

PAIN MANAGEMENT GUIDELINES REVISION

MBC PREAMBLE

In 1994, the Medical Board of California formally adopted a policy statement titled, "Prescribing Controlled Substances for Pain." The statement outlined the board's proactive approach to improving appropriate prescribing for effective pain management in California, while preventing drug diversion and abuse. The policy statement was the product of a year of research, hearings and discussions. California physicians and surgeons are encouraged to consult this policy statement and the guidelines below.

In May 2002, as a result of AB 487, a task force was established to review the 1994 Guidelines and to assist the Division of Medical Quality to "develop standards to assure the competent review in cases concerning the management, including, but not limited to, the under treatment, under medication, and over medication of a patient's pain." The task force expanded the scope of the Guidelines from intractable pain patients to all patients with pain.

Under past law, both Business and Professions Code section 2241 and Health and Safety Code section 11156 made it unprofessional conduct for a practitioner to prescribe to an addict. However, the standard of care has evolved over the past several years such that a practitioner may, under certain circumstances, appropriately prescribe to an addict. AB 2198, which became law on January 1, 2007, sought to align existing law with the current standard of care. Accordingly, a physician is permitted to prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under his or her treatment for a purpose other than maintenance on, or detoxification from, prescription drugs or controlled substances. The law, Business and Professions Code section 2241, also set forth the conditions under which such prescribing may occur. Further, Business and Professions Code 2241.5 now permits a physician to prescribe for or dispense or administer to a person under his or her treatment of pain or a condition causing pain, including, but not limited to, intractable pain.

Inappropriate prescribing of controlled substances, including opioids, can lead to drug abuse or diversion and can also lead to ineffective management of pain, unnecessary suffering of patients, and increased health costs. The Medical Board recognized that some physicians do not treat pain appropriately due to a lack of knowledge or concern about pain, and others may fail to treat pain properly due to fear of discipline by the board. These Guidelines are intended to improve effective pain management in California, by avoiding under treatment, over treatment, or other inappropriate treatment of a patient's pain and by clarifying the principles of professional practice that are endorsed by the Medical Board so that physicians have a higher level of comfort in using controlled substances, including opioids, in the treatment of pain. These Guidelines are intended to promote improved pain management for all forms of pain and for all patients in pain.

FSMB PREAMBLE

The (name of Board) is obligated under the laws of the State of (name of state) to protect the public health and safety. The (name of Board) recognizes that principles of high-quality medical practice dictate that the people of the State of (name of state) have access to appropriate, safe and effective pain management. The application of up-to-date knowledge and treatment modalities can help to restore function and thus improve the quality of life of patients who suffer from pain, particularly chronic pain [4,8,26].

This policy has been developed to articulate the Board's position on the use of controlled substances for pain, particularly the use of opioid analgesics and with special attention to the management of chronic pain. The policy thus is intended to encourage physicians to be knowledgeable about best clinical practices as regards the prescribing of opioids and be aware of associated risks. For the purposes of this policy, inappropriate treatment of pain includes non-treatment, inadequate treatment, overtreatment, and continued use of ineffective treatments.

The Board recognizes that opioid analgesics are useful and can be essential in the treatment of acute pain that results from trauma or surgery, as well as in the management of certain types of chronic pain, whether due to cancer or non-cancer causes [20,26,28]. The Board will refer to current clinical practice guidelines and expert reviews in approaching allegations of possible mismanagement of pain [8,10,12,14,26-41, 80].

MBC

vs

FSMB

- 1. ***History/Physical Exam***
- 2. ***Treatment Plan/Objectives***
- 3. ***Informed Consent***
- 4. Periodic Review
- 5. ***Consultation***
- 6. ***Records***
- 7. ***Compliance with C.S. Laws & Regulations***

- 1. Understanding Pain
- 2. ***Patient Evaluation*** and Risk Stratification
- 3. Informed Consent & Treatment Agreement
- 4. ***Development of a Treatment Plan and Goals***
- 5. Initiating an Opioid Trial
- 6. Ongoing Monitoring and Adapting the Treatment Plan
- 7. Periodic Drug Testing
- 8. ***Consultation*** & Referral
- 9. Discontinuing Opioid Therapy
- 10. ***Medical Records***
- 11. ***Compliance with C.S. Laws & Regulations***

Should this be
included in the MBC
pain management
guidelines?

2. In order to cautiously prescribe opioids, physicians must understand the relevant pharmacologic and clinical issues in the use of such analgesics, and carefully structure a treatment plan that reflects the particular benefits and risks of opioid use for each individual patient. Such an approach should be employed in the care of every patient who receives chronic opioid therapy [4,8]?

1. Yes

2. No

PATIENT EVALUATION & RISK STRATIFICATION

4. (The detailed patient) evaluation should be completed before a decision is made as to whether to prescribe an opioid analgesic?

1. Yes

2. No

8. For every patient, the initial work-up should include a systems review and relevant physical examination, as well as laboratory investigations as indicated [33,36, 48-53].

1. Yes

2. No

10. Social and vocational assessment is useful in identifying supports and obstacles to treatment and rehabilitation; for example: Does the patient have good social supports, housing, and meaningful work? Is the home environment stressful or nurturing [14].

1. Yes

2. No

11. Assessment of the patient's personal and family history of alcohol or drug abuse and relative risk for medication misuse or abuse also should be apart of the initial evaluation [11,14,21-23, 45], and ideally should be completed prior to a decision as to whether to prescribe opioid analgesics [56-58].

1. Yes

2. No

12. This can be done through a careful clinical interview, which also should inquire into any history of physical, emotional or sexual abuse, because those are risk factors for substance misuse.

1. Yes

2. No

13. Use of a validated screening tool (such as the Screener and Opioid Assessment for Patients with Pain [SOAPP-R; 48] or the Opioid Risk Tool [ORT; 49]), or other validated screening tools, can save time in collecting and evaluating the information and determining the patient's level of risk.

1. Yes

2. No

14. All patients should be screened for depression and other mental health disorders, as part of risk evaluation 15. Patients with untreated depression and other mental health problems are at increased risk for misuse of abuse of controlled medications, including addiction, as well as overdose.

1. Yes

2. No

16. Patients who have a history of substance use disorder (including alcohol) are at elevated risk for failure of opioid analgesic therapy to achieve the goals of improved comfort and function, and also are at high risk for experiencing harm from this therapy, since exposure to addictive substances often is a powerful trigger of relapse [11,31,45].

1. Yes

2. No

18. Patients who have an active substance use disorder should not receive opioid therapy until they are established in a treatment/recovery program [31] or alternatives are established such as co-management with an addiction professional.

1. Yes

2. No

19. Physicians who treat patients with chronic pain should be encouraged to also be knowledgeable about the treatment of addiction, including the role of replacement agonists such as methadone and buprenorphine.

1. Yes

2. No

20. For some physicians, there may be advantages to becoming eligible to treat addiction using office-based buprenorphine treatment.

1. Yes

2. No

21. Information provided by the patient is a necessary but insufficient part of the evaluation process.

1. Yes

2. No

22. Reports of previous evaluations and treatments should be confirmed by obtaining records from other providers, if possible.

1. Yes

2. No

23. Patients have occasionally provided fraudulent records, so if there is any reason to question the truthfulness of a patient's report, it is best to request records directly from the other providers [54-55].

1. Yes

2. No

24. If possible, the patient evaluation should include information from family members and/or significant others [22-23,49-50].

1. Yes

2. No

25. Where available, the state prescription drug monitoring program (PDMP) should be consulted to determine whether the patient is receiving prescriptions from any other physicians, and the results obtained from the PDMP should be documented in the patient record [34].

1. Yes

2. No

26. In dealing with a patient who is taking opioids prescribed by another physician—particularly a patient on high doses—the evaluation and risk stratification assume even greater importance [21-23].

1. Yes

2. No

27. With all patients, the physician's decision as to whether to prescribe opioid analgesics should reflect the totality of the information collected, as well as the physician's own knowledge and comfort level in prescribing such medications and the resources for patient support that are available in the community [21-23].

1. Yes

2. No

DEVELOPMENT OF TREATMENT PLAN & GOALS

28. The goals of pain treatment include reasonably attainable improvement in pain and function; improvement in pain-associated symptoms such as sleep disturbance, depression, and anxiety; and avoidance of unnecessary or excessive use of medications [4,8].

1. Yes

2. No

30. The treatment plan and goals should be established as early as possible in the treatment process and revisited regularly, so as to provide clear-cut, individualized objectives to guide the choice of therapies [38].

1. Yes

2. No

31. The treatment plan should contain information supporting the selection of therapies, both pharmacologic (including medications other than opioids) and non-pharmacologic.

1. Yes

2. No

INFORMED CONSENT AND TREATMENT AGREEMENT

34. The decision to initiate opioid therapy should be a shared decision between the physician and the patient.

1. Yes

2. No

35. The physician should discuss the risks and benefits of the treatment plan (including any proposed use of opioid analgesics) with the patient, with persons designated by the patient, or with the patient's surrogate or guardian if the patient is without medical decision-making capacity [32,35].

1. Yes

2. No

36. If opioids are prescribed, the patient (and possibly family members) should be counseled on safe ways to store and dispose of medications [3,37].

1. Yes

2. No

38. Informed consent documents typically address:

- The potential risks and anticipated benefits of chronic opioid therapy.
- Potential side effects (both short- and long-term) of the medication, such as constipation and cognitive impairment.
- The likelihood that tolerance to and physical dependence on the medication will develop.
- The risk of drug interactions and over-sedation.
- The risk of impaired motor skills (affecting driving and other tasks).
- The risk of opioid misuse, dependence, addiction, and overdose.
- The limited evidence as to the benefit of long-term opioid therapy.
- The physician's prescribing policies and expectations, including the number and frequency of prescription refills, as well as the physician's policy on early refills and replacement of lost or stolen medications.
- Specific reasons for which drug therapy may be changed or discontinued (including violation of the policies and agreements spelled out in the treatment agreement).

38. Should the informed consent described in the previous slide be adopted as written?

1. Yes

2. No

39. Treatment agreements outline the joint responsibilities of physician and patient [35-37] and are indicated for opioid or other abusable medications.

1. Yes

2. No

40. Treatment agreements typically discuss:

- The goals of treatment, in terms of pain management, restoration of function, and safety.
- The patient's responsibility for safe medication use (e.g., by not using more medication than prescribed or using the opioid in combination with alcohol or other substances; storing medications in a secure location; and safe disposal of any unused medication).
- The patient's responsibility to obtain his or her prescribed opioids from only one physician or practice.
- The patient's agreement to periodic drug testing (as of blood, urine, hair, or saliva).
- The physician's responsibility to be available or to have a covering physician available to care for unforeseen problems and to prescribe scheduled refills.

40. Do you agree the previous slide's description of a treatment agreement should be adopted?

1. Yes

2. No

41. Informed consent documents and treatment agreements can be part of one document for the sake of convenience.

1. Yes

2. No

INITIATING OPIOID TRIAL

42. Generally, safer alternative treatments should be considered before initiating opioid therapy for chronic, non-malignant pain.

1. Yes

2. No

43. Opioid therapy should be presented to the patient as a therapeutic trial or test for a defined period of time (usually no more than 90 days) and with specified evaluation points.

1. Yes
2. No

44. The physician should explain that progress will be carefully monitored for both benefit and harm in terms of the effects of opioids on the patient's level of pain, function, and quality of life, as well as to identify any adverse events or risks to safety [51].

1. Yes

2. No

45. When initiating opioid therapy, the lowest dose possible should be given to an opioid naïve patient and titrate to affect.

1. Yes

2. No

46. It is generally suggested to begin opioid therapy with a short acting opioid and rotate to a long acting/extended release if indicated.

1. Yes

2. No

47. A decision to continue opioid therapy beyond the trial period should reflect a careful evaluation of benefits versus adverse events [29]and/or potential risks.

1. Yes

2. No

ONGOING MONITORING & ADAPTING THE TREATMENT PLAN

49. When possible, collateral information about the patient's response to opioid therapy should be obtained from family members or other close contacts, and the state PDMP.

1. Yes

2. No

50. The patient should be seen more frequently while the treatment plan is being initiated and the opioid dose adjusted [44-51].

1. Yes

2. No

51. As the patient is stabilized in the treatment regimen, follow-up visits may be scheduled less frequently. (However, if the patient is seen less than monthly and an opioid is prescribed, arrangements must be made for the patient to obtain a refill or new prescription when needed.)

1. Yes

2. No

52. At each visit, the results of chronic opioid therapy should be monitored by assessing what have been called the “5As” of chronic pain management; these involve a determination of whether the patient is experiencing a reduction in pain (Analgesia), has demonstrated an improvement in level of function (Activity), whether there are significant Adverse effects, whether there is evidence of Aberrant substance-related behaviors, and mood of the individual (Affect) [38,52].

1. Yes

2. No

53. Validated brief assessment tools that measure pain and function, such as the three- question “Pain, Enjoyment and General Activity” (PEG) scale [47] or other validated assessment tools, may be helpful and time effective.

1. Yes

2. No

54. Continuation, modification or termination of opioid therapy for pain should be contingent on the physician's evaluation of (1) evidence of the patient's progress toward treatment objectives and (2) the absence of substantial risks or adverse events, such as overdose or diversion [21-23,45].

1. Yes

2. No

55. A satisfactory response to treatment would be indicated by a reduced level of pain, increased level of function, and/or improved quality of life [29].

1. Yes

2. No

56. Information from family members or other caregivers should be considered in evaluating the patient's response to treatment [14,35-36].

1. Yes

2. No

57. Use of measurement tools to assess the patient's level of pain, function, and quality of life (such as a visual analog or numerical scale) can be helpful in documenting therapeutic outcomes [14,49].

1. Yes

2. No

PERIODIC DRUG TESTING

58. Periodic drug testing may be useful in monitoring adherence to the treatment plan, as well as in detecting the use of non-prescribed drugs [53-54].

1. Yes

2. No

59. Drug testing is an important monitoring tool because self-reports of medication use is not always reliable and behavioral observations may detect some problems but not others [55-59].

1. Yes

2. No

60. Patients being treated for addiction should be tested as frequently as necessary to ensure therapeutic adherence, but for patients being treated for pain, clinical judgment trumps recommendations for frequency of testing.

1. Yes

2. No

61. Urine may be the preferred biologic specimen for testing because of its ease of collection and storage and the cost-effectiveness of such testing [53].

1. Yes

2. No

62. When such testing is conducted as part of pain treatment, forensic standards are generally not necessary and not in place, so collection is not observed and chain-of-custody protocols are not followed.

1. Yes

2. No

63. Initial testing may be done using class-specific immunoassay drug panels (point-of-care or laboratory-based), which typically do not identify particular drugs within a class unless the immunoassay is specific for that drug.

1. Yes
2. No

64. If necessary, this can be followed up with a more specific technique, such as gas chromatography/mass spectrometry (GC/MS) or other chromatographic tests to confirm the presence or absence of a specific drug or its metabolites [53].

1. Yes

2. No

65. In drug testing in a pain practice, it is important to identify the specific drug not just the class of the drug.

1. Yes

2. No

66. Physicians need to be aware of the limitations of available tests (such as their limited sensitivity for many opioids) and take care to order tests appropriately [54]. 67. For example, when a drug test is ordered, it is important to specify that it include the opioid being prescribed [53].

1. Yes

2. No

68. Because of the complexities involved in interpreting drug test results, it is advisable to confirm significant or unexpected results with the laboratory toxicologist or a clinical pathologist [59-60].

1. Yes

2. No

69. While immunoassay, point of care (POC) testing has its utility in the making of temporary and “on the spot” changes in clinical management, its limitations with regard to accuracy have recently been the subject of study.

1. Yes
2. No

70. These limitations are such that the use of point of care testing for the making of more long term and permanent changes in management of people with the disease of addiction and other clinical situations may not be justified until the results of confirmatory testing with more accurate methods such as LC-MS/MS are obtained.

1. Yes

2. No

71. A recent study on LC-MS/MS results following immunoassay POC testing in addiction treatment settings and found very high rates of “false negatives and positives” [53,81].

1. Yes

2. No

72. Test results that suggest opioid misuse should be discussed with the patient.

1. Yes

2. No

73. It is helpful to approach such a discussion in a positive, supportive fashion, so as to strengthen the physician-patient relationship and encourage healthy behaviors (as well as behavioral change where that is needed).

1. Yes

2. No

74. Both the test results and subsequent discussion with the patient should be documented in the medical record [53].

1. Yes

2. No

75. Periodic pill counting is also a useful strategy to confirm medication adherence and to minimize diversion (e.g., selling, sharing or giving away medications).

1. Yes

2. No

76. As noted earlier and where available, consulting the state's PDMP before prescribing opioids for pain and during ongoing use is highly recommended. A PDMP can be useful in monitoring compliance with the treatment agreement as well as identifying individuals obtaining controlled substances from multiple prescribers [21-23,55,62].

1. Yes

2. No

78. If the patient's progress is unsatisfactory, the physician must decide whether to revise or augment the treatment plan, whether other treatment modalities should be added to or substituted for the opioid therapy, or whether a different approach—possibly involving referral to a pain specialist or other health professional—should be employed [35-37,62-63].

1. Yes

2. No

79. Evidence of misuse of prescribed opioids demands prompt intervention by the physician [19,21-23,32,35].

1. Yes

2. No

80. Patient behaviors that require such intervention typically involve recurrent early requests for refills, multiple reports of lost or stolen prescriptions, obtaining controlled medications from multiple sources without the physician's knowledge, intoxication or impairment (either observed or reported), and pressuring or threatening behaviors [23].

1. Yes

2. No

81. The presence of illicit or unprescribed drugs, (drugs not prescribed by a physician) in drug tests similarly requires action on the part of the prescriber.

1. Yes
2. No

82. Some aberrant behaviors are more closely associated with medication misuse than others [62-63]. Most worrisome is a pattern of behavior that suggests recurring misuse, such as unsanctioned dose escalations, deteriorating function, and failure to comply with the treatment plan [64].

1. Yes
2. No

84. Documented drug diversion or prescription forgery, obvious impairment, and abusive or assaultive behaviors require a firm, immediate response [22-23,38,46]. 85. Indeed, failure to respond can place the patient and others at significant risk of adverse consequences, including accidental overdose, suicide attempts, arrests and incarceration, or even death [23,65-67].

1. Yes
2. No

86. For this reason, physicians who prescribe chronic opioid therapy should be knowledgeable in the diagnosis of substance use disorders and able to distinguish such disorders from physical dependence—which is expected in chronic therapy with opioids and many sedatives.

1. Yes

2. No

CONSULTATION & REFERRAL

87. The treating physician should seek a consultation with, or refer the patient to, a pain, psychiatry, addiction or mental health specialist as needed [37-38]. 88. For example, a patient who has a history of substance use disorder or a co-occurring mental health disorder may require specialized assessment and treatment, if available [31,66].

1. Yes
2. No

89. Physicians who prescribe chronic opioid therapy should be familiar with treatment options for opioid addiction (including those available in licensed opioid treatment programs [OTPs]) and those offered by an appropriately credentialed and experienced physician through office-based opioid treatment [OBOT]), so as to make appropriate referrals when needed [23,31,37,39].

1. Yes

2. No

DISCONTINUING OPIOID THERAPY

90. Throughout the course of opioid therapy, the physician and patient should regularly weigh the potential benefits and risks of continued treatment and determine whether such treatment remains appropriate [46]. (This is akin to our periodic review)

1. Yes
2. No

92. Reasons for discontinuing opioid therapy include resolution of the underlying painful condition, emergence of intolerable side effects, inadequate analgesic effect, failure to improve the patient's quality of life despite reasonable titration, deteriorating function, or significant aberrant medication use [38, 45].

1. Yes

2. No

93. If opioid therapy is discontinued, the patient who has become physically dependent should be provided with a safely structured tapering regimen. 94. Withdrawal can be managed either by the prescribing physician or by referring the patient to an addiction specialist [63].

1. Yes

2. No

95. The termination of opioid therapy should not mark the end of treatment, which should continue with other modalities, either through direct care or referral to other health care specialists, as appropriate [21-23].

1. Yes

2. No

96. Additionally, providers should not continue opioid treatment unless the patient has received a benefit, including demonstrated functional improvement.

1. Yes

2. No

MEDICAL RECORDS

98. Information that should appear in the medical record includes the following [22-23,38,43-44]:

- Copies of the signed informed consent and treatment agreement.
- The patient's medical history.
- Results of the physical examination and all laboratory tests.
- Results of the risk assessment, including results of any screening instruments used.
- A description of the treatments provided, including all medications prescribed or administered (including the date, type, dose and quantity).
- Instructions to the patient, including discussions of risks and benefits with the patient and any significant others.
- Results of ongoing monitoring of patient progress (or lack of progress) in terms of pain management and functional improvement.
- Notes on evaluations by and consultations with specialists.
- Any other information used to support the initiation, continuation, revision, or termination of treatment and the steps taken in response to any aberrant medication use behaviors [21-23,30,38,45,68]. These may include actual copies of, or references to, medical records of past hospitalizations or treatments by other providers.
- Authorization for release of information to other treatment providers.

98. The items marked in red in the previous slide (not currently set forth in our guidelines with such specificity) should be included in the description of an adequate medical record.

1. Yes

2. No

99. The medical record must include all prescription orders for opioid analgesics and other controlled substances, whether written or telephoned. In addition, written instructions for the use of all medications should be given to the patient and documented in the record [25].

1. Yes

2. No

100. The name, telephone number, and address of the patient's pharmacy also should be recorded to facilitate contact as needed [23].

1. Yes

2. No

101. Records should be up-to-date and maintained in an accessible manner so as to be readily available for review [25].

1. Yes

2. No

102. Good records demonstrate that a service was provided to the patient and establish that the service provided was medically necessary. 103. Even if the outcome is less than optimal, thorough records protect the physician as well as the patient [23,38,45,68].

1. Yes

2. No

Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain

Summary of Recommendations

Cluster 1: Deciding to Initiate Opioid Therapy

No. Recommendation

Before initiating opioid therapy, ensure comprehensive documentation of the patient's pain condition, general medical condition and psychosocial history (Grade C), psychiatric status, and substance use history. (Grade B).

Keyword

Comprehensive assessment

R02 Before initiating opioid therapy, consider using a screening tool to determine the patient's risk for opioid addiction. (Grade B).

Addiction-risk screening

R03 When using urine drug screening (UDS) to establish a baseline measure of risk or to monitor compliance, be aware of benefits and limitations, appropriate test ordering and interpretation, and have a plan to use results. (Grade C).

Urine drug screening

R04 Before initiating opioid therapy, consider the evidence related to effectiveness in patients with chronic non-cancer pain. (Grade A).

Opioid efficacy

R05 Before initiating opioid therapy, ensure informed consent by explaining potential benefits, adverse effects, complications and risks (Grade B).
A treatment agreement may be helpful, particularly for patients not well known to the physician or at higher risk for opioid misuse. (Grade C).

Risk, adverse effects, complications

R06 For patients taking benzodiazepines, particularly for elderly patients, consider a trial of tapering (Grade B). If a trial of tapering is not indicated or is unsuccessful, opioids should be titrated more slowly and at lower doses. (Grade C).

Benzodiazepine tapering

Cluster 2: Conducting an Opioid Trial

No. Recommendation

R07 During dosage titration in a trial of opioid therapy, advise the patient to avoid driving a motor vehicle until a stable dosage is established and it is certain the opioid does not cause sedation (Grade C); and when taking opioids with alcohol, benzodiazepines, or other sedating drugs. (Grade B).

Keyword

*Titration
and
driving*

R08 During an opioid trial, select the most appropriate opioid for trial therapy using a stepped approach, and consider safety. (Grade C).

*Stepped opioid
selection*

R09 When conducting a trial of opioid therapy, start with a low dosage, increase dosage gradually and monitor opioid effectiveness until optimal dose is attained. (Grade C).

*Optimal
dose*

R10 Chronic non-cancer pain can be managed effectively in most patients with dosages at or below 200 mg/day of morphine or equivalent (Grade A). Consideration of a higher dosage requires careful reassessment of the pain and of risk for misuse, and frequent monitoring with evidence of improved patient outcomes. (Grade C).

*Watchful
dose*

R11 When initiating a trial of opioid therapy for patients at higher risk for misuse, prescribe only for well-defined somatic or neuropathic pain conditions (Grade A), start with lower doses and titrate in small-dose increments (Grade B), and monitor closely for signs of aberrant drug-related behaviors. (Grade C).

*Risk:
opioid
misuse*

Cluster 3: Monitoring Long-Term Opioid Therapy (LTOT)

No. Recommendation

R12 When monitoring a patient on long-term therapy, ask about and observe for opioid effectiveness, adverse effects or medical complications, and aberrant drug-related behaviours. (Grade C).

Keyword
*Monitoring
LTOT*

R13 For patients experiencing unacceptable adverse effects or insufficient opioid effectiveness from one particular opioid, try prescribing a different opioid or discontinuing therapy. (Grade B).

*Switching or
discontinuing
opioids*

R14 When assessing safety to drive in patients on long-term opioid therapy, consider factors that could impair cognition and psychomotor ability, such as a consistently severe pain rating, disordered sleep, and concomitant medications that increase sedation. (Grade C).

*LTOT and
driving*

R15 For patients receiving opioids for a prolonged period who may not have had an appropriate trial of therapy, take steps to ensure that long-term therapy is warranted and dose is optimal. (Grade C).

*Revisiting
opioid trial
steps*

R16 When referring patients for consultation, communicate and clarify roles and expectations between primary-care physicians and consultants for continuity of care and for effective and safe use of opioids. (Grade C).

Collaborative

Cluster 4: Treating Specific Populations with Long-Term Opioid Therapy

No. Recommendation

R17 Opioid therapy for elderly patients can be safe and effective (Grade B) with appropriate precautions, including lower starting doses, slower titration, longer dosing interval, more frequent monitoring, and tapering of benzodiazepines. (Grade C).

Keyword

*Elderly
patients*

R18 Opioids present hazards for adolescents (Grade B). A trial of opioid therapy may be considered for adolescent patients with well-defined somatic or neuropathic pain conditions when non-opioid alternatives have failed, risk of opioid misuse is assessed as low, close monitoring is available, and consultation, if feasible, is included in the treatment plan. (Grade C).

*Adolescent
patients*

R19 Pregnant patients taking long-term opioid therapy should be tapered to the lowest effective dose slowly enough to avoid withdrawal symptoms, and then therapy should be discontinued if possible. (Grade B).

*Pregnant
patients*

R20 Patients with a psychiatric diagnosis are at greater risk for adverse effects from opioid treatment. Usually in these patients, opioids should be reserved for well-defined somatic or neuropathic pain conditions. Titrate more slowly and monitor closely; seek consultation where feasible. (Grade B).

*Co-morbid
psychiatric
diagnoses*

Cluster 5: Managing Opioid Misuse and Addiction in CNCP Patients

No. Recommendation

R21 For patients with chronic non-cancer pain who are addicted to opioids, three treatment options should be considered: methadone or buprenorphine treatment (Grade A), structured opioid therapy (Grade B), or abstinence-based treatment (Grade C). Consultation or shared care, where available, can assist in selecting and implementing the best treatment option. (Grade C).

Keyword

*Addiction
treatment
options*

R22 To reduce prescription fraud, physicians should take precautions when issuing prescriptions and work collaboratively with pharmacists. (Grade C).

*Prescription
fraud*

R23 Be prepared with an approach for dealing with patients who disagree with their opioid prescription or exhibit unacceptable behaviour. (Grade C).

*Patient
unacceptable
behavior*

R24 Acute or urgent health care facilities should develop policies to provide guidance on prescribing opioids for chronic pain to avoid contributing to opioid misuse or diversion. (Grade C).

*Acute care
opioid
prescribing
policy*

Figure 01. Recommendations Roadmap

