



Review

Targeting practitioners: A review of guidelines, training, and policy in pain management



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ABSTRACT

This paper reviews the current literature on clinical guidelines, practitioner training, and government/payer policies that have come forth in response to the national rise in prescription opioid overdoses. A review of clinical opioid prescribing guidelines highlights the need for more research on safe and effective treatment options for chronic pain, improved guidance for the best management of post-operative pain, and evaluation of the implementation and impact of guideline recommendations on patient risk and outcomes. Although there is increasing attention to training in pain management in medical schools and medical residency programs, educational opportunities remain highly variable, and the need for additional clinician training in the recognition and treatment of pain as well as opioid use disorder has been recognized. Mandated use of private, federal and state educational and clinical initiatives such as Risk Evaluation and Mitigation Strategies (REMS) and Prescription Drug Monitoring Programs (PDMPs) generally increase utilization of these initiatives, but more research is needed to determine the impact of these initiatives on provider behaviors, treatment access, and patient outcomes. Finally, there is an acute need for more research on safe and effective treatments for chronic pain as well as an increased multi-level focus on improving training and access to evidence-based treatment for opioid use disorder as well as non-pharmacologic and non-interventional chronic pain treatments, so that these guideline-recommended interventions can become mainstream, accessible, first-line interventions for chronic pain and/or opioid use disorders.

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1. Introduction

Chronic pain is complex and poorly understood, affecting approximately 20 million patients every year (Nahin, 2012). Although chronic pain can be managed with a variety pharmacological and nonpharmacological interventions, most of these treatments have not been evaluated in long-term studies, and there is great heterogeneity in patient presentation, course of illness, and response to treatment in chronic pain. Front-line health care providers are challenged to choose the most feasible, effective and safe treatment for each patient with this complex illness within the time constraints of routine office visits with little quality evidence to guide them.

Two of the most commonly used medications for chronic pain are non-steroidal anti-inflammatory drugs (NSAIDs) and opioid

pain medications. NSAIDs are widely taken and prescribed for the treatment of pain and inflammation in patients with various musculoskeletal conditions, with over 17% of people in the US reporting use of at least one NSAID in the past week (Kaufman et al., 2002). Prescription opioids are also commonly prescribed for pain. In 2012, US health care practitioners wrote more than 200 million prescriptions for opioids, double the number written in 1998, and 10 million more than in 2008 (Volkow, 2016). Although NSAIDs are associated with an array of potentially serious side effects and risks (Trelle et al., 2011), the increasing use of prescription opioids has been associated with an exponential rise in fatal opioid overdoses totaling more than 16,000 deaths per year (CDC, 2015). Because of this appreciable mortality risk with opioids, there has been a call for increased clinical guidance, training and mandates, aimed at practitioners prescribing opioids for pain. This paper will review the current literature on physician guidelines, practitioner training, and government/payer policies that have come forth in response to the national rise in opioid overdoses.

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2. Clinical guidelines for chronic pain management with opioids

To address concerns about high rates of prescription opioid overdose, several organizations have developed clinical practice guidelines focused on improving the safe and effective opioid prescribing for chronic non-cancer pain. Although there is a paucity of quality research in the area of long-term pain management (including opioid use), there is a general consensus that given the high levels of opioid overdose, it is prudent to move forward with guidelines based on the best currently available evidence until more rigorous research data becomes available. Existing pain guidelines caution that most recommendations are based on systematic reviews of research with notable limitations (mostly observational trials) as well as expert assessment of different care options chronic pain management. Guidelines emphasize that optimal clinical decision-making is based upon a clinician–patient relationship, taking into consideration each patient’s unique needs and circumstances, and that recommendations are not to be taken as prescriptive standards of care (Dowell et al., 2016a).

2.1. Opioid prescribing guidelines for chronic pain, 2009–2012

There has been one systematic review of opioid prescribing guidelines to date. A 2014 “systematic review and critical appraisal” evaluated the quality and content of 13 eligible pain guidelines published after 2008 addressing the use of prescription opioids for chronic pain in adults (Nuckols et al., 2014). The authors noted great variability in the quality of the opioid pain guidelines, which is not unusual compared with guidelines for other conditions such as breast cancer, migraine management, or mammography screening. However, compared with guidelines for other medical conditions, the opioid pain guidelines scored appreciably lower in the domain of “applicability,” which measures how the guidelines address likely barriers and facilitators of implementation of the recommendations, strategies to improve implementation of the recommendations, and resource implications of applying the recommendations. When the quality of the systematic review supporting each opioid pain guideline was evaluated, 10 of the 13 guidelines were found to be of poor or fair quality. Guidelines developed by the American Pain Society and the American Academy of Pain Medicine (Chou et al., 2009) and Canadian National Opioid Use Guideline Group (2010), had the highest quality scores. However, the authors note that even “the higher-quality guidelines generally relied on modest numbers of lower-quality observational studies for many recommendations” (Nuckols et al., 2014), a severe limitation common to all pain guidelines.

Despite variability in development methods, time range over which the guidelines were published, and the limited quality of evidence available, many of the evaluated guidelines made concordant recommendations about possible strategies for reducing risks of prescription opioids. This suggests clinical consensus on some measures, including: using caution with methadone, fentanyl, and higher doses of opioids (90–200 mg daily morphine milligram equivalent [MME]); titrating and switching opioids with caution; attention to drug–drug (particularly opioid–benzodiazepine) and drug–disease (e.g., sleep apnea and opioids) interactions; and incorporating office-based practices such as the use of risk assessment tools, treatment agreements, and urine toxicology for patients on opioids for chronic pain (Nuckols et al., 2014). The review suggested that developers of future opioid guidelines incorporate tools such as the GuideLine Implementability Appraisal tool (Chan, 2010) to address the barriers to guideline implementation and improve the “applicability” of opioid prescribing guidelines (Nuckols et al., 2014). They also called for future research to evaluate the effectiveness and impact of guideline recommendations on patient risk and

patient outcomes, as there have been no evaluations of outcomes related to guideline implementation to date (Nuckols et al., 2014).

2.1.1. CDC opioid prescribing guidelines, 2016. Since publication of the review by Nuckols et al. (2014), the Center for Disease Control (CDC) has published an update to their Guidelines for Prescribing Opioids for Chronic Pain (Dowell et al., 2016a). Targeted at primary care clinicians, the CDC guideline makes 12 explicit recommendations: six are based on Type 4 evidence (clinical experience/observations; or observational or randomized controlled trials [RCTs] with several major limitations); four are based on Type 3 evidence (observational studies or RCTs with notable limitations); and one is based on Type 2 evidence (RCTs with important limitations or exceptionally strong evidence from observational studies). There was no Type 1 evidence available for this guideline (RCTs or overwhelming evidence from observational studies). The CDC guideline group based recommendations upon a clinical evidence review funded by the Agency for Healthcare Research (Chou et al., 2012, 2015) on the risks and effectiveness of long-term (outcomes > 1 year) opioid therapy for chronic pain, as well as a “contextual review” of several topics published separately that supplemented the clinical evidence review and allowed outcomes of any duration (Dowell et al., 2016b). The contextual reviews streamlined the systematic review process by limiting searches and providing informal assessments of evidence quality (rather than an objective system of rating the quality of the research review). Although the authors caution that the rapid reviews “provide indirect evidence and should be interpreted accordingly” (Dowell et al., 2016a), this expedited approach was felt to be necessary given the public health urgency and need for opioid prescribing recommendations in a short time frame.

Of the 12 recommendations put forth by the CDC, the one supported with the highest level of evidence addresses the treatment of opioid use disorders (OUD): “Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder” (Dowell et al., 2016a). This is the only recommendation within the guideline based on Type 2 evidence, with the overall quality of the evidence rated as “moderate” (Dowell et al., 2016b). In the contextual review (Dowell et al., 2016b), the authors summarize four systematic reviews to support this recommendation: two evaluating methadone maintenance treatment vs non-replacement treatment (Fullerton et al., 2014; Mattick et al., 2009); one evaluating psychosocial and pharmacologic treatments vs pharmacologic (only) treatments for opioid detoxification (Amato et al., 2011); and one evaluating buprenorphine vs placebo or methadone for treatment of opioid use disorder (Mattick et al., 2014). Two reviews included participants who were heroin-dependent, and the other two reviews did not specify type of opioid dependency. Key findings of the reviews include: a moderate level of evidence of high treatment drop-out rates with opioid detoxification; high quality evidence that methadone maintenance treatment (MMT) is effective in decreasing illicit opioid use, improving treatment retention, and decreasing mortality; moderate quality evidence that MMT is effective in reducing criminal activity; and high quality evidence that buprenorphine is effective (no difference in efficacy vs MMT) in decreasing heroin use at doses of 16 mg or more, but less effective for treatment retention than MMT (Dowell et al., 2016b). The evidence for the effectiveness of buprenorphine in prescription OUD will be reviewed separately within this supplement.

In keeping with previous pain guidelines, the CDC guideline recommends the use of urine toxicology and prescription drug monitoring program (PDMP) data, acknowledging in the contextual review that clinicians do not consistently use these practices, education in data interpretation is needed, and there are risks with

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