



State of West Virginia
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Best Practices for Prescribing Opioids **in West Virginia**

Background

Prescription drug abuse is an epidemic in West Virginia. In 2015, there were approximately 686 drug overdose deaths, including 598 opiate-related fatal overdoses, in West Virginia. In 2014, West Virginia had the highest overdose death rate in the United States with 35.5 deaths per 100,000 people. This is more than double the national average of 14.7 deaths per 100,000 people. These guidelines are proposed to help reduce the misuse of prescription opioids while preserving legitimate patient access to necessary medical treatment.

One of our goals with these guidelines is to dramatically reduce the use of opioids as a first-line treatment option for patients with pain and significantly increase the use of non-opioid alternatives for these patients. We understand that there is no one-size-fits-all treatment plan for pain management and that individual plans of care may vary, but it is clear that our state is being flooded with far too many opioids than the population requires.

These guidelines provide recommendations for prescribers who are prescribing opioids for pain, including chronic pain lasting longer than three months or past the time of normal tissue healing. Applicable to adult patients that are at least eighteen years old, the guidelines exclude patients prescribed opioids for chronic pain related to active cancer treatment, palliative care, and end-of-life care.

The best practices are intended for (1) utilizing West Virginia's Controlled Substance Monitoring Program, (2) reducing risk of opioid misuse, (3) ensuring that the prescription medication, dose, and quantity is safe and appropriate, and (4) incorporating naloxone into opioid treatment discussions.

The Attorney General's Office obtained input from experts and stakeholders in drafting these guidelines. These guidelines balance the need for safe and effective pain management treatment for West Virginians while addressing the state's opioid epidemic. However, prescribers should use their professional judgment in treating patients and document their decisions.

Recommendations

1. Prescriber or his or her authorized designate should check West Virginia's Controlled Substance Monitoring Program ("CSMP") every time the prescriber writes an opioid or benzodiazepine prescription or at least once every three months. Ensure the patient's controlled substance history is consistent with the prescribing record.
2. For patients starting or continuing opioid treatment for chronic pain and pursuant to an opioid pain care agreement, prescriber should conduct random urine toxicology screening and testing. If results reveal "red flags," such as the confirmed presence of cocaine, amphetamines, non-prescribed benzodiazepines, or any other drugs not consistent with provider's prescription history or patient's self-reported history prior to conducting the urinalysis, prescriber should discuss with the patient the importance of complying with the pain management treatment plan and be willing to accept assessment and treatment for both pain management and any concurrent disorders, such as drug abuse or addiction. To help prevent diversion, discontinue opioid prescriptions if urine toxicology screening fails to confirm the presence of opioids and patient does not provide an adequate explanation for the results. Prescriber should use his or her professional judgment in administering urine toxicology screening and testing and determining the best course of action after reviewing urine toxicology testing results.
3. When considering whether to prescribe opioids for pain, screen all patients for opioid misuse risk and adverse effects using the Opioid Risk Tool (ORT), Screener and Opioid Assessment for Patients in Pain (SOAPP-R), Diagnosis, Intractability, Risk Efficacy (DIRE), National Institute on Drug Abuse (NIDA) Quick Screen, CAGE-AID, or other validated screening tools. Review the patient's medical records and converse with the patient's support system to verify the results of the risk assessments.
4. Prior to prescribing opioids for chronic pain, conduct a physical examination of patient. Check for needle marks, signs of opioid intoxication, and signs of opioid withdrawal.
5. Prior to prescribing opioids, review the patient's medical records and, if possible, consult with the patient's previous prescriber.
6. Implement a tiered approach for prescribing opioids for pain and take every possible step to utilize non-opioid options first. Prescribers should discuss the value and effectiveness of alternative approaches to opioid treatment and outline other appropriate care pathways. In addition to medication, other treatment alternatives include cognitive behavioral therapy, physical therapy, occupational therapy, massage therapy, acupuncture, chiropractic services, and osteopathic manipulative treatment. Generally, opioids should not be prescribed on the first visit. When initially prescribing opioids, prescribers should prescribe the lowest effective dosage for the shortest duration. To determine the appropriate dosage, the prescriber should follow the CDC Guideline for Prescribing Opioids for Chronic Pain.

7. When contemplating opioid treatment, the prescriber should thoroughly review the risks with the patient so the patient may make an informed decision regarding treatment options. When patients are prescribed an opioid, the patient should sign and comply with an opioid pain care agreement governing his or her use of opioids.
8. When a prescriber prescribes an opioid, the prescriber should educate the patient about the safe use, storage, and disposal of opioid medications. Prescriber should also inform the patient about the risk of family members or household members improperly accessing the drugs.
9. Prescribers should understand and be familiar with opioid equivalents and conversions. Prescribers may utilize the total morphine milligram equivalents (MME) calculator available on the CSMP. The calculator was provided by the Board of Pharmacy and Attorney General's Office and uses conversion factors and formulas from the CDC to aggregate all opioids currently dispensed to a patient into a single comprehensible score.
10. Prescribers should avoid prescribing opioids with benzodiazepines, muscle relaxants, anticonvulsants, or sedative-hypnotics unless it is medically necessary and the benefits outweigh the risks.
11. Prior to beginning opioid treatment, the prescriber should collaborate with the patient to set expectations and create a plan to end opioid treatment. The treatment goals should not focus simply on the subjective goal of reducing pain, but should include objective, function-based treatment goals. Prescribers should also set clear expectations regarding pain management.
12. Prescribers should issue a prescription so that the supply does not end on a weekend.
13. Patients prescribed an opioid should be monitored as often as necessary or at least once every three months. Monitoring should be performed in an in-person setting and include documentation of pain intensity and functional ability, assessment of progress toward treatment goals, presence of adverse effects, and presence of aberrant drug-related behaviors or substance abuse.
14. Opioid therapy should be tapered and discontinued in patients who are known to be diverting opioids or engaging in aberrant drug-related behaviors. Aberrant drug-related behaviors include multiple unexplained dose escalations, non-adherence to the treatment plan, or use of a route of drug administration other than the prescribed method, such as injecting or inhaling oral formulations. If a prescriber tapers or discontinues opioid therapy in such a situation, prescriber should refer patient to a treatment or detoxification center and/or consider alternative treatment options.

15. Prescriber should discuss and consider recommending over-the-counter naloxone to any patient at risk of experiencing an opiate-related overdose or anyone otherwise at risk of experiencing or witnessing an opioid overdose. Educate family members and/or caregivers living with the patient to watch for warning signs of an overdose, such as sedation or impaired breathing. Also, educate the patient and the patient's family members and/or caregivers about proper administration, storage, and disposal of naloxone.