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Effective Benefit Pain Management Strategies to Discourage Overuse of Opioids

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Abstract

The levelling off of fatalities from prescription opioids has coincided with declines in opioid prescriptions; after peaking in 2012, the total opioid prescribing rate has declined for commercial insurers, Medicare and Medicaid. In 2017, the prescribing rate fell to the lowest it had been in more than 10 years to nearly 59 prescriptions per 100 persons, down from more than 81 prescriptions per 100 persons at the 2012 peak in opioid prescriptions. Still, prescribing rates continue to remain very high in certain areas across the country; and the per capita opioid use in the United States continues to vastly surpass those of other countries. Overprescribing of opioids has played a role in the epidemic. Overall, estimated percentages of people prescribed opioids for chronic pain misuse them, and percentages develop an opioid use disorder.

Keywords: Prescribing opioids; Pharmacologic therapy; Physical treatment; Knee osteoarthritis; Health plan; Medicaid coverage

Introduction

Moreover, prescribing patterns for opioid naïve patients can influence the likelihood of long-term use. A recent study suggested that the chances of long-term opioid use begin to increase after just three days of use and rise rapidly thereafter [1]. At the same time, chronic pain can severely impact a person's quality of life and people who experience chronic pain need effective and safe pain management. Federal efforts to address the issue include the formation of the Pain Management Best Practices Inter-Agency Task Force, authorized by the Comprehensive Addiction and Recovery Act of 2016, and the National Pain Strategy, developed by the Interagency Pain Research Coordinating Committee [2]. Recognizing the need for clinical guidance, in 2016, CDC issued its evidence-based CDC Guideline for Prescribing Opioids for Chronic Pain, intended for primary care physicians treating adult patients with chronic pain, for the roughly 20 percentage of adults in the United States who live with chronic pain as shown in (Figure 1). CDC found that while there is well documented evidence of the potential harm of opioids, there is insufficient evidence to demonstrate sustained pain relief or improvements to quality of life or functioning with the use of opioids to treat chronic pain. Thus, CDC recommends that providers consider non-pharmacologic therapy and non-opioid pharmacologic therapy as the first-line treatment for chronic pain [3]. Exceptions to this recommendation include pain associated with active cancer treatment, palliative care, end-of-life care, or clinical circumstances in which the expected benefits of opioids for pain and function outweigh the risks. Based on a review of the evidence, CDC suggests that multi-modal therapies and multidisciplinary rehabilitation are more effective at reducing long term pain than care as usual or physical treatment alone. The CDC guideline encourages providers to continue to use their clinical judgment and base their treatment on what they know about their patients, including the use of opioids if they are determined to be the best course based on an individualized benefit/risk analysis [4]. Whatever the treatment selected, CDC stresses the importance of discussing the potential benefits and harms of all treatment options with patients and establishing treatment goals and expectations. The CDC guideline defines chronic pain as pain continuing or expected to continue for greater than three months or past the time of normal tissue healing as shown in (Figure 2). However, the guideline also urges

Figure 1: Prescribing opioids for chronic pain.

Figure 2: Clinicians prescribe lowest effective dose.

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caution in prescribing opioids for acute pain, noting that long-term opioid use often begins with treatment of acute pain, when opioids are prescribed for non-traumatic, non-surgical acute pain, clinicians should prescribe the lowest effective dose for the shortest duration possible usually three days or less is sufficient and more than seven days will rarely be needed [5]. The guideline also notes that there are other effective treatments for chronic pain. Non-pharmacologic therapies pose minimal risks, and many of these treatments such as exercise therapy, physical therapy, and cognitive behavioural therapy have been shown to effectively treat chronic pain associated with some conditions. For example, exercise therapy can be effective in treating lower back pain, osteoarthritis, and fibromyalgia.

Methodology

The guideline notes that non-opioid pharmacologic therapy, such as acetaminophen or nonsteroidal anti-inflammatory drugs can improve pain with lower risks relative to opioids for most patients. In addition, the guideline notes that selected antidepressants or selected anticonvulsants can relieve neuropathic pain [6]. Since the 2016 CDC guideline was published, the Agency for Healthcare Research and Quality developed a systematic review of the evidence base for multiple non-pharmacologic treatments for chronic pain. For example, the AHRQ review found that exercise therapy demonstrates benefits for a range of conditions associated with chronic pain, including lower back pain, neck pain, fibromyalgia, hip osteoarthritis and knee osteoarthritis [7]. Additionally, the AHRQ review found that acupuncture treatment was associated with improvements in pain and functioning for at least one month for patients with chronic low back pain, chronic neck pain, and fibromyalgia. According to a survey jointly conducted by the Kaiser Family Foundation and the National Association of Medicaid Directors, an increasing number of states are implementing the CDC opioid prescribing guideline [8]. In that survey, 34 states reported they had already implemented CDC's guideline or planned to implement the guideline in 2018 in their fee-for-service programs. Of 39 states with Managed Care Organization contracts, 18 states required MCOs to use the CDC opioid prescribing guideline or plan to add the requirement in 2018 [9]. In addition, several state Medicaid agencies have implemented their own opioid prescribing guidelines, and some states have implemented legislation to allow Medicaid recipients to access non-opioid pharmacologic and non-pharmacologic pain treatment therapies, such as acupuncture. In a State Medicaid Director letter, CMS recently announced a new opportunity to receive federal financial participation for the continuum of services to treat addiction to opioids or other substances, including services provided to Medicaid enrolees residing in residential treatment facilities [10]. One of the expectations established by CMS for states seeking approval for this FFP is that those states implement opioid prescribing guidelines along with other interventions to prevent opioid abuse.

Discussion

Preliminary data suggests that implementing opioid prescribing guidelines, such as those recommended by CDC, can decrease the quantity of opioids prescribed and dispensed, particularly when the prescribing guidelines are combined with strategies to better monitor, manage, and appropriately prescribe opioids. One integrated payer and provider health system utilized a multi-faceted strategy to improve opioid prescribing patterns to reduce opioid prescriptions in a 580,000 member health plan [11]. This approach included use of electronic health records to track prescriptions, patient and provider education, and the use of non-pharmacologic treatment as the first line for chronic pain management. Results of these efforts led to a reduction in opioid prescriptions by half since the program was initiated in 2014. Virginia's Medic-aid program began implementing the CDC guideline through strategies such as increasing access to non-opioid pain relievers, requiring prior authorizations for prescription opioids, introducing quantity limits and educating providers and patients regarding opioid prescriptions. As a result, since the project launch on July 1, 2016, Virginia saw a 59 percentage decrease in opioid pills dispensed and a 51 percentage decrease in related spending in its fee-for-service program. Several states have designed and implemented targeted initiatives to promote the provision of non-opioid pain management therapies for specific conditions [12]. In most cases, the benefits of these efforts are yet to be established through rigorous, independent evaluations, though preliminary results show some promise. Below are examples of what some states are doing to expand treatment options for the treatment of chronic pain. Beginning in July 2016, Vermont conducted a short-term state-funded pilot program to provide acupuncture as an adjunct therapy for the treatment of chronic pain among its Medicaid population. Patients with chronic pain were treated by Vermont-licensed acupuncturists. In July 2016, the Oregon Health Plan, Oregon's Medicaid program, launched an initiative to treat uncomplicated back and neck pain among the estimated 50,000 Oregon beneficiaries who were experiencing this type of pain. Through this initiative, the state modified its Prioritized List to add coverage for non-opioid treatment for pain, including acupuncture, chiropractic services, osteopathic manipulation, cognitive behavioural therapy, and physical therapy as potential alternatives, when appropriate, to surgeries, opioids, and epidural steroid injections [13]. Additionally, the Oregon Health Authority convened a Stakeholder Task Force to develop state wide opioid prescribing guidelines. On November 18, 2016, the Task Force approved adoption of Oregon-specific prescribing guidelines, based on the CDC Guideline for Prescribing Opioids for Chronic Pain. Partnership Health Plan for California provides coverage to California Medicaid beneficiaries in 14 California counties. In January 2014, the plan officially launched the Managing Pain Safely program geared toward reducing opioid prescriptions. Originally funded through the California Health Care Foundation, a significant decline in opioid prescriptions allowed Partnership to continue to invest in the MPS program through an intensive prescriber education campaign focusing on education about opioids and other options for managing pain [14]. Provider education was coupled with technical assistance and prescriber support, including a toolkit with clinical resources. The plan also initiated several formulary changes, and new benefits for chronic pain management. States and other payers have multiple pathways to provide non-pharmacologic chronic pain management options available to Medicaid providers and beneficiaries [15]. Below, we highlight a range of options for states considering ways to promote non-pharmacologic treatment approaches through their Medicaid programs. States have considerable flexibility in determining what non-pharmacologic services are available in the state plan under optional benefits. For example, a state may elect to provide coverage for acupuncture, massage therapy, chiropractic care, cognitive behavioural therapy, physical therapy or other Medicaid-coverable services through an array of Medicaid coverage authorities.

Conclusion

States wishing to add coverage in optional benefit categories described below would need to submit a state plan amendment for CMS approval.

Acknowledgement

None

Conflict of Interest

None

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