



ALASKA NATIVE  
MEDICAL CENTER



**Clinical Guidelines for Chronic Opioid Therapy for Chronic Non- Cancer Pain**

## Not including pain associated with active cancer treatment, palliative care, or end-of-life care

### Introduction

#### Purpose

The Medical Executive Committee has unanimously endorsed the CDC's 2016 Guideline for Prescribing Opioids for Chronic Pain. The intent of this clinical guideline is to further delineate, define, and outline best clinical practices for ANMC providers on the management of patients on chronic opioid therapy for chronic pain outside of active cancer treatment, palliative care, and end-of-life care.

This guideline draws guidance from the CDC's 2016 Guidelines for Prescribing Opioids for Chronic Pain, the Veteran's Affairs/Department of Defense's 2010 Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain, and the Indian Health Service's policy and procedure for the management of patients with chronic non-cancer pain.

#### Definitions

- a. Pain. Pain refers to an unpleasant sensory and emotional experience associated with tissue damage. Commonly, pain is classified into:
  - Acute Pain: typically lasting less than 2 months.
  - Chronic Pain: a pain state that continues or recurs over a period of more than 90 days, caused by various diseases or abnormal conditions.
- b. Chronic Opioid Therapy. Chronic Opioid Therapy (COT) refers to daily or near daily use of an opioid for at least 60 days.
- c. Prescription Drug Monitoring Program. Prescription Drug Monitoring Program (PDMP) refers to a tool used in ensuring drug safety. It is a state-based database that tracks and collects data on controlled medications dispensed by registered pharmacies in the state. The intent of these databases is to allow prescribers and pharmacists to monitor treatment and deter controlled medication abuse or diversion.
- d. Opioid Use Disorder. As defined by DSM-V <sup>(3)</sup>: A problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:
  1. Opioids are often taken in larger amounts, or over a longer period than was intended.

2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
4. Craving, or a strong desire or urge to use opioids.
5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.
8. Recurrent opioid use in situations in which it is physically hazardous.
9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Tolerance
11. Withdrawal

## **Scope**

This clinical guideline applies to all ANMC providers who choose to prescribe chronic opioid therapy for the purposes of treating chronic pain in a patient that does not have active cancer, not undergoing palliative care, or end-of-life care. For the purposes of this document, every reference to chronic pain implies that clinical context.

## **Background**

Pain is one of the most common reasons patients seek medical care. The 1999-2002 National Health and Nutrition Examination Survey estimates that 14.6 % of adults have current pain lasting at least 3 months <sup>(1)</sup>. When not optimally treated, pain, especially when it is chronic in nature, leads to a decrease in quality of life, negatively impacts mental and emotional well-being, and can impair activities of daily living. Prevention, assessment, and optimal treatment plans for chronic pain are challenges for health providers and health systems.

The use of opioid therapy for the treatment of acute and chronic pain rose dramatically during the past decade in the United States. Despite this trend, there have been few studies documenting the long-term efficacy of COT in relieving chronic pain.

Chronic opioid therapy presents significant risks to the patient, including overdose, narcotic-associated constipation, and risk of opioid use disorder. Within the past decade, the recorded deaths related to opioid overdose rose significantly (2), along with emergency department visits related to the misuse of OT. The rate of opioid use disorder has also risen in the last decade. These trends highlight the need for guidance for clinicians when prescribing COT for pain.

## Guideline

### A. Patient Rights and Responsibilities

- a. All patients have a right to seek care with a medical provider for the treatment of their pain.
- b. A patient and his/her caregiver should work with the medical team to establishing a care plan to address his/her pain, and adhering to that mutually agreed plan and communicating any concerns or disagreements about the plan to the provider.

### B. Provider Responsibilities

- a. A provider should perform a comprehensive medical assessment for any patient who seeks care for chronic pain management. That medical assessment should include, at a minimum:
  - i. History of present illness with specific regards to the nature and duration of patient's pain
  - ii. Past surgical, medical, and injury history
  - iii. Current medications, with special attention to medications that can potentiate the effects of narcotics
  - iv. Substance abuse history or history of opioid use disorder and any existing or previous agreements around opioid use
  - v. Pertinent significant psychiatric history
  - vi. Social history
  - vii. Allergies
  - viii. Physical exam, with a special focus on areas of described pain, and a mental status exam
  - ix. Review of pertinent diagnostic studies
  - x. Evaluation of occupational risk and ability to perform work duties if narcotics are prescribed
- b. A provider should keep in mind that for the management of chronic pain, non-pharmacologic treatment and non-opioid medications should accompany part of

the treatment plan. The management of chronic pain is best approached as a collaborative effort across many disciplines, with the inclusion of the primary care team, specialty care, behavioral health, physical therapy, occupational therapy, complementary, traditional, and alternative medicine as appropriate during the duration of COT.

- c. Prior to the initiation of COT, the provider and patient should work together to establish a treatment plan that includes clear and realistic goals regarding pain management.
- d. Prior to the initiation of COT, the provider should carefully weigh the risks and benefits of initiation of opioid therapy for chronic pain and discuss these with the patient. Careful documentation of this discussion should occur in the patient's medical record.
  - i. A provider should provide a patient and/or the patient's caregiver education about chronic pain management to ensure that patients understand the safe and effective use of all aspects of their pain management plan.
- e. Providers should not prescribe COT if deemed to be unsafe and harmful to the patient.
- f. Prior to the initiation of COT, a provider should carefully screen for any absolute contraindications for COT. Some absolute contraindications include, but are not limited to the following:
  - i. Severe respiratory instability
  - ii. Acute suicidality
  - iii. Acute psychiatric instability
  - iv. True allergy to opioid agents
  - v. Active substance use disorders (not including nicotine) not in remission and not in treatment
- g. If a provider and a patient decide to initiate COT for chronic pain as a component of the treatment plan, per CDC Grade I recommendations, immediate-release opioids should be prescribed instead of extended-release or long acting opioids.
- h. Consideration should be given to the inclusion into the medical record of a written pain agreement between the provider and any patient that the provider deems to be at moderate or high risk for opioid misuse during COT.
- i. A provider should communicate and discuss the initiation of COT with the patient's primary care provider if applicable, and maintain active discussion with

the primary care provider as indicated during the duration of COT. If the provider should also reference any clinical guidelines for COT that the patient's primary care team draws guidance from.

- j. A provider should strive to prescribe the lowest effective dose possible for the shortest clinical duration feasible when prescribing COT.
  - i. Caution should be used when prescribing opioids at any dose.
  - ii. During COT, providers should reassess the evidence of patient benefit vs risk of continued COT at all dosages of opioids.
  - iii. Per CDC Grade I recommendations, clinicians should avoid the prescription of opioids  $\geq 90$  morphine milligram equivalents/day.
  - iv. The rationale for any clinical decision to exceed past the  $\geq 90$  morphine milligram equivalent/day should be carefully documented in the patient's medical record.
  
- k. Providers should discuss with patients on any potential impairment and adverse side effects of COT.
  - i. Providers should counsel patients on the appropriate storage and disposal of opioids to minimize the risk for misuse or diversion.
  - ii. Providers should counsel patients on the common adverse effects of opioid medications.
  - iii. Providers should counsel patients on the dangers of concurrent use of opioids with alcohol and benzodiazepines.
  
- l. Before initiation and during COT, a provider should continually assess for risk factors of opioid-related patient harm and misuse, and implement strategies to mitigate identified risk, including but not limited to the follow:
  - i. Review of the Alaska state PDMP <sup>(4)</sup> data to determining whether the patient is receiving opioids from another provider.
  - ii. Review of the Alaska state PDMP to identify dangerous combinations of other scheduled II medications already being prescribed for the patient.
  - iii. Whenever possible, a provider should avoid concurrent prescription of opioids with benzodiazepines.
  - iv. An effective bowel regimen should be prescribed to prevent opioid-induced constipation.
  - v. Providers should consider the concurrent prescription of naloxone when clinical scenario indicate that this might be appropriate and helpful.
  - vi. Use of urine drug tests as appropriate during the course of COT

Attachment #A is an example of a good tool that could be used to screen and assess risk factors for opioid abuse.

- m. A provider must ensure that regular follow-up visits are scheduled as appropriate for the patient who is on COT. Each follow-up visit should include documentation of:
  - i. Current level of pain intensity
  - ii. Patient response to current pain regimen
  - iii. Adverse effects, if any, from opioid therapy
  - iv. Assessment of functional status
  - v. Adherence to treatment plan
  
- n. A provider should taper or discontinue COT if:
  - i. Opioid therapy fails to provide partial pain relief with incremental up-titration of dosage
  - ii. The risk and harm outweigh any gained benefits
  - iii. The patient requests it
  
- o. A provider should discuss with the patient any serious non-adherence behaviors, dangerous opioid use, or suspected diversion of narcotic therapy immediately, and refer the patient to Behavioral Health or the Emergency Department as indicated by the clinical scenario.
  
- p. If a provider suspects or confirms opioid-use disorder, a provider should offer or refer the patient to the appropriate venues to receive evidenced-based treatment for opioid use disorder

Footnotes:

1. Hardt J, Jacobsen C, Goldberg J, Nickel R, Buchwald D. Prevalence of chronic pain in a representative sample in the United States. *Pain Med* 2008;9:803–12
2. CDC. Multiple cause of death data on CDC WONDER. Atlanta, GA: US Department of Health and Human Services, CDC; 2016. <http://wonder.cdc.gov/mcd.html>
3. *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*. Washington, DC, American Psychiatric Association page 541.
4. <https://alaska.pmpaware.net/login>



# Attachment #A

## Opioid Abuse Risk Tool

A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

Mark each box that applies	Female	Male
<b>Family history of substance abuse</b>		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
<b>Personal history of substance abuse</b>		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
<b>Age between 16—45 years</b>	1	1
<b>History of preadolescent sexual abuse</b>	3	0
<b>Psychological disease</b>		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
<b>Scoring totals</b>		

Questionnaire developed by Lynn R. Webster, MD to assess risk of opioid addiction.

Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk too. Pain Med. 2005; 6 (6) : 43