

Evidence-Based Primary Pain Care

A New Opioid Guideline from Washington State

Highlights of the 2015 AMDG Interagency Guideline on Prescribing Opioids for Pain

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SAMPLER OF TREATMENT AND DOSE GUIDELINES

**WA State Agency Medical Directors
(AMDG) Opioid Treatment Guideline**
*Published online in April 2007, updated 2010
New Update July 2015*



**Southern Oregon Opioid
Prescribers Group**
Published online May 2013



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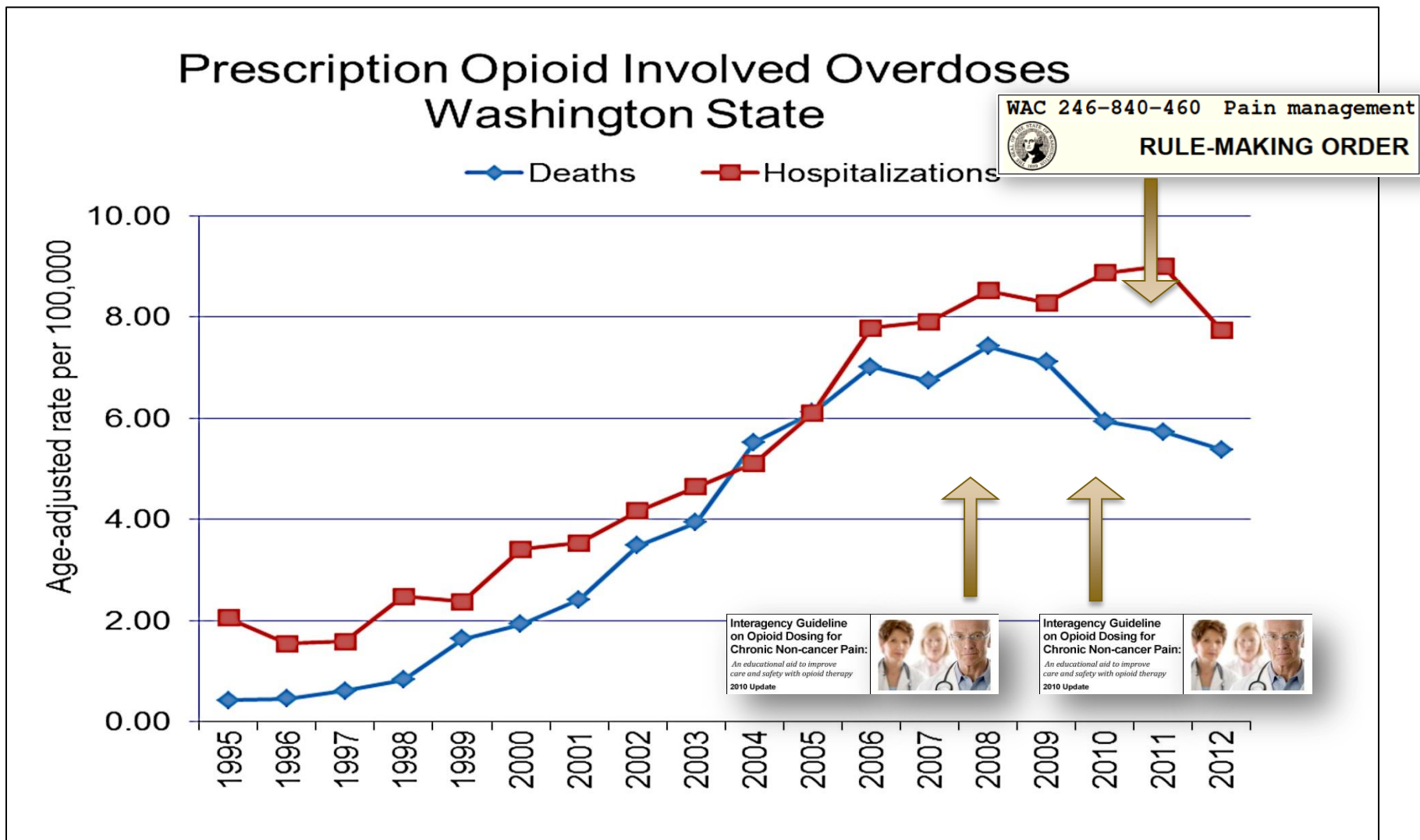


**Opioid Prescribing Guidelines for
Oklahoma Health Care Providers in the Office-Based Setting**



“BENDING THE CURVE”

WA STATE FIRST IN NATION WITH DECLINE IN OPIOID RELATED ADVERSE EVENTS



GUIDELINE STRUCTURE

Each section:

- Definitions and Indications
- Clinical Recommendations
- Evidence

COMPARISON OF 2010-2015 GUIDELINES FOCUS

2010 Guideline	2015 Guideline
Focus on Chronic Non-cancer Pain	Expanded focus
<ol style="list-style-type: none">1. Initiating, transitioning, and maintaining patients2. Optimizing treatment for patients on > 120mg daily MED	<p>New & Modified Sections</p> <ol style="list-style-type: none">1. Opioids in the Acute and Subacute Pain Phases2. Opioids in the Perioperative Phase3. Opioids in Chronic Non-cancer Pain (similar to previous guideline)

OPIOIDS IN THE ACUTE AND SUB-ACUTE PAIN PHASES

Pain: Acute Phase:

- ≤ 6 weeks post episode of pain or surgery
- For severe injuries or medical conditions, surgical procedures, or when alternative non-opioid options are ineffective or contraindicated.
- If opioids are prescribed, should be for the shortest duration and at the lowest necessary dose (usually less than 14 days).
- Use of opioids for non-specific low back pain, headaches, and fibromyalgia is not supported by evidence.

CLINICAL RECOMMENDATIONS: OPIOIDS IN THE ACUTE PAIN PHASE

- Explore non-opioid alternatives, including early activation.
- Set reasonable expectations about recovery; educate about potential risks and side effects.
- Provide patient education on safekeeping of opioids.
- Expect improvement in days to weeks: **RE-EVALUATION FOR THOSE WHO DO NOT FOLLOW THE NORMAL COURSE OF RECOVERY.**
- Check the Prescription Monitoring Program (PMP) to ensure that the patient's controlled substance history is consistent
- **Assess FUNCTION AND PAIN AT BASELINE AND WITH EACH FOLLOW-UP** visit when opioids are prescribed.
- Document clinically meaningful improvement in function and pain using validated tools for every opioid refill visit.
- Strongly consider tapering the patient off opioids once acute episode of pain improves. Taper patient by 6 weeks if clinically meaningful improvement in function and pain has not occurred.

OPIOIDS IN THE SUB-ACUTE PHASE (6 -12 WEEKS POST EPISODE OF PAIN OR SURGERY)

- Discontinuation opioids if does not lead to clinically meaningful improvement in function, or to a pain interference with function level of $\leq 4/10$.
- Discontinue opioids if treatment has led to a severe adverse outcome.
- Screen for depression, anxiety, (possibly PTSD), opioid misuse risk using validated tools before embarking onto COAT.
- Do not prescribe opioids if results of a baseline UDT reveal “red flags”.
- Avoid new prescriptions of benzodiazepines/sedative-hypnotics.
- Discontinue opioids during this phase if:
 - No clinically meaningful improvement in function and pain.
 - Patient has current or history of substance use disorder (excluding tobacco).

OPIOIDS: PERIOPERATIVE PHASE



1. Preoperative Period

- Thorough preop evaluation, risk screening, develop and inform patient of coordinated treatment plan (including who will prescribe at discharge), no new sedating Rx, avoid dose escalation

2. Intraoperative Period

- Multimodal analgesia

3. Immediate Postoperative Period

- Utilize multimodal analgesia, monitor sedation/respiratory suppression, PCA early then PO Rx immediate release opioids
- Don't add or raise dose of ER/LA opioids

4. At the Time of Hospital Discharge

- No new benzos/sedatives; avoid alcohol
- Introduce taper timeline: plan/schedule

OPIOIDS IN CHRONIC NON-CANCER PAIN

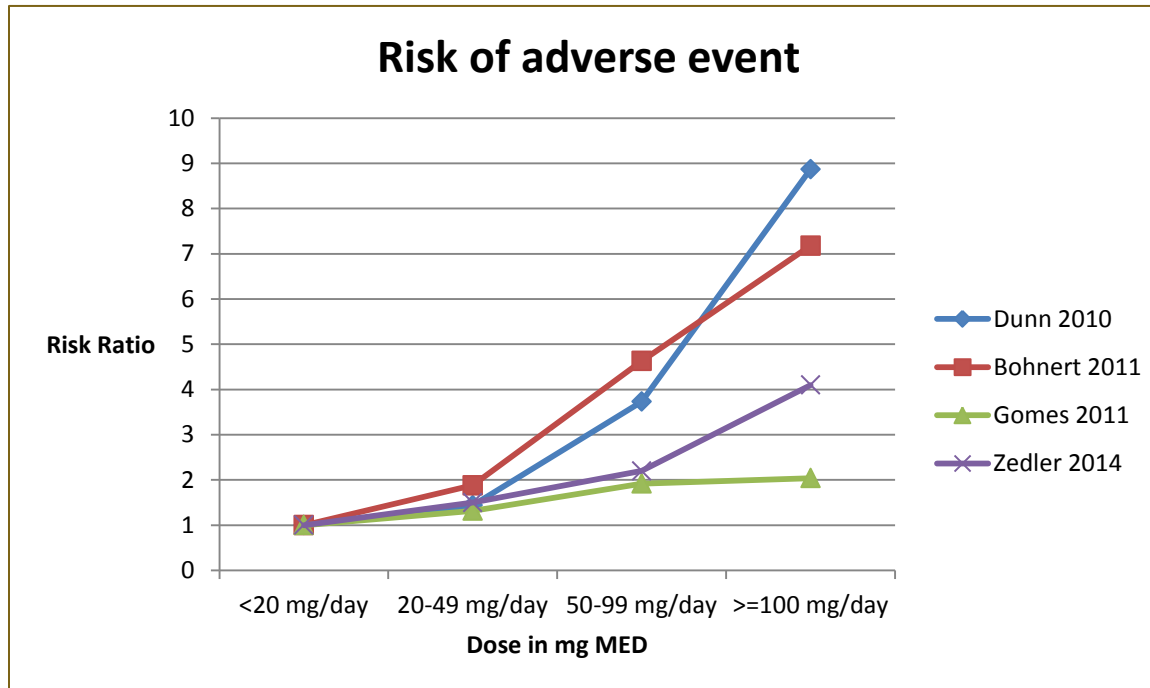
>12 WEEKS AFTER AN EPISODE OF PAIN OR SURGERY

- Use when/if sustained clinically meaningful improvement in function *AND* no serious adverse outcomes or contraindications.
- Use extreme caution/consider consultation in patients with comorbid mental health disorder, family/personal history of substance use disorder, medical condition that could increase sensitivity to opioid-related side effects, or concurrent use of benzodiazepines.
- Reassess need in transferred patients already using opioids: If current treatment is not benefiting the patient, dose reduction or discontinuation is warranted.
- If dose is increased yet does not result in CMIF, opioids should be tapered back to previous dose, or possibly discontinued.
- Routinely assess and document FUNCTION, MOOD, PAIN, RISK.
- Consider pain expertise if dose ESCALATES ≥ 120 MED and/or RISKS
- Know special METHADONE precautions due to drug's non-linear pharmacokinetics, and its many drug-drug interactions.

COMPARISON OF 2010-2015 GUIDELINES DOSING THRESHOLD

2010 Guideline	2015 Guideline
120 mg MED Opioid Dosing Threshold proposed	Expanded discussion on dosing threshold
Recommended 120mg daily MED as a “yellow flag” dose as a strategy to prevent adverse events and overdose by advising providers to seek a consultation with a pain specialist.	Remains the same, plus adds guidance for safe prescribing at any dose, based on new studies showing significant risks occurring at lower doses.

RESPONDING TO THE EVIDENCE: MORPHINE EQUIVALENT DOSE RELATED RISK



- Risk of adverse ± overdose event increases at >50 mg MED/day
- Risk increases greatly at ≥100 MED/day

2007: WA State AMDG initially recommends 120 MED threshold dose

2009: CDC recommends: 120 mg/day MED

2012: CT work comp: 90 mg/day MED

2013: OH State medical Board: 80 mg/day MED

2013: Am College Occ. & Environ Med: 50 mg/day MED

2014: CA work comp: 80-120 mg/day MED

COMPARISON OF 2010-2015 GUIDELINES NEW AND IMPROVED SECTIONS

Other New & Modified Sections

Clinically Meaningful Improvement in Function

Expanded & modified tapering / discontinuing COAT

Non-opioid Options for Pain Management

Recognizing and treating substance use disorder

Opioid use during pregnancy, including neonatal abstinence syndrome

Opioid use in children and adolescents

Opioid use in older adults

Opioid use in cancer survivors

“CLINICALLY MEANINGFUL IMPROVEMENT IN FUNCTION”

(“CMIF”) defined: An improvement in pain AND function of at least 30% as compared to the start of treatment, or in response to a dose change.

“A decrease in pain intensity in the absence of improved function is not considered meaningful improvement except in very limited circumstances such as catastrophic injuries (e.g. multiple trauma, spinal cord injury, etc.)”

“COAT that focuses only on pain intensity can lead to rapidly escalating dosage with deterioration in function and quality of life. During the chronic phase, providers should routinely review the effects of opioid therapy on function to determine whether opioid therapy should continue.”

“CLINICALLY MEANINGFUL IMPROVEMENT IN FUNCTION”

“Continuing to prescribe opioids in the absence of clinically meaningful improvement in function and pain, or after the development of a severe adverse outcome is not considered appropriate care.”

1. What number best describes your pain on average in the past week:

0 1 2 3 4 5 6 7 8 9 10

No pain Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere Completely interferes

3. What number best describes how, during the past week, pain has interfered with your general activity?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere Completely interferes

PEG Tool

EXPANDED & MODIFIED TAPERING / DISCONTINUING COAT

- Consider sequential tapers for patients who are on both chronic benzodiazepines and opioids. Taper off opioids first, then the benzodiazepines.
- Do not use ultra-rapid detoxification or antagonist-induced withdrawal under heavy sedation or anesthesia.
- Establish the *rate of taper based on safety*:
 - Immediate discontinuation: diversion or non-medical use.
 - Rapid taper (≤ 3 week period) if a severe adverse outcome such as overdose or substance use disorder
 - Slow taper when no acute safety concerns: $\leq 10\%$ per week; variably adjusted per patient response
- **MAY PRECIPITATE MENTAL HEALTH DISORDERS**; be alert for need of expert help
- Do not reverse taper

NON-OPIOID OPTIONS FOR PAIN MANAGEMENT

“COMPARING” EFFECTIVENESS

Extrapolated averages of reduction in *Pain Intensity*

Opioids:	≤ 30%
Tricyclics/SNRIs:	30%
Anticonvulsants:	30%
Acupuncture:	≥ 10+%
Cannabis:	?10-30%
<i>CBT/Mindfulness:</i>	<i>≥ 30-50%</i>
<i>Graded Exercise Therapy:</i>	<i>variable</i>
<i>Sleep restoration:</i>	<i>≥ 40%</i>
<i>Hypnosis, Manipulations, Yoga:</i>	<i>“+ effect”</i>

Turk, D. et al. Lancet 2011; Davies KA, et al. Rheum. 2008;
Kroenke K. et al. Gen Hosp Psych. 2009; Morley S Pain 2011;
Moore R, et al. Cochrane 2012; Elkins G, et al. Int J Clin Exp
Hypnosis 2007.

NON-DRUG MULTIMODAL ANALGESIA

- **Cognitive:**
 - Identify distressing negative cognitions and beliefs
- **Behavioral approaches:**
 - Mindfulness, relaxation, biofeedback
- **Physical:**
 - Activity coaching, graded exercise land & aquatic with PT, class, trainer, and/or solo
- **Spiritual:**
 - Identify and seek meaningfulness and purpose of one's life
- **Education (patient and family):**
 - Promote patient efforts aimed at increased functional capabilities

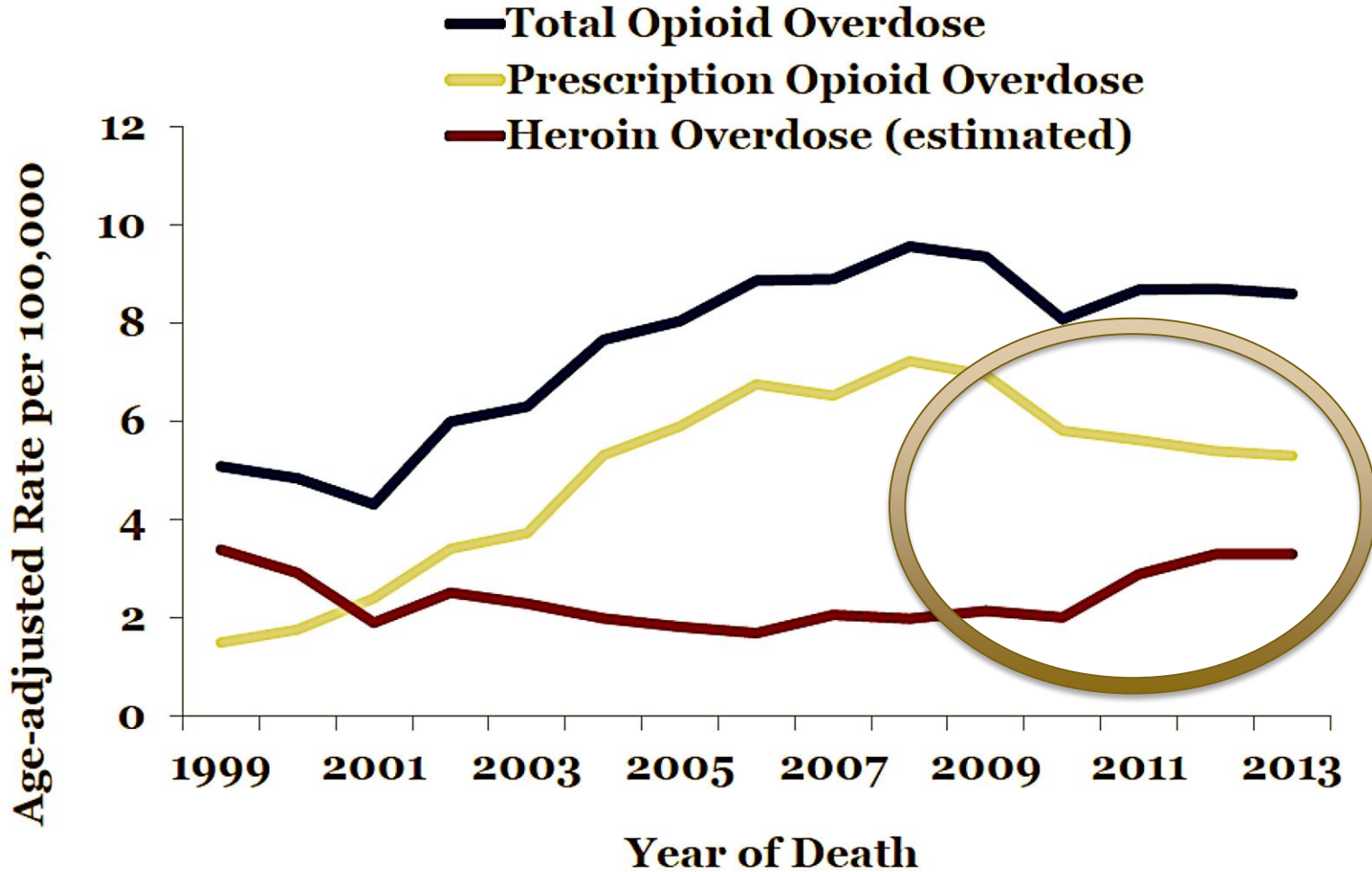
RECOGNIZING AND TREATING SUBSTANCE USE DISORDER



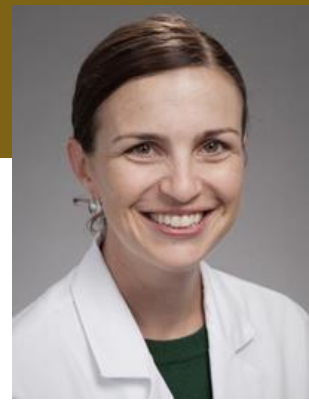
- Assess for opioid use disorder using DSM-5 criteria, or refer for a consultation with an addiction specialist if a patient demonstrates aberrant behaviors suggestive of substance use disorder
- Patients diagnosed with opioid use disorder should receive a combination of medication-assisted treatment and behavioral therapies.
- Consider prescribing naloxone as a preventive rescue medication for patients with opioid use disorder
- Be knowledgeable about treatment options

DRUG OVERDOSES

WASHINGTON STATE 1999-2013



MANAGING CHRONIC PAIN DURING PREGNANCY AND NEONATAL ABSTINENCE SYNDROME



- Recommend counseling before (preconception) and during pregnancy to assess and educate about potential maternal, fetal, and neonatal risks.
- Use caution when initiating short-acting opioids during pregnancy; limited to severe pain and when other medical treatments have failed.
- Weigh risks/benefits of opioid detoxification during pregnancy; and closely monitor the treatment plan for symptoms of withdrawal and risk of relapse.
- Assess pregnant women taking opioids for opioid use disorder. If present, refer to a qualified specialist for methadone or buprenorphine treatment for pregnant women.

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OPIOID USE IN CHILDREN & ADOLESCENTS



- Prescribe for acute pain in infants & children only if:
 - knowledgeable in pediatric medicine
 - developmental elements of pain systems
 - and differences in pharmacology in young children
- *Avoid opioids in the vast majority of chronic non-cancer pain* problems in children and adolescents: e.g. abdominal pain, headache, pervasive musculoskeletal pain.
- Opioids are indicated for a small number of persistent painful conditions with clear pathophysiology:
 - when defined endpoint: e.g. surgical procedures, trauma/burns.
 - *and* no definable endpoint: e.g. treatment at the end of life or for conditions with reoccurring severe ongoing nociception.
- Limit total number pills dispensed and educate parents about storage/disposal to minimize risk diversion or accidental ingestion.
- **ADOLESCENTS SHOULD UNDERGO SIMILAR SCREENING FOR RISK OF SUBSTANCE USE DISORDER THAT ONE WOULD CONDUCT WITH ADULTS.**

OPIOID USE IN OLDER ADULTS



“Approximately 60% of Americans over age 65 have persistent pain, commonly from MSK disorders such as arthritis/degenerative spine conditions”

- *GO LOW AND SLOW*; Short half-life agents infrequently
- Careful medical and behavioral risk/benefit when selecting ER/LA opioids
- ALERT: delirium/sedation, postural hypotension, falls
- Anticipate constipation

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PAIN MEDICINE

OPIOID USE IN CANCER SURVIVORS



Cancer survivors:

- Make the diagnosis for cause of pain
 - Recurrent cancer?
 - Residual chronic pain from effects of disease?
 - ...or from treatments?
- When no longer treating active cancer, attempt to manage as “non-cancer” pain since many principals still apply: functional goals, high value of multimodal and non-drug analgesia, similar opioid related risks...

COMPARISON OF 2010-2015 GUIDELINES APPENDICES

2010 Guideline	2015 Guideline
Opioid Dose Calculations & Calculator	Opioid Dose Calculations & Calculator
Screening Tools	Validated Risk Factor Screening Tools & combines former appendices B & C.
Tools to Assess Pain and Function	How to use the PMP
Urine Drug Testing for COAT	Urine Drug Testing for COAT
Consultative Assistance for WA State Payers	Chronic Pain Syndromes in Cancer Survivors
Patient Education Resources	Patient Education Resources (updated)
G. Sample provider-patient Agreement	Clinical Tools and Resources and combines former appendices G, H, & I
H. Additional Resources to Streamline Clinical Care	Diagnosis-based Pharmacotherapy for Pain
I. Emergency Department Opioid Guidelines	AGREE criteria

THE BREE COLLABORATIVE AGREE CRITERION

“Appraisal of Guidelines for Research and Evaluation”

Endorsed by:

- US Agency for Healthcare Research and Quality
- National Guideline Clearinghouse
- WA State Health Care Authority

Domains:

- Scope and purpose
- Stakeholder involvement
- Rigor of development
- Clarity of presentation
- Applicability
- Editorial independence

