PMG NW Pain Management Recommendations
Opioid Therapy for Non-Cancer Pain

Mission Statement

- Pain, acute and chronic, is one of the most common conditions treated in primary care. Here are tools to help.

Training

- Every new provider needs to complete the AMDG Interagency Guideline on Prescribing Opioids CME and print the certificate for clinic lead. Available at: http://www.agencymeddirectors.wa.gov/CMEActivities.asp

Documentation

- All patients receiving chronic opioid therapy (3+ months) should have "chronic pain" (ICD-10 G89.29) added to their problem list (to be done by provider). Date of last pain agreement should be entered into the problem overview.
- FYI flag "medication agreement" should be added as well (this adds a banner to the patient snapshot; to be done by MA).
- Use suggested Epic SmartPhrases for initial and follow-up office visits to align with recommendations from CDC and AMDG guidelines.

Recommendations

- Exhaust non-pharmacologic therapy and non-opioid analgesics prior to prescribing opioid analgesics.
- Every provider should have a registry of chronic pain patients (by identifying them by having "chronic pain" on the problem list).
- Do not prescribe opioid medications for those who have a history of substance abuse and/or history of intentional or accidental overdose, as this history renders opioids unsafe to take.
- All patients prescribed opioids for >3 months need to sign a chronic pain agreement annually. Reviewing the agreement with the patient is the responsibility of the signing provider.

Abuse/Misuse Risk Screening

- Urine drug screen prior to first Rx, then at least yearly.
- PMP at every visit (to be completed by MA at the start of the day).
  - Sign up via: http://www.wapmp.org/terms-and-conditions.html
  - Instructions (refer to pages 35-37): http://www.wapmp.org/wapmpfiles/2015/WA_PMP_Training_Guide_for_Practitioners.pdf
- Utilize Opioid Risk Tool (ORT) in Epic Flowsheets (to be administered by MA).

Avoid use of opioids concomitantly with:

- *Benzodiazepines*. These should be tapered/discontinued prior to starting opioids, if possible. If not, tapering of high risk medication should be an ongoing process.
- *Muscle relaxants*. PMG providers do not prescribe carisoprodol, as it and its metabolite are barbiturate-like sedatives.
- *Sedative-hypnotics*, including "Z-drugs" (eszopiclone (Lunesta), zaleplon (Sonata), zolpidem (Ambien)).
- *Medical problems that make opioid use potentially unsafe*, such as untreated sleep apnea, history of respiratory failure, or significant and uncontrolled COPD or asthma.

Acute Pain Management

Assessment

- Determine expected recovery time and set realistic expectations.
- Educate patient on expectations for pain (it is expected, intensity/duration – if known).

Non-Opioid Analgesic Options

- Non-pharmacologic therapy (ice/heat, behavior modification – rest, sleep hygiene)
- OTC medications (NSAIDs, acetaminophen, etc.)
- Antidepressants, anticonvulsants (if applicable to indication)

ACUTE Opioid Therapy

(acute phase = 3 months)

Prior to prescribing:

All other options for treating pain should be attempted – including nonpharmacologic therapy. Doses of non-opioid therapy should be maximized.

Assess for risks of opioid misuse:

- History of addiction, overdose, and/or suicidality
- Consider checking PMP
- Consider checking Urine Drug Screen

Do NOT prescribe opioids for:

- Non-specific back pain
- Headaches
- Fibromyalgia

Assess risks vs benefits

If prescribing opioids:

- Lowest effective dose
- Maximum of 10-20 tablets of 5/325 mg hydrocodone-APAP, 5/325 mg oxycodone-APAP, or 30/300 mg codeine-APAP (these agents are the preferred 1st line opioids).
- Per CDC, generally no more than a 3-5 day (and rarely a 7 day) supply is needed
  - If pain has not improved in this time period, reassessment of diagnosis may be needed along with ruling out complications, and/or an unrecognized substance abuse disorder.
  - Review benefits vs risks of opioid therapy with patient, including that "physical dependence on opioids is an expected physiologic response in patients exposed to opioids for more than a few days" (CDC 2016 guidelines)
- **If therapy is to be continued beyond the initial prescription, monthly office visits are needed for assessment of pain, function, and encouragement of self-management and appropriate activity.**

Established Patient – Transition from Acute to Chronic Opioid Treatment

For continuation of opioid Rx beyond 3 months (acute phase), the assumption is that **all treatment interventions have been pursued and patient is clinically appropriate to receive chronic opiates.** Refer to http://www.cdc.gov/drugoverdose/pdf/alternative_treatments-a.pdf.

Recommendations

- Invite patient into clinic for an initial chronic pain office visit (extended visit).
- Assess for CNS drugs and abuse potential.
- Use the lowest opioid dose possible.
- Not to exceed 50 MED. There is no evidence that doses >50 MED are more efficacious.
- Do NOT combine ER and IR formulations for chronic non-cancer pain. Science does not support use of one over the other.
    - Recommended 1st line IR agents: codeine-APAP, hydrocodone-APAP, oxycodone-APAP
    - Recommended 1st line ER agents (ONLY if switch to ER formulation is warranted): morphine ER
- Do NOT prescribe hydromorphone, fentanyl, or methadone.

Brand New to Your Practice* – Already On Chronic Opioid Therapy

*Patients who have not previously established care with you.

Providers are not obligated to prescribe opioids at the first visit (or at all, if not clinically indicated after assessment).

1. Chronic pain needs a *dedicated* appointment; not to be included in an establish care visit.
2. Request records prior to appointment, when possible. (In general, don't prescribe opioids without reviewing previous records)
3. Check PMP.
4. Check Urine Drug Screen.

>120 MED

Refer to pain management (if possible)

50-120 MED

Plan – taper (with goal of <50 MED within 1 year)

If not willing, refer to pain management

<50 MED

Usual Monitoring

Established Patients – Chronic Opioid Therapy

Goal – Aim for all patients on chronic opioid therapy to be <50 MED.

Per PCP discretion, established patients on stable opioid doses of 50-120 MED may continue. Covering providers and those to inherit patients from within PMG are not obligated to continue prescribing at this dose range.

>120 MED

1. Offer dose reduction and non-judgmental education to patient regarding risks of high MED

If patient AGREES to taper:

2. Prescribe opioids per taper plan
3. Goal of <120 MED, as a first step (Refer to taper tool)
4. Offer naloxone (Per CDC)
5. Establish goals of pain treatment
6. Appropriate monitoring
7. Educate patients that if the prescribing provider leaves the organization and MED remains >50-90, patient may be referred to pain management

If patient does NOT agree to taper:

→ Refer to pain management, if possible

50-120 MED

1. Continually offer dose reduction and non-judgmental education to patient regarding risks of high MED
2. Offer naloxone (Per CDC)
3. Transition to one formulation (ER or IR), if applicable
4. Appropriate monitoring
5. Educate patients that if the prescribing provider leaves the organization and MED remains >50-90, patient may be referred to pain management

<50 MED

1. Periodically offer education on dose reduction and cessation
2. Consider offering naloxone for patients with concurrent benzodiazepines or those with conditions that increase risk of overdose (Per CDC)
3. Establish goals of pain treatment
4. Transition to one formulation (ER or IR), if applicable
5. Appropriate monitoring

Appropriate Monitoring – (included in .CHRONICPAININITIAL and .CHRONICPAINFOLLOWUP)

- Screen for mental health disorders, abuse potential, possibility of misuse, and hyperalgesia
- Yearly signed pain management agreement
- Yearly + PRN POCT urine drug screens (see UDT tool)
- Checking and reviewing PMP (+ MED calculation) with each visit
- Assessing diagnosis, pain control, function, and adverse effects
- Assessing patient’s progress towards achieving pain management goals
- Reviewing benefits vs risks of continuing to prescribe opioid analgesics