

» Oregon Opioid Prescribing Guidelines:

Recommendations for the Safe Use of Opioid Medications



Acknowledgments

Organizations and representatives serving on the task force

American College of Emergency Medicine, Oregon Chapter:

Michael Henstrom, MD, FACEP

American College of Physicians — Oregon Chapter:

Thomas Cooney, MD, MACP

American Society of Addiction Medicine, Oregon Chapter:

Karen Weisman, MD

Co-author, CDC Guideline for Prescribing Opioids for Chronic Pain:

Roger Chou, MD

CODA/ Co-author, OHSU Guideline for Safe Chronic Opioid Therapy:

Melissa Weimer, DO, MCR

Federally Qualified Health Center, Central City Concern:

Rachel Solotaroff, MD

Federally Qualified Health Center, Clackamas Health Centers:

Andrew Suchocki, MD, MPH

Local Public Health Authority, Jackson County: Jim Shames, MD

Local Public Health Authority, Multnomah County: Paul Lewis, MD, MPH

Medical Directors, Coordinated Care Organizations: David Labby, MD

Medical Directors, Coordinated Care Organizations: Kevin Ewanchyna, MD

Medical Directors, Coordinated Care Organizations: Anna Stern, MD

Oregon Academy of Family Physicians: Kerry Gonzales

Oregon Association of Hospitals and Health Systems:

Barbara Wade, MS, BSN, RN, CPHQ

Oregon Association of Hospitals and Health Systems: Lee Milligan, MD

Oregon Association of Hospitals and Health Systems: Tim Herrmann, RN

Oregon Association of Naturopathic Physicians: Patrick Chapman, ND

Oregon Board of Dentistry: Stephen Prisby

Oregon Board of Naturopathic Medicine: Charles Wiggins, JD, LLM

Oregon Board of Pharmacy: Marcus Watt, RPh

Oregon Coalition for the Responsible Use of Medications (OrCRM):
Dwight Holton, JD

Oregon Health Leadership Council: Susan Kirchoff, MBA

Oregon Medical Association: Andris Antoniskis, MD

Oregon Medical Board: Joe Thaler, MD

Oregon Nurses Association: Larlene Dunsmuir, DNP, FNP, ANP-C

Oregon Oral Health Coalition: Gary Allen, DMD, MS

Oregon Pain Management Commission: Catriona Buist, PsyD

Oregon Primary Care Association: Irma Murauskas, MPH

Oregon State Pharmacy Association: Joshua Free, PharmD, MBA

Oregon Workers' Compensation Division: Juerg Kunz

Pharmacy Directors, Coordinated Care Organizations:
Caryn Mickelson, PharmD

Portland Area Indian Health Service (IHS): Thomas Weiser, MD

Regional opioids task force, Central Oregon Pain Standards Task Force:
Kim Swanson, PhD

Regional opioids task force, Portland Tri-County Prescription Opioid Safety Coalition: Amit Shah, MD

VA Portland Health Care System: Steven Dobscha, MD

Contents

» Acknowledgments.....	2
» Contents.....	3
» Contents.....	4
» Background.....	5
» Summary of the recommendations.....	6
» I. Determining when to initiate or continue opioids for chronic pain	6
» II. Opioid selection, dosage, duration, follow-up and discontinuation	7
» III. Assessing risk and addressing harms of opioid use.....	8
» IV. Additional considerations: marijuana and safe storage and disposal	9
» Resources.....	10

Background

There has been a dramatic increase in Oregon and across the nation in overdose deaths and hospitalizations due to prescription opioid pain medications. The key to reversing the prescription opioid overdose epidemic and associated adverse effects (e.g., increases in heroin use, non-medical use of prescription opioids, opioid use disorder, etc.) is addressing opioid prescribing practices that lead to misuse, overdose and death. In a March 2016 response, the Centers for Disease Control published the [*CDC Guideline for Prescribing Opioids for Chronic Pain*](#).

The Oregon Public Health Division convened the Oregon Opioid Prescribing Guidelines Task Force in the spring of 2016 to develop statewide guidelines for clinicians and health care organizations. The goal was to address the epidemic of opioid use, misuse and overdose by providing a consistent framework for optimizing care and improving patient safety at the local and regional level.

Task force members met from April through November of 2016, relying on expert review from the varied organizational perspectives to consider endorsement of the CDC Guideline and Oregon-specific additions. Four workgroups were formed and met separately to develop recommendations for these additions and for future work to communicate and implement the Oregon Guidelines.

The task force adopted the CDC Guideline as the foundation for opioid prescribing for Oregon, and developed a brief addendum to address Oregon-specific concerns. The task force encouraged more discussion at state, regional and organizational levels on how the guideline will be disseminated, communicated to patients and providers, and implemented.

Summary of the recommendations

The task force voted to endorse the *2016 CDC Guideline for Prescribing Opioids for Chronic Pain* as the foundation for opioid prescribing in Oregon. The full CDC Guideline can be found at: <http://www.cdc.gov/drugoverdose/prescribing/guideline.html>.

The task force recognized the need to provide additional clarity to the CDC Guideline and to address Oregon-specific issues. Below are the 12 CDC Guideline abbreviated recommendations, with Oregon additions in shaded text.

I. Determining when to initiate or continue opioids for chronic pain

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.
2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

II. Opioid selection, dosage, duration, follow-up and discontinuation

4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.
5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to ≥ 50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥ 90 MME/day or carefully justify a decision to titrate dosage to ≥ 90 MME/day.

- Clinicians should strongly consider additional evaluation of the benefits and risks of higher dose opioid therapy, document clinical justification for the higher dose in the medical record, and obtain and document pain management consultation. Options for consultation could include: 1) having a colleague evaluate the patient, 2) presenting and discussing the case to a clinician peer group or multi-disciplinary pain consultation team, 3) referring the patient to a pain specialist who has experience tapering patients off of opioids, or 4) referring the patient to a pain/addictions mental health specialist. (See CDC narrative under recommendation 8.)
- Refer to Oregon Medical Board Material Risk Notice (required in Oregon when prescribing opioids for chronic pain.): <https://www.oregon.gov/omb/OMBForms1/material-risk-notice.pdf>
- Task force members emphasized the need for compassionate and nondiscriminatory treatment for established (including transferred) patients currently taking higher doses, echoing specific suggestions found in the CDC Guideline narrative supporting this recommendation.

6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.
7. Clinicians should evaluate benefits and harms with patients within one to four weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every three months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

III. Assessing risk and addressing harms of opioid use

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate strategies into the management plan to mitigate risk, including offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥ 50 MME/day), or concurrent benzodiazepine use, are present.
9. Clinicians should review the patient's history of controlled substance prescriptions using state Prescription Drug Monitoring Program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every three months.

- The Oregon Prescription Drug Monitoring Program (PDMP) is a tool to help health care providers and pharmacists provide patients better care in managing their prescriptions.
- Inappropriate behavior identified through the PDMP should lead to discussions about opioid use disorder, but not usually lead to dismissal from practice. While opioids may need to be discontinued, treatment of addiction and other medical comorbidities is still important.

10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

- If clinicians suspect their patient might be sharing or selling opioids and not taking them, or intentionally misusing opioids, clinicians should consider urine drug testing to consider whether opioids can be discontinued abruptly or tapered, and clinicians should consider referral to substance use disorder (SUD) treatment.
- Urine drug testing is a tool that can be used to assist providers in assessing whether patients are using opioids as prescribed, using other substances or potentially diverting opioids.

11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

The task force emphasized two points included in the CDC narrative supporting this recommendation:

- Clinicians should check the PDMP for concurrent controlled medications prescribed by other clinicians (see Recommendation 9 above) and should consider involving pharmacists, pain specialists and/or mental health specialists as part of the management team when opioids are co-prescribed with other central nervous system depressants.
- Clinicians should have an informed discussion with their patient about the serious risks associated with using these medications concurrently, included in recently released FDA boxed warnings.

12. 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.

IV. Additional considerations: marijuana and safe storage and disposal

1. **Marijuana**

With Oregon's recent legalization of recreational use of marijuana, its use is relatively prevalent. Current data are limited on the interactions between opioids and marijuana.

- Clinicians should discuss and document the use of marijuana with their patients, including whether they use, if so, amount, type, reasons for use, etc.
- Clinicians and their organizations have an obligation to closely follow the emerging evidence on the use of marijuana for treatment of pain and adopt consistent best practice. Refer to the OHA medical marijuana prescribing guidelines, at <https://public.health.oregon.gov/DiseasesConditions/ChronicDisease/MedicalMarijuanaProgram/Pages/Physicians.aspx>
- As with all pain treatment, consideration of marijuana use concurrent with opioids should be focused on improving functional status and quality of life, and ensuring patient safety. Clinicians should assess for contraindications and precautions to the concurrent use of marijuana and opioids.

2. **Safe storage and disposal**

Clinicians should advise patients about safe storage and disposal of all controlled substances. For more information, see “Resources” section.

Resources

1. Additional information is available on the Oregon Public Health Division's website: www.healthoregon.org/opioids
2. The full version of the CDC Guideline includes specific details and tools for each of the 12 recommendations: <http://www.cdc.gov/drugoverdose/prescribing/guideline.html>
3. Safe and Competent Opioid Prescribing Education: <https://www.scopeofpain.org/>
4. Providers clinical support system for MAT: <http://pcssmat.org/>
5. Providers' clinical support system for opioid therapies: <http://pcss-o.org/>
6. SAMHSA's MAT website: <http://www.samhsa.gov/medication-assisted-treatment>
7. Oregon Marijuana Report, January 2016: Marijuana use, attitudes, and health effects in Oregon: <https://public.health.oregon.gov/PreventionWellness/marijuana/Documents/oha-8509-marijuana-report.pdf>
8. Oregon Medical Marijuana Prescribing Guidelines: <https://public.health.oregon.gov/DiseasesConditions/ChronicDisease/MedicalMarijuanaProgram/Pages/Physicians.aspx>
9. Oregon Prescription Drug Monitoring Program: <http://www.orpdmp.com/>
10. OHA naloxone training protocol: <http://public.health.oregon.gov/ProviderPartnerResources/EMSTraumaSystems/Pages/epi-protocol-training.aspx>
11. Oregon substance use helpline: 1-800-923-4357
12. Oregon Pain Guidance website: <http://www.oregonpainguidance.org/>
13. SAMHSA opioid treatment program directory: <http://dpt2.samhsa.gov/treatment/directory.aspx>
14. Oregon Addictions and Mental Health Services: <http://www.oregon.gov/oha/amh/Pages/gethelp.aspx>
15. University of Washington Tele-Pain for health care providers: <http://depts.washington.edu/anesth/care/pain/telepain/>

16. Oregon Drug Take-Back and Disposal: <https://public.health.oregon.gov/HealthyEnvironments/DrinkingWater/SourceWater/Pages/takeback.aspx>
17. Rx Disposal for Pharmacists and Clinics: <http://orcrm.oregonpainguidance.org/rx-disposal/rx-disposal-pharmacists-clinics/>
18. FDA – How to dispose of unused medicines: <http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm101653.htm>



You can get this document in other languages, large print, braille or a format you prefer. Contact Lisa Shields at 971-673-1036 or email lisa.m.shields@state.or.us. We accept all relay calls or you can dial 711.