Minnesota Hospital Association

Opioid Prescribing for Chronic Pain Road Map

In collaboration with the Minnesota Department of Human Services, MHA has created the Opioid Prescribing Road Maps to assist hospitals and health systems implement the Minnesota's Opioid Prescribing Guidelines (First edition, 2018). Like other MHA road maps, the prescribing guidelines were developed based on evidence-based recommendations and standards that reflect published literature and guidance from relevant professional organizations and regulatory agencies, as well as identified proven practices.

Each road map is tiered into fundamental and advanced strategies:

- **Fundamental strategies** should be prioritized for implementation, and generally have a strong evidence base in published literature in addition to being supported by multiple professional bodies and regulatory agencies.
- **Advanced strategies** should be considered in addition to fundamental strategies when there is evidence the fundamental strategies are being implemented and adhered to consistently and there is evidence that rates are not decreasing and/or the pathogenesis (morbidity/mortality among patients) has changed.

Operational definitions are included to assist organization teams with road map auditing and identifying whether current work meets the intention behind each road map element.

Resources linked within the road map include journal articles, expert recommendations, electronic order sets and other pertinent tools which organizations need to assist in implementation of best practices

Goals:

1. Reduce initiating opioid therapy for conditions not indicated for opioid analgesia. When opioid therapy is indicated for the patient, prescribe the lowest effective dose for the shortest period of time. Reduce initiating opioids at doses which are inappropriately high for the indication. Increase timely discontinuation of opioids once they are initiated in order to reduce the transition to long-term use.
2. Improve the consistency of decision making regarding opioid prescribing in the treatment of a painful condition.
3. Manage patients on COAT carefully through multidisciplinary pain treatment, improved safety monitoring and interventions to optimize the benefit to harm ratio.

This road map is intended for use in the outpatient setting where opioids are prescribed for take-home use. It is not intended for patients with cancer, sickle-cell anemia, hospice, or other end stage condition.

Road map sections	Road map questions (if not present at your hospital or answering no, please see next column for suggested resources)	If specific road map element is missing, consider the following resources:
General principals	**FUNDAMENTAL** *(check each box if "yes")* ☐ Avoid initiating opioid therapy for chronic pain. ☐ Provide patient-centered care to patients already receiving opioid therapy for chronic pain; actively assessing the benefits and harms of continued opioid therapy, especially during dose increases.	• Agency for Healthcare Research and Quality: Noninvasive Nonpharmacological Treatment for Chronic Pain: A Systematic Review [2] • Veterans Health Administration: Transforming the Treatment of Chronic Pain, VA Clinician's Guide. [7]

Road map sections	Road map questions (if not present at your hospital or answering no, please see next column for suggested resources)	If specific road map element is missing, consider the following resources:
General principals, cont.	**ADVANCED** *(check each box if "yes")* ☐ Do not abruptly taper long-term opioid therapy, unless the patient faces a life-threatening adverse effect and the taper process is supported with the appropriate level of care (e.g., inpatient tapers following a non-fatal overdose). ☐ Naloxone is a pure opioid antagonist that reverses opioid overdose when administered correctly. Consider co-prescribing naloxone to patients at elevated risk for overdose who receive opioid analgesia.	• CDC Recommended Treatments for Common Chronic Pain Conditions • Future Directions for Pain Management: Lessons from the Institute of Medicine Pain Report and the National Pain Strategy (Mackey, 2016) [6] • Weighing the risks and benefits of chronic opioid therapy (Lembke, et.al. 2016) [14] • Tapering and discontinuing opioid use (mn.gov, 2021)
Assessments: pain, function and quality of life	**FUNDAMENTAL** *(check each box if "yes")* ☐ Perform a detailed evaluation of the patient with chronic pain and establish or confirm the etiology of pain whenever possible. ☐ Assess and document pain, function and quality of life using validated (if available) or standardized assessment tools at every clinical encounter. ☐ Assess patients with indeterminate pain generators and/or whose pain generators inadequately explain their pain experience for opioid-induced pain. ☐ Perform a thorough assessment of mental health conditions prior to initiating COAT and continue assessment for the duration of the opioid therapy. **ADVANCED** *(check each box if "yes")* ☐ Assess and document other medical conditions that may complicate pain symptoms and/or treatment (Lupus, IBS, TBI, MS, etc.).	**Assessment Tools** • Pain, Enjoyment of life and General activity (PEG) • Lee M, Silverman S, Hansen H, et al. A comprehensive review of opioid-induced hyperalgesia. Pain Physician 2011;14:145-161 Mechanisms of Opioid-Induced Hyperalgesia and Future Therapeutic Approaches - Bing video

Road map sections	Road map questions (if not present at your hospital or answering no, please see next column for suggested resources)	If specific road map element is missing, consider the following resources:
Assessments: mental health conditions	**Depression and Anxiety** **FUNDAMENTAL** *(check each box if "yes")* ☐ Screen patients for depression and anxiety using a brief, validated tool at each follow-up visit for pain management. ☐ Refer patients with depression or anxiety that has not been previously treated or successfully treated for appropriate psychotherapy.	**Assessment Tools** • Depression and Anxiety • PHQ-2/PHQ-9 • Generalized Anxiety Disorder (GAD-7) • Substance Use Disorder • NIDA Quick Screen • Tobacco, Alcohol, Prescription Medication and other Substance Abuse (TAPS) tool • Alcohol, Smoking and Substance Involvement Screening (ASSIST) • NIDA-Modified Assist • CAGE-AID (Adapted to Include Drugs) • Screening Instrument for Substance Abuse Potential (SISAP) • Columbia-Suicide Severity Rating Scale (C-SSRS) SAMSHA SAFE-T suicide risk assessment • Prescription Drug Use Questionnaire (PDUQ) • Screening Tool for Addiction Risk (STARR) • Pain Medication Questionnaire (PMQ) *see Reference 3 Pain Catastrophizing Scale • Brief Trauma Questionnaire (BTQ) • Injustice Experience Questionnaire (IEQ) • Post Traumatic Stress Disorder, PC-PTSD • A list of validated tools for assessing biopsychosocial and risk factors can be found in Appendix D of the Minnesota Opioid Prescribing Guidelines. **Articles about adverse selection:** • The Association Between Depressive Disorder and Chronic Pain • Reciprocal relationship between pain and depression: A 12-month longitudinal analysis in primary care • Fear-Avoidance and Chronic Pain: Helping Patients Stuck in the Mouse Trap (Cosio, 2019) [9]
	Depression and Anxiety **ADVANCED** *(check each box if "yes")* ☐ Assess patients for a history of trauma or abuse if depression or anxiety screening tool scores remain elevated during initial treatment. Refer patients with a history of trauma or abuse who have not been previously treated for appropriate psychotherapy.	
	Substance Use Disorders, including Opioid Use Disorder **FUNDAMENTAL** *(check each box if "yes")* ☐ Screen patients for substance use disorder using a brief, validated tool. Conduct a structured interviewing using the current Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria when the patient screens positive or refer to a specialist for diagnosis. ☐ Assess patients for substance use prior to initiating chronic opioid analgesic therapy. If assessment indicates an active substance use disorder, provide the patient evidence-based treatment, or refer to a specialist. Continue to screen for substance use disorders for the duration of the opioid therapy.	
	Suicidality **FUNDAMENTAL** *(check each box if "yes")* ☐ Assess and document suicidality in every setting for every initial opioid prescription. Reassess suicidality in patients receiving chronic opioid analgesic therapy at least once a year.	

Road map sections	Road map questions (if not present at your hospital or answering no, please see next column for suggested resources)	If specific road map element is missing, consider the following resources:
Assessments: mental health conditions, cont.	**Additional screenings** **FUNDAMENTAL** *(check each box if "yes")* ☐ Assess patient for **fear avoidance tendencies or pain catastrophizing** using a brief, validated tool. If assessment indicates the presence of fear avoidance and elevated risk for chronicity, consider referring patient to a physical therapist or a pain psychologist. ☐ Discuss with the patient sources and/or targets of anger or injustice related to his or her pain. - Consider using the Injustice Experience Questionnaire (IEQ) when a patient's pain is related to an occupational injury or motor vehicle accident. ☐ Ask patients about their beliefs and attitudes about pain, its origin and what it represents during an initial clinic visit.	
Patient education	**FUNDAMENTAL** *(check each box if "yes")* ☐ Provide patient education about opioid use and pain management beginning with the first opioid prescription. Engage the patient in shared decision-making. Carefully describe the risks and benefits associated with opioid analgesic use and repeat patient education on an ongoing basis. ☐ Provide safety information about safe use, storage, and disposal with every opioid prescription. Provide information, both oral and written, to patient, family members and caregivers if appropriate. ☐ Educate patients receiving opioids that the medications impact their ability to safely operate motor vehicles. Advise patients who are initiating opioid therapy or who just had a dose increase not to operate heavy machinery, including driving a car, or participate in activities at home that may be adversely affected by the sedating effect of opioids.	• CDC patient educational materials [4] • Stratis Health: Patient Education about Pain and Opioids • Tame the Beast • Brainman videos: Understanding pain • TED Talks: Lorimor Mosley - How to explain pain to patients - Why Things Hurt • Substance Abuse and Mental Health Services Administration (SAMSHA) offers a series of free patient education fact sheets called Rx Pain Medications [5]

Road map sections	Road map questions (if not present at your hospital or answering no, please see next column for suggested resources)	If specific road map element is missing, consider the following resources:
	Pain Education **FUNDAMENTAL** *(check each box if "yes")* ☐ Provide basic pain education during the post-acute and chronic pain period to all patients. Basic pain education resources include patient handouts and online resources. ☐ Consider pain education—such as therapeutic neuroscience education—for patients whose pain experience is disproportionate to the nature of the injury or pathology, or who are found to be at high risk for chronicity or disability. Therapeutic neuroscience education involves education about the brain, spinal cord, and descending pathway nature of pain. Refer patient to an appropriate clinician, such as a pain psychologist or a physical therapist.	
Considerations prior to starting opioid therapy for chronic pain or when continuing therapy in a new patient	**FUNDAMENTAL** *(check each box if "yes")* ☐ Avoid prescribing concurrent prescriptions of opioids and benzodiazepines or other sedative-hypnotic medications. Use extreme caution when prescribing opioids to patients using benzodiazepines or other sedative-hypnotic medications on an on-going basis. Frankly discuss the risks of concomitant use—suppressed respiration—with the patient and conduct close follow-up during the period in which opioids are used. ☐ Review the patient's medical record prior to continuing opioid analgesic therapy in order to understand why opioids were initially prescribed. ☐ Avoid initiating or continuing COAT as an interim therapy while diagnosing or confirming pain etiology. An unknown or unconfirmed pain generator is not a reason to prescribe opioid therapy. ☐ Avoid prescribing opioids for fibromyalgia and headache, including migraine. Provide appropriate non-opioid alternative pain management for conditions not indicated for opioid analgesic therapy. ☐ Use extreme caution when prescribing opioids to patients with comorbid conditions that may increase risk of adverse outcomes. Comorbid conditions associated with elevated risk include Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, obstructive sleep apnea, history of alcohol or substance use disorder, advanced age, or renal or hepatic dysfunction.	**Concomitant opioid and sedative-hypnotic therapy** • CDC Guidelines for Prescribing Opioids for Chronic Pain • National Institute on Drug Abuse. Benzodiazepines and Opioids. March 2018. [1] - Available at: https://www.drugabuse.gov/drugs-abuse/opioids/benzodiazepines-opioids • Opioid Use in Fibromyalgia: A Cautionary Tale (Goldenberg , et. al, 2016) [15]

Road map sections	Road map questions (if not present at your hospital or answering no, please see next column for suggested resources)	If specific road map element is missing, consider the following resources:
COAT therapy	**FUNDAMENTAL** *(check each box if "yes")* ☐ Query the PMP prior to initiating and routinely for the duration of COAT. ☐ Establish specific, measurable treatment goals with the patient prior to initiating COAT. Create treatment goals in terms of improvement in function and quality of life. Treatment goals must be realistic and obtainable. Resolution of pain should not be a treatment goal for chronic opioid therapy, as evidence indicates that this is not an achievable goal. ☐ Implement a multidisciplinary approach to treating all patients with chronic pain. Tailor treatment modalities to the patient's individual needs as determined by the biopsychosocial assessment. ☐ Use caution when prescribing opioids at any dosage and make every effort to keep daily dosage under 50 MME/day. Re-evaluate the patient's individual risks and benefit of continued treatment when increasing dosage. Avoid increasing daily dosage to ≥ 90 MME/day. Clinicians who decide to increase the daily dosage to ≥ 90 MME/day must carefully document that the risks and benefits were weighted, and benefits warrant the risk. ☐ Limit the duration of the prescription to one month and prescribe so that the prescription does not end during a weekend or on a holiday. Face to face visits with the prescribing providers should occur at least every three months, based on the patient's risk profile. Patients at higher risk for adverse events should be seen more frequently.	• Minnesota Prescription Monitoring Program (MNPMP), Registration and Resources • ICSI: Pain Treatment Plan Algorithm • Veterans Health Administration: Opioid Safety Initiative Opioid Safety Initiative (OSI) - VHA Pain Management (va.gov) • VHA OSI Toolkit Material: - Safe and Responsible Use of Opioids for Chronic Pain - A Patient Education Guide (PDF) - Transforming the Treatment of Chronic Pain Moving Beyond Opioids - VA Clinician's Guide (PDF) - Pain Quick Reference Guide - Transforming the Treatment of Pain A Quick Reference Guide (2017) (PDF) - Effective Treatments for PTSD: Consider Cognitive Behavioral Therapy (CBT) as First Line Treatment - for Clinicians (PDF) - PTSD Overview – for Patients (PDF) - Cognitive Behavioral Therapy for Chronic Pain - Therapist Manual (PDF) - Newly Updated - Consent Form for Long-Term Opioid Therapy for Pain (Word)
	ADVANCED *(check each box if "yes")* ☐ Assess potential barriers to active participation in the treatment plan with the patient. Assess the patient's physical limitations and document physical recommendations in clear and simple language. Help the patient identify modifications that will allow him or her to maintain daily routines, when needed. ☐ Identify in the treatment plan the person who will coordinate care across the providers and services identified. Offer the patient access to a care coordinator via the telephone in case an issue arises. If possible, identify the pharmacy that the patient will use to fill all medications included in the treatment plan. ☐ Initiate a patient provider agreement or understanding prior to beginning COAT for every patient or continuing opioid therapy in a new patient.	

Road map sections	Road map questions (if not present at your hospital or answering no, please see next column for suggested resources)	If specific road map element is missing, consider the following resources:
Formulation recommendations	**FUNDAMENTAL** *(check each box if "yes")* ☐ Prescribe immediate release/short acting opioids when initiating COAT. Long acting/extended release opioids should be reserved for patients with established opioid tolerance and in whom the prescriber is confident of the patient's medication adherence. ☐ Avoid routine rotation or substitution of opioids. If substitution or conversion is indicated, use opioid conversion tables only as guidance. Doses of the new opioid should be reduced by 30-50% of the daily MME dose of the previous stable opioid agent to account for incomplete cross-tolerance. ☐ Avoid using methadone interchangeably with other extended-release/long-acting opioids for chronic pain. Only clinicians trained or experienced in the appropriate dosing and management of methadone therapy should consider using methadone for chronic pain. ☐ Exercise extreme caution when considering fentanyl therapy for pain, given the potential for diversion and harm. Clinicians trained or experienced with the dosing and absorption properties of transdermal fentanyl are best equipped to prescribe, educate, and monitor patients appropriately.	• VHA OSI • New - Methadone Fact Sheet (PDF)

Risk mitigation strategies	**FUNDAMENTAL**
	(check each box if "yes")
	☐ Complete a urine drug screen (UDS) prior to initiating or continuing COAT in a new patient and consider a random UDS at least twice a year. Complete a UDS when patients come to the clinic for a pill count. Standardize UDS policies at the clinic or health system level in order to destigmatize their use.
	☐ Use the UDS results to guide treatment decisions, improve patient-clinician communication and monitor patient safety. Consider ordering a confirmatory test for positive results to confirm substance identification. Clinicians should not dismiss patients from care solely based on UDS results that contradict the patient's self-reported adherence to therapy.
		Urine Drug Screening
		• HealthPartners Institute for Medical Education. Interpretation of Opiate Urine Drug Screens
		• CDC Urine Drug Testing Fact Sheet
		• Kale N. Urine Drug Tests: Ordering and Interpretation Am Fam Phys 2019.99(1):33-39.
		
		Opioid Use Disorder
		• ICSI Demistifying Opioids Package
		• Providers Clinical Support System (PCSS)
		• VHA OSI resources on OUD
		  - Opioid Use Disorder – a VA clinician's guide to identification and management of OUD
		  - Opioid Use Disorder – Identification and Management of OUD

Road map sections	Road map questions (if not present at your hospital or answering no, please see next column for suggested resources)	If specific road map element is missing, consider the following resources:
Risk mitigation strategies, cont.	☐ Consider pill count call backs for high risk patients. Call backs generally require patients to come to the clinic to count remaining opioid pills within 24 hours of being notified. If the pill count results in fewer or greater pills than expected, schedule a visit with the patient to discuss the results. **ADVANCED** *(check each box if "yes")* ☐ Monitor patients receiving COAT for the presence of Opioid Use Disorder (OUD). Clinicians who are unable to diagnose OUD using the DSM-5 criteria can use a brief, standardized screening tool and make a referral as appropriate. ☐ Offer or arrange evidence-based treatment for patients with OUD. Clinicians who are not authorized to provide evidence-based treatment should work with their practice group to build capacity for treatment and/or build a referral network of treatment providers. ☐ Consider consulting specialists trained in pain, addiction or mental health conditions when initiating COAT. Early consultation may help identify the potential for increased risk, even in patients at low risk of adverse events, if opioid therapy continues. ☐ Refer patients receiving COAT to addiction and mental health specialists when there is a significant risk for opioid-related harm, as appropriate for the patient's needs. The referring clinician should continue to treat the patient until a successful transfer of care has occurred, or until the patient fails to follow through on the referral and continues to be at risk.	• For patients: - Opioids: Do you know the truth about OUD? **Naloxone** • VHA OSI resources - VA OEND Program Quick Reference Guide - Provider – Opioid Overdose Education & Naloxone Distribution • For patients: - Naloxone Nasal Spring 4 mg Instructions – Pocket Card - Patient-Opioid Overdose Education & Naloxone Distribution - Opioid Safety (for patients on opioids)
Women of childbearing age	**FUNDAMENTAL** *(check each box if "yes")* ☐ Pregnancy risk is assessed prior to prescribing opioids ☐ Avoid prescribing opioids to pregnant women. Pregnant women are educated about the known risks of opioids to both the mother and the fetus. ☐ Discuss monitoring reproductive health in all women of childbearing age who receive COAT.	• ACOG: Opioid Use and Opioid Use Disorder in Pregnancy [10] • Practice Advisory on Codeine and Tramadol for Breastfeeding Women [11] • SAMHSA: Opioid Use Disorder and Pregnancy [5]

References

1. National Institute on Drug Abuse. Benzodiazepines and Opioids. March 2018. Available at: https://www.drugabuse.gov/drugs-abuse/opioids/benzodiazepines-opioids

2. Agency for Healthcare Research and Quality, "Noninvasive Nonpharmacological Treatment for Chronic Pain: A Systematic Review", June 11, 2018. Available at: https://effectivehealthcare.ahrq.gov/topics/nonpharma-treatment-pain/research-2018

3. Stratis Health (Collaboratively with Minnesota Managed Care Organizations). "A Provider Toolkit, Meeting the Challenges of Opioids and PAIN". March 2018. Available at: https://www.stratishealth.org/pip/documents/Opioid-provider-toolkit.pdf

4. CDC, Helpful materials for patients, available at: https://www.cdc.gov/drugoverdose/patients/materials.html and clinicians available at: https://www.cdc.gov/drugoverdose/prescribing/clinical-tools.html

5. Substance Abuse and Mental Health Services Administration (SAMSHA) publications. Available at: https://store.samhsa.gov/

6. Future Directions… citation: Mackey S. Future Directions for Pain Management: Lessons from the Institute of Medicine Pain Report and the National Pain Strategy. Hand Clin. 2016;32(1):91–98. doi:10.1016/j.hcl.2015.08.012

7. U.S. Department of Veterans Affairs, Veterans Health Administration, PBM Academic Detailing Service materials available at: https://www.pbm.va.gov/PBM/academicdetailingservice/Pain_and_Opioid_Safety.asp. VA Opioid Safety Initiative materials available at: https://www.va.gov/PAINMANAGEMENT/Opioid_Safety_Initiative_OSI.asp

8. Hooten M, Thorson D, Bianco J, Bonte B, Clavel Jr A, Hora J, Johnson C, Kirksson E, Noonan MP, Reznikoff C, Schweim K, Wainio J, Walker N. Institute for Clinical Systems Improvement. Pain: Assessment, Non-Opioid Treatment Approaches and Opioid Management. Updated August 2017.

9. Washington State Agency Medical Directors' Group (AMDG), "Interagency Guideline on Prescribing Opioids for Pain", 3rd Edition, June 2015.

10. Opioid Use and Misuse Disorder in pregnancy. Committee Opinion No. 711. American College of Obstetricians and Gynecologists. Obstet Gynecol 2017;130:e81-94. Available at: https://www.acog.org/-/media/Committee-Opinions/Committee-on-Obstetric-Practice/co711.pdf?dmc=1&ts=20190329T1833278386

11. Practice advisory on codeine and tramadol for breast-feeding women. April 27, 2017. Available at: https://s3.amazonaws.com/cdn.smfm.org/publications/238/download-f3b5696d35bb75e9b31bbb83981b2613.pdf

12. David Cosio, PhD, ABPP, (August 2, 2019), Fear-Avoidance and Chronic Pain: Helping Patients Stuck in the Mouse Trap, Practical Pain Management, Volume 19, (Issue # 5), 18-21

13. Center for Substance Abuse Treatment (US). Trauma-Informed Care in Behavioral Health Services. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2014. (Treatment Improvement Protocol (TIP) Series, No. 57.) Chapter 4, Screening and Assessment. Available from: https://www.ncbi.nlm.nih.gov/books/NBK207188/.

14. Lembke A. Weighing the risks and benefits of chronic opioid therapy. Am Fam Physician. 2016;93(12):982-990.

15. Goldenberg DL, Clauw DJ, Palmer RE, Clair AG. Opioid Use in Fibromyalgia: A Cautionary Tale. Mayo Clin Proc. 2016 May;91(5):640-8. doi: 10.1016/j.mayocp.2016.02.002. Epub 2016 Mar 11. PMID: 26975749.