Clinical Practice Guidelines

This section of the toolkit includes four guidelines:

- Emergency Department Opioid Prescribing Guidelines for the Treatment of Non-Cancer Related Pain (American Academy of Emergency Medicine, 2013)
- Guideline For Prescribing Opioids For Chronic Pain (Center For Disease Control, 2016)
- 2015 Washington State Interagency Guidelines on Prescribing Opioids for Pain
- Clinical Guidelines Flowchart for Evaluation and Treatment of Chronic Non-Cancer Pain (Alameda County Health Care Services Agency, 2016, adapted from the Oregon Pain Guidance Opioid Prescribing Guidelines 8/2014)

Clinical Practice Statement

Emergency Department Opioid Prescribing Guidelines for the Treatment of Non-Cancer Related Pain (11/12/2013)

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Executive summary

Pain is one of the most common chief complaints among emergency department patients with a reported rate of over 50%.[1] There is great variability among emergency clinicians in the management of pain, especially with respect to the use of opioid medications.[2] Importantly, morbidity and mortality have increased as the frequency of opioid use for the treatment of pain has increased.[3] This includes a significant increase in non-medical opioid use, addiction, drug-related emergency department visits, and death.[4,5] The dangers of prescribing opioid medications extend beyond the individual patient and may adversely impact public health.[6] Approximately 13% of high school seniors have reported non-medical use of prescription opioids. Despite emergency departments prescribing only a fraction of those prescriptions written nationally, ED prescriptions for opioids are reported to account for approximately 45% of those opioids diverted for non-medical use.[7]

These guidelines were developed to provide the emergency clinician with recommendations regarding the safe, effective, and ethical practice of pain management in the emergency department setting. These recommendations may be adopted in whole or in part and should be adapted to address individual hospital policies along with state and local regulations. This document is not meant to replace the judgment of the treating clinician who is in the best position to determine the needs of the individual patient.

Recommendations

In the management of the emergency department patient presenting with acute or chronic pain, the emergency clinician should consider the following when prescribing an opioid medication:

1. **Administer a short-acting opioid analgesic for the treatment of acute pain as a second-line treatment to other analgesics unless there is a clear**

indication for the use of opioid medication (Example-patient with acute abdomen, long bone fracture, etc).

2. **Start with the lowest effective dose of an opioid analgesic.**

3. **Prescribe a short course (up to 3 days) of opioid medication for most acute pain conditions.**

4. **Address exacerbations of chronic pain conditions with non-opioid analgesics, non-pharmacological therapies, or referral to pain specialists for follow-up.**

5. **Consider assessing for opioid misuse or addiction using a validated screening tool.**

6. **Consider accessing a centralized prescription network or state-based prescription drug monitoring program, when available, for patient information on recent controlled substance prescriptions.**

7. **Refrain from initiating treatment with long-acting, or extended-release, opioid analgesics such as methadone.**

8. **Avoid prescribing opioid analgesics to patients currently taking sedative-hypnotic medications or concurrent opioid analgesics.**

9. **Refrain from replacing prescriptions for lost, stolen, or destroyed opioid prescriptions.**

10. **Refrain from refilling chronic opioid prescriptions. Refer the patient to the treating clinician who provided the original prescription.**

11. **Encourage prescribers to provide safety information about opioid analgesics to patients. This could include information on the risks of overdose, dependence, addiction, safe storage, and proper disposal of unused medications.**

12. **Following treatment with opioids (in particular the parenteral form) consider an appropriate period of observation and monitoring before a patient is discharged.**

13. **Understand EMTALA and its requirements for the treatment of pain. The emergency clinician is required under EMTALA to evaluate an emergency department patient reporting pain. The law allows the emergency clinician to use clinical judgment when treating pain and does not require the use of opioids.**

Opioid prescribing is associated with potential misuse and future dependence.[8, 9] [10] Though attempts can be made to mitigate this, there are no set of predictors that can determine all patients at risk for opioid abuse.[11] This should be reserved for only the most painful conditions using good clinical judgment.

Higher doses of opioids are associated with an increased risk of opioid overdose deaths.[12, 13] In addition, increased doses are also associated with an increased risk of abuse.[9]

Few acutely painful conditions treated in the emergency department require more than a short 3-day course of opioid therapy.[14] Longer courses of opioid treatment are associated with increased risk of abuse[8] and disability.[15] In addition, opioid use beyond 3 days results in diminished efficacy and potential increased pain sensitivity.[16] In special circumstances, when longer courses of opioid treatment may be required, an effort should be made to ensure close follow up as an outpatient. In addition, a patient may return to the ED for reassessment if 3 days of opioid treatment was inadequate and/or they were unable to arrange outpatient follow up within that time.

The benefits and safety of opioids for the management of chronic pain remain uncertain.[17-19] Treatment of chronic pain is complicated and requires a thorough assessment and determination of appropriate long-term therapy. Patients with chronic pain are optimally managed by a single long-term provider who can frequently monitor treatment efficacy and safety. Monitoring practices such as patient-prescriber agreements and urine drug testing are not practical in the emergency department setting.[20] Importantly, predictors for opioid abuse in chronic pain patients are difficult to assess during an emergency department evaluation.[11, 21]

Patients with a history of substance abuse are at an increased risk of opioid misuse when prescribed opioid analgesics for acute pain. The single question, "How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?" was found to be 100% sensitive and 73.5% specific for the detection of a drug when the patient answered one or more times.[22] Consider alternative therapy in these patients.

Centralized prescription networks provide valuable information on a patient's prescription history. Multiple studies have shown that use of these systems leads to decreases in inappropriate prescribing practices.[23, 24]

Long acting opioids are high risk for respiratory depression and do not have a role in the treatment of acute pain syndromes.[25, 26] The pharmacokinetics of these medications result in an unpredictable peak effect and increase the risk of respiratory depression. Prescriptions for long acting and extended release opiates are more susceptible to diversion and non-medical opioid use.[26]

Consider other risk factors for respiratory depression such as obstructive sleep apnea. Prescribing new, or refilling old opioid prescriptions for patients already on opioids or sedative hypnotics have potential life threatening consequences due to respiratory depression and/or trauma secondary to mental status obtundation.

The EMTALA definition of a medical emergency makes reference to severe pain as a symptom that should be investigated; pain may be the result of an emergency medical condition. EMTALA does not state that severe pain is an emergency medical condition. EMTALA does not obstruct the emergency medical provider from applying their professional judgment to withhold opioid treatment of pain for ED patients without an emergency medical condition. [27]

Opioid dispensing and administration is fraught with it's own intrinsic problems and related morbidity and mortality. A thoughtful approach using this guideline provided will hopefully assist emergency physicians in treating pain ethically without the subsequent consequences associated with their administration.

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

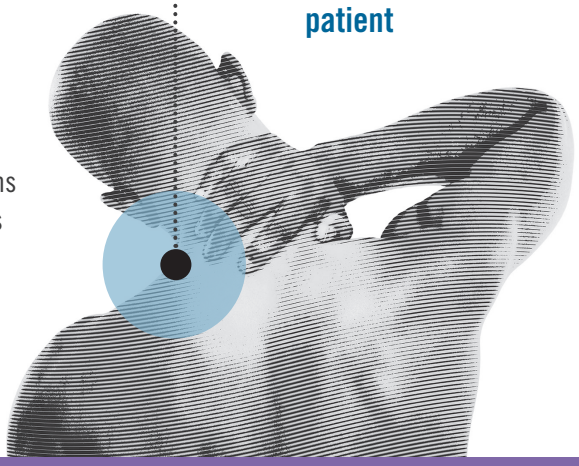
1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CLINICAL REMINDERS

- **Opioids are not first-line or routine therapy for chronic pain**
- **Establish and measure goals for pain and function**
- **Discuss benefits and risks and availability of nonopioid therapies with patient**



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LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

CLINICAL REMINDERS

- Use immediate-release opioids when starting
- Start low and go slow
- When opioids are needed for acute pain, prescribe no more than needed
- Do not prescribe ER/LA opioids for acute pain
- Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed

4 When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

5 When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

6 Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

7 Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

8 Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

9 Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10 When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11 Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

12 Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

CLINICAL REMINDERS

- Evaluate risk factors for opioid-related harms
- Check PDMP for high dosages and prescriptions from other providers
- Use urine drug testing to identify prescribed substances and undisclosed use
- Avoid concurrent benzodiazepine and opioid prescribing
- Arrange treatment for opioid use disorder if needed

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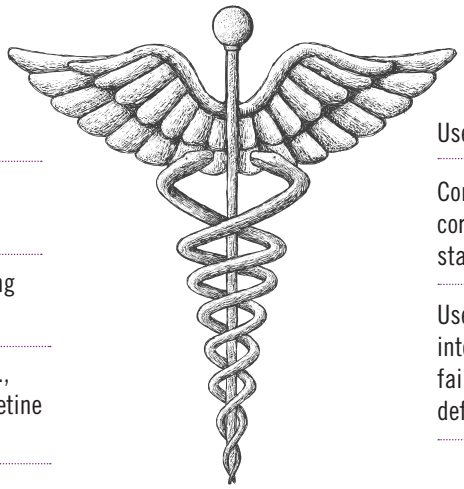
NONOPIOID TREATMENTS FOR CHRONIC PAIN

PRINCIPLES OF CHRONIC PAIN TREATMENT

Patients with pain should receive treatment that provides the greatest benefit. Opioids are not the first-line therapy for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. Evidence suggests that nonopioid treatments, including nonopioid medications and nonpharmacological therapies can provide relief to those suffering from chronic pain, and are safer. Effective approaches to chronic pain should:



- Use nonopioid therapies to the extent possible
- Identify and address co-existing mental health conditions (e.g., depression, anxiety, PTSD)
- Focus on functional goals and improvement, engaging patients actively in their pain management
- Use disease-specific treatments when available (e.g., triptans for migraines, gabapentin/pregabalin/duloxetine for neuropathic pain)
- Use first-line medication options preferentially
- Consider interventional therapies (e.g., corticosteroid injections) in patients who fail standard non-invasive therapies
- Use multimodal approaches, including interdisciplinary rehabilitation for patients who have failed standard treatments, have severe functional deficits, or psychosocial risk factors

NONOPIOID MEDICATIONS

Medication	Magnitude of benefits	Harms	Comments
Acetaminophen	Small	Hepatotoxic, particularly at higher doses	First-line analgesic, probably less effective than NSAIDs
NSAIDs	Small-moderate	Cardiac, GI, renal	First-line analgesic, COX-2 selective NSAIDs less GI toxicity
Gabapentin/pregabalin	Small-moderate	Sedation, dizziness, ataxia	First-line agent for neuropathic pain; pregabalin approved for fibromyalgia
Tricyclic antidepressants and serotonin/norephinephrine reuptake inhibitors	Small-moderate	TCAs have anticholinergic and cardiac toxicities; SNRIs safer and better tolerated	First-line for neuropathic pain; TCAs and SNRIs for fibromyalgia, TCAs for headaches
Topical agents (lidocaine, capsaicin, NSAIDs)	Small-moderate	Capsaicin initial flare/ burning, irritation of mucus membranes	Consider as alternative first-line, thought to be safer than systemic medications. Lidocaine for neuropathic pain, topical NSAIDs for localized osteoarthritis, topical capsaicin for musculoskeletal and neuropathic pain

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RECOMMENDED TREATMENTS FOR COMMON CHRONIC PAIN CONDITIONS

Low back pain

Self-care and education in all patients; advise patients to remain active and limit bedrest

Nonpharmacological treatments: Exercise, cognitive behavioral therapy, interdisciplinary rehabilitation

Medications

- First line: acetaminophen, non-steroidal anti inflammatory drugs (NSAIDs)
- Second line: Serotonin and norepinephrine reuptake inhibitors (SNRIs)/tricyclic antidepressants (TCAs)

Migraine

Preventive treatments

- Beta-blockers
- TCAs
- Antiseizure medications
- Calcium channel blockers
- Non-pharmacological treatments (Cognitive behavioral therapy, relaxation, biofeedback, exercise therapy)
- Avoid migraine triggers

Acute treatments

- Aspirin, acetaminophen, NSAIDs (may be combined with caffeine)
- Antinausea medication
- Triptans-migraine-specific

Neuropathic pain

Medications: TCAs, SNRIs, gabapentin/pregabalin, topical lidocaine

Osteoarthritis

Nonpharmacological treatments: Exercise, weight loss, patient education

Medications

- First line: Acetamionphen, oral NSAIDs, topical NSAIDs
- Second line: Intra-articular hyaluronic acid, capsaicin (limited number of intra-articular glucocorticoid injections if acetaminophen and NSAIDs insufficient)

Fibromyalgia

Patient education: Address diagnosis, treatment, and the patient's role in treatment

Nonpharmacological treatments: Low-impact aerobic exercise (i.e. brisk walking, swimming, water aerobics, or bicycling), cognitive behavioral therapy, biofeedback, interdisciplinary rehabilitation

Medications

- FDA-approved: Pregabalin, duloxetine, milnacipran
- Other options: TCAs, gabapentin

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

Summary of

2015 Interagency Guideline on Prescribing Opioids for Pain

AMDG agency medical directors' group

A collaboration of state agencies, working together to improve health care quality for Washington State citizens.

See full guideline at
www.AgencyMedDirectors.wa.gov

All pain phases

- Use non-opioid therapies, such as behavioral intervention, physical activity and non-opioid analgesics.
- Avoid opioids if the patient has significant respiratory depression, current substance use disorder, history of prior opioid overdose or a pattern of aberrant behaviors.
- Assess and document function and pain using a validated tool at each visit where opioids are prescribed.
- Don't prescribe opioids with benzodiazepines, carisoprodol, or sedative-hypnotics.

Acute phase (0–6 weeks)

- Check the state's Prescription Monitoring Program (PMP) before prescribing.
- Don't prescribe opioids for non-specific back pain, headaches, or fibromyalgia.
- Prescribe the lowest necessary dose for the shortest duration.
- Opioid use beyond the acute phase is rarely indicated.

Perioperative pain

- Evaluate thoroughly preoperatively: check the PMP and assess risk for over-sedation and difficult-to-control pain.
- Discharge with acetaminophen, NSAIDs, or very limited supply (2–3 days) of short-acting opioids for some minor surgeries.
- For patients on chronic opioids, taper to preoperative doses or lower within 6 weeks following major surgery.

Subacute phase (6–12 weeks)

- Don't continue opioids without clinically meaningful improvement in function (CMIF) and pain.
- Screen for comorbid mental health conditions and risk for opioid misuse using validated tools.
- Recheck the PMP and administer a baseline urine drug test (UDT) if you plan to prescribe opioids beyond 6 weeks.

Chronic phase (>12 weeks)

- Continue to prescribe opioids only if there is sustained CMIF and no serious adverse events, risk factors, or contraindications.
- Repeat PMP check and UDT at frequency determined by the patient's risk category.
- Prescribe in 7-day multiples to avoid ending supply on a weekend.
- Don't exceed 120 mg/day MED without a pain management consultation.

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When to discontinue

- At the patient's request
- No CMIF
- Risks outweigh benefits
- Severe adverse outcome or overdose event
- Substance use disorder identified (except tobacco)
- Aberrant behaviors exhibited
- To maintain compliance with DOH rules or consistency with AMDG guideline

Considerations prior to taper

- Help the patient understand that chronic pain is complex and opioids cannot eliminate pain.
- Consider an outpatient taper if the patient isn't on high-dose opioids or doesn't have comorbid substance use disorder or other active mental health disorder.
- Seek consultation if the patient failed previous taper or is at greater risk for failure due to high-dose opioids, concurrent benzodiazepine use, comorbid substance use disorder or other active mental health disorder.

How to discontinue

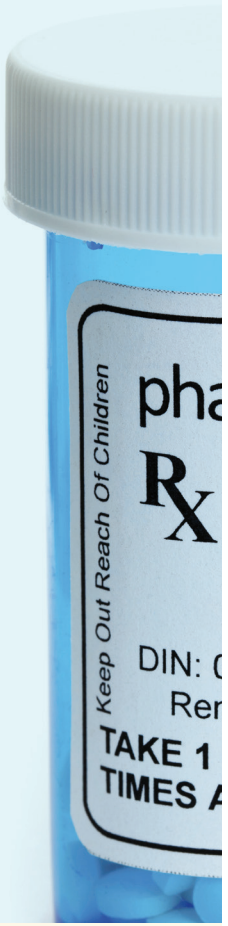
- Taper opioids first if patients are also on benzodiazepines.
- Unless safety considerations require a more rapid taper, start with 10% per week and adjust based on the patient's response.
- Don't reverse the taper; it can be slowed or paused while managing withdrawal symptoms.
- Watch for unmasked mental health disorders, especially in patients on prolonged or high-dose opioids.

Recognizing and treating opioid use disorder

- Assess for opioid use disorder and/or refer for a consultation if the patient exhibits aberrant behaviors.
- Help patients get medication-assisted treatment along with behavioral therapies.
- Prescribe naloxone (especially if you suspect heroin use) and educate patient's contacts on how to use it.

Special populations

- Counsel women before and during pregnancy about maternal, fetal, and neonatal risks.
- For children and adolescents, avoid prescribing opioids for most chronic pain problems.
- In older adults, initiate opioids at 25–50% lower dose than for younger adults.
- For cancer survivors, rule out recurrence or secondary malignancy for any new or worsening pain.



Check out the resources at
www.AgencyMedDirectors.wa.gov

- Free online CME
- Opioid Dose Calculator
- Videos from Primary Pain Care Conference

CLINICAL GUIDELINES FLOWCHART
for Evaluation and Treatment of Chronic Non-Cancer Pain

START

REVIEW MEDICAL & MEDICATION HISTORY

- ⇨ Review medical history, including records from previous providers before prescribing. Check CURES and UTox.
- ⇨ Do a physical exam to determine baseline function and pain.
- ⇨ What prior attempts were made to treat this pain with non-opioid modalities?
- ⇨ Is the diagnosis appropriate for opioid treatment? There is no evidence of benefit in chronic lower back pain, migraines, fibromyalgia, or neuropathy.
- ⇨ Prescribing chronic opioids is rarely appropriate on the first visit. Bridge with a few days' supply while documenting.
- ⇨ Do a psychosocial and risk assessment for medication abuse, e.g. Opioid Risk Tool (ORT) and Screener & Opioid Assessment for Patients with Pain (SOAPP). Screen for psychiatric co-morbidity.
- ⇨ Do a physical assessment for safety of opioid use, e.g., bone density, EKG, sleep study, testosterone level, and STOP BANG for sleep apnea.

GREEN LIGHT

INCORPORATE NON-OPIOID INTERVENTIONS

Create a plan of treatment with the patient that incorporates non-opioid interventions, such as:

- ⇨ Patient lifestyle improvement: Exercise, weight loss
- ⇨ Behavioral therapies: Cognitive Behavioral Therapy (CBT), peer-to-peer or other peer support, mindfulness training, psychotherapy, case management
- ⇨ Physiotherapy modalities: OT, PT, passive modalities
- ⇨ Medical interventions: Pharmacological, procedural, surgical
- ⇨ Treatment modalities: Acupuncture, massage

CAUTION

IF YOU DECIDE ON OPIOID TREATMENT: START LOW & GO SLOW

- ⇨ Counsel patients on potential risks. Agree on and document treatment goals. Patient signs informed consent and treatment agreement.
- ⇨ Check for evidence of possible misuse (CURES) and baseline urine screen.
- ⇨ Track medical and age-related conditions that increase risks of opioids.

REASESS

REASSESS EVERY 6 MONTHS

- ⇨ Evaluate progress toward treatment goals. If no improvement or progress on goals, stop and reassess. Use tools to assess for changes in function and pain: ORT, Tampa_Scale_for Kinesiophobia, or Current Opioid Misuse Measure (COMM) 1 to 2 x per year.
- ⇨ Assess for worrisome behaviors and side effects every six months.

STOP!

STOP!

- ⇨ Seek help from community partners, specialists, medical director, or review committee if you have:
  - Concerns from your visit assessment, or
  - Notice signs of significant misuse or illicit drug use.
- ⇨ Re-evaluate your treatment plan/seek help if the patient is at high risk of death. For example if prescribing:
  - More than 120 mg MED/day without functional improvement, or
  - Opioids with benzodiazepines, or
  - More than 40 mg of methadone/day.
- ⇨ Drug screen: Quarterly (standard) or more often (higher risk).

Alameda County Health Care Services Agency *adapted this from the Oregon Pain Guidance guidelines at www.oregonpainguidance.org.*
Find this flowchart at www.acgov.org/health/indigent/coalition.htm.