

MMS Opioid Therapy and Physician Communication Guidelines

Acute Care Guidelines

Initiation of Opioid Treatment

1. Physicians must be familiar with and follow the requirements of the law and regulations on use of the prescription monitoring program prior to initiating opioid treatment.
2. Patients should also be screened or assessed for: pregnancy; personal or family histories of substance use disorder; mental health status; or, relevant behavioral issues.
3. Physicians prescribing opioids should inform their patients about the cognitive and performance effects of these prescriptions and warn them about the dangers to themselves and others in operating machinery, driving and related activities while under treatment.
4. Patients with complex pain conditions, serious co-morbidities and mental illness, or a history or evidence of substance use disorder should be considered for consultation from a colleague or specialist referral.
5. When clinically indicated, opioids should be initiated as a short term trial to assess the effects and safety of opioid treatment on pain intensity, function, and quality of life. In most instances, the trial should begin with a short-acting opioid medication.
6. The starting dosage should be the minimum dosage necessary to achieve the desired level of pain control and to avoid excessive side effects.
7. Duration should be short term with possible partial fill prescriptions or short term, low dosage sequential prescription approaches considered.
8. Physicians should be aware of published dosing guidelines for pediatric patients and consider body weight and age as a factor in treating pediatric patients.^[1]
9. Concurrent prescriptions should be reviewed, including paying close attention to benzodiazepines and other medications that may increase the risks of harm associated with opioid use.
10. Physicians must maintain records and engage in patient assessments consistent with prescribing guidelines of the Board of Registration in Medicine which are available on the Board's website.
11. Patients should be counseled to store the medications securely, never share with others, and properly dispose of unused and expired prescriptions.

Common Elements of Best Practices for Ongoing Opioid Treatment of more than 60 Days Duration

1. There should be regular visits scheduled for evaluation of progress.
2. Evaluating Opioid Treatment
 1. Continuing opioid treatment should be a deliberate decision that takes into consideration the risks and benefits of ongoing opioid treatment for that patient. Patients and health care providers should periodically reassess the need

for continued opioid treatment, tapering whenever possible, as part of the comprehensive pain care plan. A second opinion or consultation from a colleague or specialist may be useful in making that decision.

2. Routinely assess function and pain status. An assessment of function and pain should consistently measure the same elements to determine the degree of progress.

Chronic Pain Guidelines

Threshold for Considering Pain Chronic

1. The MMS supports a duration of treatment of 90 days consistent with the Institute of Medicine's definition in the 2011 report RELIEVING PAIN IN AMERICA^[2] rather than morphine equivalents to trigger these guidelines.
 1. This time period should trigger a face to face reevaluation of the treatment provided to date, its long term efficacy and risks of continued opioid therapy. Physicians should consider consulting with other physicians or referrals as part of the process in developing and implementing an ongoing treatment plan.

Common Elements of Best Practices when a 90 Day Treatment Threshold is Reached (To be implemented before continuing further opioid treatment)

1. A detailed reevaluation of the patient's history and a physical should be done as soon as possible after the 90 day threshold is reached.
2. The physician should have the patient complete an objective pain assessment tool. The MMS will work with an advisory group to provide recommended tools.
3. The physician should do a risk of substance abuse assessment.
 1. The MMS will develop a list of recommended tools with assistance from the Massachusetts Chapter of the American Society of Addiction Medicine (MASAM).
 2. The physician should consider the use of appropriate baseline urine drug testing if the risk assessment or other evidence indicates there may be issues with use of other drugs or with compliance with prescribed treatment.
4. The physician should tailor a diagnosis and treatment plan with functional goals at the initial 90 day threshold visit and every 60-90 days thereafter.
5. Chronic pain is multi-dimensional. Physicians should inform patient of the risks, benefits, and terms of continuation of opioid treatment. Alternative pain management options should be reviewed at the 90 day threshold visit and at subsequent 60-90 day follow-up visits.
6. Women should be counseled again on risks associated with opioid treatment and pregnancy.
7. Physicians should be aware of published dosing guidelines for pediatric patients and consider body weight and age as a factor in treating pediatric patients.

8. Physicians prescribing opioids should inform their patients about the cognitive and performance effects of these prescriptions and warn them about the dangers to themselves and others in operating machinery, driving and related activities while under treatment.
9. The physician should review the patient's current prescription monitoring program record at the 90 day threshold visits and at every 60-90 day follow-up visit thereafter. One goal of this review is to avoid duplicative or conflicting treatments from other providers.
10. Treatment Agreements
 1. A treatment agreement plan should be established and incorporated into the medical record that includes measurable goals for reduction of pain, reduction in opioid therapy concomitant with reduction or resolution of the pain, and improvement of function. Goals should include improved function and quality of life as well as improved control of pain, and should be developed jointly by the patient and the physician. It should address what circumstances would allow a patient to receive prescriptions from other providers.
 2. It may be preferable for such a treatment agreement to be signed by the patient, with updated signature at least yearly.
11. Physicians should discuss risks and warning signs of opioid dependence and addiction with their chronic pain patients.
12. Physicians should discuss naloxone and its use to reverse overdoses. Physicians should offer to prescribe naloxone to their patients after such discussions.
13. Physicians who are not pain management specialists should not initiate treatment plans which call for in excess of 100 milligrams of morphine equivalent opioids per day without a documented consultation with a pain management specialist.
14. If a patient is currently receiving > 100 mg morphine equivalent per day a plan should be instituted to begin tapering of the dose and, if not possible to do so, consultation with a pain management specialist should be obtained.
15. When possible, physicians should preferentially select abuse resistant and abuse-deterrent medications when clinically indicated.
16. If high risk or low benefit warrants a discontinuation of opioid therapy, physicians should prescribe non-opioid alternatives for continued pain management.