AUSTIN PAIN WELLNESS

Suggested Guidelines for Chronic Opioid Management

In the United States, the rate of prescription drug overdoses had quadrupled since 1999.[1] Deaths from drug overdoses have surpassed that of motor vehicle crashes as the leading cause of injury death.[2] Opioids cause the most harm, with more than 33,000 deaths per year.[3] Approximately two- thirds of these deaths are from prescription opioids. Annually, there are up to 400,000 emergency room visits related to opioid side-effects and overdose.[4]

In response to this national epidemic, Austin Pain Wellness has adopted several recommendations along with a thoughtful chronic opioid-prescribing protocol to guide our providers in their treatment of patients utilizing chronic opioids. These recommendations are designed to protect our patients and help combat the opioid misuse epidemic present in our communities.

Prescribing Recommendations

- Avoid high dosages of opioids (high doses are correlated with 7 to 9 times the risk of overdose and death[5]). We recommend staying below 100 mg morphine equivalents per day; however, this can be exceeded in certain circumstances if medically appropriate.
- Avoid use of multiple psychotropic substances.[6] Polypharmacy is associated with 61% of overdose deaths. We typically do not prescribe benzodiazepines or Soma and advise our patients to avoid the use of these medications while taking an opioid. Educate patients to also avoid consuming ETOH.
- Maximize appropriate use of short-acting opioids before initiating a trial of a long-acting opioid.
- Avoid exceeding a maximum of 120 tablets per month or QID dosing of short-acting opioids.
- Except in unusual circumstances or cancer patients, stick with a maximum of one short-acting and one long-acting opioid medication prescribed per month.
- Methadone should not be utilized as 1st line opioid therapy.[7] Patients who are taking Methadone should be placed in the high-risk category (see risk stratification below).
- Avoid rapidly cycling through different pain medications.
- Avoid refilling opioid prescriptions early without clear documentation and sound reasoning.
- Consider prescribing naloxone as an analgesic for patients who are in the moderate and high-risk categories (see risk stratification below).[8]
- We do not prescribe opioids for patients using THC (both medicinal and recreational).

Clinical Recommendations

- Utilize a risk stratification tools (such as SOAPP-R, COMM, STORM, and/or other studied modalities) to place patients into a low, moderate or high-risk category. More careful monitoring of patients in higher risk categories is advised. The Stratification Tool for Opioid Risk Mitigation (STORM) data notes that any of the following factors place a patient at higher three factors that increase the risk of opioid-related adverse events[9]:
  1. Personal or family history of mental health and/or substance use disorder
  2. Multiple medical comorbidities
  3. High doses of opioids and/or polypharmacy
- Routinely check prescription drug monitoring reports.
- Perform random urine drug testing.
- Include thorough documentation regarding risk stratification, prescription drug monitoring reports, and urine drug testing results within the medical record.
- Minimum of monthly office visits for patients on chronic opioids. This may be modified, as clinically appropriate, for low-potency opioids (Tramadol, Tylenol #3) or established patients with consistent record of compliance.
- Assess patients for a therapeutic response to opioid therapy (e.g., 30% or greater reduction in pain, increase in activities of daily living, etc.). If a therapeutic response is not found, discontinue their use.
- Accept the limitations of opioid use.[10] Set realistic expectations with your patient and avoid chasing the pain with increased/additional opioids.
- Implement a comprehensive approach in the treatment of the chronic pain patient with the goal of lowering their opioid dosage(s) or discontinuing them altogether. Utilize evidence- supported non-pharmacological therapies including but not limited to physical therapy, behavioral health and interventional procedures. Also include the use of non-opioid pharmacological therapies such as non-steroidal anti-inflammatory drugs (NSAIDS) and membrane stabilizers.

In addition to the above prescribing and clinical recommendations, we suggest referencing the Centers for Disease Control Guideline for Prescribing Opioids for Chronic Pain and the Texas Medical Board's Chapter 170 guidelines for prescribing controlled substances for pain. These suggested guidelines are based on national data and trends as well as best practices from physician pain management groups around the country. They should not be a substitute for medical decision making.

[1] https://www.cdc.gove/media/releases/2015/p1218-drug-overdose.html

[2] CDC Morbidity and Mortality Weekly Report, January 1, 2016, https://www.cdc.gov/mmwr/preview//mm6450a3.htm

[3] The White House. (2016). Continued Rise in Opioid Overdose Deaths in 2015 Shows Urgent Need for Treatment [Press release]. Retrieved from http://www.whitehouse.gov/the-press-office/2016/12/08/continued-rise-opioid-overdose-deaths-2015-shows-urgent-need-treatment.

[4] Highlights of the 2009 Drug Abuse Warning Network (DAWN) Findings on Drug-Related Emergency Department Visits. *The DAWN Report.* December 28, 2010. Retrieved from http://www.oas.samhsa.gov/2k10/dawn034/edhighlights.htm

[5] Imtiaz S, Shield KD, Fischer B, Rehm J. Harms of prescription opioid use in the United States. *Subst Abuse Treat Prev Policy.* 2014; 9:43.

[6] Baumlatt JA, Wiedeman C, Dunn JR, Schaffner W, et al. High-risk use by patients prescribed opioids for pain and its role in overdose deaths. JAMA Intern Med. 2014 May; 174(5):796-801.

[7] Paulozzi LJ, Jones, CM, Mack KA. Vital signs: risk for overdose from methadone used for pain relief–United States, 1999-2010. *Morb Mortal Wkly Rep*. 2012;61,493-7.

[8] January 28, 2016 Bulletin: Best Practices for Addressing Prescription Opioid Overdoses, Misuse and Addiction, http://medicaid.gov/federal-policy- guidance/downloads/CIB-02-02-16.pdf.

[9] Olivia O, Bowe T, Tavakoli S, Martins S, et al. Development and applications of the Veterans Health Administration's Stratification Tool for Opioid Risk Mitigation (STORM) to improve opioid safety and prevent overdose and suicide. Psychological Services, Vol 14(1), Feb 2017, 34-39.

[10] Bloodworth D. Issues in opioid management. *Am J Phys Med Rehabil*. 2005 Mar;84(3 Suppl): S42-55.