

Common Elements in Guidelines for Prescribing Opioids for Chronic Pain

The use of opioids for treating chronic pain has been increasing.¹ In 2010, an estimated 20% of patients presenting to physician offices in the United States with pain symptoms or diagnoses were prescribed opioids.² Improving the way opioids are prescribed through clinical practice guidelines can ensure patients have access to safe, effective treatment while reducing the number of people who misuse, abuse or overdose from these powerful drugs.

The Centers for Disease Control and Prevention's (CDC) National Center for Injury Prevention and Control, along with the National Institute on Drug Abuse (NIDA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Office of the National Coordinator for Health Information Technology (ONC), reviewed eight guidelines to identify common recommendations (see accompanying Table). Guidelines on chronic pain that had been issued on or before January 2013 and developed by professional societies, states, or Federal agencies for general practitioners were considered. Guidelines for specific conditions or subpopulations were excluded, as were those specific to pain specialists.

Guidelines varied by development methodology (systematic review, expert opinion) and conflict of interest management (disclosure, voting recusal) (see Table). According to the Institute of Medicine, trustworthy clinical practice guidelines appropriately manage conflict of interest, use systematic reviews of the evidence to inform recommendations, and rate the strength of the evidence and recommendations.³

The following guidelines were reviewed:

- American Pain Society/American Academy of Pain Medicine Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain (2009)⁴
- Utah State Clinical Guidelines on Prescribing Opioids for Treatment of Pain (2009)⁵
- Veterans Affairs/Department of Defense Management of Opioid Therapy for Chronic Pain (2010)⁶
- Washington State Agency Medical Directors Group Interagency Guideline on Opioid Dosing for Chronic Noncancer Pain (2010)⁷
- Canadian Guideline for Safe and Effective Use of Opioids for Chronic Noncancer Pain (2011)⁸
- American College of Occupational and Environmental Medicine Guidelines for the Chronic Use of Opioids* (2011)⁹
- New York City Department of Health and Mental Hygiene Opioid Prescribing Guidelines (2011)¹⁰
- American Society of Interventional Pain Physicians Guidelines for Responsible Opioid Prescribing in Chronic Noncancer Pain (2012)¹¹

Recommendations from each of these guidelines were reviewed, extracted, and coded into categories of provider actions associated with pre-treatment, initial opioid treatment, follow-up, and discontinuation phases. This process resulted in a common set of provider actions and associated recommendations that can be seen in the table.

Common recommendation elements found in all the guidelines include:

- Conducting a physical exam, pain history, past medical history, and family/social history
- Conducting urine drug testing, when appropriate
- Considering all treatment options, weighing benefits and risks of opioid therapy, and using opioids when alternative treatments are ineffective
- Starting patients on the lowest effective dose
- Implementing pain treatment agreements
- Monitoring pain and treatment progress with documentation; using greater vigilance at high doses
- Using safe and effective methods for discontinuing opioids (e.g., tapering, making appropriate referrals to medication-assisted treatment, substance use specialists, or other services)

An additional recommendation element appearing in several guidelines that will become more feasible as states enhance their data systems includes:

- Using data from Prescription Drug Monitoring Programs (PDMPs) to identify past and present opioid prescriptions at initial assessment and during the monitoring phase

It is useful to identify common recommendation elements across guidelines to help inform others who may be considering developing their own guidelines.

In addition, rigorous, evidence-based recommendations can be incorporated into clinical decision support, such as within the electronic health record, to make it easier for health providers to follow guidelines.

*ACOEM guidelines have changed since this review; current guidelines can be found at www.acoem.org/OpioidAbuseUpdate.aspx

Provider Action	Guideline Recommendations							
	APS/AAPM	Utah	VA/DoD	WA State	Canadian	ACOEM	NYC	ASIPP
PRE-TREATMENT								
Pain history	Conduct history; diagnostic tests to evaluate pain condition	Assess prior treatment of pain	Evaluate prior pain treatment, fear, interference with function	Assess function, pain status, current opioid therapy	Assess history of pain condition; previous opioid trials	Conduct detailed pain history	Conduct detailed history that includes medications, onset, location, quality, duration, and intensity	Conduct detailed pain history; previous medication trials; pain intensity and functional impairment
Past medical history	Conduct history; substance abuse/misuse/addiction testing	Assess medical and mental health conditions, medications, substance addiction or dependence	Assess medical and psychiatric history; substance use; suicide	Screen for depression and anxiety; substance use	History of general medical condition, psychosocial history, psychiatric status, substance use history	Comprehensive medical history; screening for addiction	Comprehensive medical history	Comprehensive medical history
Family History/Social History	Conduct psychosocial assessment and family history	Assess social history	Concurrent interview of family members; comprehensive social history	Not addressed	Comprehensive family/social history	Comprehensive family/social history	Comprehensive family/social history	Comprehensive family/social history
Pregnancy	Counsel women of childbearing potential; Minimal/no use during pregnancy; Anticipate and manage risks during pregnancy	Not addressed	Estimate risk of opioid therapy in pregnancy	Not addressed	Prescribe lowest effective dose; discontinue if possible	Not addressed	Not addressed	Not addressed
Prescription Drug Monitoring Program - Initial assessment of past use	Not addressed	Check PDMP	Not addressed	Not addressed	Check PDMP	Not addressed	Check PDMP	Check PDMP
Physical Exam	Conduct physical exam	Assess pain severity, functional status, quality of life	Comprehensive physical examination	Comprehensive baseline assessment	Comprehensive physical examination	Conduct physical exam	Conduct physical exam	Comprehensive physical examination

Provider Action	Guideline Recommendations							
	APS/AAPM	Utah	VA/DoD	WA State	Canadian	ACOEM	NYC	ASIPP
Laboratory - Urine Drug Screening initial assessment	Not addressed	Perform before initiating long term opioids	Obtain in all patients prior to initiation of opioids.	Conduct baseline on all current prescription opioid users and for those considering chronic opioid therapy	Conduct baseline measure of risk	Conduct at baseline	Consider for all patients	Must be used to establish a baseline measure of risk
Opioid Indication	Consider alternatives to opioids and trial when benefits are likely to outweigh risks and no alternative therapy likely to pose favorable benefit/harm balance	Consider all options, including non-pharmaceutical treatment; opioids considered only when other therapies not beneficial	Inadequate response to non-drug or non-opioid modalities, or when benefits outweigh risks of opioid therapy	Consider when other physical, behavioral, and non-opioid measures have failed and no contraindication to use (e.g., substance abuse)	Use in mild to moderate or severe pain.	Anatomical/physiologic abnormalities; other non-opioids, adjuvants, and alternative pain control modalities inadequate; no contraindications	Consider when potential benefits are likely to outweigh potential harm; when other approaches to analgesia are ineffective	Establish medical necessity based on moderate/severe pain, organic problem, failure to respond to non-controlled substance, adjuvants, physical therapy/exercise, and other interventions
INITIAL OPIOID TREATMENT								
Drug choice	Initial therapeutic trial (weeks to months); Selection, dosing, titration individualized based on health status, opioid exposure, goals, and harms	Short term trial; start with short acting opioids	Start with trial; shared decision-making process with patient; education and knowledge when selecting a specific opioid	Trial of short acting opioids before long acting	Select opioid based on clinical profile and individual circumstances; Codeine or Tramadol suggested as first-line	Start short-acting opioids; avoid high-dose opioids; meperidine, propoxyphene, combination agonists, and mixed agonists/antagonists not recommended	Short acting opioids for acute pain; avoid long acting opioids; do not consider opioids first line for chronic non-cancer pain	Start with short acting opioids; long acting opioids recommended only in specific circumstances
Methadone	Initiate and titrate cautiously by clinicians familiar with use/risks	Prescribed by clinicians familiar with its risks and use	Initiate and titrate cautiously by clinicians familiar with use/risks or consult with experienced clinician	Special care should be taken	Use methadone under select circumstances	Not addressed	Additional caution needed	Use after failure of other opioids; use by clinicians with specific training in the risks and uses

Provider Action	Guideline Recommendations							
	APS/AAPM	Utah	VA/DoD	WA State	Canadian	ACOEM	NYC	ASIPP
Starting dosage	Start at low dose and titrate slowly	Start at low dose and titrate slowly	Start at low dose	Use lowest effective dose	Start at low dosage, increase gradually	Start with low dose	Start with the lowest possible effective dose	Start at low dosage, increase gradually
Duration of initial treatment	Several weeks to months	Short term trial	Not addressed	Not addressed	Not addressed	Not to exceed 4 weeks; in rare situations may extend by 2 weeks	Not addressed	8 to 12 weeks
Co-prescribing	Not addressed	Close attention to benzodiazepines/other sedatives	Not addressed	Do not combine with sedative-hypnotics, benzodiazepines or barbiturates unless indicated	Exercise caution; consider tapering benzodiazepine or opioid	Evaluate based on individual patient needs	Avoid benzodiazepines or other depressants	Do not combine with sedative hypnotics, benzodiazepines, or barbiturates unless indicated
Documentation	Informed consent; Written management plan	Written treatment plan; Informed consent; written education material to patient, family, caregiver	Written agreement; informed consent; document patient preferences; provide written educational materials to patient, family	Written treatment agreement	Informed consent; goal setting; oral or written treatment agreements	Written opioid agreement; goal setting; expectations; risks/benefits	Written treatment agreement; goal setting; expectations; risks/benefits	Informed consent; Written management plan
FOLLOW-UP VISITS								
Treatment progress	Monitor pain intensity, level of functioning, progress toward goals, adverse events, adherence; assess aberrant drug-related behaviors, substance use, psychological issues	Regular visits with evaluation of progress; assess analgesia, activity, adverse effects, and aberrant behavior	Evaluate pain intensity at each visit; evaluate function; assess patient satisfaction	Assess function and pain status, adverse effects, comorbidities, drug combinations or other substance abuse at each visit	Assess pain intensity and function at each visit; monitor adverse effects, medical complications, compliance, and risks	Evaluate functional activity, participation in social activities,	Regular follow-up visits; assess pain level, adverse events, functional improvement, and compliance	Regular follow up visits; assess compliance, adverse events, aberrant behaviors, improvement
High-dose opioids	>200mg/day; more frequent and intense monitoring for high dose	>120-200 MME/day; increase clinical vigilance	Refer or consult if the dose is > 200 MME/day	>120 MME/day consultation from expert	>200 MME/day; reassess or monitor	MME not specified; frequent follow-up; documentation of improved function	>100 MME/day, reassess pain status or consider other approaches	>91 MME/day; consider pain management consultation

Provider Action	Guideline Recommendations							
	APS/AAPM	Utah	VA/DoD	WA State	Canadian	ACOEM	NYC	ASIPP
Co-prescribing	Not addressed	Not addressed	Careful monitoring	Do not combine with sedative-hypnotics, benzodiazepines or barbiturates unless indicated	Exercise caution; consider tapering benzodiazepine or opioid	Use Tramadol cautiously in patients taking tricyclic, SSRI, or SNRI anti-depressants	Avoid prescribing opioids with benzodiazepines or other depressants	Do not combine opioids with sedative hypnotics, benzodiazepines, or barbiturates unless indicated
Past controlled prescription drug use	Routine behavior assessment; Check PDMP	Check PDMP regularly	Not addressed	Not addressed	Check PDMP	Not addressed	Routine behavior assessment; Check PDMP	Continued PDMP checks
Laboratory - Urine Drug Screening Monitoring	If high risk, periodic urine drug screens; if not high risk, consider periodic screens	Randomly selected visits and when aberrant behavior is suspected	Conduct randomly at follow-up visits, increase frequency based on risk level	Random testing based on risk category	Consider risk for opioid misuse and addiction, aberrant drug-related behaviors, and availability of UDS during follow-up	Random screening; at least once and up to 4 times a year and at termination	Repeat randomly, based on risk level (yearly for low risk to every 3 months for high risk)	Randomly repeat at frequency determined by risk
OPIOID DISCONTINUATION								
Rationale documentation	Taper/wean patients engaging in repeated aberrant drug-related behaviors or abuse/diversion; no progress; intolerable adverse effects	Document nonadherence to the treatment plan; discontinue if goals are not met, if adverse effects outweigh benefits or if dangerous or illegal behaviors are demonstrated	Document any evidence of misuse, abuse, or addiction	No improvement; adverse effects; aberrant behaviors	Document all aspects of opioid trial; discontinue if pain remains unresponsive	Failure to improve; aberrant behaviors	Document all aspects of opioid trial; discontinue if signs of opioid misuse	Document all aspects of opioid trial; consider taper or discontinue if no improvement, adverse effects or aberrant behavior
Tapering plan	Slow 10% reduction/week to rapid 25%-50% reduction/few days	10% reduction/week over 6 to 8 weeks	Taper by 20%-50% per week; faster or slower tapering may be warranted	10% reduction/week over 6 to 8 weeks	Variable; 10% of the total daily dose every day, or 10% of the total daily dose every 1–2 weeks	Not addressed	Reduction of 10% each day, 20% every 3 to 5 days, or 25% each week	Decrease by 10% of the original dose per week

Provider Action	Guideline Recommendations							
	APS/AAPM	Utah	VA/DoD	WA State	Canadian	ACOEM	NYC	ASIPP
Referral for Medication Assisted Treatment or other substance abuse treatment services as appropriate	Make treatment available and arrange continued follow-up	Consider consultation for complex cases or referral to a pain management, mental health or substance use specialist	Refer to SUD specialty when behavior suggests addiction; refer to behavioral health specialty for psychological problems	If signs of alcohol or substance abuse refer to an addiction specialist	When needed, consult pain management or addiction specialists; referral for treatment intervention	Referral for mental health, substance use specialist, pain management specialist	Explain the option of buprenorphine and refer to an addiction specialist, buprenorphine provider, or methadone maintenance treatment program	Assess for abuse/addiction and refer for addiction treatment and pain management as appropriate
GUIDELINE DEVELOPMENT METHODS								
Evidence review, grading, and decision making	Systematic review; Grading of Recommendations Assessment, Development and Evaluation; majority approval	Review of previous guidelines; consensus approval	Systematic review; expert opinion; US Preventive Services Task Force evidence grading	Expert opinion	Systematic review; expert opinion; consensus approval; Canadian Task Force on Preventive Healthcare grading	Expert opinion	Not addressed	Systematic review; expert opinion; consensus approval; US Preventive Services Task Force grading
Conflicts of Interest	Disclosed; recused from voting	Disclosed	Not addressed	Not addressed	Disclosed	Not addressed	Not addressed	Disclosed

Guidelines

APS/AAPM = American Pain Society/American Academy of Pain Medicine Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain

Utah = Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain

VA/Dod = Veteran's Administration/Department of Defense Management of Opioid Therapy for Chronic Pain

WA State = Washington State Agency Medical Directors Group Interagency Guideline on Opioid Dosing for Chronic Noncancer Pain

Canadian = Canadian Guideline for Safe and Effective Use of Opioids for Chronic Noncancer Pain

ACOEM = American College of Occupational and Environmental Medicine Guidelines for the Chronic Use of Opioids*

NYC = New York City Department of Health and Mental Hygiene Opioid Prescribing Guidelines

ASIPP = American Society of Interventional Pain Physicians Guidelines for Responsible Opioid Prescribing in Chronic Noncancer Pain

*ACOEM guidelines have changed since this review; current guidelines can be found at www.acoem.org/OpioidAbuseUpdate.aspx

References

1. Von Korff MR. Long-term use of opioids for complex chronic pain. *Best Pract Res Clin Rheumatol*. 2013 Oct;27(5):663-72.
2. Daubresse M , Chang HY , Yu Y , Viswanathan S , Shah ND , Stafford RS , Kruszewski SP , Alexander GC . Ambulatory diagnosis and treatment of nonmalignant pain in the United States, 2000-2010. *Med Care*. 2013 Oct;51(10):870-8.
3. Graham R, Mancher M, Wolman DM, Greenfield S, Steinberg, E (Eds). *Clinical practice guidelines we can trust*. National Academies Press, 2011.
4. Chou R, Fanciullo GP, Fine PG, Adler JA, Ballantyne JC, Davies P et al. Clinical Guidelines for the use of chronic opioid therapy in chronic noncancer pain. *J Pain*. 2009;10(2):113-130.
5. Rolfs RT, Johnson E, Williams NJ, Sundwall DN, Utah Department of H. Utah clinical guidelines on prescribing opioids for treatment of pain. *Journal of Pain & Palliative Care Pharmacotherapy*. 2010;24(3):219-35.
6. VA/DOD. VA/DoD clinical practice guideline for management of opioid therapy for chronic pain. Washington, DC: Veterans Administration; 2010, Available at: http://www.va.gov/painmanagement/docs/cpg_opioidtherapy_fulltext.pdf
7. Washington Agency Medical Directors Group. Interagency guideline on opioid dosing for chronic noncancer pain. 2010, Available at: <http://www.agencymeddirectors.wa.gov/Files/OpioidGdline.pdf>
8. Kahan M, Wilson L, Mailis-Gagnon A, Srivastava A, National Opioid Use Guideline G. Canadian guideline for safe and effective use of opioids for chronic noncancer pain: clinical summary for family physicians. Part 2: special populations. *Canadian Family Physician*. 2011;57(11):1269-76, e419-28.
9. American College of Occupational and Environmental Medicine. Guidelines for the chronic use of opioids. 2011, Available at: http://www.acoem.org/Guidelines_Opioids.aspx .
10. Paone D, Dowell D, Heller D. Preventing misuse of prescription opioid drugs. *City Health Information*. 2011;30(4):23-30.
11. Manchikanti L, Abdi S, Atluri S, Balog CC, Benyamin RM, Boswell MV, et al. American Society of Interventional Pain Physicians (ASIPP) guidelines for responsible opioid prescribing in chronic non-cancer pain: Part 2--guidance. *Pain Physician*. 2012;15(3 Suppl):S67-116.