Overview of existing opioid guidelines

March 15, 2014

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Objectives

- Review existing opioid guidelines written prior to 2010
- Review existing opioid guidelines written after to 2010

Review of Opioid guidelines – Ann IM 2014

- Conclusion: Despite limited evidence and variable development methods, recent guidelines on chronic pain agree on several opioid risk mitigation strategies:
  - upper dosing thresholds (90 – 200 mg/d MED depending on date published)
  - cautions with certain medications (methadone and fentanyl patches)
  - attention to drug–drug (e.g. benzodiazepines) and drug–disease interactions (e.g. SUD and psychiatric illness)
  - use of risk assessment tools
  - treatment agreements
  - urine drug testing

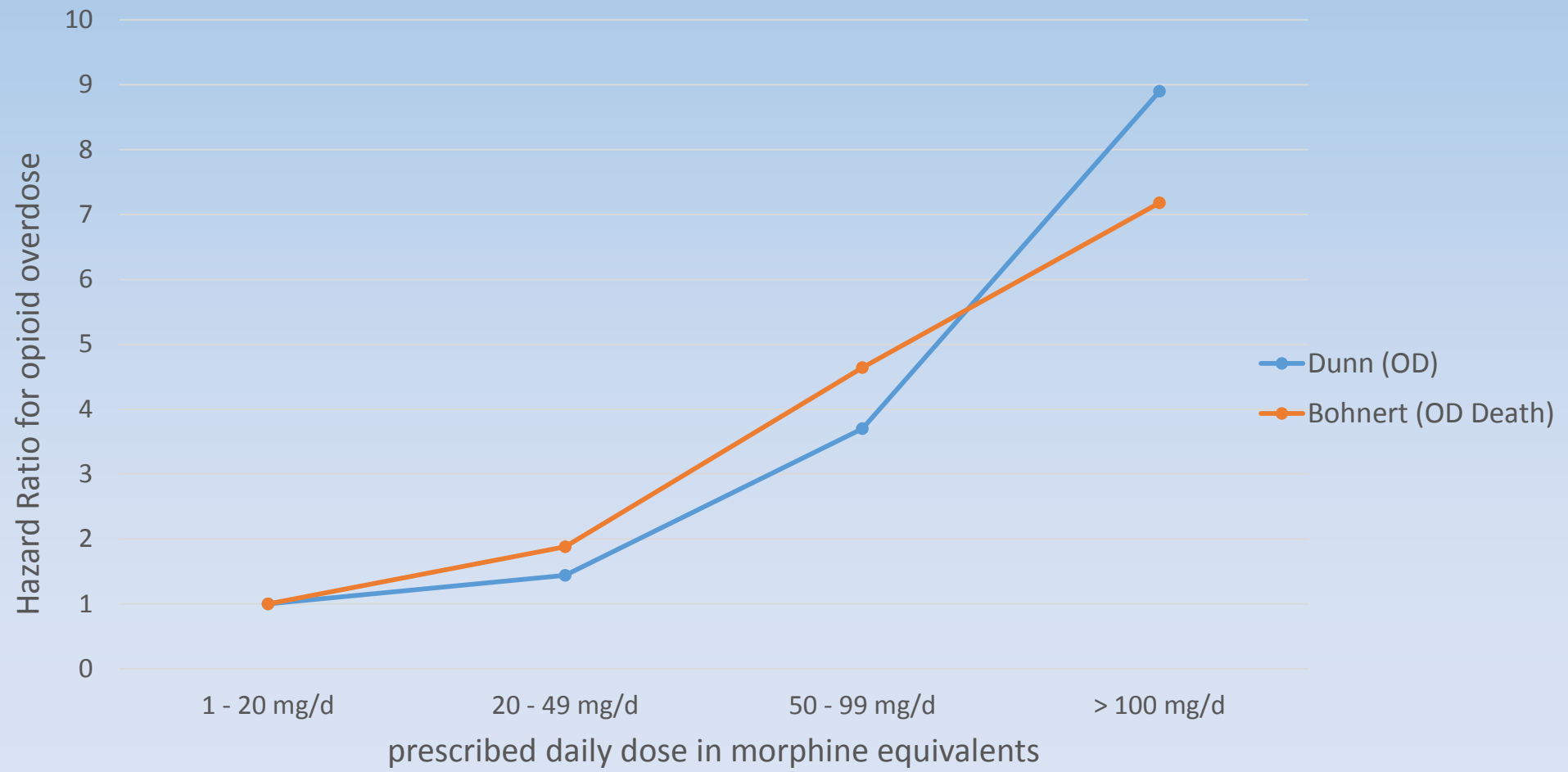
Guidelines prior to 2010

	APS/AAPM	Canada	VA/DoD
Date Updated	2008	2009	2009
Trigger Dose	200 mg/d MED	200 mg/d MED	200 mg/d MED
Cautions with Methadone	Yes	Yes	Yes
Risks with Benzos	Discuss Risks	Try to taper benzo	Watch for increased adverse effects
Drug - Disease	SUD/Ψ → ↑ risk OD/ misuse	SUD/Ψ → ↑ risk OD/ misuse	SUD/Ψ → ↑ risk OD/ misuse
Screening Tools	Yes	Consider	Yes
UDS	If high risk; optional otherwise	Consider pros/cons	Baseline then random
Treatment Agreement	Consider	May be helpful; particularly if high risk	Request pt to sign

Guidelines after 2010

What happened in 2010?

- New data associating dose of opioid prescribed with overdose risk



	ASIPP	FSMB	UMHS
Date Updated	2012	2013	2011
Trigger Dose	90 mg/d MED	---	100 mg/d MED
Cautions with Methadone	Yes	Not mentioned	Yes
Risks with Benzos	If on benzos; opioid CI	Dose escalation in setting of benzo may be inappropriate care	Avoid benzos and opioids
Drug - Disease	SUD/Ψ → ↑ risk OD/ misuse	SUD/Ψ → ↑ risk OD/ misuse	SUD/Ψ → ↑ risk OD/ misuse
Screening Tools	Consider	Can save time	Consider
UDS	Must use; baseline then random	Important monitoring tool	Baseline then at least yearly
Treatment Agreement	Yes	Yes	Strongly Consider; particularly if high risk

WA State – Agency Medical Directors' Group

- Updated 2010
- MED > 120 mg/d require pain consultation if no improvement in pain *and* function
- Tools included
  - Risk screening – ORT
  - UDS interpretation
  - Opioid dose calculator
  - Taper calculator
- Starting process to review trigger dose: ? 80 MED

Ohio State

- published 2013
- Brief – 2 pages
- Trigger dose = 80 mg/d

Overview of Proposed AZ Guidelines for Acute Opioid Prescribing

March 15, 2014

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Acute Pain

- Pain is an inevitable part of being human.
- Unfortunately, there is no objective way to measure a person's pain. It is strictly a subjective experience as individual and unique as the patient.

Acute Pain

- Prescribing of opioid medications has substantially increased over the past 20 years, including greater use for both acute and chronic pain.

Acute Pain

- The CDC estimates that enough prescription painkillers were prescribed in 2010 to medicate every American adult around the clock for a month *(Centers for Disease Control and Prevention, 2011).*

Acute Pain

In a 2009 survey, it was reported that the majority of opioids were prescribed by multiple specialties, including:

- family practice,
- internal medicine,
- dentistry,
- emergency medicine and
- orthopedic surgeons, rather than pain physicians.

Acute Pain

Primary care physicians prescribed

- 42% of immediate release opioids and
- 44% of long-acting opioids

Acute Pain

Pain management, anesthesiology and physical medicine and rehabilitation, contributed to

- 6% of immediate-release opioids and
- 23% of long-acting opioids

(Volkow, 2011 [Low Quality Evidence]).

Acute Pain

The key goal of this Guideline is to:

- seek balance between appropriate treatment of pain and
- safety in the use of opioids for that purpose.

Acute Pain

This guideline is not intended to apply to

- hospice patients
- palliative care patients
- patients with acute, post-operative,
- end of life, or
- cancer-related pain.

Acute Pain

However, thoughtful opioid prescribing for acute and post-operative pain can improve safety and prevent the subsequent unintended long term use of opioid medications.

GUIDELINE 1	PURPOSE
Opioid medications should only be used for treatment of acute pain when the severity of the pain warrants that choice. It should be determined that other non-opioid pain medications or therapies will not provide adequate pain relief.	Prescribe only when no other alternative modalities are present to treat pain.

GUIDELINE 2	PURPOSE
When opioid medications are prescribed for treatment of acute pain, the number dispensed should be no more than the number of doses needed. This should be based on the usual duration of pain severe enough to require opioids for that condition.	Prescribe only what is needed to treat acutely and for short term.

GUIDELINE 3	PURPOSE
Patient should be counseled on the following regarding any prescription of opioid: ✓ Store the medications securely, ✓ Sharing with others is prohibited, ✓ Dispose of medications properly when the pain has resolved to prevent non-medical use of the medications. ✓ Opioids are intended for short term use only.	Counsel patient about storing, not sharing, and disposing opioids properly.

GUIDELINE 4	PURPOSE
Long acting opioids should not be used for treatment of acute pain, including post-operative pain, except in situations where monitoring and assessment for adverse effects can be conducted.	Do not prescribe long acting opioids.

GUIDELINE 5	PURPOSE
The continued use of opioids should be considered carefully, including assessing the potential for abuse. If persistence of pain suggests the need to continue opioids beyond the anticipated time period, then the patient should be carefully reevaluated.	Reevaluate patient if pain persists.

GUIDELINE 6	PURPOSE
For treatment of both acute and chronic pain, the Prescription Drug Monitoring Program (Arizona Controlled Substances Prescription Monitoring Program or CSPMP) should be checked prior to prescribing opioids.	Allows the prescriber access to a database to assist in treating patients and to identify patients who might be doctor shopping.

Last Thought:

In the words of Mark Twain:

"Always do what is right. It will gratify half of mankind and astound the other."

References:

Utah Department of Health. Utah clinical guidelines on prescribing opioids. 2008. (Guideline)

Volkow ND, McLellan TA, Cotto JH, et al. Characteristics of opioid prescriptions in 2009. *JAMA* 2011;305:1299-1301. (Low Quality Evidence)

U.S. Department of Health and Human Services. Prescription drugs: abuse and addiction. National Institute on Drug Abuse. NIH Publication Number 11-4881. October 2011.

Ohio Emergency and Acute Care Facility Opioids and Other Controlled Substances (OOCS) Prescribing Guidelines. 2013.

PVAHCS 2014 Guideline. Clinical Guidelines for the Use of COT for CNTP.

References:

Thorson D, Biewen P, Bonte B, Epstein H, Haake B, Hansen C, Hooten M, Hora J, Johnson C, Keeling F, Kokayeff A, Krebs E, Myers C, Nelson B, Noonan MP, Reznikoff C, Thiel M, Trujillo A, Van Pelt S, Wainio J. Institute for Clinical Systems Improvement. Acute Pain Assessment and Opioid Prescribing Protocol. Published January 2014.

Overview of Proposed AZ opioid guidelines for CNTP

March 15, 2014

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Objectives

- Present proposed AZ opioid guideline statements
- Present sources for guideline statements

STATEMENT 1	PURPOSE	SOURCE
A comprehensive medical and pain related evaluation including assessment for substance use, psychiatric comorbidities, and functional status should be performed before initiating opioid treatment for chronic pain.	Comprehensive Assessment	APS/AAPM VA/DoD (natl) Phx VAHCS Canada UMHS ASIPP WA UT FSMB

STATEMENT 2	PURPOSE	SOURCE
A goal directed trial of opioid therapy is considered appropriate when pain is severe enough to interfere with quality of life and function and the patient has failed to adequately respond to indicated non-opioid and non-drug therapeutic interventions. Potential benefits should be determined to outweigh risks and the patient should agree to participate in other aspects of a pain care plan such as physical therapy and cognitive behavioral therapy.	Medical Necessity / Appropriateness of COT	APS/AAPM VA/DoD Phx VAHCS Canada UMHS ASIPP WA UT FSMB

STATEMENT 3	PURPOSE	SOURCE
The provider should assess for risk of abuse, addiction, or adverse effects, and perform a risk stratification before initiating opioid treatment.	Risk assessment for opioid abuse	APS/AAPM VA/DoD Phx VAHCS Canada UMHS ASIPP WA UT FSMB

STATEMENT 4	PURPOSE	SOURCE
Initiating opioids in patients with CNTP should ideally be limited to the evidence-based indication of short term therapy with the purpose of facilitating participation in a comprehensive care plan; however, if COT is considered, a goal directed trial lasting ≤90 days should always be the starting point. Continuing opioid treatment after the treatment trial should be a deliberate decision that considers the risks and benefits of chronic opioid treatment for that patient. A second opinion or consult may be useful in making that decision.	Trial of opioid therapy	APS/AAPM VA/DoD Phx VAHCS Canada UMHS WA UT FSMB

STATEMENT 5	PURPOSE	SOURCE
When a trial of opioid therapy is determined to be appropriate, patients and family members should be engaged in an educational, shared decision making, and informed consent process. The provider should obtain and document informed consent including discussion of risks, benefits, and conditions under which opioids are prescribed. Documentation of this discussion is ideally accomplished by using a signed Opioid Pain Care Agreement (OPCA).	Education, Informed Consent, Opioid Pain Care Agreement	APS/AAPM VA/DoD Phx VAHCS Canada UMHS ASIPP WA UT FSMB

STATEMENT 6	PURPOSE	SOURCE
Clinicians treating patients with opioids for chronic pain should maintain records documenting the evaluation of the patient, treatment plan with measurable goals, discussion of risks and benefits, informed consent, treatments prescribed, results of treatment, and any aberrant behavior observed.	Documentation	APS/AAPM VA/DoD Phx VAHCS Canada UMHS ASIPP WA UT FSMB

STATEMENT 7	PURPOSE	SOURCE
For patients on COT, monitoring progress with and adherence to treatment goals is essential and represents an opportunity to optimize the care plan and the overall benefit to risk profile. Appropriate monitoring for COT includes (1) regular assessment with face to face encounters (2) assessment of response to therapy including assessment of the 6 A's (analgesia, activity, aberrant drug related behaviors, adverse effects, affect, and adjuncts), (3) periodic query of the AZ CSPMP, and (4) periodic completion of UDT. Frequency of monitoring should be determined by risk category.	Monitoring	APS/AAPM VA/DoD Phx VAHCS Canada UMHS ASIPP WA UT FSMB

STATEMENT 8	PURPOSE	SOURCE
Clinicians should consider consultation for patients with complex pain conditions, patients with serious co-morbidities including mental illness, patients who have a history or evidence of current drug addiction or abuse, or when the provider is not confident of his or her abilities to manage the treatment.	Consultation for complex patients	APS/AAPM VA/DoD Phx VAHCS Canada UMHS ASIPP WA UT FSMB

STATEMENT 9	PURPOSE	SOURCE
An opioid treatment trial should be discontinued if the goals are not met and opioid treatment should be discontinued at any point if adverse effects outweigh benefits or if dangerous or illegal behaviors are demonstrated.	Discontinuation	APS/AAPM VA/DoD Phx VAHCS Canada UMHS ASIPP WA UT FSMB

STATEMENT 10	PURPOSE	SOURCE
COT should be used in the lowest possible doses to achieve treatment goals. Opioid related adverse events increase with doses > 50-100 mg/d MED and reaching these doses should trigger a re-evaluation of therapy.	Dosing Trigger	UMHS 2011 (100) ASIPP 2012 (90) Ohio 2013 (80) **Original Research** Dunn, 2010 (50-100) Bohnert, 2011 (50-100) Gomes, 2011 (50-100) Paulozzi, 2012 (40-120) Saunders, 2010 (50) **2012 Opioid Summit** Von Korff, 2013 (50-100)

STATEMENT 11	PURPOSE	SOURCE
Combined use of opioids and benzodiazepines should be avoided.	Opioids and benzodiazepines	Phx VAHCS UMHS ASIPP WA Wesber 2013

STATEMENT 12	PURPOSE	SOURCE
Methadone should only be prescribed by clinicians who are familiar with its risks and appropriate use and who are prepared to conduct the necessary careful monitoring. Methadone should not be prescribed to opioid naïve patients.	Unique properties of Methadone	APS/AAPM VA/DoD Phx VAHCS Canada UMHS ASIPP WA UT