

Oregon Medical Group

**Primary Care Guidelines
for Chronic Opioid Prescribing**

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Created by OMG Opioid Prescribing Task Force

Reviewed by OMG Patient Care Committee

Rationale:

Chronic pain is a common condition evaluated and treated in primary care medicine. It greatly impacts employment and daily function for patients and can be draining and frustrating for the primary care team. It is the responsibility of all primary care providers to evaluate patients with chronic pain and to develop treatment plans that relieve pain and improve function with the lowest risk to the patient and the community. When treatment with opioids as an appropriate part of pain treatment it should be performed and documented in compliance with professional and community standards of care and in accordance with applicable state and federal laws.

Treatment Objective:

The primary goal of treating chronic pain is not to completely eliminate pain but to improve function. The decision to prescribe opioids for chronic pain should be based on an assessment of how pain impacts the patient's functioning and whether treating the pain successfully improves the functioning without significant risk. Opioids should only be considered when other methods for treating chronic pain have been tried and failed.

Definition of "Chronic":

Non-cancer pain is considered chronic if it lasts beyond 3 months. The threshold for what is considered chronic opioid prescribing is:

Ongoing opioid Rx of at least one dose daily for greater than 3 months

Essential Elements:

I. Risk Assessment

Before initiating or assuming chronic opioid prescribing, a standardized assessment of abuse/addiction risk should be performed. (See ***Opioid Risk Tool***) The result of the risk score helps determine whether it is advisable to begin or assume treatment and also informs the process of how closely to monitor the patient's treatment.

Further assessment of risk is accomplished by **review of prior records** and by consulting the **Oregon Prescription Drug Monitoring Program** for past prescription information.

A **Urine Drug Screen (UDS)** should be performed on all patients at the initiation of treatment or when assuming care of a patient.

Parts of the patient past medical history are relevant. Concomitant mental illness always raises the risk of opioid treatment. Some medical conditions (including COPD, CHF, Sleep Apnea, Hepatic or Renal Insufficiency) increase the medical risk of opioid use, elderly patients are at greater risk of side effects, and caution should be

exercised in patients also using benzodiazepines, sedative/hypnotics or barbiturates. The use of opioids in patients using marijuana is discouraged because of increased accident risk and potential of liability for the prescriber.

II. Documentation

The medical record should clearly state the cause(s) of the patient's pain, the presence of a previous medical work-up, a review of other non-opioid treatments attempted and the impact of pain on essential functioning.

The **Material Risk Notice** and **Opioid Treatment Agreement** should be reviewed with the patient and signed by both the patient and provider, then scanned into the medical record. A Centricity Care Alert is then created to notify all providers that there is a pain contract.

III. Monitoring

Ongoing opioid prescribing should be accompanied by regular followup. The typical standard is **every 3 months**, but the interval can be adjusted according to the risk level of the patient. The followup visit should assess and document the **four A's**:

- Analgesia** – pain score and assess the level of pain control
- Activity** – level of functioning
- Adverse Effects**
- Aberrant Behavior**

Depending on previous risk assessment or aberrancy, the UDS can be used to monitor compliance. Any **Red Flag Behaviors** should be noted and acted upon.

IV. Reasons to Stop or Taper

If opioid treatment is clearly not improving function or the patient is on very high doses without improved function, the provider should consider stopping opioids and trying alternatives. Other reasons to considering stopping or tapering include signs of aberrancy, evidence of diversion, or abnormal UDS findings. While patients should be dismissed for illegal acts (falsifying prescriptions, etc), noncompliance with a pain contract is, in itself, not grounds for dismissal, but a sign to wean or stop the opioids and discuss possible need for addiction treatment.

V. When to Refer

Consider referring to pain specialist if patient scores in high risk range on ORT

Multiple written guidelines recommend referral to a pain specialist if:

Opioid dose exceeds 120mg/day Morphine equivalent without evidence of functional improvement