering.

The CDC Guideline is intended for primary care physicians, internists, nurse practitioners, and physician assistants who are delivering treatment to chronic pain patients. However, other stakeholders such as pharmacists, behavioral health providers, Tribal leaders, and traditional healers may benefit from familiarity with the CDC Guideline.

The clinical recommendations are based on current clinical and contextual evidence, along with the solicited expert and public feedback garnered via federal partner engagement, stakeholder review groups, peer review, public comment, constituent engagement, and Federal Advisory Committee review and recommendation.
2.2 SUMMARY OF CDC’S GUIDELINE RECOMMENDATIONS

1. Opioids are not first-line therapy.
Nonpharmacological therapy is preferred for chronic pain. Providers 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 nonpharmacological therapy and non-opioid pharmacologic therapy, as appropriate.

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

3. Discuss risks and benefits.
Before starting and periodically during opioid therapy, providers should discuss with patients known risks and realistic benefits of opioid therapy and patient and provider responsibilities for managing therapy.

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

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

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

Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, providers 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. Three days or less will often be sufficient; more than seven days will rarely be needed.

7. Evaluate benefits and harms frequently.
Providers should evaluate benefits and harms with patients within one to four weeks of starting opioid therapy for chronic pain or of dose escalation. Providers should evaluate benefits and harms of continued therapy with patients every three months or more frequently. If benefits do not outweigh harms of continued opioid therapy, providers should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.
ASSESSING RISK AND ADDRESSING HARMs OF OPIOID USE

8. Use strategies to mitigate risk.
Before starting and periodically during continuation of opioid therapy, providers should evaluate risk factors for opioid-related harms. Providers 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 ($\geq 50$ MME per day), or concurrent benzodiazepine use, are present.

9. Review prescription drug monitoring program (PDMP) data.
Providers should review the patient’s history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Providers 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 three months.

10. Use urine drug testing.
When prescribing opioids for chronic pain, providers 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.

11. Avoid concurrent opioid and benzodiazepine prescribing.
Providers should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

12. Offer treatment for opioid use disorder.
Providers 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.

See appendix for a checklist for using these guideline recommendations.
TIPS FOR TAILORING THE CDC GUIDELINE TO YOUR AUDIENCE

• Providers are highly encouraged to work with staff at their Tribal clinic who are from the community to learn about the appropriate way to engage with patients and community members.

• While traditional and cultural ceremonies have not been studied, there is practice-informed evidence to consider encouraging traditional and cultural ceremonies as an option for nonpharmacological therapy for patients who are interested. For more information: https://store.samhsa.gov/system/files/tip_61_alian_full_document_020419_0.pdf

• When needed, deliver the information in the patient’s Native language. Providers may need to ask for consent to have a Tribal clinic staffer discuss risks and benefits in the patient’s preferred language.

• Tribal providers should use their best clinical judgment to weigh the risks and benefits of continuing opioid therapy, based on what is known about the individual patient.

• Tribal providers should screen and educate about substance use disorder. Some data show low levels of substance use education, and earlier onset of drug and alcohol use in Tribal communities, especially among Tribal youth.14,15,16,17

• Not all Tribal clinics or providers report to the state PDMP or are authorized PDMP users. Directly calling pharmacies for prescription history might be necessary until a Tribe participates in the state PDMP.

• Address historical, intergenerational, and current trauma that may affect treatment, and refer to culturally appropriate behavioral health services, when available.
Section 3. Implementing the CDC Guideline in Tribal Clinics

The CDC Guideline can assist any healthcare provider treating adult patients with chronic pain (outside of cancer, palliative, or end-of-life care). NIHB examined the CDC Guideline as it applies to the infrastructure, environment, cultural practices, and resources in Tribal clinics and provided tips and considerations. Every Tribe and Tribal health center is different and not all of the items will apply to every situation.

3.1 OVERVIEW: APPLYING THE CDC GUIDELINE IN TRIBAL COMMUNITIES

As Tribal clinics adopt the CDC Guideline, consider these practical measures to improve the implementation process:

- Tribal Health Directors should be included in planning and initiation of implementing the CDC Guideline. Consider including the Tribal Council as implementation may require changes in policies and procedures and it is important for the community to be aware.

- Learn if the Tribal health clinic already has any strategies in place for opioid dosing and prescribing and consider reconciling these with the CDC Guideline.

- Providers from outside of the Tribal community they serve should meet with Tribal clinic administrators to learn about culturally-appropriate ways to discuss pain and pain management with patients.

- Consider holding clinic-wide trainings for all clinic staff on the CDC Guideline. Develop a plan for new-hire trainings as turnover can be frequent in Tribal clinics.

- Work with Tribal clinic administrators to assess the availability of opioids in the hospital formulary. Reducing the availability may help decrease overprescribing opioids.

- Discuss with patients and record all locations they are seeking health services. Some patients may utilize providers at multiple locations including the Tribal clinic, IHS facilities, the Veterans Administration, specialty clinic referrals via IHS Purchased/Referred care, private practices, and urban Indian health centers.

PRESCRIPTION DRUG MONITORING PROGRAMS (PDMPS)

- No Indian Health Service/Tribal/Urban Indian Health (I/T/U) specific PDMP system is currently in operation.

- The Indian Health Manual (Chapter 32) discusses the IHS policy on utilization of PDMPs. Although a 2016 IHS Policy mandated all IHS healthcare providers utilize their state’s PDMP system prior to prescribing or dispensing opioid medications, certain restrictions to PDMP access may still exist.
• Tribal pharmacies or providers report to the state PDMP or are authorized users. Check with your Tribal administrators to assess available options. Discuss with your Tribal health director or administrator on how your Tribal clinic can start using the state PDMP.

• Health information technology (HIT) and electronic health record (EHR) systems vary across Tribal communities. HIT and Prescription Drug Monitoring Program (PDMP) integration and interoperability can be challenging. Consider establishing a user manual with HIT tips specific to the clinic. Electronic reminders can keep track of follow-up appointments, referrals, and other patient data.

3.2 CONSIDERATIONS FOR TRIBAL CLINICS ACROSS FOCUS AREAS

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

To reduce the risks of opioid misuse and overdose, CDC advises minimizing the prescription of opioids chronic pain by first considering other treatments for pain management, helping patients establish goals for pain and function, and educating patients. The steps below offer additional considerations to help integrate the first three Guideline Recommendations into Tribal health systems.

• Check with Tribal administrators and health directors to determine what nonopioid treatments are available on the formulary and appropriate. Determine whether the Tribal clinic can reimburse any nonpharmacologic treatments such as physical therapy, massage, weight loss strategies, and exercise therapy.

• Discuss these options with each patient to develop individual pain management and treatment plans.

• Discuss community resources or activities that patients might turn to when coping with pain such as traditional healing services, ceremonies, sweat lodges, traditional song and dance, etc. as a way to augment other evidence-based modalities.

• Providers that are new to a community can ask patients about their knowledge and experiences with opioid medications to better understand the culture and perspectives of patients in the community.

Recommendations 1-3

1. Opioids are not first-line therapy.
2. Establish goals for pain and function.
3. Discuss risks and benefits.
To increase the safety of prescribing opioids for chronic pain, healthcare providers can refer to Recommendations 4-7. Consider these steps to adapt the CDC Guideline for Tribal communities.

- Adapt and use a checklist when prescribing opioids to help monitor patient progress. Use the checklist found in the resource section as a guide.

- Ensure all providers in the Tribal clinic are using the same guidance and messaging to patients.

- Closely monitor pregnant and postpartum women using prescription opioids to monitor and reduce risk of neonatal abstinence syndrome (NAS).

- Work with Tribal leadership to determine safe strategies for safe disposal of excess medication (like community takeback days or centers).

- Learn the signs of opioid misuse and opioid use disorder.

- Work with your Tribal clinic behavioral health or mental health services or nearby facilities to establish a system linking patients to mental/behavioral healthcare if they begin to struggle with opioid misuse.

Recommendations 4-7

4. Use immediate-release opioids.

5. Start low and go slow.

6. When opioids are needed for acute pain, prescribe no more than needed. Do not prescribe ER/LA opioids for acute pain.

7. Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue use if needed.
ASSESSING RISK AND ADDRESSING HARMs OF OPIOID USE

Assessing risk and addressing the harms of opioid use takes a multidisciplinary approach. Many people who misuse prescription opioids seek prescriptions from different providers or take more than the amount prescribed. Patients taking certain other medications may also be at higher risk for accidental overdose.

- Work with Tribal leaders and hospital administration to establish policies and protocols for discharge and follow up care for patients who overdose.

- Work with Tribal leaders and hospital administration to expand treatment services and MAT.

- Encourage the community to expand Tribal healing to wellness courts and other drug courts to reduce incarceration for non-violent drug-related offenses.18

- Expand wrap-around and holistic care to address issues of homelessness, mental health and other conditions that interact with drug misuse or drug use disorder.

» Consult with Tribal health administrator about existing policies and perspectives around urine drug testing (UDT).

» Work with IHS, Tribal police, Tribal clinic, or Bureau of Indian Affairs (BIA) facility to establish or learn policies around naloxone access and ensure those who need it receive training on naloxone administration.

» Reach out to your Tribal clinic administrator or a nearby IHS facility to discuss your options for obtaining the necessary training to receive a DATA waiver to prescribe buprenorphine to assist with OUD treatment.

» Consider using SAMHSA and IHS tools to screen for trauma, depression, suicide and other risk factors for trauma-informed care

- https://www.integration.samhsa.gov/clinical-practice/trauma-informed

Recommendations 8-12

8. Evaluate risk factors for opioids.

9. Check PDMP for high dosages and prescriptions from other providers.

10. Use urine drug testing to identify prescribed substances and undisclosed use.

11. Avoid concurrent benzodiazepine and opioid prescribing.

12. Arrange treatment for opioid use disorder if needed.

SECTION 3

USING THE CDC GUIDELINE FOR PRESCRIBING OPIIODS FOR CHRONIC PAIN
**SPOTLIGHT ON THE EASTERN BAND OF CHEROKEE INDIANS**

The Cherokee Indian Hospital, independently operated by the Eastern Band of Cherokee Indians, developed a pain management policy to assist with implementation of recommendations in the CDC Guideline. Some examples are included here that directly align with the CDC Guideline. The Tribe identified the opioid crisis as a priority community issue to address. The Tribal Council empowered subject matter experts and medical staff under the direction of Dr. Richard Bunio, Executive Clinical Director, to plan, develop, and implement solutions. The Tribe took an integrative approach.

*Cherokee Indian’s Pain Policy Strategy includes the following:*

1. Trained and equipped all medical and nursing staff on
   - Guidance for conducting UDT
   - Instructions for checking PDMP

2. Established a Multi-Disciplinary Pain Clinic to
   - Serve as a first line of treatment for pain
   - Provide acupuncture, massage therapy, physical therapy, nutrition and mental health services, and other non-pharmaceutical interventions

3. Assisted medical providers in obtaining their license to access the PDMP in neighboring Tennessee, where the Tribe also has satellite clinics.

4. Eliminated certain opioid and benzodiazepine medications deemed to be “high-risk” from their core formulary.

5. Strengthened relations with the Tribe’s public health department in order to coordinate efforts and further connect patients with services and harm reduction services.
Conclusion

Prescription opioid overdose deaths continue to increase in AI/AN populations. The *CDC Guideline for Prescribing Opioids for Chronic Pain* helps healthcare providers reduce the risk of opioid use disorder and prevent overdose. This Guide provides information, strategic tips, and special considerations for operationalizing the CDC Guideline in Tribal healthcare settings effectively. While addressing the opioid overdose epidemic requires a multi-sector and multi-disciplinary approach, aligning provider prescribing practices with the CDC Guideline will help prevent new cases of opioid misuse, opioid use disorder, and overdose. As the sole national, Tribal organization serving all federally-recognized Tribes in the health arena, NIHB is dedicated to working with Tribes and Tribal providers to help stem the tide of the epidemic, and improve the health status of all AI/AN populations.
References


APPENDIX A: BACKGROUND INFORMATION ABOUT OPIOIDS: FOR TRIBAL LEADERS AND COMMUNITIES

OPIOIDS
Natural or synthetic chemicals that interact with opioid receptors on nerve cells in the body and brain, and reduce the intensity of pain signals and reduce feelings of pain. This class of drugs includes the illegal drug heroin, synthetic opioids such as fentanyl, and pain medications available legally by prescription, such as oxycodone, hydrocodone, codeine, morphine, and many others. Risks associated with opioid pain medications can be reduced when taken for a short time and as prescribed by a doctor, but because they produce euphoria, or “high,” in addition to pain relief, opioids can be misused.

HISTORY
Opioids are natural or synthetic chemicals derived from the opium plant that have been used for thousands of years. Initially, use of opium was primarily for personal, spiritual, or ceremonial purposes; however, it began playing a more central role in modern medical practice around the mid-19th century. For instance, morphine was used extensively during the American Civil War to treat wounded soldiers. Between the 1840s and 1890s, opioid consumption in the United States soared by nearly 540%, increasing the rate of opioid addiction in the country from roughly 0.72 per 1,000 persons to roughly 4.59 per 1,000 persons.

Heroin, a synthetic opioid derived from morphine, was first sold as medical-grade drug beginning in 1898. In 1915, after the Harrison Narcotics Tax Act was passed, the United States government began regulating the production, importation and distribution of drugs including opiates.

The current opioid overdose epidemic began in the 1990s taking on different trends over time. Initially, prescription opioids were responsible for the highest numbers of opioid overdose deaths from the early 1990’s to around 2010. In 2010, there was a rise in heroin deaths which rapidly increased until around 2013. Since 2013, synthetic opioids, especially illicitly manufactured fentanyl (IMF), are the largest contributors in rising opioid overdose deaths.

PRESCRIPTION AND ILLICIT OPIOIDS
All opioid drugs are controlled substances – meaning that they are subject to federal government regulation and oversight – with some being classified as more dangerous than others in terms of their potential for psychological or physical dependence, and in their potential to cause death.

Opioids that have been authorized for medical purposes are all classified as Schedule II Controlled Substances by the Drug Enforcement Agency (DEA). Schedule II drugs are known for their high potential for misuse and dependence. Heroin is classified as a Schedule I Controlled Substance. Schedule I drugs, such as heroin, are classified as having no recognized medical use and are illicit drugs.

For more information about opioids, visit https://www.cdc.gov/drugoverdose/opioids/index.html
APPENDIX B: RESOURCES FROM THE INDIAN HEALTH SERVICE (IHS)

HOPE COMMITTEE
In March 2017, IHS established a National Committee on Heroin, Opioid, and Pain Efforts (HOPE Committee) through an official charter. The HOPE Committee is comprised of multidisciplinary members with backgrounds in pharmacy, medicine, nursing, and behavioral health. The HOPE Committee will work from a framework based on six elements:

1. Establishing IHS policies;
2. Training health care providers;
3. Ensuring effective pain management;
4. Increasing access to naloxone;
5. Expanding medication-assisted treatment (MAT); and
6. Reducing the inappropriate use of methadone.

For more information on the HOPE committee, please visit
- IHS Dear Tribal Leader Letter on Opioid Epidemic and HOPE Committee
- Indian Health Manual Circular 17-04: HOPE Committee

Providers can sign up to receive newsletters, trainings, toolkits, webinars, and tips from the HOPE committee as well as other IHS behavioral health resources by subscribing to the IHS Behavioral Health listserv.

PAIN AND OPIOID USE DISORDER (OUD)
IHS’s Pain and Opioid Use Disorder website provides information about pain management and opioid use disorder, data, information on medication assisted treatment, OUD prevention, pain management, and funding opportunities. Highlighted resources include:

- Indian Health Manual: Chapter 30- Chronic Non-Cancer Pain Management establishes the requirements for the development of local policies and procedures for the management of chronic non-cancer pain among patients seeking care in Indian Health Service (IHS) facilities.
- Proper Pain Management: Tools for assessing patients with chronic pain, screening for substance use, legal considerations for prescribers, and training opportunities.
- Resources on managing withdrawal: Describes the effects and what to expect with patient withdrawal, how to assess withdrawal, and how to manage patients who are experiencing withdrawal.
- First Responder Naloxone Training Toolkit: Training materials for anyone who may administer naloxone.
- Quick Reference Tool for law enforcement and first responders on how to handle substances suspected to be Fentanyl.
- Dispensing Considerations for MAT provides a link to the providers’ certification required for providers to prescribe buprenorphine, naltrexone, or methadone for MAT and information on patient monitoring. Shares formulary resources for pharmacists.
- Supportive Services: Describes holistic approaches to care and provides resources.
PRESCRIPTION DRUG MONITORING PROGRAM (PDMP)

- The IHS Health Manual includes a chapter on PDMP for Tribal health providers.

TRIBAL RESOURCES

- Tribal Leaders Toolkit created by the National Congress of American Indians (NCAI) Addiction Task Force includes information on Tribal clinical resources on more safe and effective opioid prescribing practices along with treatment and recovery resources.

- Northwest Tribal Opioid Response Strategic Agenda draft was released by the Northwest Portland Area Indian Health Board in collaboration with regional tribes and national Tribal organizations. Currently available resources include free clinical trainings, trainings on harm reduction services, and Project ECHO trainings on management and treatment of patients with substance use disorders.

IMPLEMENTATION RESOURCES FOR PROVIDERS

Clinical tools have been developed with you, the healthcare provider, in mind, to help you carry out the complex task of balancing pain management with the potential risks that prescription opioids pose.

Resources including a guide for calculating dosages, a pharmacists’ brochure, a mobile app, a pocket guide on tapering, and more are available for download on the Guideline Resources: Clinical Tools page.

PRESCRIPTION DRUG MONITORING PROGRAM (PDMP)

A prescription drug monitoring program (PDMP) is an electronic database that tracks controlled substance prescriptions. PDMPs can help identify patients who may be misusing prescription opioids or other prescription drugs and who may be at risk for overdose. PDMP Fact Sheet (pdf)

QUALITY IMPROVEMENT AND CARE COORDINATION

This resource is for healthcare systems to support care coordination and to integrate the CDC Guideline into clinical workflow through quality improvement measures. Quality Improvement and Care Coordination At-a-Glance (pdf)

ONLINE TRAININGS AND WEBINARS

Interactive Training Series: Applying the CDC Guideline for Prescribing Opioids

This interactive, web-based training features self-paced learning, case-based content, knowledge checks, and integrated resources to help healthcare providers gain a deeper understanding of the Guideline. Find tips on implementing the CDC Guideline into primary care practice and overcoming challenges. Earn free continuing education credits.

The Quick Reference for Healthcare Providers compiles and summarizes these resources and CDC trainings.
CLINICIAN OUTREACH AND COMMUNICATION ACTIVITY
(COCA) OPIOID WEBINAR SERIES
Learn about applying CDC’s Guideline in a primary care practice setting from CDC and University of Washington experts. Watch archived webinars which include slides, real case examples, and question-and-answer sessions. Earn free continuing education credits.

ADDITIONAL RESOURCES

RESOURCES FOR PATIENTS
Managing chronic pain requires a partnership between patients and providers. Patients need to be informed about their options, the risks and benefits of prescription opioid therapy, what to expect if they are prescribed opioids, and how to safely use and dispose medication. There are many tools and resources to share with patients to keep them informed.

Print Materials
Nonopioid Treatments for Chronic Pain: This handout provides patients with information about the different options for managing chronic pain.

Safer, More Effective Pain Management: This poster explains your commitment, as a healthcare provider, to providing the best treatment to patients. It explains what patients can expect for their pain management and steps they can take to work with you.

Prescription Opioids: What You Need to Know: Share this handout with patients who are being considered for opioid prescription treatment to help them understand the risks of opioid use.

Opioid Overdose Tip Card: This card helps patients and their families know the risks and signs of opioid overdose and what to do if they suspect an overdose.

Pregnancy and Opioids: This handout provides information for women who are pregnant or are trying to become pregnant about the risks associated with opioid use during pregnancy.

Patient Materials Explaining the CDC Guideline
Help patients understand how you come to decisions about how to manage their chronic pain by displaying or sharing these materials.

Guidelines Patient Poster: Manage Your Pain, Minimize your Risk
Infographic: CDC Guideline for Prescribing Opioids for Chronic Pain

Videos
Even When Prescribed by a Doctor: Informational, 91-second animated video that raises awareness about prescription opioids.