



DEPARTMENT OF
HEALTH AND HUMAN SERVICES

Promoting and protecting health, well-being, self-sufficiency, and safety of all in Marin County.



PUBLIC HEALTH ADVISORY

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New Guidelines for Marin County Prescribers Treating Chronic Pain

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Dear Colleagues:

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DEPUTY PUBLIC HEALTH OFFICER

This advisory is to inform you of new communitywide standards for prescribing narcotics for chronic pain in Marin County.

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In Marin County, drug overdoses are the leading cause of accidental death, and the majority are due to prescription drugs. The number of narcotics prescribed in Marin County doubled between 2004 and 2014, with a corresponding increase in narcotic-related Emergency Department visits, treatment admissions for narcotic addiction, and overdose deaths. The majority of narcotic prescriptions are written in Primary Care settings.

In response to this epidemic of prescription narcotic abuse, the Marin County Department of Health and Human Services, the Marin Medical Society, and the RxSafe Marin Prescribers and Pharmacists Committee have developed countywide standards for the safe treatment of chronic pain. These voluntary guidelines reflect a shared commitment to safe pain management for all patients and are attached below.

These guidelines complement the Safe Pain Medication Prescribing for Marin County Emergency Departments adopted countywide in July 2014. With a common understanding of what can be expected in narcotic prescribing as a community, patients and prescribers can be more effective partners in safe and effective pain management.

Sincerely,

Matthew D. Willis, MD, MPH
Public Health Officer

Opioid Prescribing for Chronic Pain: Guidelines for Marin County Clinicians

Although prescription pain medications are intended to improve the lives of people with pain, their increased use and misuse have led to a rise in narcotic addiction and overdoses in Marin County and across the country. These guidelines are designed to help clinicians improve patient outcomes and limit the risk of unintended harm when considering the use of opioids for the treatment of chronic non-cancer pain (CNCN). These guidelines do not address the use of opioids for acute pain, nor do they address the use of opioids for the treatment of pain at the end of life. These guidelines are intended to supplement and not replace individual prescriber's clinical judgment.

For prescribers considering opioids for the treatment of chronic non-cancer pain, these guidelines suggest key practices in the following areas:

- **ASSESSMENT AND MONITORING**
- **PATIENT AND FAMILY INFORMATION**
- **PATIENT/PROVIDER AGREEMENTS**
- **CHRONIC NON-CANCER PAIN TREATMENT RECOMMENDATIONS**
- **NON-NARCOTIC ALTERNATIVES**
- **CAUTIONS REGARDING CO-MORBIDITIES OR INTERACTIONS**
- **RELATIONSHIP WITH PHARMACIES AND EMERGENCY DEPARTMENTS**
- **SAFE STORAGE AND DISPOSAL**
- **ADDICTION AND DEPENDENCE REFERRALS**

These guidelines were developed in collaboration between Marin County Department of Health and Human Services, the RxSafe Marin Prescribers and Pharmacists Committee, and the Marin Medical Society.



A. ASSESSMENT AND MONITORING

- Before considering chronic opioid therapy, clinicians should gain a clear understanding of the pain condition and document a history, including current medications, prior pain treatment and results, along with a relevant and specific physical examination.
- The initial evaluation should also include documentation of the patient's mental health and substance use history, including review of the CURES system.
- The history should include a functional description of limitations on the patient's activities due to pain.
- Clinicians should consider using a validated screening tool to determine the patient's risk for harmful drug-related behavior.
- Appropriate screening and testing should be completed before, and not after starting a trial of opioids.
- Clinicians should reassess patients on chronic opioid therapy periodically and as warranted by changing circumstances. Monitoring should include documentation of response to therapy, adverse events and adherence to prescribed therapies.
- Clinicians should consider increasing the frequency of ongoing monitoring as well as referral for specialty care, including psychiatric and addiction experts for patients at high risk for harmful drug-related behavior. Monitoring may include periodic review of CURES database, urine or saliva drug screening or pill counts.
- Treatment with more than one opioid or concurrent treatment with benzodiazepines, antihistamines and other sedating medications substantially increase risk and should be approached with caution.
- Opioids should not be used as a sole treatment modality for pain. Rather, opioids should be considered as a treatment option after failure of other modes of treatment and as part of a multimodal approach including exercise and behavioral therapy.
- Providers should recognize that high-risk patients, including those with significant psychiatric co-morbidities, may require specialty care. Treatment of some comorbid conditions may be less effective when opioids are used. Chronic opioid therapy may not be safe or effective absent needed specialty care.
- Opioids should be discontinued if an initial trial of chronic opioid treatment results in adverse effects, insufficient reduction in pain or insufficient improvement in function.

B. PATIENT AND FAMILY INFORMATION

- Patients and, where appropriate, their families should be given information about and discuss the risks, adverse effects and possible benefits of chronic opioid use before initiation of a trial of chronic opioids.
- Patients being offered opioids should be made aware that opioids are the leading cause of drug overdose deaths nationally, can cause adverse outcomes to patients or to others who may misappropriate the medication, and can cause harm if not managed safely.
- The clinician should advise the patient and significant others of the risk of cognitive impairment that can adversely affect the patient's ability to drive, work in a safety-sensitive position, or safely do other activities.

C. PATIENT/PROVIDER AGREEMENTS

- When starting a trial of chronic opioid therapy, providers and their patients should document a common understanding of the process through the use of an opioid treatment agreement.
- The provider and patient should participate in shared decision-making, informed by the potential benefits and risks associated with treatment.
- The patient should understand how care will be provided, including agreement to obtain prescriptions from one provider or his or her designee during weekday business hours, use of one pharmacy for medication, proper and secure storage, and the proper return of unused medications.

- If chronic opioid treatment results in significant adverse effects, or insufficient reduction in pain or functional status, opioids therapy should be discontinued.
- Providers should proactively describe the rationale for regular office visits, examinations, urine or saliva drug testing, CURES report monitoring, and pill counts.

D. CHRONIC NON-CANCER PAIN TREATMENT RECOMMENDATIONS

- Initial treatment with opioids should be considered by clinicians and patients as a therapeutic trial to determine whether opioid therapy is safe and effective for the individual patient. Chronic opioid therapy will not be effective for some patients, either due to lack of efficacy or the development of unacceptable adverse events, including aberrant drug-related behavior.
- Opioid selection, initial dosing, and dose adjustments should be individualized according to the patient's health status, previous exposure to opioids, response to treatment, and predicted or observed adverse events.
- When considering dose escalation, clinicians should consider that dose escalation can be a sign of hyperalgesia, which renders opioids less effective.
- Total daily opioid doses above 100 mg / day of oral morphine or its equivalent is associated with a significant increase in risk of harm and in many cases worsening pain. Clinicians should carefully consider if doses above 100 mg / day of oral morphine or its equivalent are indicated. Consultation for specialty care may be appropriate for patients receiving high daily doses of opioids. (On-line tools are available to assist in converting daily opioid doses to morphine equivalents <http://www.nyc.gov/html/doh/html/mental/MME.html>.)
- Prescribers should be aware that buprenorphine therapy can be a safe and effective method for tapering patients from high doses of opioids as well as a lower risk long-term therapy for those patients too medically or psychiatrically fragile to taper off opioids completely.

E. NON- NARCOTIC ALTERNATIVES

- Exercise is frequently effective for the management of CNCP.
- Non-steroidal anti-inflammatory drugs (NSAIDS) and acetaminophen have demonstrated effectiveness in the reduction of CNCP.
- Cognitive behavioral therapy, especially addressing management of emotional distress, can help control pain non-pharmacologically.
- Anti-epileptic medications have some evidence of effectiveness for neuropathic pain such as diabetic neuropathy and post-herpetic neuralgia.

F. CAUTIONS REGARDING CO-MORBIDITIES OR INTERACTIONS

- Caution should be used in patients taking other centrally acting sedatives, including alcohol, antihistamines and benzodiazepines, as such use with chronic opioid therapy increases the risk of over-sedation and adverse events.
- Caution should be used with the administration of methadone. Providers should be aware of the special pharmacokinetics of methadone and the need for careful dosing and monitoring.
- Caution should be used with the administration of chronic opioids in women of childbearing age, as opioid therapy during pregnancy increases risk of harm to the newborn. Opioids should be administered with caution in breastfeeding women as some opioids may be transferred to the baby in breast milk.
- When chronic opioid therapy is used for an elderly patient, clinicians should consider starting at a lower dose, using a longer dosing interval, and monitoring more frequently.
- Caution should be used in patients under age 40 due to increased lifetime exposure with long-term opioid therapy and the risks of central nervous system damage, and the higher rates of misuse among this age group.
- Patients with obstructive sleep apnea (OSA) are at increased risk for harm with the use of chronic opioid therapy.

- Caution should be used for patients over age 65 due to declining renal and hepatic function, leading to reduced metabolism and excretion, balance and gait problems, fall risk, declining bone density and muscle mass, and cognitive decline.
- Patients with co-existing psychiatric disorder(s) may be at increased risk of harm related to chronic opioid therapy. If chronic opioids are used, clinicians should consider careful dose selection, frequent monitoring and consultation where feasible.
- Clinicians should consider prescribing naloxone to the patient and provide instructions in how and when to administer naloxone for family members or friends of patients identified to be at high risk for overdose or aberrant drug-related behavior.

G. RELATIONSHIP WITH PHARMACIES AND EMERGENCY DEPARTMENTS

- Pharmacists who dispense medications have corresponding responsibility to ensure the prescription is legal and not for purposes of abuse. Pharmacists may employ screening guidelines to trigger communications with clinicians to verify prescription orders.
- It is appropriate **for** pharmacists to have educational conversations with patients on potential side effects of opioids, drug-drug interactions, and adverse effects. With patients receiving over 100 mg /day, pharmacists should feel enabled to initiate discussions with clinician and patient about naloxone.
- Pharmacists should educate patients regarding safe storage and disposal of medications.
- Emergency Department providers should consider referring patients seeking opioids for chronic pain to their primary care providers to maintain continuity of treatment.
- Emergency Department prescribing standards have been developed and are in place in all Marin County hospital Emergency Departments. These standards were developed in partnership with Marin County Public Health and Emergency Medical Services.

H. SAFE STORAGE AND DISPOSAL

- Patients should receive education and information on safe storage and disposal or return of controlled substances. Materials should include information on lock-boxes for safe in-home storage of prescriptions.
- Drop boxes for unwanted/unused medications are located throughout Marin County. For a current list of drop-off locations go to www.marincounty.org/ehs.

I. ADDICTION AND DEPENDENCE REFERRALS

In Marin County, the following organizations can provide information for drug treatment services:

Access to Mental Health & Substance User Services: 1.888.818.1115

Assessment & Referral Services: Recovery Connections Services— 415.755.2345

Detoxification Services: The Vine (Residential Detox): 415.492.0818

Marin Treatment Center (Outpatient Opiate Detox): 415.457.3755

Adult Gender-Specific Residential Treatment: Center Point: 415.456.6655

Adult Outpatient Treatment: Center Point: 415.456.6655;

Marin Outpatient Recovery Services: 415.485.6736

Marin Treatment Center: 415.457.3755

Adolescent Outpatient Treatment: Bay Area Community Resources: 415.755.2345

Huckleberry Youth Programs: 415.258.4944