

Opioid Prescribing Task Force Issues Matrix – Chronic Non-Cancer Pain

Date/Location:

October 19/Spokane

Tech Experts:

Dr. Lynda Williamson, DO, Family Medicine & Sub-specialty in Chronic Pain Management

Dr. Matthew Layton MD, PhD, FACP, DFAPA, Clinical Professor, Elson Floyd College of Medicine, WSU

AMDG/CDC Recommendations:

AMDG—

- Chronic phase is defined as greater than 12 weeks.
- Continue to prescribe opioids only if there is sustained clinically meaningful functional improvement.
- No serious adverse events, risk factors or contraindications.
- Repeat PMP check and urine drug testing as warranted by patient's risk category.
- Prescribe in 7-day multiples to avoid a prescription ending on a weekend.
- Don't exceed 120 mg/day MED without a pain management consultation.

CDC—

- Determining when to initiate or continue opioids for chronic pain
 - Selection of non-pharmacologic therapy, nonopioid pharmacologic therapy, opioid therapy
 - Establishment of treatment goals
 - Discussion of risks and benefits of therapy with patients
- Opioid selection, dosage, duration, follow-up, and discontinuation
 - Selection of immediate-release or extended-release and long-acting opioids
 - Dosage considerations (evaluate risks/benefits at ≤ 50 mg/day MED, and avoid dosing above 90 mg/day MED)
 - Duration of treatment (evaluate risks/benefits within 1-4 weeks, then at least every three months thereafter)
 - Considerations for follow-up and discontinuation of opioid therapy
- Assessing risk and addressing harms of opioid use
 - Evaluation of risk factors for opioid-related harms and ways to mitigate patient risk
 - Review of prescription drug monitoring program (PDMP) data
 - Use of urine drug testing (at least annually)
 - Considerations for co-prescribing benzodiazepines

- Arrangement of treatment for opioid use disorder

1. What issues are there?	2. How can we address these issues?
<p>Definitions—are they still accurate and do they apply broadly? What possible additional terms need to be added? Dual diagnosis concept should be included. Mental health, chronic pain. Chronic medical condition. Example: diabetes.</p>	<ul style="list-style-type: none"> • Revise definitions as needed later in process to ensure accuracy and consistency. • Consider whether they apply more broadly to all opioid prescribing. • Consider moving to a “general provisions” part of opioid rules.
<p>Patient Evaluation—In chronic opioid prescribing, do current requirements still apply? Is additional regulation needed? Do these requirements apply broadly? Do they need to be modified for other prescribing settings (e.g. acute)?</p>	<ul style="list-style-type: none"> • Evaluate current rule and consider if revisions/additions are needed. • Consider moving to a “general provisions” part of opioid rules if they apply broadly, or else highlight appropriate requirements for other prescribing settings. • Valid and reliable pain assessment tool. Example: PROMIS to include breadth of collection of symptoms • Consider all sources for pain: work-related, domestic violence; other concerns
<p>Treatment Plan—does this section need to be expanded, for example, with respect to clinically meaningful improvement or use of other treatment modalities?</p>	<ul style="list-style-type: none"> • Consider additional language to further define and direct incorporation of clinically meaningful improvement and the use of other treatment modalities into treatment plans. • Check PMP as a starting point before starting a treatment plan; have a treatment plan for anyone on an opioid. • Requirement for face to face visits at certain intervals as part of the treatment plan (rule). • Rules for long term care; why not a phone visit as opposed to a face to face for stable, long term patient; still occasional face to face, periodic visits.

	<ul style="list-style-type: none"> •
<p>Informed Consent—should it be moved to “general provisions”? Do the same consent requirements apply regardless of prescribing setting?</p>	<ul style="list-style-type: none"> • Consider moving to a “general provisions part of opioid rules. • Educational process; educate patient and document. Trigger to remind physicians to have conversation with patient. • Decision making, implications, consequences and benefits associated with starting a patient on opioid therapy
<p>Written Agreement for Treatment—Should agreements be required for chronic prescribing? Are current elements sufficient?</p>	<ul style="list-style-type: none"> • Consider making agreements mandatory. • Language of contract/pain management agreement should be inclusive; collaborative • Consider seven elements described by Dr. Williamson
<p>Periodic Review—Can we better quantify clinically meaningful improvement and pain level? Are other requirements of this rule sufficient? Should UA testing be a component?</p>	<ul style="list-style-type: none"> • Consider incorporating requirements for quantifiable progress in CMI as a precondition to continued opioid therapy. • Consider pain indicators other than intensity • Consider whether additional requirements are needed.
<p>Long-acting Opioids, Including Methadone—should the prescribing of methadone be moved to a separate part of the rules on co-prescribing?</p>	<ul style="list-style-type: none"> • Consider moving this rule to a separate rule part on co-prescribing, including medication-assisted treatment (MAT).
<p>Episodic Care—does this rule better fit with either in a separate part on prescribing opioids for special populations or in the part on Acute prescribing?</p>	<ul style="list-style-type: none"> • Consider whether the part on chronic/non-cancer prescribing is the best location for episodic care requirements, or if it should be moved.

<p>Consultation—Recommendations and Requirements—should 120 MED remain as the threshold for consult? Do sufficient consultants exist? Will they exist if the MED threshold is lower? Is consult still needed?</p>	<ul style="list-style-type: none"> • Consider whether the mandatory consultation is the best approach. • In lieu of consultation, should additional education/training be required for those who prescribe higher opioid doses? • Is a dual-threshold approach, such as 50/90 MEDs, a more suitable approach?
<p>Clear benefits of prescribing opioids?</p>	
<p>Lack of training about treating pain patients? Training beyond prescription pad only.</p>	<p>How do we provide structure and education to providers to allow them to make rational decisions and to talk to their patients. Hearing what patients have to say; motivational interviewing; explain physician position in relation to patient position. <i>Concern:</i> increasing attendance at continuing education opportunities. Incentives to participate in education = providers trying to use best practices. Professional validation.</p>
<p>Lack of data about the actual amount of opioids patients take.</p>	
<p>Insurance coverage/reimbursement</p>	<p>Collaboration with insurance providers to lower/remove barriers; Use leverage with insurance companies to authorize higher cost medication to reduce pain effects Propose recommendation to the insurance commission for modifying coverage</p>
<p>Mail order pharmacies</p>	
<p>Time to work with patients</p>	
<p>Fear of treating pain patients based on complexity, lack of resources, oversight, and insurance coverage</p>	
<p>Consultation requirement is a barrier because of the timing and because modalities are not available to all patients</p>	
<p>Guidelines are not clear; desire for physician discretion</p>	<p>Incentive for physicians;</p>
<p>Freedom for physicians to choose their treatment areas</p>	
<p>Incentivize as opposed to mandate managing pain appropriately</p>	<p>Consider two levels of certification Destigmatize pain management instead of chronic medical condition</p>

Language used when describing pain treatment	Language that includes pain management/opioid prescribing as part of good practice
Genetic predisposition to addiction	Genetic testing (pharmacogenomics); screening process for addiction flags; streamlined hand-off mechanisms
HIPPA restrictions for patient handouts	Uniform pain management agreement; patient signs and releases
Rules are lengthy and confusing; not the place for education	Significantly shorter: education should be preamble; guidelines could be one page
Isolated patient and physician	Telehealth resource; educational resource.
Contributing factors to patient pain	Can be modified
Unreliability of UA	Should not be mandatory

3. What concerns/ impacts are there?	4. How might we mitigate these concerns?
Definitions—will additional terms need to be defined?	<ul style="list-style-type: none"> At the end of the process review the proposed rules to see if definitions need to be added or modified.
Consultation—What about patients already over 120 MEDs, availability of specialists,	<ul style="list-style-type: none"> Consider whether “grandfathering” in existing patients, with prior documentation of treatment at over 120 MEDs, makes sense. Consider Lower MED threshold for new patients but have special cases for patients already on high dose. Remove consultation requirement. Require additional CE.

5. *What further information do we need?*

- AMDG Guidelines
- CDC Guidelines
- Existing B/C chronic non-cancer pain rules
- Sun et al; “Incidence of and Risk Factors for Chronic Opioid Use Among Opioid-Naïve Patients in the Postoperative Period”; JAMA Internal Medicine; online July 11, 2016.

6. What is this group’s recommendation?