Pain Management Part 3 – Opioid Therapy Care Guide

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SUMMARY

GOALS

- ✓ Add analgesic intensity for severe intractable pain.
- ✓ Assure patient safety, prevent complications/morbidity.
- ✓ Establish realistic expectations.
- ✓ Monitor for appropriate use & meaningful improvement.
- ✓ Taper and discontinue if benefits do not outweigh risks.

ALERTS

- Opioids are **not** the preferred treatment for chronic pain.
- In select patients, opioids may be considered in combination with non-pharmacologic treatments and non-opioid medication.
- Always use caution when prescribing opioids and prescribe the lowest effective dose; increased dose = increased risk.
- Ongoing monitoring for risk/benefit is essential.

This care guide is the final part of a 3-part series of care guides for pain management. Its content is based on the 2016 Centers for Disease Control and Prevention (CDC) Guidelines for Prescribing Opioids[1] (See Attachment G), and cumulative evidence demonstrating limited utility for opioid use in most chronic, non-cancer pain. Exceptions are made for clinical scenarios involving active cancer treatment, palliative care, and hospice. In all cases, the use of opioids should not be considered before completing a thorough pain assessment and initiating/optimizing non-opioid therapies as described in the CCHCS Pain Management: Part 1 & 2 Care Guides.

EVALUATION/PATIENT SELECTION

Patient Selection Criteria:

1. Biomedical diagnosis with evident indication for opioids (primarily somatic pain).
2. Non-opioid and non-pharmacologic treatment have been trialed or are being trialed concurrently.
3. Pain is severe enough to interfere significantly with daily function.
4. Patient is not at high risk for opioid-related harm (see page 4).
5. Patient is compliant with assessment and monitoring including urine drug testing (UDT).
6. Patient able to engage in goal setting, understand the potential adverse effects and risks, and sign informed consent.

TREATMENT

Opioid Selection:

1. New prescriptions for any controlled medication (CII-V) are limited to 7 days and must be re-evaluated before continuing. Most opioid use in the acute/trauma setting will require less than 7 days of therapy.
2. Initial opioid selection should be an immediate release agent of low potency (e.g., codeine, tramadol).
3. More potent opioids (e.g., morphine) should be used as second line agents.
4. Long-acting/extended release opioid preparations should be used only after initial titration with immediate release agent AND if the opioid therapy is intended to last more than 3 months (i.e., for severe, intractable pain).

Chronic Opioid Initiation:

1. Assure that initial UDT is consistent with therapy.
2. Set goals that are primarily function-based using the Specific, Measurable, Achievable, Relevant and Time-based (SMART) method.
3. Discuss the short-term benefits, potential side effects, risks, and the potential loss of efficacy over time.
4. Avoid co-prescription of sedative agents, especially benzodiazepines [CDC Recommendation #11].
5. Agree on duration of the trial (typically 2-3 weeks at optimal dose).
6. Discuss how opioids will be discontinued if they do not produce benefits that outweigh risks.
7. Target dose 0-50 Morphine Milligram Equivalents (MMEs); aim to keep dose under 90 MME. If larger doses are required, strongly consider an interdisciplinary case conference to discuss the patient.

MONITORING

Schedule a follow-up visit within 7 days when initiating opioids, then every 1-4 weeks with any dose change; may gradually increase follow-up interval to maximum of every 3 months if no dose change and the patient is clinically/functionally stable.

At each follow-up visit assess:

1. Progress towards, or maintenance of, functional treatment goals.
2. Adherence to all aspects of treatment plan.
3. Evident adverse effects or aberrant behaviors.
4. Complications or co-morbid conditions (e.g., mental health or medical conditions, emerging opioid use disorder)

Complete Risk Mitigation Strategies:

1. Order random surveillance UDT.
2. Provide education on overdose protection.
3. Repeat assessment tools e.g., Clinical Opiate Withdrawal Scale (COWS) (Attachment E), and Patient Health Questionnaire-9 (PHQ-9) (Attachment A).

[1]Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1): 1–49.