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Guideline and Policy Updates for Use of Opioids for Non-cancer Pain and Opioid Use Disorder

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Assessment and treatment of chronic pain is challenging because of its associated clinical, psychological and social consequences. Pain can limit the ability to perform certain activities, and can result in decreased work productivity, reduced quality of life, and stigma. Certain patient populations can also be at increased risk for inadequate pain treatment, such as the elderly, racial and ethnic minority groups, persons with cognitive impairment, and patients with cancer or at the end of life.[1] Furthermore, all patients will build tolerance with regular use of opioids which can result in the practice of prescribing higher and higher doses at the expense of higher risk for serious adverse events such as respiratory suppression and death.

About 20% of patients who present to clinicians with non-cancer pain symptoms or pain-related diagnoses (acute or chronic) receive an opioid prescription.[1] Opioid analgesics are now the most commonly prescribed class of medications in the U.S.[2] Although they have been used for decades to manage pain, there are serious harms associated with opioid use. Opioids can produce feelings of euphoria, tranquility and sedation that have resulted in an epidemic of misuse and abuse. From 2007 to 2014, the number of private insurance claims with an opioid dependence diagnosis increased 3,203%, with most of the claims for persons between 19-35 years of age.[3] With the dramatic increase in misuse and abuse of prescription opioids and ease of accessibility to illicit opioids such as heroin and potent synthetic fentanyl analogs, it is imperative that clinicians understand how to manage pain carefully; and, if necessary, navigate treatment strategies of opioid use disorder with their patients.

CDC Recommendations for Management of Chronic Non-cancer Pain

To address some of these issues, the U.S. Centers for Disease Control and Prevention (CDC) issued guidance this year for prescribing opioids for chronic non-cancer pain.[1] Final recommendations were based on a systematic review of controlled clinical trials and observational studies over the past 20 years, expert clinical opinion, and review from key stakeholders.[1] The 12 recommendations focus on 1) determining when to initiate or continue an opioid for chronic pain; 2) opioid selection, dosage, duration, follow-up and discontinuation; and 3) assessing risk and addressing harms of opioid use.[1] A summary of the 12 CDC recommendations for opioid prescribing in non-cancer pain are provided in Table 1. It is recommended the reader review the CDC guideline for more information.[1]

Table 1. Summary CDC Recommendations.[1]

Recommendation	Supporting Evidence
When to Initiate or Continue Opioids for Chronic Pain.	
1. Try non-pharmacological therapy and/or non-opioid analgesics first.	Physical therapy, psychological therapies (e.g., CBT), exercise and weight loss have shown to ameliorate many types of chronic pain without the harm associated with opioids. Acetaminophen, NSAIDs, and some antidepressants and anticonvulsants can also effectively treat many types of pain.
2. Establish realistic treatment goals for pain and function first. Develop a plan for discontinuation of the opioid if goals are not met.	There is insufficient evidence to determine long-term benefits of opioid therapy for chronic pain; however, some patients who can tolerate opioids may experience clinically meaningful pain relief.
3. Regularly discuss patient and clinician responsibilities for managing therapy; also reassess risks and benefits of opioid therapy regularly.	Many patients lack information about opioids. Given the substantial gaps in evidence for opioids, uncertain benefits of long-term use and potential for serious harms, patient education and discussion of treatment expectations can mitigate harms.
Opioid Selection, Dose, Duration, Follow-up and Discontinuation.	
4. Prescribe an intermittent SAO instead of a LAO when starting opioid therapy for chronic pain.	Continuous, regularly-scheduled use of a LAO is not more effective than intermittent use of a SAO but is associated with higher risk for accidental overdose. There is also insufficient evidence to determine the safety of a SAO for breakthrough pain in patients already on a LAO for chronic non-cancer pain. This practice is associated with dose escalation over time.
5. Use caution when increasing the dose of a LAO ≥ 50 MME/day. Daily doses ≥ 90 MME should be avoided.	Data show increasing the dose of an opioid beyond 50 MME/day does not provide further pain or functional benefit. Doses ≥90 MME/day significantly increase risk for motor vehicle accidents, opioid use disorder, and overdose by nearly 5-fold compared to doses < 20 MME/day.
6. Most acute pain can be managed sufficiently with 3 days or less of a SAO. Rarely is 7 days of SAO needed. Avoid LAOs for acute pain.	Use of a SAO for acute pain is associated with long-term opioid use. Greater initial exposure is associated with greater risk for long-term use. Limiting days of opioid exposure also minimizes the need to taper and prevents withdrawal symptoms.
7. Evaluate benefits and harms of opioid therapy within 1 to 4 weeks of initiation or dose escalation. Follow-up should occur routinely at least every 3 months with chronic opioid use. Discontinue or reduce the opioid dose if harms outweigh the benefit.*	Patients who do not experience benefit with an opioid in the first month are unlikely to experience benefit at 6 months. Because there is substantial risk for opioid use disorder with continuing an opioid beyond 3 months, it is imperative that both benefits (decreased pain, improved function and quality of life*) and harms (tolerance, dependence, addiction or overdose risk, and adverse CNS/GI effects) are routinely and frequently re-evaluated, even in chronic opioid users. *Pain control, quality of life, and function can be quickly assessed in the primary care setting using the 3-item PEG scale.[4,5]
Assessing Risk and Addressing Harms of Opioid Use.	
8. Develop strategies to mitigate opioid-related harms in patients at risk for opioid overdose. Routinely reassess risk factors which can evolve over time.	Patients at risk for overdose include patients with: 1) history of substance overdose; 2) history of substance use disorder; 3) higher opioid dosages (≥50 MME/day); or 4) concurrent benzodiazepine use. Mitigation management strategies for these patients include offering naloxone and referral to a pain and/or behavioral health specialist. Other important populations at risk include: 1) patients with sleep disorders (e.g., sleep apnea); 2) pregnant women; 3) patients with hepatic or renal impairment; 4) patients ≥65 years of age; and 5) patients with mental health conditions.
9. Enroll and routinely review the state PDMP when initiating an opioid and at least once every 3 months for patients on chronic opioid therapy.	Most fatal overdoses are associated with patients who receive opioids from multiple prescribers and/or patients who on high total daily doses of opioids. Implementation of the PDMP has been associated with a reduction in opioid-related deaths.[6]
10. Perform a UDS before starting an opioid and at least once annually for chronic opioid users.	Concurrent use of prescription opioids with other opioids, benzodiazepines, or heroin increase risk for overdose and death. Routine use, rather than random use, of UDS testing can result in less stigmatization to patients

	but still provide important information to clinicians. Note that some immunoassays do not detect synthetic opioids such as fentanyl and methadone.
11. Avoid prescribing an opioid with a benzodiazepine.	The combined use of an opioid with a benzodiazepine or other drugs that suppress the CNS have resulted in numerous cases of respiratory depression and death.[7]
12. Treat opioid use disorder.	Buprenorphine/naloxone and methadone are equally effective for maintenance therapy of opioid use disorder when offered with psychosocial interventions as part of a supportive treatment program.
Abbreviations: CBT = cognitive behavior therapy; CNS = central nervous system; GI = gastrointestinal; LAO = long-acting opioid; MME = morphine milligram equivalent; PDMP = prescription drug monitoring program (www.orpdmp.com); SAO = short-acting opioid; UDS = urine drug screen.	

The Oregon Health Plan (OHP) has adopted policies based on the CDC recommendations.[8] Patients on chronic opioids for non-cancer pain or not on palliative care must taper their opioid dosage down to less than an equivalent of 90 mg of morphine per day (e.g., oxycodone <60 mg/day). Prescribers will also be asked to routinely assess prescription data of controlled substances in the Oregon Prescription Drug Monitoring Program. Pain associated with fibromyalgia and chronic headache will continue to not be covered under the OHP.

In addition, the Health Evidence Review Commission (HERC) has implemented strict opioid use policies for back pain. Patients prescribed opioids for back pain, for which there is insufficient evidence for meaningful effectiveness,[9] will be limited to 7 days of a short-acting opioid only after an initial trial of a non-opioid analgesic has failed. Spinal manipulation, physical therapy, yoga, and acupuncture therapies are encouraged and will be covered under the OHP to manage chronic back pain. Implementation of these policies will be a long and arduous process since thousands of patients will be initially affected. The Oregon Health Authority understands the substantial burden this will place on clinicians and this newsletter is only one part of a coordinated outreach to prescribers to inform them of these upcoming changes. Details of what is covered for pain associated with back and spine conditions are outlined in Guideline Note 60 (*Opioids for Conditions of the Back and Spine*) of the Prioritized List of Health Services published by the HERC.[10] Beginning January 1, 2017, the OHP will require an individualized taper plan for each patient on a chronic opioid for back pain. The taper must include an end-date of no later than December 31, 2017. Taper plans must include non-pharmacological treatment strategies based on the HERC Guideline Note 56 (*Non-Interventional Treatments for Conditions of the Back and Spine*) of the Prioritized List of Health Services.[10] As always, prescribers can appeal these policies for individual patients who benefit from their current opioid dose without signs of adverse effects or aberrant behaviors.

Tapering Off Opioids

Long-term use of opioids results in physical and psychological dependence which makes tapering down opioid doses especially challenging. Opioid dose reduction can cause anxiety in patients on established doses and may unmask opioid use disorder. However, all patients on high doses of opioids should be offered the opportunity to re-evaluate their continued use of opioids in light of the evidence for increased harms.[1] Taper protocols that reduce opioid dosage by 10% per week of the original dose is recommended, but slower tapers (e.g., 10% per month) may be needed to minimize signs and symptoms of withdrawal in patients who have been on chronic opioids for years.[1] Tapers should be considered successful as long as the patient is making progress; however, a taper should not be reversed. Clinicians should remain alert to signs of anxiety, depression, and opioid use disorder that might be unmasked by the taper.[1] Tapers can always be slowed or temporarily paused to manage withdrawal symptoms. Several helpful tools and guidance documents are available free to clinicians from the Washington State Agency Medical Directors' Group at www.agencymeddirectors.wa.gov.

Management of Opioid Use Disorder

State and Federal agencies have responded to expand resources to treat opioid overdose and manage patients struggling with opioid use disorder. In July 2016, the Comprehensive Addiction and Recovery Act was enacted which authorizes the federal government to strengthen opioid prevention and treatment programs and expand the availability of naloxone to first responders.[11] The Substance Abuse and Mental Health Services Administration (SAMHSA) oversees accreditation of opioid treatment programs and requests that providers adhere to recognized clinical practice guidelines when treating patients with opioid use disorder (Table 2).[12]

Table 2. Clinical Practice Guidelines for Opioid Use Disorder

American Society of Addiction Medicine National Practice Guidelines for the Use of Medications in the Treatment of Addiction Involving Opioid Use www.asam.org
SAMHSA Treatment Improvement Protocol 40: Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction https://store.samhsa.gov
World Health Organization Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence www.who.int/substance_abuse/publications/
Department of Veterans Affairs /Department of Defense Clinical Practice Guideline on Management of Substance Use Disorder www.healthquality.va.gov/guidelines/
Federation of State Medical Boards' Model Policy on the Drug Addiction Treatment Act of 2000 and Treatment of Opioid Addiction in the Medical Office www.fsmb.org

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