VA/DoD CLINICAL PRACTICE GUIDELINE FOR OPIOID THERAPY FOR CHRONIC PAIN

Department of Veterans Affairs

Department of Defense

Clinician Summary

QUALIFYING STATEMENTS

The Department of Veterans Affairs and the Department of Defense guidelines are based upon the best information available at the time of publication. They are designed to provide information and assist decision making. They are not intended to define a standard of care and should not be construed as one. Neither should they be interpreted as prescribing an exclusive course of management.

This Clinical Practice Guideline is based on a systematic review of both clinical and epidemiological evidence. Developed by a panel of multidisciplinary experts, it provides a clear explanation of the logical relationships between various care options and health outcomes while rating both the quality of the evidence and the strength of the recommendation.

Variations in practice will inevitably and appropriately occur when clinicians take into account the needs of individual patients, available resources, and limitations unique to an institution or type of practice. Every healthcare professional making use of these guidelines is responsible for evaluating the appropriateness of applying them in the setting of any particular clinical situation.

These guidelines are not intended to represent TRICARE policy. Further, inclusion of recommendations for specific testing and/or therapeutic interventions within these guidelines does not guarantee coverage of civilian sector care. Additional information on current TRICARE benefits may be found at www.tricare.mil or by contacting your regional TRICARE Managed Care Support Contractor.

Version 3.0 – 2017

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I. Introduction

The Department of Veterans Affairs (VA) and Department of Defense (DoD) Evidence-Based Practice Work Group (EBPWG) was established and first chartered in 2004, with a mission to advise the "…Health Executive Council on the use of clinical and epidemiological evidence to improve the health of the population across the Veterans Health Administration and Military Health System," by facilitating the development of clinical practice guidelines (CPGs) for the VA and DoD populations.[1] The VA/DoD CPG is intended to provide healthcare providers with a framework by which to evaluate, treat, and manage the individual needs and preferences of patients with chronic pain who are on or being considered for long-term opioid therapy (LOT).

In 2010, the VA and DoD published the *Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain* (2010 OT CPG), which was based on evidence reviewed through March 2009. Since the release of that guideline, there has been growing recognition of an epidemic of opioid misuse and opioid use disorder (OUD) in America, including among America's Veterans. At the same time, there is a mounting body of research expanding our knowledge and understanding of the troublesome effects of LOT.

Consequently, a recommendation to update the 2010 OT CPG was initiated in 2015. The updated CPG, titled *Clinical Practice Guideline for Opioid Therapy for Chronic Pain* (OT CPG), includes objective, evidence-based information on the management of chronic pain. It is intended to assist healthcare providers in all aspects of patient care, including, but not limited to, diagnosis, treatment, and follow-up. The system-wide goal of the guideline is to improve the patient's health and well-being by providing evidence-based guidance to providers who are taking care of patients on or being considered for LOT. The expected outcome of successful implementation of the guideline is to:

- Assess the patient's condition and determine, in collaboration with the patient and his or her care team, the best treatment methods
- Optimize the patient's health outcomes and function and improve quality of life
- Minimize preventable complications and morbidity
- Emphasize the use of patient-centered care

II. How to Use the Clinical Practice Guideline

The VA/DoD OT CPG can be used in a variety of ways. It can be used by general clinicians or specialists to study and consider the latest information on OT and how and whether to incorporate that information or recommendations into their practice. It can be used to provide specific information to guide a patient encounter, such as looking up the dosing of a medication used less frequently or the meaning of the urine drug test (UDT) result. The section on tapering and its accompanying appendix (in the full text OT CPG) can be used to assist in the development of a framework for guiding an individualized, informed discussion when tapering is being considered. Patients can examine the guideline to educate themselves and better understand their care. A healthcare system can use the CPG to assure that its clinicians and patients have the resources available to compassionately, effectively, and safely evaluate and deliver LOT in a timely, culturally sensitive manner. The guideline can also be used to suggest specific education for identified gaps.

The guideline is not intended as a standard of care and should not be used as such. Standards of care are determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge and technology advances and patterns evolve. Today there is variation among state regulations, and the guideline does not cover the variety of ever-changing state regulations that may be pertinent. The ultimate judgement regarding a particular clinical procedure or treatment course must be made by the individual clinician, in light of the patient's clinical presentation, patient preferences, and the available diagnostic and treatment options. As noted previously, the guideline can assist care providers, but the use of a CPG must always be considered as a recommendation, within the context of a provider's clinical judgment and patient values and preferences, in the care for an individual patient.

III. Recommendations

The following recommendations were made using a systematic approach considering four domains as per the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach as detailed in the section on Methods and Appendix E in the full text OT CPG. These domains include: confidence in the quality of the evidence, balance of desirable and undesirable outcomes (i.e., benefits and harms), patient or provider values and preferences, and other implications, as appropriate (e.g., resource use, equity, acceptability).

Given the relevance of all four domains in grading recommendations, the Work Group encountered multiple instances in which confidence in the quality of the evidence was low or very low, while there was marked imbalance of benefits and harms, as well as certain other important considerations arising from the domains of values and preferences and/or other implications. In particular, the harms due to the potential for severe adverse events associated with opioids, particularly overdose and OUD, often far outweigh the potential benefits. As such, in accounting for all four domains, these factors contributed to Strong recommendations in multiple instances.

#	Recommendation	Strength*	Category†
Initiation and Continuation of Opioids			
1.	a) We recommend against initiation of long-term opioid therapy for chronic pain. b) We recommend alternatives to opioid therapy such as self-management strategies and other non-pharmacological treatments. c) When pharmacologic therapies are used, we recommend non-opioids over opioids.	a) Strong against b) Strong for c) Strong for	Reviewed, New-replaced
2.	If prescribing opioid therapy for patients with chronic pain, we recommend a short duration. Note: Consideration of opioid therapy beyond 90 days requires re-evaluation and discussion with patient of risks and benefits.	Strong for	Reviewed, New-added
3.	For patients currently on long-term opioid therapy, we recommend ongoing risk mitigation strategies (see Recommendations 7-9), assessment for opioid use disorder, and consideration for tapering when risks exceed benefits (see Recommendation 14).	Strong for	Reviewed, New-replaced
4.	a) We recommend against long-term opioid therapy for pain in patients with untreated substance use disorder. b) For patients currently on long-term opioid therapy with evidence of untreated substance use disorder, we recommend close monitoring, including engagement in substance use disorder treatment, and discontinuation of opioid therapy for pain with appropriate tapering (see Recommendation 14 and Recommendation 17).	a) Strong against b) Strong for	Reviewed, Amended
5.	We recommend against the concurrent use of benzodiazepines and opioids. Note: For patients currently on long-term opioid therapy and benzodiazepines, consider tapering one or both when risks exceed benefits and obtaining specialty consultation as appropriate (see Recommendation 14 and the VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders).	Strong against	Reviewed, New-added

#	Recommendation	Strength*	Category†
6.	a) We recommend against long-term opioid therapy for patients less than 30 years of age secondary to higher risk of opioid use disorder and overdose. b) For patients less than 30 years of age currently on long-term opioid therapy, we recommend close monitoring and consideration for tapering when risks exceed benefits (see Recommendation 14 and Recommendation 17).	a) Strong against b) Strong for	Reviewed, New-replaced
Risk Mitigation			
7.	We recommend implementing risk mitigation strategies upon initiation of long-term opioid therapy, starting with an informed consent conversation covering the risks and benefits of opioid therapy as well as alternative therapies. The strategies and their frequency should be commensurate with risk factors and include: ■ Ongoing, random urine drug testing (including appropriate confirmatory testing) ■ Checking state prescription drug monitoring programs ■ Monitoring for overdose potential and suicidality ■ Providing overdose education ■ Prescribing of naloxone rescue and accompanying education	Strong for	Reviewed, New-replaced
8.	We recommend assessing suicide risk when considering initiating or continuing long-term opioid therapy and intervening when necessary.	Strong for	Reviewed, Amended
9.	We recommend evaluating benefits of continued opioid therapy and risk for opioid-related adverse events at least every three months.	Strong for	Reviewed, New-replaced
Type, Dose, Follow-up, and Taper of Opioids			
10.	If prescribing opioids, we recommend prescribing the lowest dose of opioids as indicated by patient-specific risks and benefits. Note: There is no absolutely safe dose of opioids.	Strong for	Reviewed, New-replaced
11.	As opioid dosage and risk increase, we recommend more frequent monitoring for adverse events including opioid use disorder and overdose. Note: ■ Risks for opioid use disorder start at any dose and increase in a dose dependent manner. ■ Risks for overdose and death significantly increase at a range of 20-50 mg morphine equivalent daily dose.	Strong for	Reviewed, New-replaced
12.	We recommend against opioid doses over 90 mg morphine equivalent daily dose for treating chronic pain. Note: For patients who are currently prescribed doses over 90 mg morphine equivalent daily dose, evaluate for tapering to reduced dose or to discontinuation (see Recommendations 14 and 15).	Strong against	Reviewed, New-replaced
13.	We recommend against prescribing long-acting opioids for acute pain, as an as-needed medication, or on initiation of long-term opioid therapy.	Strong against	Reviewed, New-replaced
14.	We recommend tapering to reduced dose or to discontinuation of long-term opioid therapy when risks of long-term opioid therapy outweigh benefits. Note: Abrupt discontinuation should be avoided unless required for immediate safety concerns.	Strong for	Reviewed, New-added

#	Recommendation	Strength*	Category†
15.	We recommend individualizing opioid tapering based on risk assessment and patient needs and characteristics. Note: There is insufficient evidence to recommend for or against specific tapering strategies and schedules.	Strong for	Reviewed, New-added
16.	We recommend interdisciplinary care that addresses pain, substance use disorders, and/or mental health problems for patients presenting with high risk and/or aberrant behavior.	Strong for	Reviewed, New-replaced
17.	We recommend offering medication assisted treatment for opioid use disorder to patients with chronic pain and opioid use disorder. Note: See the VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders.	Strong for	Reviewed, New-replaced
Opioid Therapy for Acute Pain			
18.	a) We recommend alternatives to opioids for mild-to-moderate acute pain. b) We suggest use of multimodal pain care including non-opioid medications as indicated when opioids are used for acute pain. c) If take-home opioids are prescribed, we recommend that immediate-release opioids are used at the lowest effective dose with opioid therapy reassessment no later than 3-5 days to determine if adjustments or continuing opioid therapy is indicated. Note: Patient education about opioid risks and alternatives to opioid therapy should be offered.	a) Strong for b) Weak for c) Strong for	Reviewed, New-added

*For additional information, please refer to the section on Grading Recommendations (in the full text OT CPG).

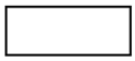
†For additional information, please refer to the section on Recommendation Categorization and Appendix H (in the full text OT CPG).

IV. Algorithm

The CPG follows an algorithm that is designed to facilitate understanding of the clinical pathway and decision making process used in management of LOT. The use of the algorithm format as a way to represent patient management was chosen based on the understanding that such a format may promote more efficient diagnostic and therapeutic decision making and has the potential to change patterns of resource use. Although the Work Group recognizes that not all clinical practices are linear, the simplified linear approach depicted through the algorithm and its format allows the provider to assess the critical information needed at the major decision points in the clinical process. It includes:

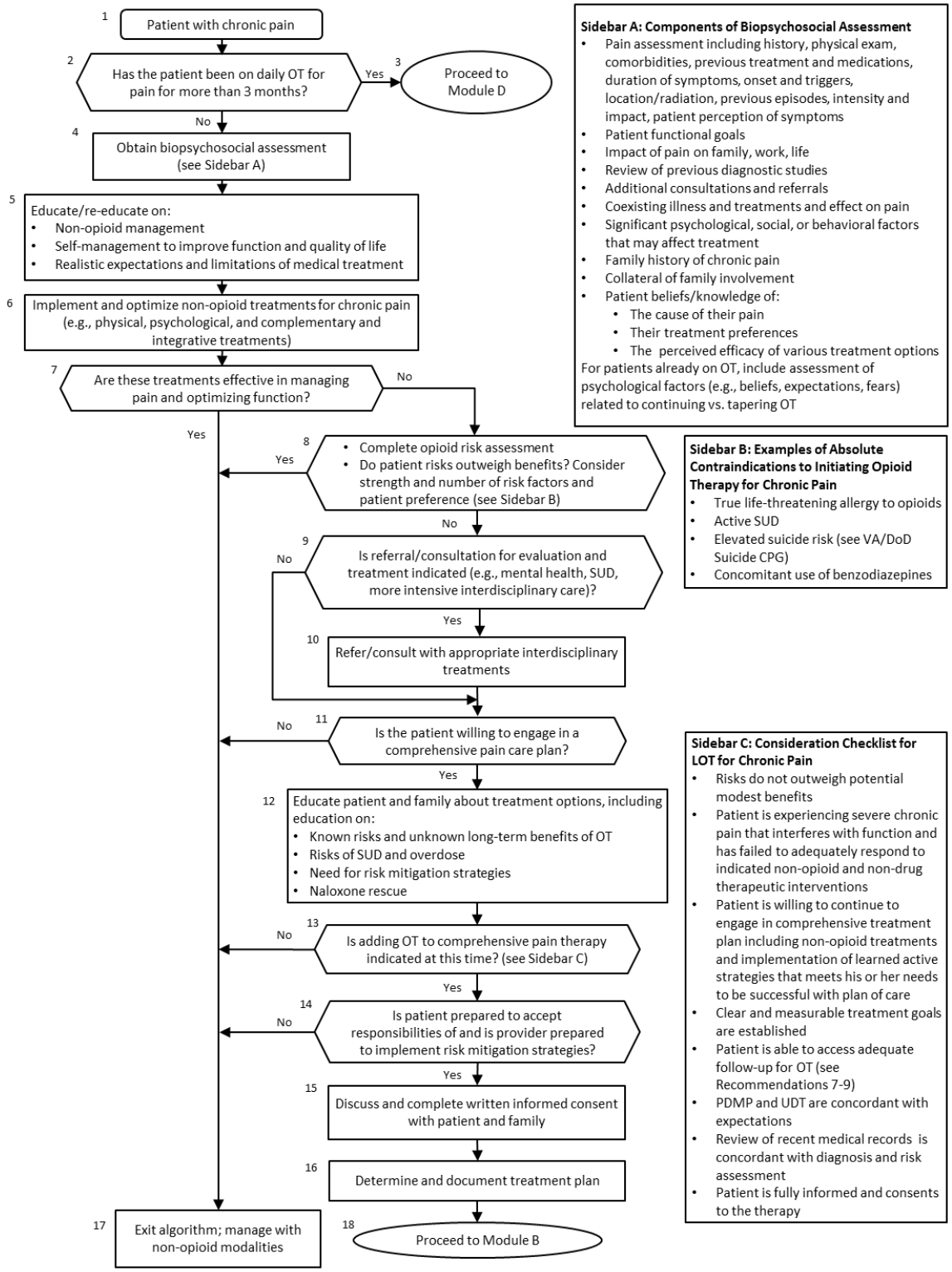
- An ordered sequence of steps of care
- Recommended observations and examinations
- Decisions to be considered
- Actions to be taken

For each guideline, the corresponding clinical algorithm is depicted by a step-by-step decision tree. Standardized symbols are used to display each step in the algorithm, and arrows connect the numbered boxes indicating the order in which the steps should be followed.[2]

	Rounded rectangles represent a clinical state or condition.
	Hexagons represent a decision point in the guideline, formulated as a question that can be answered Yes or No.
	Rectangles represent an action in the process of care.

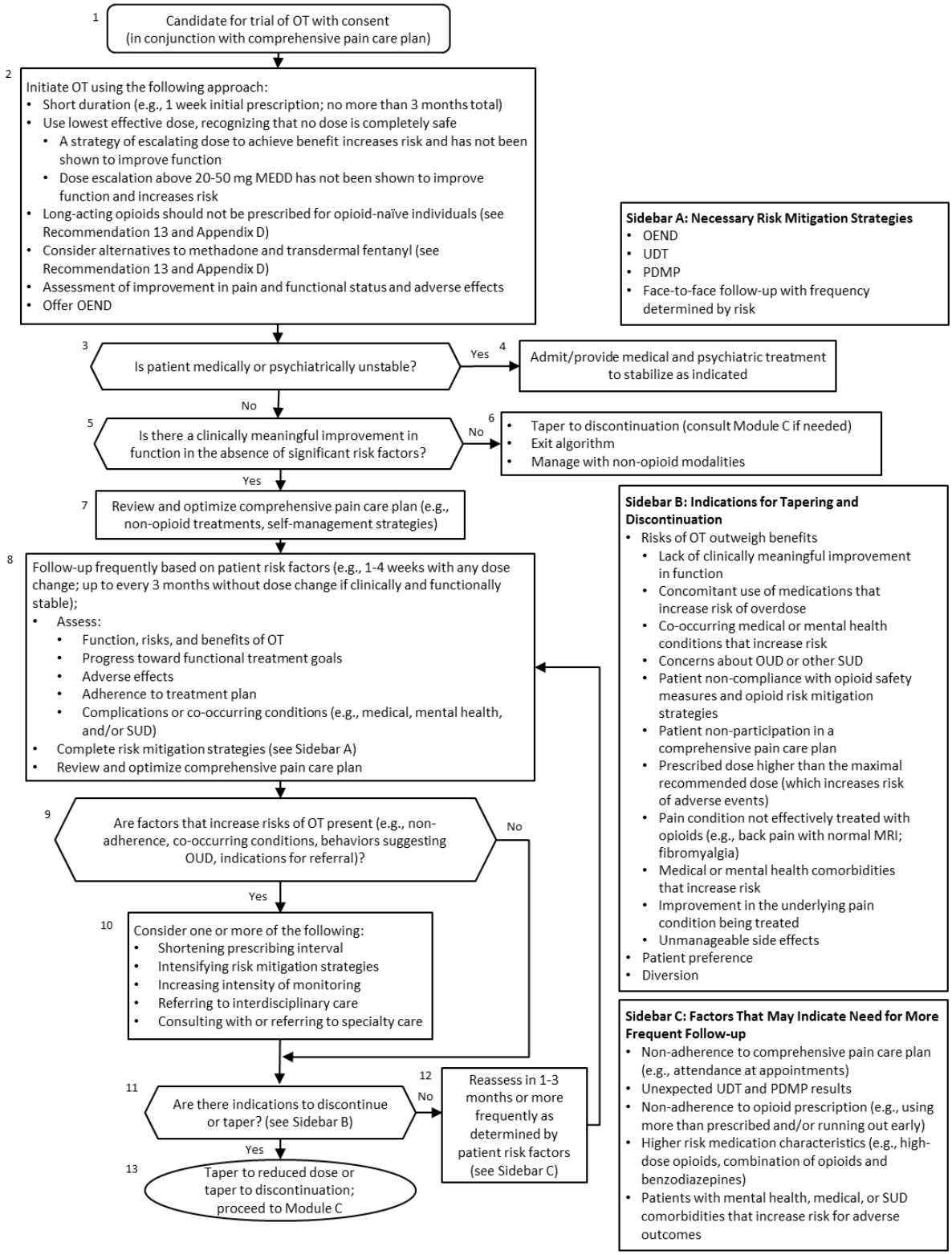
A. Module A: Determination of Appropriateness for Opioid Therapy

Note: Non-pharmacologic and non-opioid pharmacologic therapies are preferred for chronic pain.



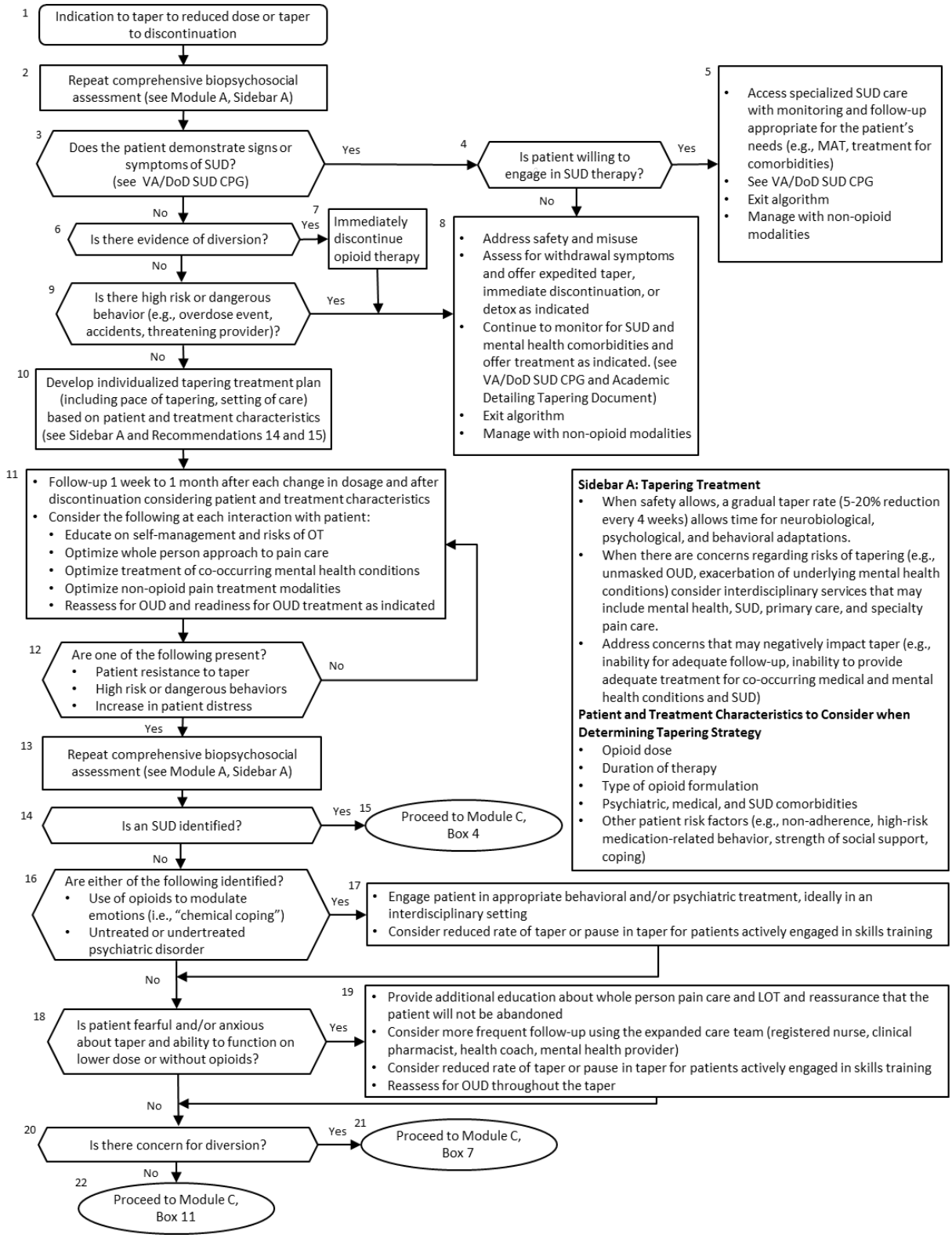
Abbreviations: LOT: long-term opioid therapy; OT: opioid therapy; PDMP: Prescription Drug Monitoring Program; SUD: substance use disorders; UDT: urine drug test; VA/DoD Suicide CPG: VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide

B. Module B: Treatment with Opioid Therapy



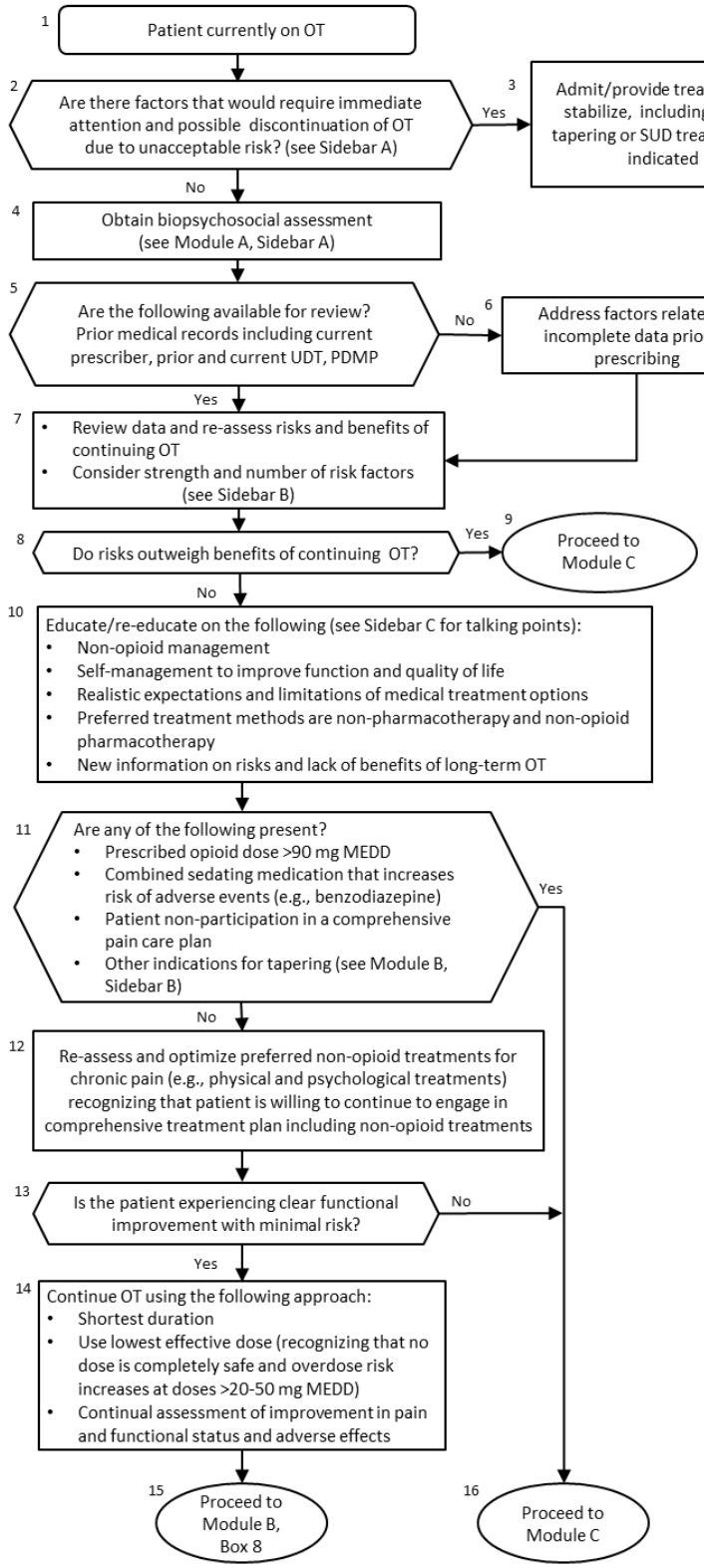
Abbreviations: MEDD: morphine equivalent daily dose; mg: milligram(s); MRI: magnetic resonance imaging; OEND: Overdose Education and Naloxone Distribution; OT: opioid therapy; OUD: opioid use disorder; PDMP: Prescription Drug Monitoring Program; SUD: substance use disorders; UDT: urine drug test

C. Module C: Tapering or Discontinuation of Opioid Therapy



Abbreviations: LOT: long-term opioid therapy; MAT: medication assisted treatment; OT: opioid therapy; OUD: opioid use disorder; SUD: substance use disorders; VA/DoD SUD CPG: VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders

D. Module D: Patients Currently on Opioid Therapy



Sidebar A: Factors Requiring Immediate Attention and Possible Discontinuation

- Untreated SUD
- Unstable mental health disorder
- Medical condition that acutely increases opioid risks (e.g., compromised or worsening cognitive or cardiopulmonary status)
- Other factors that acutely increase risk of overdose
  - Recent overdose
  - Current sedation
  - Recent motor vehicle accident
- Acutely elevated suicide risk (see VA/DoD Suicide CPG)

Sidebar B: Considerations During Re-assessment

Risks

- Increase in all-cause mortality
- Increase risk of unintentional overdose death
- Increase risk of developing OUD
- Risk of developing or worsening:
  - Depression
  - Falls
  - Fractures
  - Sleep disordered breathing
  - Worsening pain
  - Motor vehicle accidents
  - Hypogonadism
  - Prolonged pain
  - Nausea
  - Constipation
  - Dry mouth
  - Sedation
  - Cognitive dysfunction
  - Immune system dysfunction
  - Reduction in function
  - Reduction in quality of life

Benefits

- Modest short-term improvement in pain
- Possible short-term improvement in function

Sidebar C: Talking Points for Education and Re-education for Patients Currently on OT

- "Doctors used to think that opioids were safe and effective when used for long periods of time to treat chronic pain."
- "New information has taught us that long-term opioid use can lead to multiple problems including loss of pain relieving effects, increased pain, unintentional death, OUD, and problems with sleep, mood, hormonal dysfunction, and immune dysfunction."
- "We now know that the best treatments for chronic pain are not opioids. The best treatments for chronic pain are non-drug treatments such as psychological therapies and rehabilitation therapies and non-opioid medications."

Abbreviations: MEDD: morphine equivalent daily dose; mg: milligram(s); OT: opioid therapy; OUD: opioid use disorder; PDMP: Prescription Drug Monitoring Program; SUD: substance use disorders; UDT: urine drug test; VA/DoD Suicide CPG: VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide

V. Scope of the CPG

The VA/DoD OT CPG is designed to assist healthcare providers in managing or co-managing patients on or being considered for LOT. Specifically, the CPG is intended for adults, including Veterans as well as deployed and non-deployed Active Duty Service Members, their beneficiaries, and retirees and their beneficiaries, with chronic pain who are receiving care from the VA or DoD healthcare delivery systems. The CPG is not intended for and does not provide recommendations for the management of pain with LOT in children or adolescents, in patients with acute pain, or in patients receiving end-of-life care. As is so for any pharmacotherapy, any decision about prescribing opioids, or alternative medications for pain, for pregnant women should be made with due caution and cognizance of applicable U.S. Food and Drug Administration (FDA) labeling. Any patient in the VA or DoD healthcare system should be offered access to the interventions that are recommended in the guideline after taking into consideration the patient's specific circumstances.

While these guidelines are broadly recommended, their implementation is intended to be patient-centered. Thus, treatment and care should take into account a patient's needs and preferences. Good communication between healthcare professionals and the patient about the patient's pain experience, treatment goals, and challenges is essential and should be guided by evidence-based information tailored to the patient's needs. An empathetic and non-judgmental (versus a confrontational or adversarial) approach to communication with a patient is highly recommended in order to build trust and facilitate frank discussions relating to the social, economic, emotional, and cultural factors that influence patients' perceptions, behaviors, and decision making.

The information that patients are given about treatment and care should be culturally appropriate and also available to people with limited literacy skills. It should also be accessible to people with additional needs such as physical, sensory, or learning disabilities. Family involvement should be considered if appropriate.

VI. Guideline Work Group

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*Additional contributor contact information is available in Appendix I (in the full text OT CPG).

VII. Patient-centered Care

VA/DoD CPGs encourage clinicians to use a patient-centered care approach that is tailored to the patient's capabilities, needs, goals, prior treatment experience, and preferences. Regardless of setting, all patients in the healthcare system should be offered access to evidence-based interventions appropriate to that patient. When properly executed, patient-centered care may decrease patient anxiety, increase trust in clinicians,[3] and improve treatment adherence.[4] Improved patient-clinician communication through patient-centered care can be used to convey openness to discuss any future concerns.

As part of the patient-centered care approach, clinicians should review the patient's history including previous treatment approaches, their results, and any other outcomes with the patient. They should ask the patient about his or her willingness to accept a referral to an addiction or other behavioral health specialist when appropriate. Lastly, they should involve the patient in prioritizing problems to be addressed and in setting specific goals regardless of the selected setting or level of care. The below approach may be used in setting SMART (Specific, Measurable, Action Oriented, Realistic, Timed) goals for the patient (Table 1).

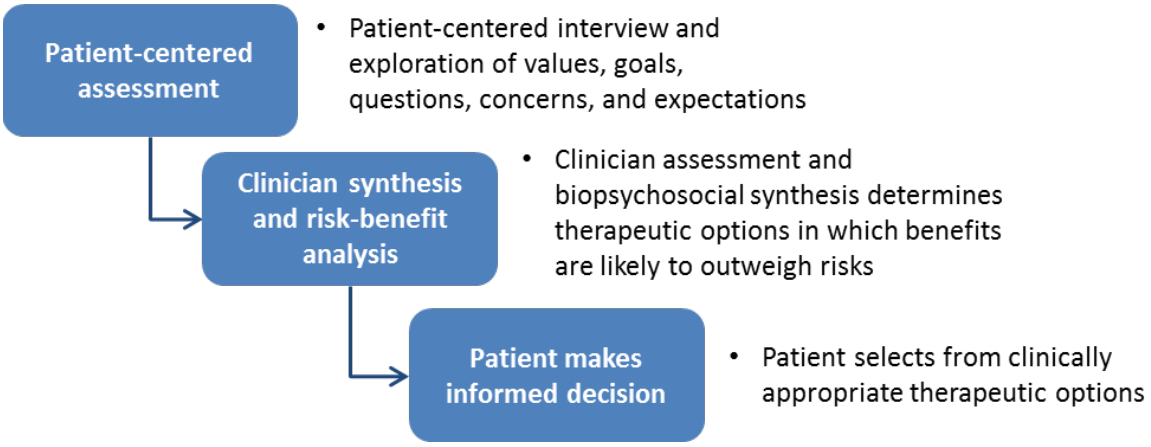
Table 1. Guide in Setting SMART Goals [5]

Specific	A goal should be clear and concise. It is difficult to know when action toward a goal has been started and when it has been completed if it is not specific.
Measurable	A goal should be measurable so that Veterans can track their progress. Veterans need to have clear criteria for progress and completion when taking action on a goal. Keeping tabs on progress can be inspiring.
Action Oriented	A goal should include action. And that action should be in direct control of the Veteran.
Realistic	A goal should be largely within the reach of the Veterans. It is best to work on small lifestyle changes that are doable. Avoid the pitfalls of having Veterans see only the big picture and not the small steps.
Timed	A goal should be tied to a timetable for completing specific, measurable and realistic action.

VIII. Shared Decision Making

The shared decision making process for chronic pain treatment planning is based on the foundation of a patient-centered assessment of risks and benefits and a clinical synthesis performed by the provider (Figure 1). The patient-centered assessment incorporates a patient-centered interview, and exploration of patient values, goals, questions, concerns, and expectations. Next, the clinician performs a biopsychosocial assessment and determines clinically appropriate therapeutic options in which benefits are likely to outweigh risks. The process culminates in a shared decision making process to develop a patient-centered treatment plan by the patient selecting from the clinically appropriate treatment options generated in the first two steps.

Figure 1. Shared Decision Making for Chronic Pain Treatment and Long-Term Opioid Therapy



IX. Chronic Pain Treatment Options

A. Known Risks and Lack of Benefit of Opioid Therapy for Chronic Pain

There is a rapidly growing understanding of the significant harms of LOT (e.g., overdose, OUD). At the same time there is a lack of high-quality evidence that LOT improves pain, function, and/or quality of life. Given the lack of evidence showing sustained functional benefit of LOT and moderate evidence outlining harms, non-opioid treatments are preferred for chronic pain. When considering the initiation or continuation of LOT, it is important to consider patient values, goals, concerns, and preferences and whether LOT will result in clinically meaningful improvements in function (e.g., readiness to return to work/duty, measurable improvement in other areas of function) such that the benefits of LOT outweigh the potential harms.

B. Preferred Chronic Pain Treatment Options

Psychological therapies (e.g., cognitive behavioral interventions such as Cognitive Behavioral Therapy [CBT], biofeedback), exercise treatments (e.g., aerobic exercise, physical therapy), and multidisciplinary psychosocial rehabilitation (described as a combination of a physical intervention such as graded exercise and a psychological, social, or occupational intervention) have been found to be effective for reducing pain.[6-11] These interventions are safe and have not been shown to increase morbidity or mortality. There is insufficient evidence to recommend psychological over physical therapies or vice versa; the choice of which to try first should be individualized based on patient assessment and a shared decision making process.[6] In light of the low harms associated with exercise and psychological therapies when compared with LOT, these treatments are preferred over LOT and should be offered to all patients with chronic pain including those currently receiving LOT.

In addition to non-pharmacological therapies (e.g., exercise, CBT), appropriate mechanism and condition-specific non-opioid pharmacologic agents should be tried and optimized before consideration of opioid medications (e.g., gabapentin in neuropathic pain states).[9]

C. Patient Populations at Additional Risk for Adverse Events with Long-term Opioid Therapy

The following subgroups face additional risk (e.g., for OUD, overdose, death) with use of LOT. We recommend against initiating LOT for pain particularly in these patient populations. For patients already on LOT, increased monitoring and consideration for tapering should be used as appropriate. See Recommendations 4, 5, and 6 in Recommendations.

- Patients with untreated substance use disorders (SUD)
- Patients concurrently using benzodiazepines
- Patients less than 30 years of age

X. Initiation of Long-term Opioid Therapy

If a clinician determines that LOT may be beneficial, despite the known risks, and if OT is prescribed for a patient, all opioid risk mitigation strategies outlined in the guideline should be put into place (see Risk Mitigation Strategies for Long-term Opioid Therapy).

A. Duration of Opioid Therapy

OT should only be used for a short duration. Of utmost concern is the heightened risk for developing OUD in patients who receive OT beyond 90 days. Similar to other risk factors, continuing OT beyond 90 days' duration should be weighed heavily in the risk-benefit calculus for LOT. Continuing OT for longer than 90 days is not an absolute contraindication to LOT. There may be some situations where the benefits of LOT clearly outweigh the risks. That must be determined through individual clinical assessment.

Patients should be informed that progression from acute to long-term OT is associated with little evidence for sustained analgesic efficacy but a substantial increase in risk for OUD. Providers should discuss this information with patients at initiation of OT and continuously thereafter to ensure that the patient understands the associated risks and benefits of LOT. Fully informed, some patients may desire continuation of OT while others may decline its continued provision.

B. Dose of Opioid Therapy

The risk of prescription opioid overdose and overdose death exists even at low opioid dosage levels and increases as dosage increases. Significant risk (approximately 1.5 times) exists at a daily dosage range of 20 to <50 mg morphine equivalent daily dose (MEDD) and further increases (approximately 2.6 times) at a range of 50 to <100 mg MEDD compared to risk at <20 mg MEDD. Risk continues to increase at higher dosage ranges (≥100 mg MEDD).[12-15]

Achieving an improved understanding of the factors contributing to prescription opioid-related overdose is an essential step toward addressing this epidemic problem. Although it is widely accepted that progressively higher doses of prescribed opioids result in correspondingly higher risks of opioid overdose, patients using any dose of opioids can still experience life-threatening respiratory or central nervous system (CNS) depression, especially when opioid-naïve. This risk begins to increase with as low as 20-50

mg MEDD. Risk is further increased when certain concomitant demographic factors, co-occurring medical or psychiatric conditions, or interacting medications or substances exist.

Recognizing the lack of evidence of long-term benefit associated with LOT used alone and the risks of harms with use of opioids without risk mitigation, dosing determinations should be individualized based upon patient characteristics and preferences, with the goal of using the lowest dose of opioids for the shortest period of time to achieve well-defined functional treatment goals. Understandably, there will be greater mortality, co-occurring medical conditions, and other adverse events in patients who require higher doses of opioids, even in those who benefit from such therapy. When closer follow-up is needed, healthcare resources and patient adherence should be considered.

C. Selection of Opioid Therapy

Long-acting opioids should not be used for treatment of acute pain, on an as-needed basis, or during initiation of LOT. In general, however, no single opioid or opioid formulation is preferred over the others. However, individuals may have a better response, degree of safety, or tolerability depending on their individual characteristics and preferences. There was insufficient evidence to recommend for or against any specific opioid or opioid formulation, specifically the following:

- Short-acting versus long-acting opioids (for LOT for chronic pain)
- Route of administration/delivery among alternatives such as transdermal, buccal, sublingual, or pumps
- Abuse deterrent formulations of opioids compared to non-abuse deterrent formulations
- Tramadol and other dual-mechanism opioids
- Buprenorphine for pain (compared to other opioids)
- Methadone (with QT [time interval from the start of the Q wave to the end of the T wave] monitoring)

Additional information when deciding on appropriate pharmacological treatment of pain for a specific patient can be found in the full text OT CPG.

XI. Risk Mitigation Strategies for Long-term Opioid Therapy

Providers should consider and implement risk mitigation strategies prior to prescribing opioids in the setting of LOT. Certain patients may appreciate the use of risk mitigation strategies but others may not. Patients may decline risk mitigation strategies, however providers should discuss such a decision, how that may increase the risks of an adverse outcome, and thus likely outweigh the benefit of the treatment. Clinical decision making should remain patient-centered including focusing on patient safety. Risk mitigation strategies alone or in combination improve patient safety. The strategies and their frequency should be commensurate with risk factors and include:

- An informed consent conversation covering the risks and benefits of opioid therapy as well as alternative therapies.
- Ongoing, random UDT (including appropriate confirmatory testing)

- Checking state prescription drug monitoring programs
- Monitoring for overdose potential and suicidality
- Providing overdose education
- Prescribing of naloxone rescue and accompanying education

A. Written Informed Consent and Opioid Treatment Agreements

Opioid therapy entails risks. Providers should inform patients about such risks in a patient-centered manner through informed consent. VA policy directs use of an informed consent document for patients on LOT. See VA Signature Informed Consent, *Taking Opioids Responsibly for Your Safety and the Safety of Others: Patient Information Guide on Long-term Opioid Therapy for Chronic Pain* (found at http://www.healthquality.va.gov/guidelines/Pain/cot/OpiodTheraphyforChronicPainPatientTool20May2013print.pdf), and 38 C.F.R. §17.32 (2012).

B. Urine Drug Testing

Substance misuse in patients on LOT is more than 30% in some series.[16] The inaccuracies inherent to patient self-report coupled with the evident mortality and morbidity to the treated patients, their families, and others require additional methods to ascertain patient and public safety. It is critical that the UDT and confirmatory testing be done in a timely, confidential, accurate, and easily available manner to assure the prescribers, patients, and public that safety, fairness, and trust are being addressed. In addition, a mechanism for specimen validity that may include urinary creatinine, temperature, pH (potential of hydrogen), specific gravity, and/or nitrates should be in considered. More detailed information on evaluating for the possibility of false positives, false negatives, and review of the opiate metabolic pathway can be found in Appendix B of the full text OT CPG. It is important that UDT be viewed in a therapeutic framework so that appropriate follow-up with SUD evaluation and treatment are offered when indicated.

There are three main types of UDT currently being used in clinical settings: immunoassay, gas chromatography-mass spectrometry (GCMS) confirmatory testing, and liquid chromatography-mass spectrometry (LCMS) confirmatory testing. Immunoassay screening is inexpensive, fast, and widely available. However, there are a number of drawbacks for using this test alone. There is a higher potential for false positives and negatives as well as lack of specificity of the actual opiate or benzodiazepine being tested. GCMS is highly sensitive and specific; however, it is expensive and time consuming. LCMS is less expensive than GCMS but more expensive than immunoassay. It can provide confirmation for a large number of medications, substances, and drugs at one time and may be helpful to many patients at initiation of OT, periodically during OT, and following cessation of OT if SUD is a possibility.

C. State Prescription Drug Monitoring Programs

State database queries for detection of multi-sourcing of controlled substances are used throughout the country. The Centers for Disease Control and Prevention (CDC) currently recommends at least quarterly checks of the state database system.[17]

D. Monitoring for Overdose Potential and Suicidality

Opioid medications are potentially lethal, and suicide risk should be assessed on an ongoing basis whether one is initiating, maintaining, or terminating LOT. The VA/DoD Suicide CPG[1] recommends restricting the availability of lethal means for patients considered to be at intermediate or high acute risk of suicide. Some patients on LOT who suffer from chronic pain and co-occurring OUD, depression, and/or personality disorders may threaten suicide when providers recommend discontinuation of opioids. However, continuing LOT to "prevent suicide" in someone with chronic pain is not recommended as an appropriate response if suicide risk is high or increases. In such cases, it is essential to involve behavioral health to assess, monitor, and treat a patient who becomes destabilized as a result of a medically appropriate decision to taper or cease LOT.

E. Prescribing of Naloxone Rescue and Accompanying Education

Naloxone administration has been identified as a life-saving measure following opioid overdose. Clinical efficacy has been established for its use on short-acting opioids, but not for its use on long-acting opioids such as methadone or exceptionally potent opioids.[18] Providers should discuss providing naloxone rescue kits and accompanying education with their LOT patients (and family members).

F. Follow-up

- Prior to initiating OT, an individualized assessment of potential opioid-related harms relative to realistic treatment goals must be completed.
- Frequent visits contribute to the appropriate use and adjustment of the planned therapy.
- Follow-up is recommended at least every three months or more frequently.
- The CDC guideline for OT recommends re-evaluating harms versus benefits within one to four weeks of starting OT or at any dose change, and at least every three months or more frequently if needed.[17]
- At follow-up visits, the clinician should re-examine the rationale for continuing the patient on OT.

XII. Tapering

Clinicians prescribing LOT should continually reassess the risks and benefits of LOT, and when risks are determined to outweigh benefits or when patients voice a preference for reducing their risk, OT should be tapered to a reduced dose or tapered to discontinuation. A biopsychosocial assessment including evaluation of co-occurring medical and psychiatric conditions, SUD, as well as the patient's social support system, will guide the opioid tapering process. Determination of the rate of opioid tapering takes into

[1] See the VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk of Suicide. Available at: http://www.healthquality.va.gov/guidelines/MH/srb/

account many factors that include initial dose, formulations available, and risk factors that increase potential for harm. A gradual taper pace of reducing opioid dosage by 5-20% every four weeks with the option to pause periodically allows time for neurobiological equilibration as well as the acquisition of new skills to manage pain and emotional distress. In some patients, a faster taper may be needed when risks are too high to consider a gradual taper; consider tapering the dose by 5-20% per week in this patient population. Regardless of the initial speed of taper, the pace of taper should be reevaluated frequently and adjusted as needed to maximize safety and patient comfort as safety allows. When there is evidence of diversion, opioids should be discontinued immediately.

Follow-up should occur within a range of one week to one month after any opioid dosage change with the frequency and type of follow-up adjusted as needed throughout the course of the taper. Each follow-up interaction with the patient is an opportunity to provide education about self-management strategies and the risks associated with OT while optimizing whole person approaches to pain care and treatment of co-occurring medical and mental health conditions. The care team should take great efforts to ensure that the patient does not feel abandoned during the opioid tapering process by maintaining frequent contact and emphasizing that the care team will continue to pursue non-opioid pain care options during and after opioid tapering.

The risks and benefits of continuing OT should be evaluated along with the risks and benefits of tapering OT. It is important to maintain vigilance for symptoms of OUD and/or exacerbation of an underlying mental health condition that may manifest during an opioid taper. Clinicians should consider using an interdisciplinary, team-based approach that may include primary care, mental health, pain specialty/rehabilitation, pharmacy, physical therapy, and/or SUD services during the opioid tapering process, and in particular for patients with significant risk factors for adverse outcomes including very high prescribed opioid doses (> 90 mg MEDD), combined use of opioids and benzodiazepines, high risk patient behaviors, and the presence of psychiatric, medical, or SUD comorbidities. Patients on LOT with OUD are at increased risk of overdose when opioids are either continued or discontinued without appropriate treatment for OUD. We recommend medication assisted treatment (MAT) for OUD (e.g., MAT using methadone, buprenorphine/naloxone, or extended-release injectable naltrexone) (see the VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders (VA/DoD SUD CPG)[2] and Recommendation 17 in the full text OT CPG).

Opioid overdose education should be provided and naloxone should be offered as an antidote to all patients at risk for an opioid overdose including those who are in the process of tapering or who have recently discontinued OT. Strongly caution patients that it takes as little as a week to lose tolerance to their prior opioid dose and that they are at risk of an overdose if they resume their prior dose.

[2] See the VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders. Available at: http://www.healthquality.va.gov/guidelines/mh/sud/index.asp.

XIII. Diagnosis and Treatment of Opioid Use Disorder

OUD (also known as opioid addiction, abuse, or dependence) is a chronic brain disease that impairs one's ability to control opioid use. Repeated opioid use over time can lead to OUD, and long-term opioid analgesics use is by far the most powerful risk factor for developing OUD. All persons using opioid analgesics are at risk for developing an OUD, even those who take opioid analgesics as prescribed. Opioid misuse may be an early sign of a developing OUD. Other early signs of developing OUD include: gradually becoming more and more preoccupied with opioid use and spending more time seeking the drug, using it, or recovering from its effects. Persons with OUD may continue to use opioids even though they:

- Know that opioid use is harmful
- Often use more than they intended
- Engage in risky behaviors such as driving while intoxicated or combining opioids with alcohol or other sedatives
- Have multiple unsuccessful attempts to cut down or control opioid use
- Report strong craving or urges to use opioids in response to withdrawal symptoms, stress, negative emotions, or simply cues that the drug is available

OUD is associated with premature death from opioid overdose and other medical complications such as acquired immunodeficiency syndrome (AIDS), hepatitis C, and sepsis. On average, OUD carries a 40-60% 20-year mortality rate.[19] Persons with OUD are at high-risk for premature death, not only from opioid overdose, but from other consequences. Thus, providing first-line treatment is important to save lives as well as to improve the quality of life.

Strong evidence supports the use of opioid agonist therapy (e.g., methadone, buprenorphine/naloxone) as first-line treatment for moderate-to-severe OUD (see VA/DoD SUD CPG).[3] Patients and their treating clinicians may be concerned that treatments proven effective in different OUD populations may not be effective for patients with chronic pain, or may not be necessary for patients who have become addicted to prescription opioid analgesics. This concern may be unfounded and was addressed by Weiss and colleagues in the Prescription Opioid Abuse Treatment Study (POATS).[20]

In studies with patients with Diagnostic and Statistical Manual of Mental Disorders [DSM] IV diagnostic criteria for opioid dependence (which were conducted prior to use of DSM-5), buprenorphine maintenance therapy is more effective than a four-week taper. MAT with moderate dose buprenorphine/naloxone and brief, structured counseling by the prescribing physician can be successful for about half of selected patients with prescription OUD, whereas withdrawal management alone, even with close weekly follow-up and counseling, is successful for less than 10% of patients.

[3] See the VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders. Available at: http://www.healthquality.va.gov/guidelines/mh/sud/index.asp.

Furthermore, the presence of chronic pain does not seem to interfere with the success of MAT.[20,21] Given the high mortality associated with OUD and the safety and efficacy of MAT for OUD in multiple clinical trials and meta-analyses, we recommend MAT for those chronic pain patients who meet DSM-5 criteria for OUD. Those who do not respond to minimal counseling may benefit from a comprehensive assessment and more intensive treatment of OUD and any co-occurring conditions in SUD specialty care settings.

XIV. Clinical Pearls for Prescribing Opioids

1. Chronic pain is a complex human experience strongly influenced by psychosocial factors including the patient's relationship with the healthcare system.
   a. Opioid prescribing is a powerful way to communicate about the goals, methods, and responsibilities of chronic pain treatment.
   b. Teach your patient that self-management, not effortless relief with medications, is the foundation of high quality pain care.
2. Safety is always more important than urgent pain relief.
   a. Titrating to effect is not a rational prescribing strategy.
   b. When risk outweighs benefit or adequate risk mitigation is not possible opioids should not be used.
3. As risks increase, mitigation and monitoring increases.
   a. Opioid risks and benefits can change over time.
   b. Opioid prescribing requires ongoing evaluation and documentation of risks and benefits.
4. Generally avoid initiating LOT for chronic pain; however, when opioids are prescribed and when titrating up, start low and go slow.
   a. Do not exceed 50 mg MEDD unless you are able to closely follow and monitor risks.
   b. Avoid titrating to doses greater than 90 mg MEDD.
5. Improved function, not pain relief, is the primary clinical goal.
   a. Opioids should only be continued when patients demonstrate functional benefit and are actively engaged in self-management of pain.
   b. Opioid prescribing should be conducted as an ongoing trial documenting high benefit and low risk.
6. When your patient is not benefitting, being exposed to undue risk, or misusing, the question is not "if" the patient should be tapered but "how."
   a. When tapering down, be clear about the rationale, be specific about the process, be empathic but not apologetic. Bad care is not an option.
   b. Your goal is to ensure safety while supporting and educating your patient. Offer alternative pain treatments and be prepared to address other problems such as OUD or suicidality.

XV. Additional Resources

- Veterans Administration Pain Management website: https://www.va.gov/painmanagement/
- Defense and Veterans Center for Integrative Pain Management website: http://www.dvcipm.org/
- Chronic Pain Information Page from the National Institute of Neurological Disorders and Stroke: https://www.ninds.nih.gov/Disorders/All-Disorders/Chronic-Pain-Information-Page.
- The patient information guide titled *Taking Opioids Responsibly for Your Safety and the Safety of Others: Patient Information Guide on Long-term Opioid Therapy for Chronic Pain*: https://www.va.gov/PAINMANAGEMENT/docs/TakingOpioidsResponsibly20121017.pdf

XVI. VA Signature Informed Consent

For the most current information on informed consent, see the VA National Center for Ethics in Health Care website (http://www.ethics.va.gov/).

Department of Veterans Affairs	Consent for Long-Term Opioid Therapy for Pain
A. IDENTIFICATION	
1. Patient Name, Social Security Number, and Date of Birth: Name: Last, First, Middle | Social Security Number | Date of Birth	
2. Decision-making capacity: ☐ The patient HAS decision-making capacity (skip to item 3). ☐ The patient DOES NOT HAVE decision-making capacity. Enter surrogate name and relationship to the patient. (If the patient's surrogate is not established or available, refer to Handbook 1004.01 for guidance). **Name: Last, First, Middle** | Relationship	
3. Name of the treatment: Long-Term Opioid Therapy for Pain	
4. Practitioner obtaining consent: Name: Last, First, Middle	
5. Supervising practitioner: (if applicable) **Name: Last, First, Middle**	
6. Additional practitioner(s) performing or supervising the treatment: (if not listed above)	
B. INFORMATION ABOUT THE TREATMENT	
7. Reason for long-term opioid therapy (diagnosis, condition, or indication):	
8. Location of pain:	
9. Goal(s) of long-term opioid therapy (e.g., pain score, functional abilities such as go back to work, climb stairs, walk short distances, sleep through the night, do daily household chores, start a light exercise program):	
10. Name of current or initial opioid medication(s):	

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11. Brief description of the treatment:

Opioids are very strong medicines that may be used to treat pain. You may already be taking opioids. Or your provider may try to give you opioids to find out if they will help you. They may try them for a short time or continue them for the rest of your life. Your provider will learn more about your risks and side effects when you are trying the opioids. If the risks and side effects outweigh the benefits, your provider will stop the prescription.

If your provider continues your opioid prescription, the goals of your treatment may change over time. The names and doses of your opioids may also change. You will not need to sign another consent form for these changes. You may be asked to sign another consent form if you seek opioid pain care from another VA provider.

Your provider will monitor your prescription. This may include checking how often you refill and renew your prescription, counting pills, asking you about your symptoms, and testing your urine, saliva, and blood. If you do not take opioids responsibly, your provider may stop your prescription. For example, if you do not let your provider monitor how you are responding to the opioids or tell them if you are taking other drugs that may affect the safety or effectiveness of your opioid treatment, your provider may stop the prescription.

For your safety, your provider and pharmacist will monitor when you renew and refill your opioids within VA. Consistent with state law, they will also monitor this outside of VA. Most states have monitoring programs that track unsafe patterns of prescription drug use. VA and these programs may obtain and share information about you without your specific consent.

Your provider will review with you a Patient Information Guide called "Taking Opioids Responsibly" to make sure that you know how to take your medication safely. You will be given a copy of the guide so that you can use it as a reference

12. Potential benefits of the treatment:

Opioids -- when added to other treatments as part of your pain care plan -- may reduce your pain enough for you to feel better and do more. It is unlikely that opioids will eliminate your pain completely. It is possible that you may not receive any benefits from opioid therapy.

13. Known risks and side effects of the treatment:

Possible opioid side effects include:

- Sleepiness or "slow thinking"
- Mental confusion, bad dreams, or hallucinations
- Constipation
- Intestinal blockage
- Itching
- Sweating
- Nausea or vomiting
- Decreased sex hormones
- Irregular or no menstrual periods
- Depression
- Dry mouth that causes tooth decay
- Allergies

Other risks of opioid therapy:

- Withdrawal symptoms if you suddenly stop taking opioids, lower the dose of your opioids too quickly, or take a drug that reverses the effects of your opioids. Withdrawal symptoms are caused by physical dependence that is a normal result of long-term opioid therapy. Some common withdrawal symptoms are runny nose, chills, body aches, diarrhea, sweating, nervousness, nausea, vomiting, mental distress, and trouble sleeping.
- Sleep apnea (abnormal breathing pauses during sleep)
- Worsening of pain
- Impaired driving or impaired ability to safely operate machinery
- Tolerance, which means that you may need a higher dose of opioid to get the same pain relief, resulting in an increase in the likelihood of the other side effects and risks
- Addiction (craving for a substance that gets out of control). Some patients become addicted to opioids even when they take opioids as prescribed.
- Drug interactions (problems when drugs are taken together). Taking small amounts of alcohol, some over-the counter medications, some herbal remedies, and other prescription medications can increase the chance of opioid side effects.
- Risks in pregnancy:
  - ***Continued use of opioids during pregnancy can cause your baby to have withdrawal symptoms after birth and require your baby to stay in the hospital longer after birth.**
  - ***Stopping opioids <u>suddenly</u> if you are pregnant and physically dependent on opioids can lead to complications during pregnancy.**
  - ***Studies have not shown a clear risk for birth defects with opioid use in pregnancy. If there is an increased risk for birth defects in pregnancy with opioid use, it is likely small.**
- Death

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14. Alternatives to the treatment:

You have the option not to take opioids. Other treatments can be used as part of your pain care plan. Alternatives include:

- Heat and cold therapy (heating pads, ice packs)
- Stretching
- Exercise
- Weight loss
- Massage
- Acupuncture
- Chiropractic
- Nerve Stimulation
- Relaxation or stress reduction training
- Physical therapy
- Occupational therapy
- Mental health treatment
- Self-care techniques
- Counseling and coaching
- Meditation
- Rehabilitation
- Non-opioid pain medicines (Non-steroidal anti-inflammatory drugs, antidepressants, anticonvulsants)
- Injections
- Specialist pain care
- Surgery
- Pain classes
- Support groups
- Attention to proper sleep

15. Additional Information:

16. Comments:

C. SIGNATURES

Practitioner obtaining consent:

- All relevant aspects of the treatment and its alternatives (including no treatment) have been discussed with the patient **(or surrogate) in language that s/he could understand. This discussion included the nature, indications, benefits, risks, side effects, monitoring, and likelihood of success of each alternative that was considered.**
- I have discussed all of the information contained in the education document "Taking Opioids Responsibly" with the patient (or surrogate).
- The patient (or surrogate) demonstrated comprehension of the discussion.
- I have given the patient (or surrogate) an opportunity to ask questions.
- I did not use threats, inducements, misleading information, or make any attempt to coerce the patient/surrogate to consent to this **treatment.**
- I have offered the patient (or surrogate) the opportunity to review and receive a printed copy of the consent form.
- If the patient is a woman of childbearing age (ages 15-50), I have discussed the patient's pregnancy status and pregnancy intentions.
  - **If the patient is not considering pregnancy, I have discussed (or referred the patient for) contraceptive counseling.**
  - **If the patient is considering pregnancy, I have discussed (or referred the patient for) preconception counseling.**

Signature _____ Date _____ Time _____

Patient or surrogate:

- I understand that to receive long-term opioids I must agree to my opioid treatment plan by signing this consent form.
- Someone has explained the treatment, what it is for, and how it could help me.
- Someone has explained things that could go wrong, including serious side effects and death, particularly if I do not take my medicine as prescribed.
- Someone has told me about other treatments that might be done instead, and what would happen if I have no treatment.
- I have discussed the information in the document "Taking Opioids Responsibly" with my provider.
- I understand the importance of:
  - **telling my provider about side effects.**
  - **telling my provider about changes in my pain and daily function.**
  - **getting my opioids from only my VA provider and no one else.**
  - **not giving away (or selling) my opioids to other people.**
  - **storing my opioids in a safe place away from children, family, friends, and pets.**
  - **safely getting rid of opioids I do not need.**
  - **not drinking alcohol or taking illegal street drugs when I am on opioids.**
  - **for women, telling my provider if I think I might be pregnant, know I am pregnant, or am planning to become pregnant.**

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- I plan to use my medications responsibly, and take them as prescribed.
- I understand how to refill my opioid prescription or get a new prescription. I understand that my VA pharmacy may be closed on weekends, holidays, and after regular clinic hours. I understand that my provider might not give me early medication refills or replace doses that are lost or stolen.
- I understand that my provider may order urine or blood drug tests with my consent (separate from this consent). I understand that the results of these tests or my refusal to be tested may cause my provider to talk to me about changing my opioid treatment plan.
- I understand that I may have to stop opioids if my provider thinks that it is unsafe for me to continue.
- Someone has answered all my questions.
- Someone has given me information about how to contact the clinic, if there is a problem and who to call in an emergency.
- I know I may refuse or change my mind about having treatment. If I do refuse or change my mind, I will not lose my health care or any other VA benefits.
- I have been offered the opportunity to review and receive a copy of my consent form.
- I choose to have this treatment.

Signature _____ Date _____ Time _____

Witnesses: No witness is required if the patient or surrogate signs their name. Two witnesses are required only when the patient's signature is indicated with an "X" or some other identifying mark.

Witness Name (Please Print) _____

Witness Signature _____ Date _____ Time _____

Witness Name (Please Print) _____

Witness Signature _____ Date _____ Time _____

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