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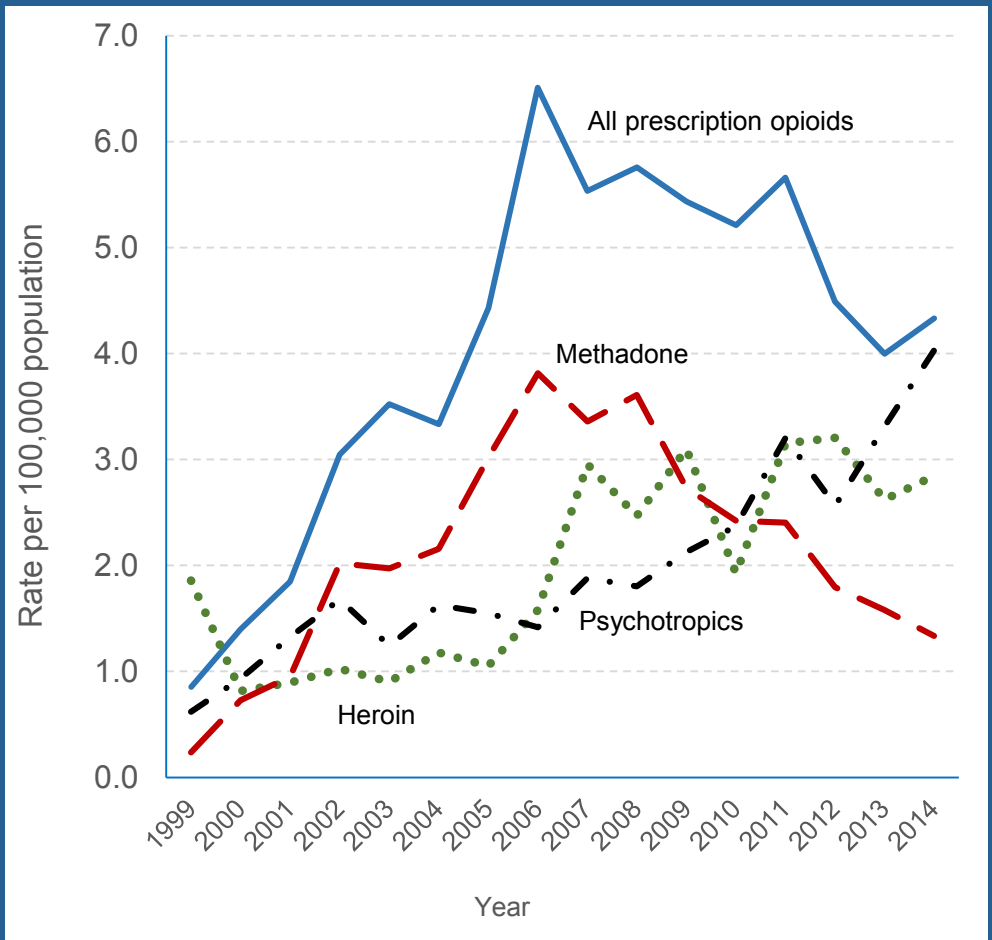
Prescribing Opioids for Chronic Pain: Guidelines are one piece of the puzzle

Prior to 1999, prescription opioid overdose deaths were uncommon in Oregon. In 1999, 29 Oregonians died from prescription opioid overdose. That number rose steadily until 2006 when 239 people died, an increase of >600%. This dramatic rise has been seen throughout the US: the CDC estimates that from 1999 through 2014, 165,000 people in the US died from prescription opioid overdoses.[1] In Oregon, more than 2,400 people died from a prescription opioid overdose in that same time period; deaths that were largely premature and preventable. Since 2006, the prescription opioid overdose death rate in Oregon has decreased 34% (Figure). This is progress, but not yet a victory, and there is no guarantee that this decrease will be sustained. Of added concern is the increase in mortality associated with

Figure . Prescription opioid, methadone, psychotropic drugs, and heroin overdose death rates, Oregon, 1999–2014*



*Excludes suicide deaths

prescriptions of other psychotropic medications, such as benzodiazapines. By now, public health experts agree that this is an epidemic, and it has a driver: prescriptions.

Opioids have a place in pain treatment; however, the degree to which prescription opioid access has saturated the population in the past 2 decades is unprecedented in recent history. In 2014, enough opioids were prescribed in Oregon for nearly every person in the state to have a bottle. While this might hint at the ubiquity of pain in the population, it's now recognized that while opioid sales in the US quadrupled since 1999,[2] no overall change has been observed in the amount of pain Americans report.[3,4] What is perhaps largely responsible for these prescribing changes since the 1990s was an increase in treatment of chronic non-cancer pain with opioids, in spite of insufficient evidence to conclude that long term opioid treatment for chronic non-cancer pain is effective.[5] However, evidence for the risks and adverse outcomes associated with opioid prescribing for chronic pain is ample and compelling.

While progress has been made in the effort to decrease deaths from prescription opioid overdoses, much remains to be done. This effort requires multiple strategies including: decreasing the number of opioids in circulation (e.g. prescribing guidelines, using the Oregon Prescription Drug Monitoring Program; improving non-opioid pain management options; providing drug take-back options); improving access to treatment for people on chronic opioids (e.g. medication-assisted treatment); improving access to naloxone for patients who have overdosed; and using data to target and evaluate these interventions (see Resources for more information).

This *CD Summary* is devoted to the topic of opioid prescribing guidelines for chronic non-cancer pain. The Centers for Disease Control and Prevention published new opioid prescribing guidelines in March 2016[6] — in April Oregon convened a Task Force (including a broad array of Oregon medical organizations and the Oregon Health Authority) for the purpose of reviewing the guidelines, addressing any Oregon-specific amendments that might be needed, and developing plans for dissemination, communication (to providers and patients) and implementation. In June, the Task Force voted to endorse the CDC guidelines as the foundation for opioid prescribing in Oregon.

The CDC Guideline

The Guideline outlines 12 recommendations in 3 broad areas summarized as follows.

I. Determining when to initiate or continue opioids for chronic pain

1. Non-opioid therapy is preferred for chronic pain. Clinicians should consider prescribing opioids only if expected benefits for both pain and function outweigh risks to the patient. If opioids are used, they should be combined with other treatment modalities, as appropriate.

   - Opioids should not be considered first-line therapy for chronic pain outside of active cancer, palliative, and end-of-life care.

- Integrated pain management requires coordination of medical, psychological, and social aspects of health care and includes primary care, mental health care, and specialist services when needed.
- To guide patient-specific selection of therapy, clinicians should evaluate the patient's history and characteristics of pain, potentially contributing factors (e.g., function, psychosocial stressors) and physical exam.

2. Before prescribing opioids for chronic pain, treatment goals should be established for all patients, including realistic goals for pain relief, and emotional, social and physical functioning, and how to discontinue opioids if benefits do not outweigh risks. Opioid therapy should only be continued with meaningful improvement in pain and function.

- Setting a plan in advance will clarify expectations regarding how opioids will be prescribed, monitored, as well as tapered and discontinued.
- Validated instruments should be used to track patient outcomes and monitor progress toward functional goals, as well as to assess for psychological co-morbidities which often coexist and can interfere with resolution of pain.

3. Before starting, and periodically during, opioid therapy, clinicians and patients should discuss risks and realistic benefits of opioid therapy, and responsibilities for managing therapy.

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

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

- ER/LA opioids should be reserved for severe, continuous pain and prescribed only to patients who have received immediate-release opioids for at least 1 week.
- Only prescribe ER/LA opioids with predictable pharmacokinetics to minimize overdose risk. In particular, unusual characteristics of methadone and transdermal fentanyl make safe prescribing of these medications especially challenging.

5. When opioids are started, clinicians should prescribe the lowest effective dose. Clinicians should carefully reassess patient benefits and risks when increasing the dose to ≥50 morphine milligram equivalents (MME) per day, and should avoid increasing to ≥90 MME per day or justify and document a decision to prescribe ≥90 MME per day.

- If a patient's opioid dosage (from all sources combined) is ≥50 MME/day, clinicians should consider increasing frequency of follow-up, and offering naloxone and overdose prevention education to patients and household members.
- Reducing or discontinuing opioids may be very anxiety-provoking for patients who have been on high doses of opioids for years; tapering opioids can be especially challenging because of physical and psychological dependence. The CDC guideline offers suggestions for tapering patients to opioid doses <90 MME/day.

6. Long-term opioid use often begins with treatment of acute pain. Clinicians should prescribe the lowest effective dose of immediate-release opioids for the shortest possible duration when treating acute pain. Three days or fewer will often be sufficient; more than seven days will rarely be needed.

7. Clinicians should evaluate benefits and harms within 1–4 weeks of starting opioid therapy for chronic pain, and re-evaluate at a minimum every 3 months. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper or discontinue opioids.

- At initiation of opioid therapy and at least every 3 months, clinicians should assess benefits in function, pain control, and quality of life and/or ask patients about progress toward functional goals. Clinicians should ask about adverse effects and assess for signs of more serious problems, such as overdose or opioid use disorder.
- Clinicians should re-evaluate patients at risk of opioid use disorder or overdose (e.g., patients with depression or other mental health conditions, a history of substance use disorder, a history of overdose, taking ≥50 MME/day, or taking other central nervous system depressants with opioids) more frequently than every 3 months.

III. Assessing risk and addressing harms of opiod use

8. Before starting opioid therapy, and periodically thereafter, clinicians should evaluate risk factors for opioid-related harms. Clinicians should offer naloxone to patients at risk for opioid overdose, such as those with a history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use.

- Additional strategies for mitigating risks include referral to pain and/or behavioral health specialists and increased frequency of patient monitoring.
- Special considerations should be used when prescribing opioids to patients in specific at-risk subgroups, including:
  - Patients with sleep-disordered breathing, including sleep apnea
  - Pregnant women
  - Patients with renal or hepatic insufficiency
  - Patients aged ≥65 years
  - Patients with mental health conditions
  - Patients with substance use disorder
  - Patients with prior nonfatal overdose

9. Clinicians should review the patient's history of controlled substance prescriptions using the Prescription Drug Monitoring Program (PDMP) when starting, and periodically during, opioid therapy to determine whether the patient is receiving opioid doses or dangerous combinations that increase the risk for overdose.

- PDMP information should not be used as a basis for dismissing patients from one's practice.

- If patients are found to be on high opioid dosages, dangerous combinations of medications, or multiple controlled substance prescriptions from different clinicians, several actions can be taken to augment clinicians' abilities to improve patient safety:
  - Discuss information with patient and confirm they are aware of the prescriptions.
  - Discuss safety concerns and consider offering naloxone.
  - Avoid prescribing opioids and benzodiazepines concurrently whenever possible.
  - Calculate the total MME/day for concurrent opioid prescriptions to help assess the patient's overdose risk.
  - Discuss safety concerns with other clinicians who are prescribing controlled substances for the patient.
  - Consider the possibility of a substance use disorder and discuss concerns with patient.
  - If clinicians suspect their patient might be sharing or selling opioids and not taking them, clinicians should consider urine drug testing to help determine whether opioids can be discontinued without causing withdrawal.

10. Clinicians should use urine drug testing before starting opioid therapy and at least annually to assess for prescribed medications, other controlled prescription drugs and illicit drugs.

- Clinicians should not test for substances for which results would not affect patient management.
- Clinicians should ask patients about use of prescribed and other drugs.
- Clinicians should use unexpected results to improve patient safety (e.g., offering alternative pain treatment, tapering or discontinuing opioids, more frequent re-evaluation, offering naloxone, or referral for treatment for substance use).

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

- Pharmacists and pain specialists should be considered as part of the care team when opioids are co-prescribed with other central nervous system depressants.
- When patients receiving both benzodiazepines and opioids require tapering to reduce risk for fatal respiratory depression.
- Clinicians should taper benzodiazepines gradually if discontinued (a commonly used tapering schedule that has been used safely and with moderate success is reducing the dose of benzodiazepines by 25% every 1–2 weeks) and consider offering Cognitive Behavioral Therapy and/or specific anti-depressants or other nonbenzodiazepine medications.

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

- Clinicians should identify treatment resources for opioid use disorder in the community and should work to ensure sufficient treatment capacity for opioid use disorder at the practice level.
- If clinicians suspect opioid use disorder, based on patient concerns, behaviors, on PDMP or Urine Drug Screening findings, they should discuss their concern with their patient. Clinicians should assess for the presence of opioid use disorder using DSM-5 criteria, or arrange for a substance use disorder treatment specialist to assess for the presence of opioid use disorder.

Next steps in Oregon

While endorsing the CDC Guidelines as the foundation for opioid prescribing in Oregon, the Task Force recognized that several topics deserved more specific recommendations for Oregon prescribers. Over the summer, work groups have met to come up with recommendations for the following:

- Considerations for prescribing opioids in patients who use marijuana;
- Other substantive issues of importance to Oregon prescribers, including: treating acute pain, additional settings and providers, and justification process for prescribing outside the Guideline recommendations, such as higher MME, co-prescribing opioids and benzodiazepines, urine drug testing considerations;
- Implementation;
- Communication of the Guidelines to providers, patients, health systems, payers, the public, policy-makers.

Resources

- For more information about the work of the Task Force see: http://public.health.oregon.gov/PreventionWellness/SubstanceUse/Opioids/Pages/task-force.aspx
- Additional information on resources and data available on the Public Health Division website: www.healthoregon.org/opioids
- Prescribers can use the prescription drug monitoring program (PDMP) to track a patient's prescription history: http://www.orpdmp.com/
- For an overview of Medication assisted treatment (MAT) for opioid use disorder: www.integration.samhsa.gov/clinical-practice/mat/mat-overview#implement
- MAT implementation checklist: www.integration.samhsa.gov/clinical-practice/mat/MAT_Implementation_Checklist_FINAL.pdf;

- SAMHSA Clinical Guidelines for the use of Buprenorphine in the Treatment of Opioid Addiction: www.buprenorphine.samhsa.gov/Bup_Guidelines.pdf
- Information on Naloxone: http://prescribetoprevent.org/prescribers/palliative/

References

1. Centers for Disease Control and Prevention. Injury Prevention and Control: Drug Overdose. See: www.cdc.gov/drugoverdose/data/overdose.html
2. CDC. Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2016. Available at http://wonder.cdc.gov.
3. Chang H, Daubresse M, Kruszewski S, et al. Prevalence and treatment of pain in emergency departments in the United States, 2000 – 2010. Amer J of Emergency Med 2014; 32: 421–31.
4. Daubresse M, Chang H, Yu Y, Viswanathan S, et al. Ambulatory diagnosis and treatment of nonmalignant pain in the United States, 2000–2010. Medical Care 2013; 51: 870–8.
5. Chou R, Deyo R, Devine B, et al. The effectiveness and risks of long-term opioid treatment of chronic pain. Evidence Report/Technology Assessment No. 218. AHRQ Publication No. 14-E005-EF. Rockville, MD: Agency for Healthcare Research and Quality; 2014
6. Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR 2016; 65: 1–50. See: www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6501e1.pdf

Zika update

You might recall the April 22, 2016, issue of the *CD Summary*, devoted to Zika virus. A lot has happened since then. Just this week, CDC announced the first known mosquito-borne transmission of Zika in the mainland United States — which occurred in a neighborhood in Miami, Florida — and extended its advisory against travel by pregnant women to this neighborhood.

In other recent developments:

- CDC now recommends asking all pregnant women about possible Zika exposures at each prenatal care visit.
- The algorithm for Zika testing has gotten a bit more complex.
- Commercial labs have joined the Zika-testing fray.
- CDC's recommendations to prevent sexually transmitted Zika virus now address the possibility of sexual transmission from an infected woman.

Sound confusing? You bet it is. But don't despair!

We will continue to update our one-stop shop Zika information for healthcare providers. Keep current at www.bitly.com/zikaoregon.

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