



## **Non-Opioid Pain Management Resources**

At CareOregon, we understand the importance of offering members pain management alternatives as they work with their providers to reduce opioid use. The following list includes suggested alternatives, but is not an all-inclusive list of benefits. All CareOregon OHP benefits are subject to change. If you have questions regarding CareOregon OHP benefits, please contact CareOregon Customer Service at 1-800-224-4840, Monday through Friday, 8 a.m. to 5 p.m.

**Acupuncture:** No authorization is required.

**Alternative medications:** NSAIDs, gabapentin, amitriptyline, nortriptyline.

**Chiropractic manipulation:** Authorization is required for evaluation and treatment.

**Counseling:** Is available to all patients for mental health, pain management, or alcohol and drug abuse. No referral is required.

**Physical/Occupational therapy:** No authorization is required for evaluations for covered diagnoses. However, authorization is required for therapy visits. CareOregon will allow an evaluation and up to 5 total visits annually with authorization for a patient with a “below the line” diagnosis.

**Home Health Visits:** No authorization is required for home health nursing, physical therapy, or occupational therapy visits for “above the line” diagnoses. MSW home health visits not covered.

**Salonpas Pain Relief Patches (menthol/methyl salicylate):** FDA-approved over-the-counter pain patches are available for purchase at most drug stores.

**TENs units:** Are available with authorization.

More detailed authorization information may also be accessed via our website at:

[http://www.careoregon.org/Res/Documents/Providers/CO\\_Auth\\_Guidelines.pdf](http://www.careoregon.org/Res/Documents/Providers/CO_Auth_Guidelines.pdf)

## Portland Metro Regional Safe Opioid Prescribing Standards and Reference Appendix

In June 2014, the Healthy Columbia Willamette Collaborative (<https://multco.us/healthy-columbia-willamette-collaborative>) began a year-long effort to develop consensus safe opioid prescribing standards. Like the rest of the nation, the State of Oregon and the Portland metro area suffer from a pattern of excessive opioid prescribing and associated problems. While opioids are potent pain relievers, they also result in respiratory depression, slowed reaction times, and addictive potential. Since many states and regions have developed safe opioid prescribing guidelines, healthcare leaders in our area supported a similar effort here.

To do so, the Healthy Columbia Willamette Collaborative convened a workgroup comprised of four metro area county health departments (Clark, Clackamas, Multnomah, Washington), the two Oregon metro area Coordinated Care Organizations (FamilyCare Health and HealthShare of Oregon), and the Adventist, Legacy, Kaiser, OHSU, Providence, and Tuality Health Systems. We also convened a group of community partners including professional associations and safety net clinics to provide additional input.

The product of nearly a year's work, the following guidelines provide a minimum standard of care for safe prescribing of opioids to patients suffering from chronic pain that is not related to cancer or a terminal condition. Many of our partners have already adopted stricter prescribing standards. We urge practitioners to avoid opioids for chronic pain or to use the lowest possible doses for the least possible time.

Two similar prescribing standards follow; one is for patients with chronic pain who are not currently receiving opioids, the second is for patients with chronic pain who are already on opioids. Each standard is a single page but an annotated version is appended.

The safe prescribing workgroup was chaired by Melissa Weimer, DO, Assistant Professor, OHSU. Participants in the safe prescribing workgroup included representatives from:

#### Clinics

Central City Concern  
Clackamas Health Centers  
NARA  
OHSU Richmond  
Oregon College of Oriental Medicine  
Outside In  
Virginia Garcia  
University of Western States

#### Coordinated Care Organizations

FamilyCare Health  
HealthShare of Oregon

#### Hospitals and Health Systems

Adventist Health  
Kaiser Permanente  
Legacy Health  
OHSU  
Peace Health Southwest  
Providence Health and Services  
Tuality Healthcare

#### Public Health Departments

Clackamas County  
Clark County, Washington  
Multnomah County  
Washington County

#### Professional Organizations

Oregon Academy of Family Physicians  
Oregon Association of Naturopathic Physicians  
Oregon College of Emergency Physicians  
Oregon Section American College of Obstetrics and Gynecology

As of December 1, 2015, these Standards have been formally endorsed by the following institutions and organizations:

Adventist Health

CareOregon

Central City Concern

Clackamas County Health Centers

FamilyCare Health

HealthShare of Oregon

Kaiser Permanente

Multnomah County Clinics

OHSU Health System

Providence Health and Services

Tuality Healthcare

Virginia Garcia Memorial Health Centers

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## Standard for **New** Opioid Prescriptions for Patients with Chronic Non-Cancer/Non-Terminal Pain

### **1: Perform a patient evaluation/history.**

- Obtain a detailed Pain History
- Perform an appropriate physical exam, including evaluation of neurologic and musculoskeletal systems
- Evaluate mental health and substance abuse history

### **2: Document initial and periodic functional evaluation.**

- Consider a physical and/or occupational therapy evaluation prior to opioid prescribing

### **3: Regularly monitor and document subjective pain measures.**

### **4: If considering prescribing an opioid, screen for opioid risk.**

- Review prior PCP and any specialist notes
- Review medication list
- Check the prescription drug monitoring program (Oregon PDMP and/or Washington PMP) prior to prescribing opioids
- Perform baseline urine drug screen (UDS)
- Assess opioid risk and document

### **5: Establish an opioid prescribing daily dosing limit.**

- Avoid a total opioid dose greater than 120mg MED in a 24 hour period without a qualified secondary review (i.e. pain specialist, internal opioid review process, etc.)

### **6: Develop a comprehensive treatment plan with agreed upon treatment goals prior to beginning chronic pain treatment with daily opioids.**

- Individual institutions should develop a consistent standard for obtaining and periodically reviewing an informed consent and opioid agreement.
- Discuss and establish mutual treatment goals for a 1 month trial. Discontinue opioids in favor of alternatives if goals not met.
- Ensure the treatment plan includes a timely follow-up appointment to evaluate effectiveness and safety
- Short-acting opioid agents are strongly preferred in the initial opioid trial

### **7: Recommend behavioral health evaluation for patients with current or prior behavioral health conditions.**

### **8: Avoid use of high-risk medications or substances with opioids.**

- Avoid concomitant use of alcohol and opioids
- Avoid concomitant use of any benzodiazepines and opioids. If the patient is already prescribed benzodiazepines, consider tapering before prescribing opioids.
- Avoid concomitant use of other sedative-hypnotics (e.g. barbiturates, SOMA, or sleeping pills)
- In the absence of clear evidence, individual institutions should develop a consistent standard on the concomitant use of marijuana and opioids.
- Provide counseling on the risks of combining the above substances with opioids

### **9: Patients who develop an opioid use disorder during treatment should be referred to an addiction specialist/appropriate specialist and/or addiction treatment.**

### **10: Consider prescription for naloxone rescue kit in high risk individuals.**

## **Standard for On-going Opioid Prescriptions for Patients with Chronic Non-Cancer/Non-terminal Pain**

### **1: Perform a patient evaluation/history.**

- Obtain a detailed Pain History
- Perform an appropriate physical exam including periodic evaluation of neurologic and musculoskeletal systems
- Review and periodically update mental health and substance abuse history

### **2: Perform periodic functional evaluation.**

### **3: Regularly monitor and document subjective pain measures.**

### **4: Regularly monitor for opioid risk.**

- Review prior PCP and any specialist notes
- Review medication list
- Check the prescription drug monitoring program (Oregon PDMP and/or Washington PMP) prior to refilling prescribing opioids at least annually
- Perform a random urine drug screen (UDS) at least annually
- Assess opioid risk and document at least annually
- If concerned about aberrant drug related behavior (e.g. early refill requests), then increase frequency of UDS and pill counts; prescribe shorter opioid refills
- If methadone is prescribed, obtain an ECG at least annually for high doses or in patients with increased cardiovascular risk

### **5: Establish an opioid prescribing daily dosing limit.**

- Avoid a total opioid dose greater than 120mg MED in a 24 hour period without a qualified secondary review (i.e. pain specialist, internal opioid review process, etc.)

### **6: Maintain a comprehensive treatment plan with agreed upon treatment goals.**

- Individual institutions should develop a consistent standard for obtaining and periodically reviewing an informed consent, opioid agreement, and designate of a primary prescriber
- Regularly review and discuss mutual treatment goals
- Regularly evaluate effectiveness and safety of opioid treatment
- In the absence of functional gains or improved pain control, taper opioids and seek specialty consultation
- If opioids are prescribed at a high dose, document discussion of tapering to a lower dose at each visit
- Regularly recommend physical modalities and self-care strategies to manage chronic pain

### **7: Document behavioral health plan for patients with current or prior behavioral health conditions.**

### **8: Avoid use of high-risk medications or substances with opioids.**

- Avoid concomitant use of alcohol and opioids
- Avoid concomitant use of any benzodiazepines and opioids. If the patient is already prescribed benzodiazepines, consider tapering if opioids are continued
- Avoid concomitant use of other sedative-hypnotics (e.g. barbiturates, SOMA, or sleeping pills)
- In the absence of clear evidence, individual institutions should develop a consistent standard on the concomitant use of marijuana and opioids.
- Provide counseling on the risks of combining the above substances with opioids

### **9: Patients who develop an opioid use disorder during treatment should be referred to an addiction specialist/appropriate specialist and/or addiction treatment.**

### **10: Consider prescription for naloxone rescue kit in high risk individuals.**

## Annotated Prescribing Standards

### Community Standard for *New* Opioid Prescriptions for Patients with [Chronic Non-Cancer/Non-Terminal Pain](#)

**GP1: Perform a patient [evaluation/history](#).**

- Obtain a detailed Pain History
- Perform an appropriate physical exam, including evaluation of neurologic and musculoskeletal systems
- Evaluate mental health and substance abuse history

**GP2: Document initial and periodic [functional evaluation](#).**

- Consider a physical and/or occupational therapy evaluation prior to opioid prescribing

**GP3: Regularly monitor and document [subjective pain measures](#).**

**GP4: If considering prescribing an opioid, [screen for opioid risk](#).**

- Review prior PCP and any specialist notes
- Review medication list
- Check the [prescription drug monitoring program](#) (Oregon PDMP and/or Washington PMP) prior to prescribing opioids
- Perform baseline urine drug screen (UDS)
- Assess opioid risk and document

**GP5: Establish an opioid [prescribing daily dosing limit](#).**

- Avoid a total opioid dose greater than 120mg [MED](#) in a 24 hour period without a qualified secondary review (i.e. pain specialist, internal opioid review process, etc.)

**GP6: [Develop a comprehensive treatment plan](#) with agreed upon treatment goals prior to beginning chronic pain treatment with daily opioids.**

- Individual institutions should develop a consistent standard for obtaining and periodically reviewing an informed consent and opioid agreement.
- Discuss and establish mutual treatment goals for a 1 month [trial](#). Discontinue opioids in favor of alternatives if goals not met.
- Ensure the treatment plan includes a timely follow-up appointment to evaluate effectiveness and safety
- Short-acting opioid agents are strongly preferred in the initial opioid trial

**GP7: Recommend behavioral health evaluation for patients with current or prior behavioral health conditions.**

**GP8: Avoid use of high-risk medications or substances with opioids.**

- Avoid concomitant use of alcohol and opioids
- Avoid concomitant use of any benzodiazepines and opioids. If the patient is already prescribed benzodiazepines, consider tapering before prescribing opioids.
- Avoid concomitant use of other sedative-hypnotics (e.g. barbiturates, SOMA, or sleeping pills)
- In the absence of clear evidence, individual institutions should develop a consistent standard on the concomitant use of marijuana and opioids.
- Provide counseling on the risks of combining the above substances with opioids

**GP9: Patients who develop an [opioid use disorder](#) during treatment should be referred to an addiction specialist/appropriate specialist and/or addiction treatment.**



GP10: Consider prescription for [naloxone rescue kit](#) in high risk individuals.

**Community Standard for *On-going* Opioid Prescriptions for Patients with [Chronic Non-Cancer/Non-terminal Pain](#)**

**GP1: Perform a patient [evaluation/history](#).**

- Obtain a detailed Pain History
- Perform an appropriate physical exam including periodic evaluation of neurologic and musculoskeletal systems
- Review and periodically update mental health and substance abuse history

**GP2: Perform periodic [functional evaluation](#).**

**GP3: Regularly monitor and document [subjective pain measures](#).**

**GP4: Regularly monitor for [opioid risk](#).**

- Review prior PCP and any specialist notes
- Review medication list
- Check the [prescription drug monitoring program](#) (Oregon PDMP and/or Washington PMP) prior to refilling prescribing opioids at least annually
- Perform a random urine drug screen (UDS) at least annually
- Assess opioid risk and document at least annually
- If concerned about aberrant drug related behavior (e.g. early refill requests), then increase frequency of UDS and pill counts; prescribe shorter opioid refills
- If methadone is prescribed, obtain an ECG at least annually for high doses or in patients with increased cardiovascular risk

**GP5: Establish an [opioid prescribing daily dosing limit](#).**

- Avoid a total opioid dose greater than 120mg [MED](#) in a 24 hour period without a qualified secondary review (i.e. pain specialist, internal opioid review process, etc.)

**GP6: [Maintain a comprehensive treatment plan](#) with agreed upon treatment goals.**

- Individual institutions should develop a consistent standard for obtaining and periodically reviewing an informed consent, opioid agreement, and designate of a primary prescriber
- Regularly review and discuss mutual treatment goals
- Regularly evaluate effectiveness and safety of opioid treatment
- In the absence of functional gains or improved pain control, taper opioids and seek specialty consultation
- If opioids are prescribed at a high dose, document discussion of tapering to a lower dose at each visit
- Regularly recommend physical modalities and self-care strategies to manage chronic pain

**GP7: Document behavioral health plan for patients with current or prior behavioral health conditions.**

**GP8: Avoid use of high-risk medications or substances with opioids.**

- Avoid concomitant use of alcohol and opioids
- Avoid concomitant use of any benzodiazepines and opioids. If the patient is already prescribed benzodiazepines, consider tapering if opioids are continued
- Avoid concomitant use of other sedative-hypnotics (e.g. barbiturates, SOMA, or sleeping pills)
- In the absence of clear evidence, individual institutions should develop a consistent standard on the concomitant use of marijuana and opioids.
- Provide counseling on the risks of combining the above substances with opioids

**GP9: Patients who develop an [opioid use disorder](#) during treatment should be referred to an addiction**

specialist/appropriate specialist and/or addiction treatment.

GP10: Consider prescription for [naloxone rescue](#) kit in high risk individuals.

**COMMUNITY STANDARD RESOURCE APPENDIX**  
**By Guiding Principles 1-10**

**Guiding Principle (GP) 1: Perform a patient evaluation/history. (New and On-going)**

Oregon Pain Guidance Group. **Five-Step Approach to Treating Patients with Chronic Complex Non-Cancer Pain. Pg 9**

[http://www.southernoregonopioidmanagement.org/app/content/uploads/2014/04/OPG\\_Guidelines.pdf?b2ab8b](http://www.southernoregonopioidmanagement.org/app/content/uploads/2014/04/OPG_Guidelines.pdf?b2ab8b)

*5-step recommendation for assessing patients with chronic or persistent pain. These steps can be followed whether the patient is already on opioid therapy or undergoing initial evaluation. Full evaluation may take more than one visit.*

**PQRST Method for Pain Assessment.**

[https://www.mcgill.ca/anesthesia/files/anesthesia/mch\\_pain\\_guidelines.pdf](https://www.mcgill.ca/anesthesia/files/anesthesia/mch_pain_guidelines.pdf)

*Explanation of method where P=Provocation, Q=Quality, R=Radiation S=Severity, and T=Timing.*

**GP2: Perform and document initial and periodic functional evaluation (New and On-going)**

*Extensive menu of validated functional and risk assessment tools available at [National Guideline Clearinghouse | Assessment and management of chronic pain.](#)*

**Physical Functional Ability Questionnaire (FAQ5)**

[https://www.icsi.org/\\_asset/bw798b/ChronicPain.pdf](https://www.icsi.org/_asset/bw798b/ChronicPain.pdf). Calculator accessible at [Physical Functional Ability \(FAQ5\) Score | SOAPnote.org](#).

*5-item clinical-administered questionnaire to help assess level of function in order to identify significant areas of disability, establish functional outcome goals, and measure effectiveness of interventions.*

**Oswestry Low Back Pain Disability Index**

[http://www.aadep.org/documents/resources/appendix\\_d\\_the\\_oswestry\\_disability\\_477e0ae6e8258.pdf](http://www.aadep.org/documents/resources/appendix_d_the_oswestry_disability_477e0ae6e8258.pdf)

*The Oswestry Disability Questionnaire is used to assess and quantify the patient's subjective rating of perceived disability related to his or her functional limitations (e.g., work status, difficulty caring for oneself). The higher the score, the more perceived disability.*

**GP3: Regularly monitor and document subjective pain measures. (New and On-going)**

**Brief Pain Inventory (BPI).** <https://www.painedu.org/Downloads/tools/bpilong.pdf>

*Used in clinical trials, and contains more descriptive information than may be clinically useful in complex pain assessments..*

**Brief Pain Inventory – Short Form.** [http://www.painedu.org/Downloads/NIPC/Brief\\_Pain\\_Inventory.pdf](http://www.painedu.org/Downloads/NIPC/Brief_Pain_Inventory.pdf).

*Easier for patients to complete, simplified for the busy clinical setting.*

*Both measures can be administered in 5-10 minutes. The tools ask patients to rate their pain and also assesses the patient's ability to complete activities of daily living.*

**PEG-S Pain Scale.**

Krebs, E. et al. (2009). Development and initial validation of the PEG, a three-item scale assessing pain intensity and interference. J Gen Intern Med. 24(6): 733-738.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2686775>

*The PEG-S Pain Scale is a shortened three-item pain measure to assess average pain intensity (P), interference with enjoyment of life (E), and interference with general activity (G) and with sleep (S).*

*When assessing the patient’s pain and functional status, it is helpful to set reasonable expectations about the level of relief that an opioid may offer. Experience suggests an approximate 30% reduction in pain, similar to other modalities. A shared decision process around these treatment goals is encouraged.*

[http://www.southernoregonopioidmanagement.org/app/content/uploads/2014/04/OPG\\_Guidelines.pdf?b2ab8](http://www.southernoregonopioidmanagement.org/app/content/uploads/2014/04/OPG_Guidelines.pdf?b2ab8)

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<b>CHRONIC PAIN TREATMENT</b>	
<b>“COMPARING EFFECTIVENESS”</b>	
<i>Extrapolated averages of reduction in Pain Intensity</i>	
Opioids:	≤ 30%
Tricyclics/SNRIs:	30%
Anticonvulsants:	30%
Acupuncture:	≥ 10+%
Cannabis:	10-30%
<i>CBT/Mindfulness:</i>	<i>≥ 30-50%</i>
<i>Graded Exercise Therapy:</i>	<i>variable</i>
<i>Sleep restoration:</i>	<i>≥ 40%</i>
<i>Hypnosis, Manipulations, Yoga:</i>	<i>+ effect</i>

Turk, D. et al. Lancet 2011; Davies KA, et al. Rheum. 2008; Kroenke K. et al. Gen Hosp Psych. 2009; Morley S Pain 2011; Moore R, et al. Cochrane 2012; Elkins G, et al. Int J Clin Exp Hypnosis 2007.

**UW Medicine**  
PAIN MEDICINE

Source: David Tauben, MD, UW Center for Pain Relief.

**GP4: If considering prescribing an opioid, screen for opioid risk. (New)**

**GP4: Regularly monitor for opioid risk. (On-going)**

**Screening Tools**

**Disability, Intractability, Risk, Efficacy (DIRE).** <http://www.opioidrisk.com/node/1202>

*The DIRE tool is a 7-question survey designed for the primary care setting that assesses the risk of opioid abuse and the likelihood that long-term opioid therapy will be effective for the patient.*

**Opioid Risk Tool (ORT).** <http://www.opioidrisk.com/node/884>

*The ORT is a simple assessment tools for establishing patient's susceptibility for the misuse of opioids.*

**Patient Health Questionnaire (PHQ-4 or PHQ-9).**

[http://www.phqscreeners.com/overview.aspx?Screener=02\\_PHQ-9](http://www.phqscreeners.com/overview.aspx?Screener=02_PHQ-9)

*The Patient Health Questionnaire is a diagnostic tool for mental health disorders used by health care professionals that is quick and easy for patients to complete.*

**The Screener and Opioid Assessment for Patients in Pain – Revised (SOAPP-R).**

[http://nationalpaincentre.mcmaster.ca/documents/soapp\\_r\\_sample\\_watermark.pdf](http://nationalpaincentre.mcmaster.ca/documents/soapp_r_sample_watermark.pdf)

*SOAPP-R is a brief validated paper-based tool to facilitate assessment and planning for chronic pain patients being considered for long-term opioid treatment.*

**The Current Opioid Misuse Measures (COMM).** <http://www.painedu.org/soap.asp>

*COMM will help clinicians identify aberrant behaviors associated with opioid misuse in patients who are currently on long-term opioid therapy.*

### **State Prescription Drug Monitoring**

**Oregon Prescription Drug Monitoring Program (PDMP) Fact Sheet.**

[http://www.orpdmp.com/orpdmpfiles/PDF\\_Files/PDMP\\_FactSheet\\_2013\\_v1.0.pdf](http://www.orpdmp.com/orpdmpfiles/PDF_Files/PDMP_FactSheet_2013_v1.0.pdf)

**Oregon PDMP User Access & Registration.** <http://www.orpdmp.com/health-care-provider>

*The Oregon Prescription Drug Monitoring Program (PDMP) is a Web-based data system that contains information on controlled prescription medications dispensed by Oregon-licensed retail pharmacies.*

*Pharmacies are required by law to submit data weekly for all Schedule II– IV controlled substances dispensed. Controlled substances reported include opioids, sedative hypnotics, benzodiazepines, stimulants, and other drugs.*

**Washington Prescription Monitoring Program (PMP) Fact Sheet.**

[http://www.wapmp.org/wapmpfiles/Provider\\_Factsheet\\_May14.pdf](http://www.wapmp.org/wapmpfiles/Provider_Factsheet_May14.pdf)

**Washington PMP Registering for Prescription Review.** <http://www.wapmp.org/practitioner/pharmacist>

*The PMP, referred to as Prescription Review, is a secure online database that is used across Washington State to improve public health. Practitioners have access to their patient's information before they prescribe or dispense drugs. This allows them to look for duplicate prescribing, possible misuse, drug interactions, and other potential concerns.*

### **Urine Drug Screening**

It is important to work closely with your laboratory, as the testing methods vary by institution. It is important to understand the characteristics of your particular test: its specificity (screening vs. confirmatory in terms of false positives) and sensitivity (minimum thresholds in terms of false negatives). You should also

know the identities of the substances detected by your test. There is no reliable evidence to correlate drug dose with urine metabolite levels.

Peppin, J. et al. (2012). **Recommendations for Urine Drug Monitoring** as a component of opioid therapy in the treatment of chronic pain. *Pain Medicine*, 13(7): 886-896. <http://mytopcare.org/wp-content/uploads/2013/07/Peppin.pdf>

*Several prominent guidelines recommend that patients on long-term opioid therapy have periodic urine drug monitoring (UDM) for appropriate use; however, none address the specific questions of which patients to test, which substances to test for, how often to test, and how to act on the results. In the absence of adequate scientific evidence in the literature, a panel of experts in the field of pain and addiction medicine was convened to develop consensus UDM recommendations. The panel met three times between March 2010 and April 2011, and reviewed several drafts of the recommendations document between meetings. The group was able to achieve consensus on a set of UDM recommendations addressing test selection, test frequency, interpretation of results, and how to handle discrepancies based on specific results.*

Oregon Pain Guidance Group. (2015). **Urine Drug Screenings (UDS) FAQ**. [http://old.southernoregonopioidmanagement.org/wp-content/uploads/2014/04/UDS\\_FAQs.pdf](http://old.southernoregonopioidmanagement.org/wp-content/uploads/2014/04/UDS_FAQs.pdf)

*The purpose of drug testing is to identify aberrant behavior, undisclosed drug use and/or abuse, and to verify compliance with treatment. If a decision has been made to prescribe opioids for chronic non-cancer pain, the prescriber should get a baseline UDS prior to prescribing and periodically thereafter. Risk determination may change over time as you get to know the patient better, so clinical judgment is critical in determining an appropriate testing schedule. Often explaining the need for routine UDS can lead to a beneficial discussion between provider and patient concerning risky concomitant substance use. Prior to drug testing, the prescriber should inform the patient of the reason for testing, frequency of testing and consequences of unexpected results. This gives the patient an opportunity to disclose drug use and allows the prescriber to modify the drug screen for the individual circumstances and more accurately interpret the results.*

#### **GP5: Establish an opioid prescribing daily dosing limit. (New and Ongoing)**

*While a dose equivalent to 120 mg of oral morphine daily is given as a guideline, evidence suggests that there is still substantial danger in lower doses and many institutions have already adopted more stringent policies. The very lowest effective dose should be prescribed, as risk appears to increase significantly beyond 50 mg MED daily.*

**Opioid calculator – Global RPH.** <http://www.globalrph.com/narcoticonv.htm>

Note that dose equivalency calculators are crude estimates and can vary substantially. Institutions should adopt a single calculator and use it consistently to avoid confusion.

It should also be emphasized that these calculators are for expressing various medications as a single equianalgesic equivalent, not for converting patients between different opioid medications. Drug half-lives, cross-tolerance, receptor subtype differences, and patient-specific factors may lead to considerable variation.

#### **GP6: Maintain a comprehensive treatment plan with agreed upon treatment goals. (On-going)**

*When patients are on high doses of opioids, a taper is advised. Guidance on a tapering timeline, as well as*

patient/provider talking points and tools to aid these difficult conversations are highlighted in sections beginning on p. 23 and p. 34.

[http://www.southernoregonopioidmanagement.org/app/content/uploads/2014/04/OPG\\_Guidelines.pdf?b2ab8b](http://www.southernoregonopioidmanagement.org/app/content/uploads/2014/04/OPG_Guidelines.pdf?b2ab8b)

#### **GP10: Consider prescription for naloxone rescue kit in high risk individuals. (New and On-going)**

**Naloxone for opioid safety:** a provider's guide to prescribing naloxone to patients who use opioids

<http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/N/PDF%20NaloxoneOpioidSafetyPatients.pdf>

**Prescribe to Prevent:** Overdose Prevention and Naloxone Rescue Kits for Prescribers and Pharmacists.

[http://www.opioidprescribing.com/naloxone\\_module\\_1-landing](http://www.opioidprescribing.com/naloxone_module_1-landing)

**Naloxone Information specific to Washington State.** <http://stopoverdose.org/pharmacy.htm>

#### **Definitions**

##### *Aberrant drug-related behaviors*

Actions that indicate addiction, including the following: rapidly escalating drug dosage, running out of prescriptions early, acquiring prescription drugs from outside sources, inconsistent UDS, multiple providers from OR PDMP/WA PMP data, stolen medications, chewing/snorting/injecting medications, and altering/stealing/selling prescriptions ([NC Medical Board](#))

##### *Substance Use Disorder*

Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.

<http://www.samhsa.gov/disorders/substance-use> Accessed 5/28/15

##### *Chronic Pain (also known as Persistent Pain):*

Chronic pain is often defined as any pain lasting more than 12 weeks. Chronic pain may arise from an initial injury, such as a back sprain, or there may be an ongoing cause, such as illness. However, there may also be no clear cause. Chronic pain may limit a person's movements, which can reduce flexibility, strength, and stamina. This difficulty in carrying out important and enjoyable activities can lead to disability and despair. Chronic Pain/NIH Medline Plus <http://www.nlm.nih.gov/medlineplus/magazine/issues/spring11/articles/spring11pg5-6.html> Accessed 5/28/15.

##### *MED: Morphine Equivalent (Daily) Dose*

Used to translate the dose and route of each of the opioids the patient has received over the last 24 hours to a parenteral morphine equivalent using a standard conversion table.

Schneider, C. et al. (2003). Principles of Pain Management. Clin Med Res; 1(4): 337-340.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1069064> Accessed 5/28/15.

##### *Prescription Drug Monitoring Programs (PDMPs)*

The Prescription Drug Monitoring Program is a program to allow providers to view all dispensed doses of scheduled medications for their patients.

Oregon: <http://www.orpdmp.com>



Washington: <http://www.wapmp.org>

*Trial period*

The period of time when medication or other treatment efficacy is tested to determine whether treatment goals can be met. If goals cannot be met, the trial is discontinued and an alternate treatment may be considered.

[http://library.fsmb.org/pdf/2013\\_model\\_policy\\_treatment\\_opioid\\_addiction.pdf](http://library.fsmb.org/pdf/2013_model_policy_treatment_opioid_addiction.pdf) Accessed 5/28/15.

## Educational Resources

**Opioids 911:** [www.opioids911.org](http://www.opioids911.org)

*Extensive toolkit devoted to patient safety, including patient education on safe use and disposal, overdose prevention, and emergency response.*

**Providers' Clinical Support System for Opioid Therapies (PCSS-O).** <http://pcss-o.org>

*National training and mentoring project providing CME at no cost to providers treating patients who may be affected by chronic pain, misuse of opioids, or opioid use disorder.*

**Provider's Clinical Support System for Medication Assisted Treatment (PCSS-MAT).** <http://pcssmat.org>

*National training and mentoring project providing CME at no cost to providers, with specific emphasis on widespread use of effective treatment for opioid use disorder in the primary care, psychiatric, and pain management settings.*

**Physicians for Responsible Opioid Prescribing.** <http://www.supportprop.org>

*Coalition of healthcare providers and the interested public to promote responsible use of opioids, educate the public, and draw attention to advocacy and policy issues surrounding opioid therapy and misuse. Also includes the CDC's Primary Care and Public Health Initiative (2012) on Managing Pain With and Without Opioids in the Primary Care Setting. [http://www.supportprop.org/news/SupportPROP\\_ManagingPain\\_508.pdf](http://www.supportprop.org/news/SupportPROP_ManagingPain_508.pdf)*

**COPE (Collaborative Opioid Prescribing Education).** University of Washington School of Medicine.

<http://www.coperems.org>

*Collaboration headed by University of Washington School of Medicine providing healthcare provider education, tools, and free CME on the safe and effective management of patients with chronic pain. Emphasis is placed on functionality and safe treatment methods, as opposed to the pain experience.*

**SCOPE of Pain (Safe and Competent Opioid Prescribing Education).** Boston University.

<https://www.scopeofpain.com>

*Series of online and live CME activities for healthcare professionals on the safe use of Extended Release/Long-Acting (ER/LA) opioids in patients with chronic pain. Funded with support from 21 pharmaceutical companies in response to an education requirement issued by the FDA in order to prescribe these medications.*

**SAMHSA Opioid Overdose Toolkit: Information for Prescribers.** [http://store.samhsa.gov/shin/content//SMA14-4742/Toolkit\\_Prescribers.pdf](http://store.samhsa.gov/shin/content//SMA14-4742/Toolkit_Prescribers.pdf)

*Information for providers specific to treating overdose, legal considerations, claims coding and billing, and links to educational resources such as PCSS-O and SCOPE.*

## **Selected references from national, state, and professional sources on the safety and efficacy of long-term opioid therapy.**

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Deyo, R.A. (2015). Opioids for low back pain. BMJ, 350: 6380. <http://www.bmj.com/content/350/bmj.g6380>

Miller, M. (2015). Prescription opioid duration of action and the risk of unintentional overdose among patients receiving opioid therapy. JAMA Intern Med 175(4): 608-615. <http://www.ncbi.nlm.nih.gov/pubmed/25686208>

### **Guideline/Community Standard References**

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*Expert agreement*

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CDC. Common Elements in Guidelines for Prescribing Opioids for Chronic Pain.

*Comparison of specific policy strategies present in state and professional guidelines*

[http://www.cdc.gov/drugoverdose/pdf/common\\_elements\\_in\\_guidelines\\_for\\_prescribing\\_opioids-a.pdf](http://www.cdc.gov/drugoverdose/pdf/common_elements_in_guidelines_for_prescribing_opioids-a.pdf)

SAMHSA Federal Guidelines for Opioid Treatment Programs. (2015).

*Federal guidelines for substance abuse treatment programs*

<http://store.samhsa.gov/shin/content//PEP15-FEDGUIDEOTP/PEP15-FEDGUIDEOTP.pdf>

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