OPIOID THERAPY:
EFFECTIVE CASE PLANNING

FAST FOCUS

Healthesystems included some of the leading opioid therapy guidelines issued by various state and industry groups in this planning guide.

Opioid use is rarely indicated beyond the acute phase of injury in workers' compensation. Long-term opioid prescribing and the use of opioids overall are major challenges for workers' compensation payers. Chronic use is associated with extended disability durations, less successful outcomes and higher medical costs.[6,7,8,9] Long-term use can also lead to drug abuse and is often an indicator of misuse and diversion. Many states have implemented guidelines or rules to limit opioid use and require documentation by prescribers to justify continued opioid therapy.

Medical guidelines published by the American College of Occupational and Environmental Medicine (ACOEM), and the Official Disability Guidelines (ODG) cite the ineffectiveness of opioid analgesics for many work-related types of injuries. Continuing these medications beyond when they are necessary or when objective signs of improvement in functional ability are absent increases risks to injured workers.

GUIDELINES FOR OPIOID THERAPY

The ODG[10] as well as several leading state and industry guidelines for opioid prescribing divide pain into three phases following injury and make recommendations for each phase.[11,12]

WITHOUT EARLY CLINICAL INTERVENTION

15% OF PATIENTS USING **OPIOIDS**

↑INCREASE DOSE STRENGTH (MED) by **414%** WITHIN 1 YEAR

—BASED ON HEALTHESYSTEMS CLINICAL FINDINGS

THREE PHASES FOLLOWING INJURY

2-6 weeks
following injury

Opioid analgesics are recommended for short-term use in the case of pain that follows severe injury or surgery. Therapy should not continue beyond the acute phase. Long-acting or extended release opioids are rarely appropriate in the acute phase of an injury.

1-3 months
following injury

Continuing opioid use in the subacute phase of injury increases the risk that the patient may experience dependency on medication, and can prolong a return to work.

It is extremely important to screen for associated depression, anxiety, and substance abuse disorders

3 months
following injury

Use of opioid analgesics is not recommended as first-line therapy in chronic pain, and all other options should be maximized.

If used, doses should remain under 120mg daily oral morphine equivalents (MED). Patients should be routinely screened for psychiatric comorbidities, risk of abuse and misuse, and adherence to therapy using such tools as urine drug screening.

ACUTE PAIN

SUBACUTE PAIN

CHRONIC PAIN

INDUSTRY SCREENING TOOLS

Substance Abuse

CAGE-AID: CAGE Adapted to Include Drugs
AUDIT: Alcohol Use Disorders Identification Test
DAST: Drug Abuse Screening Test

Risk Assessment

OAPP-R: Screener and Opioid Assessment for Patients with Pain-Revised
ORT: Opioid Risk Tool
DIRE: Diagnosis, Intractability, Risk, Efficacy

For Use During Treatment

COMM: Current Opioid Misuse Measure
PADT: Pain Assessment & Documentation Tool
ABC: Addiction Behaviors Checklist
Chabal: 5-Point Prescription Opiate Abuse Checklist

Mental Health

HAM-A: Hamilton Depression Scale (HAM-D)
HAM-D: Hamilton Depression Scale (HAM-D)
BDI: Beck Depression Inventory

BEFORE STARTING THERAPY

Healthesystems drew these guidelines from the leading guidelines issued by ACOEM, ODG, Agency Medical Directors Group, American Pain Society, American Academy of Pain Medicine[13], and the states of Washington and Colorado.[14]

Opioids should only be one part of a treatment plan. There are other considerations prior to starting opioids.

- Optimize alternative therapies such as NSAIDs, acetaminophen or neuropathic agents if nerve pain is present.
- Determine if there are underlying psychological issues such as anxiety, depression and post-traumatic stress disorder.
- Screen the patient for risk of drug abuse, misuse or diversion.
- Decide what conditions will warrant discontinuing opioids.

STARTING OPIOID THERAPY

If the patient is a candidate for opioid therapy:

- Start therapy with the end in mind.
- Check the State's Prescription Drug Monitoring Program (PDMP).
- Assess the patient's complaints in light of objective evidence from imaging or physical exam findings.
- Discuss with the patient the risks versus benefits of opioid therapy, goals of therapy and weaning steps that will be followed.
- Set realistic expectations about controlling pain.
- Establish a return to work date.
- Conduct a baseline urine drug screen to evaluate use of non-prescription medications or illegal substances.
- Perform baseline assessments that measure physical, social, and psychological factors such as pain and functional ability, activities of daily living, daily social and work activities, mental state and well-being.
- Document the patient's understanding of risks by having a signed informed consent on file, a written treatment plan, expected duration of therapy and the expectation that a single provider and single pharmacy will be used for prescriptions.

CONTINUING OPIOID THERAPY

- Continue therapy only if improvement in pain relief and function is documented.

WHEN PAIN PERSISTS

If pain persists after opioid therapy has been discontinued, recommend other therapies such as:

Neuropathic agents

— Anticonvulsants - gabapentin, pregabalin

— Antidepressants- venlafaxine, duloxetine, nortriptyline, desipramine

Non-opioid analgesics

— NSAIDs, acetaminophen

Physical and occupational therapy

Alternative therapies (see page 18)

— Massage, Acupuncture, Chiropractic therapy

DIS-CONTINUING OPIOID THERAPY

A number of circumstances may warrant discontinuation of opioid therapy. The following or similar scenarios may require referral for detoxification or to a pain management or addiction specialist.

- Lower back pain and/or a strain/sprain injury continues in to the chronic phase.
- Pain persists despite frequent or high-doses of opioids, especially if doses exceed 120mg MED.
- The patient is experiencing side effects, especially if they are severe enough to require addition of medications to treat opioid-induced adverse effects.
- Ongoing screenings reveal a risk for drug misuse, abuse or addiction.
- Concerns arise such as psychological issues, substance abuse, arrests, overdoses, violent behavior or hospitalizations related to opioid use.
- The treatment agreement is violated.
  - Inconsistent office dose counts, frequent early refills, aberrant urine drug screening results
  - State PDMP reveals multiple prescribers or multiple non-affiliated prescribers

DOSE TAPERING

Discontinuation of therapy has many approaches and can range from a slow dose reduction to a more rapid reduction every few days. There is a lack of evidence to make specific recommendations on the rate of dose reduction. This must be assessed on a case-by-case basis, though a slower rate may help reduce symptoms of opioid withdrawal.

Factors that may influence the rate of dose tapering include the patient's fear of pain, the current morphine equivalent dose, and severity of withdrawal symptoms that might occur as tapering starts.

INPATIENT DETOXIFICATION

Patients who are not able to wean or taper successfully within a primary care setting may need more aggressive intervention. Patients who may be at high risk of failure may also be candidates for more aggressive intervention such as medication-assisted detoxification or in-patient treatment.

FOR MORE INFO

American College of Occupational and Environmental Medicine
www.acoem.org/Guidelines.Opioids

Washington State Guidelines
www.lni.wa.gov

Interagency Guidelines on Opioid Dosing for Chronic Non-Cancer Pain
www.agencymeddirectors.wa.gov

OpioidRisk: Extended Release/Long Acting Opioid REMS Training
www.opioidrisk.com

Department of Health and Human Services, Substance Abuse and Mental Health Services Administration
www.dpt.samhsa.gov