



**Preface:** These guidelines address the use of opioids for the treatment of chronic, non-terminal pain. “Chronic pain” means pain that has persisted after reasonable medical efforts have been made to relieve the pain or cure its cause and that has continued, either continuously or episodically, for longer than three continuous months. The guidelines are intended to help health care providers review and assess their approach in the prescribing of opioids. The guidelines are points of reference intended to supplement and not replace the individual prescriber’s clinical judgment. The 80 mg MED is the maximum daily dose at which point the prescriber’s actions are triggered; however, this 80 mg MED trigger point is not an endorsement by any regulatory body or medical professional to utilize that dose or greater.

## Introduction

Recent analysis by the Centers for Disease Control and Prevention (CDC) shows that “patients with mental health and substance use disorders are at increased risk for nonmedical use and overdose from prescription painkillers as well as being prescribed high doses of these drugs.” Drug overdose deaths increased for the 11th consecutive year in 2010. Nearly 60% of the deaths involved pharmaceuticals, and opioids were involved in nearly 75%. Researchers also found that drugs prescribed for mental health conditions were involved in over half. These findings appear consistent with research previously published in the *Annals of Internal Medicine* that concluded that “patients receiving higher doses of prescribed opioids are at an increased risk for overdose, which underscores the need for close supervision of these patients” (Dunn, et al., 2010).

## Non-Opioid Therapies First

Health care providers are not obligated to use opioids when a favorable risk-benefit balance cannot be documented. Providers should first consider non-pharmacologic and non-opioid therapies. Providers should exercise the same caution with tramadol as with opioids and must take into account the medication’s potential for abuse, the possibility the patient will obtain the medication for a nontherapeutic use or distribute it to other persons, and the potential existence of an illicit market for the medication.

## Avoid Long-Term and Co-Prescribing

Providers must be vigilant to the wide range of potential adverse effects associated with long-term opioid therapy and misuse of extended-release formulations. That vigilance and detailed attention has to be present from the outset of prescribing and continue for the duration of treatment. Providers should avoid starting a patient on long-term opioid therapy when treating chronic pain. Providers should also avoid prescribing benzodiazepines with opioids as it may increase opioid toxicity, add to sleep apnea risk, and increase risk of overdose deaths and other potential adverse effects.

## Press Pause

Providers can further minimize the potential for prescription drug abuse/misuse and help reduce the number of unintentional overdose deaths associated with pain medications by recognizing times to “press pause” in response to certain “trigger points.” This pause allows providers to reassess their compliance with accepted and prevailing standards of care. The 80 mg Morphine Equivalent Daily Dose (MED) “trigger point” is one such time.

## Review Treatment Plan

The 80 MED “trigger point” is an opportunity to review the plan of treatment, the patient’s response to treatment, and any modification to the plan of treatment that is necessary to achieve a favorable risk-benefit balance for the patient’s

care. If opioid therapy is continued, further reassessment will be guided by clinical judgment and decision-making consistent with accepted and prevailing standards of care. The “trigger point” also provides an opportunity to further assess addiction risk or mental health concerns, possibly using Screening, Brief Intervention, and Referral to Treatment (SBIRT) tools, including referral to an addiction medicine specialist when appropriate.

For providers treating acute exacerbation of chronic, non-terminal pain, clinical judgment may not trigger the need for using the full array of reassessment tools.

Providers treating patients with acute care conditions in the emergency department or urgent care center should refer to the Ohio Emergency and Acute Care Facility Opioids and Other Controlled Substances Prescribing Guidelines. <http://www.healthy.ohio.gov/ed/guidelines>

## Ensure Patient Safety

Providers treating chronic, non-terminal pain patients who have received opioids equal to or greater than 80 mg MED for longer than three continuous months should strongly consider doing the following to optimize therapy and help ensure patient safety:

- Reestablish informed consent, including providing the patient with written information on the potential adverse effects of long-term opioid therapy.
- Review the patient’s functional status and documentation, including the 4A’s of chronic pain treatment:
  - » Activities of daily living
  - » Adverse Effects
  - » Analgesia
  - » Aberrant behavior
- Review the patient’s progress toward treatment objectives for the duration of the treatment.
- Utilize OARRS as an additional check on patient compliance.
- Consider a patient pain treatment agreement that may include: more frequent office visits, different treatment options, drug screens, use of one pharmacy, use of one provider for the prescription of pain medications, and consequences for non-compliance with terms of the agreement.
- Recons ng the patient evaluated by one or more other providers who specialize in the treatment of the area, system, or organ of the body perceived as the source of the pain.

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