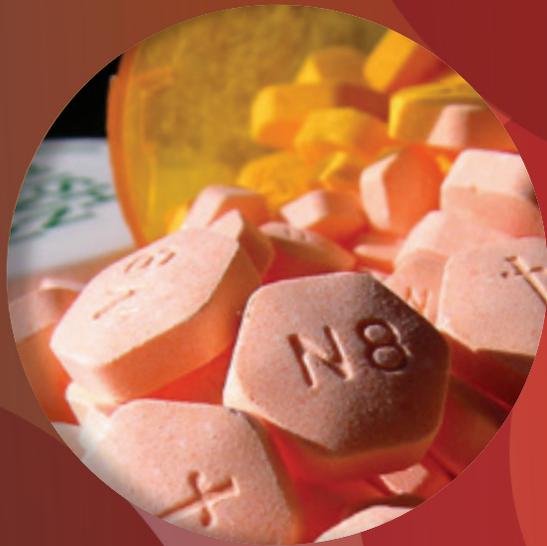


Opioid Prescribing Guidelines

A PROVIDER AND COMMUNITY RESOURCE





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INTRODUCTION

Oregon Pain Guidance (OPG) of Southern Oregon created these guidelines in response to the alarming rise in opioid overdose deaths in our community and the need for a standard of care for the treatment of chronic pain. Each year overdoses claim scores of our citizens’ lives, and the fact is the majority of these deaths are related to the misuse of medications that have been prescribed by healthcare providers. Our goal is to furnish resources to local prescribers to help them understand and adopt best practices for the treatment of complex chronic non-cancer pain (CCNP).

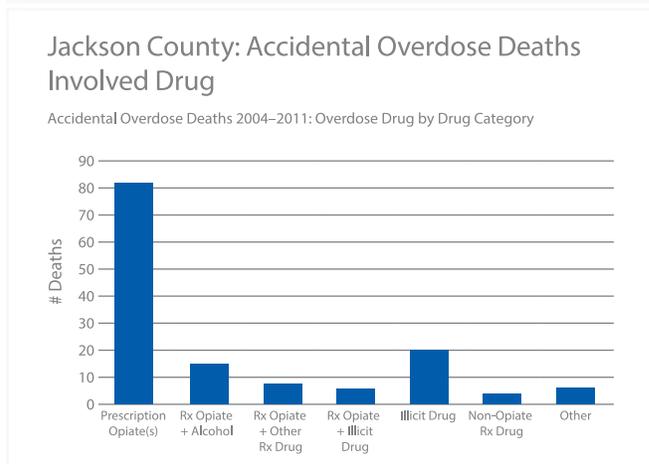
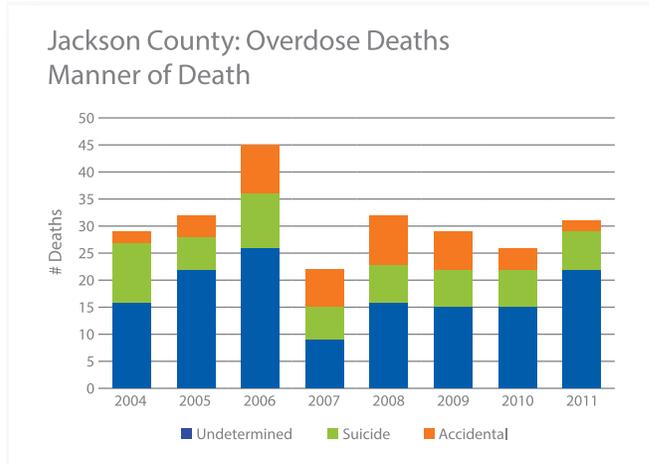
In 2011, more than 70 local healthcare professionals formed the OPG group. We have been meeting monthly ever since—first to brainstorm, then to create a guidance document, and now to encourage the practice of safe, scientifically based chronic pain management.

Who is the OPG? We are local professionals: nurses, prescribing healthcare providers, pharmacists, behavioral health clinicians, and administrators. We represent private medical groups, public health, coordinated care organization (CCOs), hospitals, emergency departments, the Veterans Administration, specialty care, chemical dependency treatment centers, and federally qualified health centers (FQHCs).

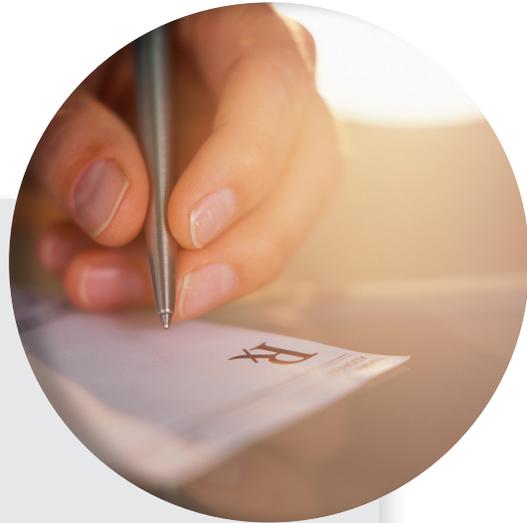
In addition to helping reduce the morbidity and the mortality associated with the inappropriate use of opiate drugs, we hope that by shifting the focus from opioid use to non-opioid treatments, patients will experience an overall improvement in well-being.

An OPG website has been developed that includes all of the information included in these guidelines, as well as links to important documents, community and web-based resources, and our educational video. We encourage you to use these helpful tools within your practice.

We are grateful to the members of the OPG group for all of their hard work, as well as to the subject-matter experts both within and outside our community for their invaluable assistance.



How to Use These Guidelines



SIX MAIN SECTIONS

1. Tools
2. Non-opioid treatments
3. Opioid management strategies
4. Special issues
5. Tapering
6. Difficult conversations

TREATMENT AND TAPERING FLOW SHEETS

In addition to the main sections of these guidelines there are two flow sheets, which can be laminated for easy reference. One is an overview of the assessment and treatment of CCNP. It is color coded to match the sections of this book to provide easy access to further reading on each subject matter. The other contains a flow sheet for the tapering of opioids and benzodiazepines.

If you have decided to treat your patient with opioids for CCNP, the five-step approach to treating patients with CCNP on page 6 will lead you through recommended steps for the best possible outcomes. The chronic pain checklist (Appendix L on page 59) will help assure that you have considered all of your options and complied with recommended procedures.

WEBSITE

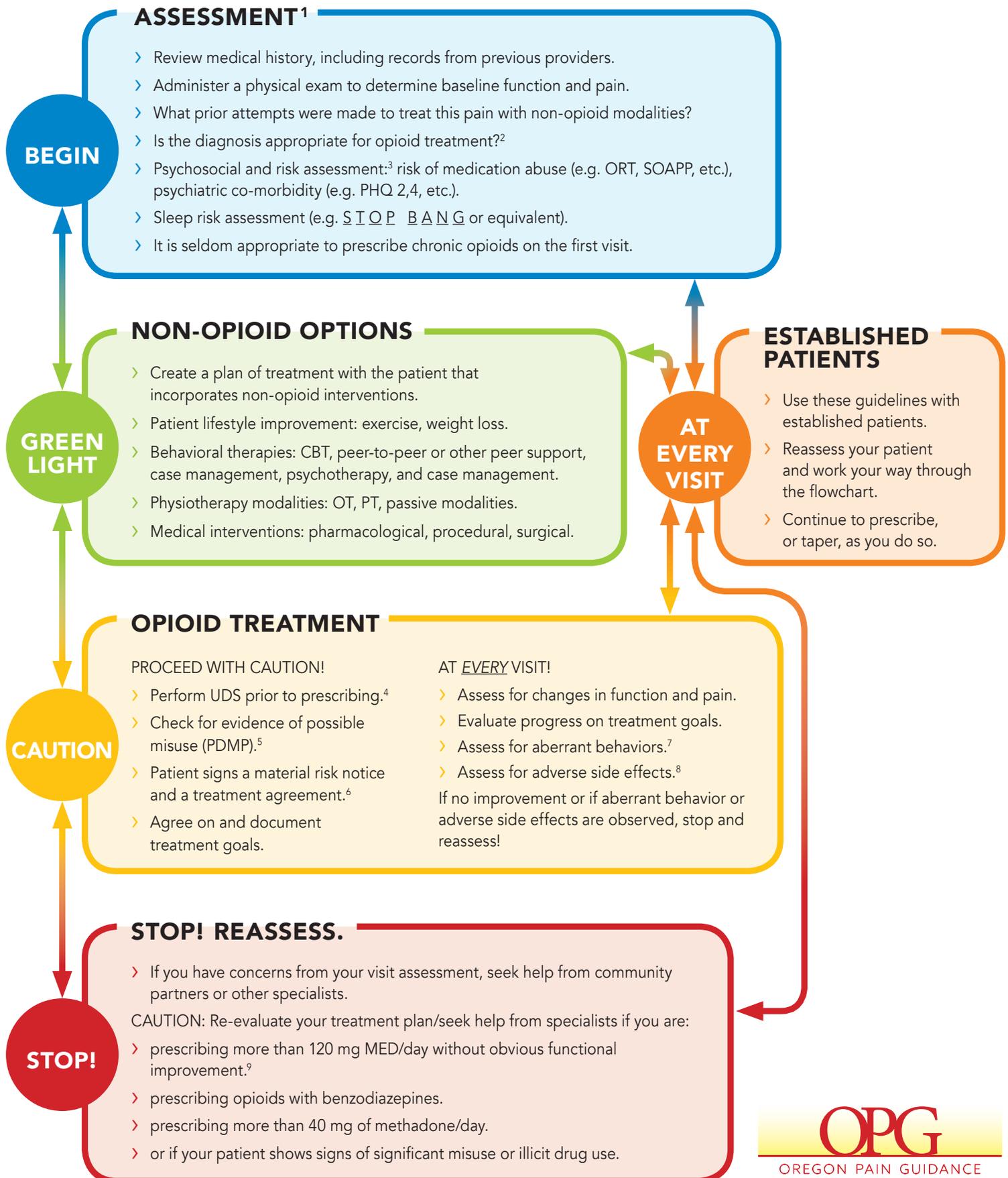
These guidelines, plus links, videos, and other useful information can be found at www.oregonpainguidance.org.

VIDEO

In collaboration with AllCare Health Plan, a CCO in Grants Pass, Oregon, the Oregon Pain Guidance has created an educational video to help prescribers and their staff understand the new paradigms and best practices for the treatment of CCNP. The tools referenced in the video are included in these guidelines, either reproduced in their entirety or provided as links. For more information, you can access the video and this document at www.oregonpainguidance.org.

GUIDELINES FLOWCHART

FOR THE EVALUATION AND THE TREATMENT OF COMPLEX CHRONIC NON-CANCER PAIN



Footnotes to the Guidelines Flowchart for the Evaluation and the Treatment of Complex Chronic Non-Cancer Pain

- 1 Prior to prescribing opioids, fully assess the patient for appropriateness. This is recommended whether the patient is new or established, already taking opioids, or opioid-naïve. This implies that it is unlikely you will prescribe opioids on the first visit. We recommend that the patient be informed of this by clinic support staff before meeting with the provider.
- 2 Certain medical conditions, such as fibromyalgia, low-back pain, chronic pelvic pain, and headaches, are relative contraindications for opioid treatment. Benzodiazepines should be used with extreme caution in combination with opioids.
- 3 Individuals who are at risk of misusing opioids can be predicted, to some extent, by evaluating for mental health disorders and substance abuse risk (using the Opioid Risk Tool (ORT)). There is a very strong correlation between certain psychiatric conditions and the misuse of opioids. These may include depression (PHQ-4), bipolar disorder, ADD, and PTSD.
- 4 Urine drug screenings (UDSs) come in many panel configurations. They can be point-of-care (POC) or lab-based. Be sure you have a plan in place to handle unexplained positive and negative tests. We recommend direct and compassionate intervention with patients upon any indication that they may be addicted to the medicines or if they are unable to use them safely.
- 5 The Oregon Prescription Drug Monitoring Program (PDMP) (www.orpdmp.com) provides instant feedback concerning opioid prescribing.
- 6 Treatment agreements come in many forms, but certain elements are considered essential. They include: utilizing one provider and one pharmacy, no early refills, and consequences for falsification, substitution, sales/distribution, use of illicit or contraindicated drugs, misuse, and disruptive behaviors. The consequences of such violations must be clearly communicated to the patient and documented in the chart. In addition to the treatment agreement, a Material Risk Notice is required by the Oregon Medical Board. Samples of both are provided in the Appendix of these guidelines.
- 7 Aberrant behaviors violate the treatment agreement. To identify such behaviors, monitoring tools such as UDSs, patient call-backs for pill counts, and PDMP reviews should be considered. The frequency of such monitoring should be determined by the degree of risk identified in the assessment phase. For example, if you choose to treat someone with a high ORT score, you might perform a UDS every three months, whereas for someone with a low score, only once or twice a year.
- 8 Frequent reassessments of improvement in pain and function are recommended. Assessment of the side effects of medication is important, too. Sexual dysfunction, endocrine dysfunction, and constipation are almost universal. Sleep disturbance, drowsiness, emotional disruption, and interactions with other medications are common.
- 9 Escalation of patient dose should be gradual. Increases and high doses should be tied to improvement of pain and function. Morphine equivalent doses (MEDs) can be determined by using the following online calculator: <http://agencymeddirectors.wa.gov/mobile.html>. Seek consultation for doses above 120mg MED. Methadone should be used cautiously. Generally, doses should not exceed 40mg/day.

TAPERING FLOWCHART

START HERE

Consider opioid taper for patients with opioid MED > 120/methadone > 40, aberrant behaviors, significant behavioral/physical risks, lack of improvement in pain and function.

Consider benzodiazepine taper for patients with aberrant behaviors, behavioral risk factors, impairment, or concurrent opioid use.

- 1 Explain to the patient the reason for the taper: "I am concerned..."
- 2 Determine rate of taper based on degree of risk.
- 3 If multiple drugs involved, taper one at a time (e.g., start with benzos, follow with opioids).
- 4 Set a date to begin, provide information to the patient, and set up behavioral supports, prior to instituting the taper. See page 26 of OPG guidelines.

BENZODIAZEPINE TAPER

Basic principle: Expect anxiety, insomnia, and resistance. Patient education and support very important. Risk of seizures with abrupt withdrawal increases with higher doses. The slower the taper, the better tolerated.

- 1 **Slow taper:** Calculate total daily dose. Switch from short acting agent (alprazolam, lorazepam) to longer acting agent (diazepam, clonazepam). Upon initiation of taper reduce the calculated dose by 25–50% to adjust for possible metabolic variance.
- 2 First follow up visit 2–4 days after initiating taper to determine need to adjust initial calculated dose.
- 3 Reduce the total daily dose by 5–10% per week in divided doses.
- 4 After ¼ to ½ of the dose has been reached, with cooperative patient, you can slow the taper.
- 5 Consider adjunctive agents to help with symptoms: trazodone, buspirone, hydroxyzine, clonidine, antidepressants, neuroleptics, and alpha blocking agents.

- 1 **Rapid taper:** See the tapering guidelines on page 28 of the OPG guidance documents.

OPIOID TAPER

Opioids (not methadone)

Basic principle: For longer acting drugs and a more stable patient, use slower taper. For shorter acting drugs, less stable patient, use faster taper.

- 1 Utilize the drug the patient is taking as the tapering medication. If you switch medications, follow MED equivalency chart and then reduce the dose by 25–50% as starting dose. Metabolic variability can be quite significant. Utilize a 90% dose reduction if switching to methadone. See dose calculator link below.
- 2 Decrease total daily starting dose by 5–15% per week in divided doses.
- 3 See patient frequently during process and stress behavioral supports. Consider UDS, pill counts, and PDMP to help determine adherence.
- 4 After ¼ to ½ of the dose has been reached, with cooperative patient, you can slow the process down.
- 5 Consider adjuvant medications: antidepressants, NSAIDs, clonidine, anti-nausea, anti-diarrhea agents.

Methadone

Basic principle: Very long half life may necessitate a more protracted tapering process. Otherwise follow opioid principles.

MED for Selected Opioids

Opioid	Approximate Equianalgesic Dose (oral and transdermal)
Morphine (reference)	30mg
Codeine	200mg
Fentanyl transdermal	12.5mcg/hr
Hydrocodone	30mg
Hydromorphone	7.5mg
Methadone	Chronic: 4mg†
Oxycodone	20mg
Oxymorphone	10mg

Link to Morphine Equivalent Dosing (MED) Calculator

agencymeddirectors.wa.gov/mobile.html



OREGON PAIN GUIDANCE

Benzodiazepine Equivalency Chart

Drug	Half-life (hrs)	Dose Equivalent
Chlordiazepoxide (Librium)	5–30 h	25mg
Diazepam (Valium)	20–50 h	10mg
Alprazolam (Xanax)	6–20 h	0.5mg
Clonazepam (Klonopin)	18–39 h	0.5mg
Lorazepam (Ativan)	10–20 h	1mg
Oxazepam (Serax)	3–21 h	15mg
Triazolam (Halcion)	1.6–5.5 h	0.5mg

www.oregonpainguidance.org

Five-Step Approach to Treating Patients with Chronic Complex Non-Cancer Pain (CCNP)

The five steps listed below are recommended for treating patients with CCNP. These steps can be followed whether the patient is already receiving opioid therapy or coming to you for the first time. Implementation of the five steps may require multiple visits.

Step 1 Practice Assessment

Establish a standard policy regarding chronic pain treatment, with uniform guidelines for all patients. This will help minimize some of the challenges surrounding opiate prescribing and ensure consistent policies for all. New patients should be advised of these policies prior to receiving care. After determining your policy, it's important that you identify current patients receiving opioid therapy for more than 90 days and schedule them for a full assessment. At that time, inform them of your new policies. See *Difficult Conversations* on page 34.

Step 2 Patient Assessment

We've found that taking the time to learn about a patient's goals, preferences, and views about opioids can be enormously helpful. With this information, you can formulate strategies and set realistic expectations for chronic pain treatment. You'll find that many chronic pain patients are ambivalent about opioids. Some are concerned about dependency or side effects. Others may fear that opioids will be abruptly withdrawn. Keep the following in mind:

- › Risk assessments such as the ORT, PHQ and the S T O P B A N G will help determine whether opioids are appropriate for a patient and, if so, guide the frequency of monitoring. See *Tools* section, starting on page 11.
- › Careful screening can reduce the possibility of opioid misuse.
- › For new patients, you should rarely prescribe opioids on the first visit, even if they come to your office with pill bottles and old records in hand. You will need time to thoroughly review each patient's history and determine the appropriateness and the safety of prescribing opioids.

Step 3 Non-Opioid Treatment

It is best to begin chronic pain treatment without opioids and instead use patient self-management strategies. (During this process, it may become clear that a patient has PTSD, depression or anxiety and would benefit from professional help.) Treating patients with chronic pain requires a care plan and consistent follow-through. During these sessions, focus on the functional goals (see *Graded Pain and Function Scale* on page 55), not on pain relief alone. This type of care planning is an ongoing process and may involve other members of your team. To keep other clinicians informed, documentation is necessary, including:

- › Treatment goals outlining pain and functional expectations.
- › Possible steps to achieve those goals.
- › A schedule for periodic monitoring and what monitoring will include.
- › If needed, documentation of discussion regarding the risks and the benefits of any opioid treatment.

Step 4 Patient Reassessment

Over time, you can determine if the treatment plan has improved patient functionality and reduced pain. Following non-opioid treatment, you may determine that low-dose opioid therapy will be beneficial. As you share information about opioid risks and benefits, it's important to show your patients that you understand and sympathize with the frustration and the difficulties of living with chronic pain.

It's also essential that you discuss with your patients the medical, psychosocial, and addiction risks of opioids. The Oregon Medical Board mandates that a discussion occur between providers and patients regarding risks and benefits of opioid treatment. If you choose to prescribe opioids, the Oregon Medical Board requires that a Material Risk Notice be signed by both patient and provider and that it remain on the chart.

In addition to the Material Risk Notice, many practices require that patients sign a treatment agreement. Samples of treatment agreements can be found in Appendix F, starting on page 48. Remember: Patient safety is your primary concern.

Step 5 Follow-Up Visits

Whether or not opioids are prescribed, you should schedule periodic follow-up visits to assess safety and progress toward treatment goals. Nurses, medical assistants, and other support staff can assist with follow-up monitoring by assessing progress toward treatment goals and noting problems with medications.

Periodic follow-up visits are necessary and the frequency of both visits and screening for aberrancy should be determined by degree of risk established during the assessment process. During these visits:

- › Watch for opioid adverse effects, including problems with affect and sedation.
- › Remember that exacerbations of chronic pain are expected and should not automatically result in a dose increase.
- › Remind patients that chronic pain ebbs and flows.
- › Reinforce realistic expectations of opioid benefits.
- › If a patient achieves reasonable pain reduction with stable doses and makes progress toward self-management goals, you can consider less frequent follow-ups.
- › Chronic pain is a chronic condition with bio-psychosocial determinants. Behavioral health collaboration is strongly recommended in the care of patients with CCNP.

It's important to avoid dose escalating when treating acute pain in a patient with chronic pain using opiates. If necessary, use a short-acting opioid for a short period of time.

TOOLS

There are various tools which can assist you in evaluating and managing your chronic pain patients. The following is a brief description, while the tools themselves can be found in the appendix.

Assessment Tools

Opioid Risk Tool (ORT)

The ORT is one of the easiest assessment tools for establishing a patient’s susceptibility to misuse of opioids. Other excellent tools are available and are equally appropriate. The ORT is provided in Appendix A on page 41.

Patient Health Questionnaire (PHQ)

The correlation between mental health issues and opioid misuse is well established. The PHQ is a tool to help you identify individuals who are at risk of misusing opioids and benzodiazepines because of mental health issues. Depression and, to a lesser extent, anxiety are well-known risk factors. Bipolar disorder, PTSD, and certain personality disorders are risk factors, as well. Tools like the PHQ are especially useful when used in the context of behavioral health evaluation and/or physical exam. The PHQ-4 is a short questionnaire and can be found in Appendix B on page 42.

PTSD in the form of childhood trauma is a very common confounding problem in patients with CCNP, and in those who become dependent on benzodiazepines. Ensuring you practice “trauma-informed care” is essential to managing chronic pain patients.

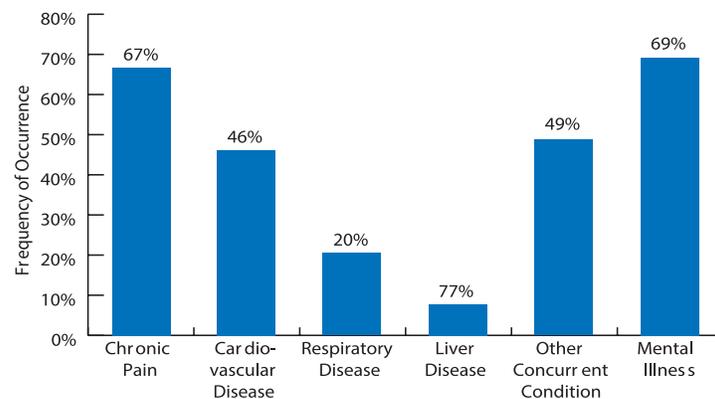
A positive score, the presence of suicidal ideation, and/or your clinical judgment can indicate that further assessment is warranted. Immediate referral is recommended for those with suicidal ideation and/or a severe score. The PHQ-4 is only a screening tool and does not diagnose depression—that is done by appropriately licensed healthcare personnel.

The chart in this section represents actual Jackson County, Oregon, deaths data (2004–2011) from the Jackson County Medical Examiner’s Office and illustrates the importance of screening for substance abuse and mental health disorders.

The graph on this page illustrates the importance of screening for mental illness and substance abuse. (See Assessment section of this document.) More than half of all overdose deaths, when patient documentation was obtained, included a history of either mental illness, substance abuse, or both. Almost half of all overdoses included a benzodiazepine as a co-existing factor.

Co-occurring Medical Conditions in Overdose Deaths

Jackson County , 2004–2011



Source: Medical Examiners Data, Jim Shames, MD.

S T O P B A N G

S T O P B A N G helps evaluate the risk of respiratory depression with opioids.

Snororing. **T**iredness. **O**bstruction symptoms. High blood **P**ressure **B**MI. **A**ge. **N**eck circumference. **G**ender

Pain often disrupts sleep in chronic pain patients, and the resulting insomnia may increase pain intensity and reduce the pain threshold. Narcotic administration can significantly increase the chance of obstructive sleep apnea, and must be used with caution, especially in those patients identified to have possible obstructive sleep apnea (OSA) prior to the initiation of opioid therapy. Assessment of sleep disturbances is a key metric for evaluating patient risk as well as for monitoring opioid therapy.¹

The S T O P B A N G assessment is provided in Appendix C on page 43.

Aberrancy Screening

Urine Drug Screen (UDS)

UDS helps monitor for unexpected licit and illicit drugs that may be present in your patient’s urine. UDSs should be used with every chronic pain patient as a standard part of your office policy. There are two basic types of UDS: POC testing (in office) and confirmatory (laboratory-based). See Appendix D on page 44 for Urine Drug Screening Frequently Asked Questions.

Point-of-Care (POC)

Advantages and limitations. POC tests are inexpensive and easily performed. Testing kits can be configured to your needs. Most common drugs to be included: opiates, benzodiazepines, methadone, amphetaminemethamphetamine, cocaine, THC, and oxycodone. Other tests commonly included are: PCP, barbiturates, and alcohol, but many others are often optional single tests (fentanyl, buprenorphine, for example).

Remember that these are management tools, not definitive tests to determine deception or illicit use. These tests have a fairly high rate of false negative and false positives. Their interpretation is fraught with difficulties. Understanding of metabolic pathways, cutoff levels, drug-drug interactions, and what drugs are and are not picked up on a particular test are essential to the interpretation of POC testing. Some examples:

- › Hydrocodone often is not detected on the POC opioid strip
- › Hydrocodone can metabolize to hydromorphone and be detected as dilaudid when in fact none was prescribed
- › Diazepam metabolizes to oxazepam and can present as a drug “not prescribed”
- › Clonazepam and lorazepam are sometimes not detected on the benzodiazepine screen.

1. Manchikanti L, Malla Y, Wargo BW, et al. Protocol for accuracy of point-of-care (POC) or in-office urine drug screening (immunoassay) in chronic pain patients: a prospective analysis of immunoassay and liquid chromatography tandem mass spectrometry. *Pain Physician Journal*. 2010;13:E1-E22.

Confirmatory Lab-Based Tests

Advantages. These tests, GC-MS and LC/MS-MS, can be highly accurate, depending on the type used. For instance, LC/MS-MS testing allows for extremely low opiate cutoffs.

Limitations. Many lab-based tests are quite expensive. Use them for verification purposes. We recommend using POC testing first and, if results are unexpected, following up with a laboratory test.

Prescription Drug Monitoring Program (PDMP)

The PDMP is an online tool available to all prescribers, pharmacists, and patients in Oregon. Once a prescriber is registered with the program, he or she can learn exactly which prescription medications a patient has taken and is taking. The value of this information cannot be overstated. We strongly encourage its regular use as an assessment and management tool. Below is a sample of the kind of information that can be obtained within minutes. Without question, a query of the PDMP should be completed for each patient prior to prescribing. Prescribers can now delegate “look-up authority” to their support staff. Go to www.orpdmp.com for details.

A sample PDMP printout is provided in Appendix E on page 47.

Patient-provider Communication

Patient Treatment Agreements

Many providers wish to have conditions of treatment clearly stated in a written document prior to prescribing. Sample patient agreements are provided in Appendix F on page 48.

Material Risk Notice

The Oregon Medical Board states that a material risk notice needs to be signed by the patient whenever opioids are prescribed chronically. A Material Risk Notice is provided in Appendix G on page 53.

Medical Risks of Long-term Opioid Use – Patient Education Handout

Many patients are not familiar with the wide range of medical risks of long-term opioid use. When they understand the risks involved, they are more likely to be receptive to reducing or discontinuing opioid use. We recommend that you print out this one-page document, give it to your patient and go over with them the many risks and side effects of using opioids long term. This patient education handout is provided in Appendix H on page 54.

Assessing Progress

Graded Pain and Function Scale

The goal of opioid treatment is to improve function, both physical and emotional. Activities of daily living (ADLs) are critical to evaluate at each visit, as are other quality of life indicators. This is a very simple tool to track function and pain over time.

The Graded Pain and Function Scale is provided in Appendix I on page 55.

Oswestry Low-back Pain Disability Questionnaire

A comprehensive functional assessment tool provided in Appendix J on page 56.

Opioid Dose Calculator

This tool helps calculate opioid doses and find Morphine Equivalent Doses (MED) for commonly used opioids. A sample calculator can be found at www.agencymeddirectors.wa.gov/Files/DosingCalc.xls.

Additional Assessment Tools

See Appendix K on page 58 for additional assessment tools.

NON-OPIOID OPTIONS

Treatment Comparison

Studies show that opioids are only moderately successful in relieving pain and, in fact, are inferior to sleep restoration, mindfulness training, and physical exercise in providing long-term benefit.

Any non-opioid treatment should include the following:

- › Encouraging patients to resume rewarding and enjoyable activities to reduce their attention on pain.
- › Asking patients to practice relaxation exercises and to apply heat or cold for counterstimulation to distract during times of pain flare-up.
- › Encouraging patients to perform exercises that gradually increase flexibility, strength, and aerobic capacity.
- › Encouraging patients to join facilitated group discussions concerning attitudes and beliefs about pain.
- › Asking patients to think about and address unrealistic fears regarding causes and consequences of chronic pain.
- › Suggesting ways that patients can change their sleep behavior so that they benefit from restorative sleep.

Reduction in Pain Intensity	Numeric Rating Scale
Physical fitness	30–60%
CBT/mindfulness	30–50%
Sleep restoration	30–40%
Opioids	<30%
Tricyclics	<30%
Anti-epileptics	<30%
Acupuncture	>10%

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

Table of Non-Opioid Treatment Options

Patient Lifestyle	Physiotherapy Interventions
<ul style="list-style-type: none"> › Healthy sleep management › Weight reduction › Diet/nutrition › Stress reduction › Exercise 	<ul style="list-style-type: none"> › Functional therapies <ul style="list-style-type: none"> — Physical therapy (PT) — Occupational therapy (OT) — Passive modalities
Behavioral Interventions	Medical Interventions
<ul style="list-style-type: none"> › Educational groups <ul style="list-style-type: none"> — Preventive — Support — Peer-to-peer/Living Well workshops — Shared medical appointments › Psychotherapy <ul style="list-style-type: none"> — Individual counseling — Group therapy — Cognitive behavioral therapy › Supportive care <ul style="list-style-type: none"> — Case management › Substance abuse treatment <ul style="list-style-type: none"> — Residential — Outpatient — Medication-assisted treatment referral › Trauma-informed care <ul style="list-style-type: none"> — PTSD screening — Domestic violence screening — Child abuse screening 	<ul style="list-style-type: none"> › Non-opioid medications that may aid in chronic pain management <ul style="list-style-type: none"> — NSAIDs, acetaminophen — Tricyclic antidepressants (neuropathic pain) — Anti-epileptics (neuropathic pain) — Antidepressants (treating underlying depression) — Topical medications › Minimally invasive surgical procedures <ul style="list-style-type: none"> — Nerve blocks, steroid injections — Interventional treatments: ablations, restorative injections, stimulators, implantable devices — Surgical treatment › Complementary and alternative treatments <ul style="list-style-type: none"> — Manipulation therapy — Acupuncture



Behavioral Treatment Options

Peer-to-Peer, Living Well, and Shared Medical Appointments for Chronic Pain Patients

- › Self-management classes such as Living Well with Chronic Illness workshops and other peer-to-peer groups may be offered in your community and are a valuable tool. Some clinics employ a shared-medical appointment model when treating CCNP. Patients are seen in a group setting to address health concerns surrounding chronic pain, controlled medications, and related issues.
- › The Patient and Community Resources list (Appendix Q on page 64) shows local options for behavioral treatment and peer-to-peer programs.
- › The previous table is a list of non-opioid treatment options you may want to consider. These same treatments can also be used with patients whom you are tapering off opioids.

Cognitive Behavioral Therapy

What is CBT?

CBT is a form of psychotherapy that emphasizes the importance of “thinking” in how we feel and what we do. Simply put: the cognitive, or thinking part of our experience, very much affects the behavioral, or action, part of our experience. Indeed, there is a causal relationship between our thinking and our feelings and behaviors. With training, we can change the way we think in order to feel and behave more comfortably and acceptably, even if the situation has not changed. CBT has an educational focus and teaches rational self-counseling skills.

What does the research say about CBT for the treatment of chronic pain?

Studies show that a patient’s report of chronic pain intensity is far more about that individual’s capacity to manage his or her pain than it is about stimulation of nociceptors (source: Wilbur Fordyce, PhD c 1970). Additional studies show that patients experience between 30% to 60% reduction in pain intensity by learning and applying CBT techniques (source: David Tauben, MD, UW Center for Pain Relief). This compares favorably to the estimated efficacy of 30% for chronic opioids.

What are some of the key components of CBT for patients with CCNP?

In general, CBT for chronic pain works to reduce patients’ pain, distress, and pain behavior while improving their daily functioning. Components of CBT may include helping patients to decrease negative emotional responses to pain and perceptions of disability while increasing their acceptance of pain and orientation toward selfmanagement. CBT helps patients change the way they relate to pain so they can experience life more fully.

What is the goal of CBT for patients with CCNP?

Two fundamental concepts are at play. One is that a person must accept the aspects of the pain that cannot be changed, including all the difficult thoughts, feelings, and bodily sensations that come with it. The second is that this acceptance allows for the possibility of the patient opening to the pain and committing to acting in ways that make the patient feel vital and energized. Learning to accept pain to live life is often referred to as “victory by surrender.”

Source: Living Beyond Your Pain by J. Dahl and T. Lundgreen, 2006

OPIOID MANAGEMENT STRATEGIES

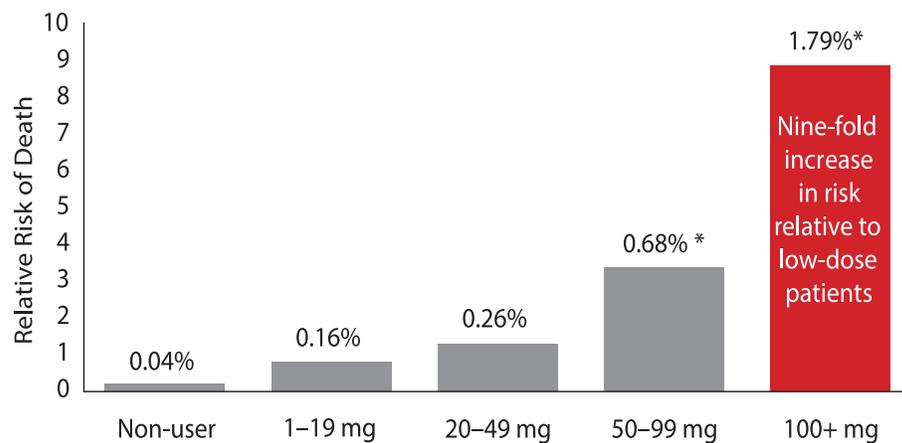
Pharmacological Treatment and Tools

This section provides tools and resources for patients who are currently being treated with opioids and for those who are at low-risk of misuse. The basic principles of using opioids for chronic pain management can be summarized by the phrase start low, go slow. Sometimes, intermittent use of a short-acting opioid may be preferable to daily, continuous use of long-acting opioids. Notice on the daily Morphine Equivalency Dose (MED) mortality graph to the right that overdose deaths increase dramatically as the MED dose gets above 50mg per day. There is little evidence that most people achieve significant improvement in CCNP with higher doses.

The Importance of MED

Significant Increment in Risk $p < 0.05^*$

Source: Dunn et al., Annals of Int. Med., 2010.



Pharmacological Considerations in Chronic Opioid Therapy (COT)

Under limited circumstances, patients can benefit from chronic opioid use. In these situations, please consider the following:

Opioid Selection

- › Consider previous treatment.
- › Start with short-acting medications.

Managing Doses and Expectations

- › Consider a 30 percent pain reduction with narcotics alone to be a success.
- › Keep total daily dose below 120mg MED.
- › Refer to www.oregonpainguidance.org for other resources and links.

Conversion/Rotation of Opioid

- › Consider alternate opioid if treatment goal is not reached.
- › Some opioids will not be as effective in some patients due to variations in CYP2D6 enzymes.
- › Use clinical calculators such as: <http://agencymeddirectors.wa.gov/mobile.html>.
- › Monitor periodically according to risk group. Refer to Opioid Risk Stratification table on page 21.

Discontinuation and Tapering

Please refer to the Tapering section, beginning on page 23, for more information as well as the Tapering Flowchart on page 8.

Safety and Concerns

- › Total daily acetaminophen dose should not exceed 2500mg, long term (1500mg for patients with liver disease/ alcohol misuse).
- › Benzodiazepines: Discontinue sedative medications to reduce risk of fatal drug-drug interactions. Discontinuing benzodiazepines can be difficult and prolonged. Residential treatment may be necessary. For additional guidance, visit: www.benzo.org.uk/manual.
- › Drug-specific considerations:
 - **Hydromorphone**. Increased risk of unintentional overdose.
 - **Tramadol**. Increased risk of seizures (especially with SSRIs).
 - **Meperidine**, Neurotoxic metabolite; its use is discouraged.
 - **Methadone**. Long half-life, can prolong Q/T interval, unpredictable dosing, high-dose/lethality ratio. This drug is overrepresented in overdose statistics, and its use should be restricted. The dose for the treatment of chronic pain in an outpatient setting should be limited to 40mg per day or fewer.
 - **Fentanyl**. Not appropriate for opioid-naïve patients. Be aware that the patches can be cut, licked, and abused.
 - For geriatric patients, refer to the AGS Beers Criteria at: www.americangeriatrics.org/files/documents/beers/PrintableBeersPocketCard.pdf.
 - **Naloxone (Narcan)**. Recent legislation in Oregon allows naloxone to be prescribed to individuals who may witness a friend's or relative's opioid overdose (similar to the situation with epinephrine or glucagon for emergency use by lay people). There is excellent data concerning successful overdose rescues when naloxone is available to this population. The medication is available as I.M. or intra-nasal spray. The Oregon Health Plan will pay for Naloxone. We strongly recommend that you consider prescribing naloxone to family members, friends, or others who may accompany your chronic opioid patients to appointments.

Morphine Equivalent Dose

Opioid doses above the MED of 120mg are associated with greater adverse outcomes without a corresponding increase in benefit. The Washington State Agency Medical Directors' Group has developed a calculator to help clinicians determine the total daily MED dose for their patients. This is an approximation of equivalency and caution should be exercised when adjusting medications. Methadone should be treated separately since its pharmacodynamics are widely variable.

www.agencymeddirectors.wa.gov/Files/DosingCalc.xls

MED for Selected Opioids

Opioid	Approximate Equianalgesic Dose (oral and transdermal)*
Morphine (reference)	30mg
Codeine	200mg
Fentanyl transdermal	12.5mcg/hr
Hydrocodone	30mg
Hydromorphone	7.5mg
Methadone	Chronic: 4mg †
Oxycodone	20mg
Oxymorphone	10mg

*Adapted from VA 2003 and FDA labeling

†Equianalgesic dosing ratios between methadone and other opioids are complex; thus, requiring slow, cautious conversion (Ayonrinde 2000).

Source: Interagency Guideline on Opioid Dosing for Chronic Non-Cancer Pain, 2010 Update, page 16, Table 4. Available at:

www.agencymeddirectors.wa.gov/opioiddosing.asp.

Medication Refill Considerations

For more information on side effects, contraindications, and other pharmacy-related issues, consult a pharmacist. Before refilling a prescription, clinicians are encouraged to:

- › Calculate and document the total morphine equivalent dose (MED); doing this can help assess the magnitude of seemingly small incremental dosage changes over time.
- › Calculate and document the total acetaminophen dose (including prescribed and over the counter):
 - Acute use: Maximum single dose 1000mg, maximum daily dose 4000mg. (For elderly patients and patients with alcohol or liver disease, maximum single dose 650mg, maximum daily dose 2000mg.)
 - Long-term use (>10 days): Maximum daily dose 2500mg.
- › Follow best prescribing practices:
 - Order medication in multiples of 7 days and include “to last __ days.”
 - Provide specific instructions (e.g., schedule for taking).
- › Ask patients about potential medication problems or concerns related to chronic opioid therapy.

Clinicians involved in treating a patient on COT are expected to clarify—both among themselves and for the patient—which clinician holds primary responsibility for prescribing.

An electronic Morphine Equivalent Dose Calculator is available at:

www.agencymeddirectors.wa.gov/Files/DosingCalc.xls

All conversions between opioids are estimates generally based on “equianalgesic dosing,” or ED. Patient variability in response to these EDs can be large, due primarily to genetic factors and incomplete cross-tolerance. Additionally, methadone has unique characteristics that make it difficult to translate dose to MED.

Patient Education

All candidates for chronic opioid therapy must be informed of the side effects of opioids, your policies, and the patient’s responsibilities.

See page 34, Questions to Use with Patients, to facilitate a discussion with each patient. Before prescribing opioids, the state of Oregon requires that both patient and provider sign a Material Risk Notice (see Appendix G on page 53).

In addition to the Material Risk Notice, a treatment agreement is a tool that many providers use to manage opioid treatment. If a patient refuses to sign your treatment agreement, consider that a red flag.

Treatment Agreements

There are some variations in treatment agreements, but all have the following essential components in common. Sample agreements can be found in Appendix F on page 48.

- › Patients should utilize one prescriber and one pharmacy.
- › No early refills and no telephone refills.
- › Expect certain monitoring: pill counts, recall visits, and UDSs.
- › Behavioral expectations: following advice, respectful behavior, and working toward goals.
- › Consequences for concerning behaviors: substance abuse referrals, increased scrutiny, or discontinuation of opioid prescribing (without dismissal from care).

Opioid Risk Stratification

Risk stratification is based on several factors: the opioid dosage level, whether misuse of prescribed opioids has been observed, and whether there is a personal or family history of substance abuse or mental health problems. Using the table below, you can determine whether a patient is in the high-, moderate-, or low-intensity monitoring group. For moderate- and high-risk patients, more frequent monitoring is needed, and it is standard practice to use UDSs. The monitoring frequency shown in the following table is quite conservative. Many providers require more office visits for patients receiving chronic opioid prescriptions.

HIGH RISK

High-intensity monitoring (3+ visits per year)	Recommended steps
Dose: More than 100mg MED per day, or more than 40mg per day for methadone Or elevated opioid misuse/safety risk: <ul style="list-style-type: none"> › Opioid misuse or substance abuse › Losing prescriptions or borrowing opioids › Demanding opioids or getting opioids from multiple prescribers and pharmacies › Recurring emergency department visits 	<ul style="list-style-type: none"> › Increase frequency of follow-up and monitoring to assess stability and to look for misuse or opioid-related problems. › At least two UDSs per year. › Pill counts at all visits.

MODERATE RISK

Moderate-intensity monitoring (2+ visits per year)	Recommended steps
Dose: 41–100mg MED per day Intermediate opioid misuse/safety risk: <ul style="list-style-type: none"> › Personal or family history of alcohol or drug abuse or mental health issues 	<ul style="list-style-type: none"> › Increase frequency of monitoring if there is opioid misuse or opioid-related problems. › At least one UDS per year.

LOW RISK

Low-intensity monitoring (1+ visit per year)	Recommended steps
Dose: Less than 40mg MED per day Low opioid misuse/safety risk: <ul style="list-style-type: none"> › Compliant with treatment agreement › No personal or family history of alcohol or drug abuse › No mental health diagnoses 	<ul style="list-style-type: none"> › Safe to begin or continue opioids. › Recommend UDS and pill counts. › Maintain vigilance for adverse medical and psychosocial effects. › Re-evaluate if risk factors of aberrant drug use are observed.

STOP! REASSESS.

Prescribing opioids in the following situations can be dangerous.

USE CAUTION

Re-evaluate your treatment plan and/or seek help from specialists if you:

- › Prescribe more than 120mg MED per day without obvious functional improvement
- › Prescribe opioids with benzodiazepines, carisoprodol, or alcohol
- › Prescribe more than 40mg of methadone per day
- › Or if your patient shows signs of significant misuse or illicit drug use.



TAPERING

Opioid Taper/Discontinuation

Opioid therapy should be tapered down or discontinued if any of the following situations occur:

- A. The medication fails to show significant analgesia despite incremental dose increases.
- B. MED is in excess of 120mg. or methadone dose is in excess of 40mg, without clear sustained improvement in pain and function.
- C. Trials of different opioids at equivalent doses fail to provide adequate analgesia.
- D. Significant physical risk factors are present (sleep apnea, prolonged QT, pulmonary disease, etc.).
- E. Side effects of medication are interfering with quality of life.
- F. Patient request.
- G. Evidence of misuse, abuse, diversion, or other behavioral/psychological dysfunction.
- H. Other violations of opioid agreement.

Opioids should be weaned, rather than abruptly stopped, after chronic use (30 days or greater). When opioids are being sold, injected, used in a dangerous or clearly illegal fashion, immediate discontinuation should be undertaken for patient safety and compliance with the law. Referral to a medication-assisted treatment program (methadone or buprenorphine) may be a safer and more appropriate treatment consideration under these circumstances.

Some providers have found the following dialogue useful when explaining the process to patients:

“ Medical knowledge changes over time, and just as we have discovered that some of our recommendations today concerning the treatment of cancer or heart disease are different from 10 years ago, the same is true of the treatment of chronic pain. We now know that it can be dangerous to take large amounts of opioids every day. We have also learned that pain relief with high doses may not be any better than with lower doses of pain killers. ”

General Considerations

- › Some short-term increase in pain is to be expected during the tapering process. This is usually transient, and after achieving a reduced baseline dose, the patient is likely to experience decreased medication-related side effects and a reduced risk of unintentional overdose, without an increase in pain. Many times, opioids may be completely discontinued with no increase in pain, but improved function and quality of life.
- › The slower the taper, the less the short-term discomfort. Educating the patient about the risks of their current regimen and what to expect as they taper off the medications is often/can be helpful.
- › Some highly motivated patients prefer a rapid taper (weeks versus months). Patient preference needs to be considered in designing a tapering schedule.

- › Psychosocial support is an essential component of successful medication withdrawal for patients who have been on long-term opioid therapy. Discussions about weaning are often associated with fear and anxiety about the recurrence or worsening of pain and/or the development of other withdrawal symptoms. Reassure the patient that supportive adjunctive treatment of withdrawal will be provided as needed, and may be quite helpful, but set expectations that this will not include replacement medications such as other opioids or benzodiazepines. Certain medications that treat autonomic responses, medications such as clonidine, loperamide, or hydroxyzine may be useful short-term adjuncts.
- › Patient empowerment is key to success. Involve patients in the planning from the beginning. Elicit suggestions from them for healthful activities that can replace reliance on medications.
- › Certain therapies, CBT and Living Well With Chronic Illness workshops, for example, can be quite helpful in supporting patients through the tapering process and beyond.
- › The last part of the dosage reduction is the most difficult for the patient. This is a phenomenon that is true for many psychoactive drugs. The prescriber and the patient should anticipate this, and utilize supports that are meaningful to the patient. In motivated patients, a slow-down of the tapering process may be necessary toward the end. Liquid forms of medication can be helpful for more precise dosing and can be obtained from a compounding pharmacy.

Early Symptoms of Opioid Withdrawal

- Agitation
- Anxiety
- Muscle aches
- Increased tearing
- Insomnia
- Runny nose
- Sweating
- Yawning

Late Symptoms of Withdrawal

- Abdominal cramping
- Diarrhea
- Dilated pupils
- Goose bumps
- Nausea
- Vomiting

Initial Steps

- 1 Calculate the MED, review the ORT and patient progress in treatment, including UDS, PDMP, and any signs of aberrant behavior. Use that review to inform the patient concerning the appropriateness of tapering. Involve the patient in the creation of his or her new care plan.
- 2 Sometimes, giving the patient some time to assimilate this new information may be appropriate. Starting the taper at the follow-up visit may help to build trust.
- 3 Patients at risk for aberrant behaviors during the tapering process (suicidality, illicit drug use, loss of impulse control) will need referral to a behavioral health specialist prior to the initiation of the taper. It is helpful to work in parallel with such behavioral specialists during the tapering process for those patients.
- 4 Document your plan and the reasons for the taper in the chart note, and provide appropriate information to your patient.
- 5 Medication tapering may be a very stressful experience for patients. Close monitoring for aberrant behaviors is critical during this period to assure patient compliance and safety. Misuse of medications, use of illicit drugs, and “doctor shopping” may necessitate a change in approach, requiring a switch from a tapering strategy to substance abuse treatment (residential care or medication-assisted treatment, such as buprenorphine).

Slow-Taper Protocol

- 1 Long-acting opioids: Decrease total daily dose by 5–10% of initial dose per week.
- 2 Short-acting opioids: Decrease total daily dose by 5–15% per week.
- 3 These regimens may need to be slowed toward the end of the tapering process (see General Considerations above). Often, once 25–50% of the total dose is reached, the rate of taper can be slowed to 5% per week.
You and your patient should know the signs and symptoms of opioid withdrawal. Some of those symptoms may be present during this process, and can be controlled by support medication, psychosocial supports, or slowing the tapering process.
Remain engaged with the patient through the taper and provide psychosocial support as needed. Peer-to-Peer, Living Well With Chronic Pain workshops, group visits, CBT, and other counseling modalities may be quite helpful.
- 4 Consider the following adjuvants as needed:
 - Antidepressants to manage irritability, sleep disturbance (e.g. Trazodone)
 - Hydroxyzine for insomnia and anxiety
 - Anti-epileptics for neuropathic pain
 - Clonidine for autonomic withdrawal symptoms such as rhinorrhea, diarrhea, sweating, tachycardia, hypertension
 - NSAIDs for myalgia (e.g., Ibuprofen)
 - Anti-diarrheal agents for diarrhea

Special Considerations for Methadone

Methadone withdrawal symptoms take longer to manifest due to the very long and unpredictable metabolism of the drug. Patients may be overconfident early in the tapering process, only to experience severe withdrawal over time. The same principles of opioid tapering are true for methadone; although, a more drawn-out taper may be necessary. Understanding the unique metabolic characteristics of methadone will be helpful for the patient and provider to achieve a successful dosage reduction.

Benzodiazepine Taper/Discontinuation

Benzodiazepines are potentially addictive drugs that can produce physical dependence, amnesia, emotional blunting, psychomotor retardation, and synergistic respiratory depression when combined with opioids. Anxiety, although initially ameliorated by benzodiazepines taken short term, often returns to near baseline levels with chronic use. Patients may be reluctant to taper off of these medications, fearing the exacerbation of anxiety that usually accompanies the dose reduction process.

Unlike opioids, abrupt withdrawal from high doses of benzodiazepines can result in seizures and death. The detoxification resembles alcohol withdrawal in terms of symptomatology and risk. Some patients will need medically supervised residential treatment to successfully discontinue benzodiazepines.

Withdrawal: The longer the treatment, the higher the dosage, the shorter the half-life, or the faster the taper, then the more likely the patient will have withdrawal symptoms. Even small doses of benzodiazepines taken chronically may produce uncomfortable symptoms if discontinued abruptly.

Common Benzodiazepine Withdrawal Symptoms

Anxiety	Restlessness	Agitation	Fatigue/Lethargy
Nausea	Loss of Appetite	Diaphoresis	Insomnia
Faintness/Dizziness	Tremor	Tinnitus	Increased Acuity to Stimuli
Muscle Cramps/Twitches	Poor Coordination	Difficulty Concentrating	Paresthesia
Perceptual Distortions	Depersonalization	Confusion	

General Considerations

- › Some short-term increase in anxiety is to be expected during the tapering process. This is usually transient, and after achieving a reduced baseline dose, the patient is likely to experience decreased medication-related side effects without an increase in anxiety. Many times, benzodiazepines may be completely discontinued with no increase in symptoms, but improved function and quality of life.
- › The slower the taper, the less the short-term discomfort. Educating the patient about the risks of their current regimen and what to expect as they taper off the medications is often/can be helpful.
- › Some highly motivated patients prefer a rapid taper (weeks versus months). Patient preference needs to be considered in designing a tapering schedule.
- › Psychosocial support is an essential component of successful medication withdrawal for patients who have been on long-term benzodiazepine therapy. Discussions about weaning are often associated with fear and anxiety about the recurrence or worsening of anxiety and/or the development of other withdrawal symptoms.

Reassure each patient that supportive adjunctive treatment of withdrawal will be provided as needed, and may be quite helpful, but set expectations that this will not include dangerous replacement medications. Certain non-habit forming medications that treat insomnia specifically (such as Trazodone or Hydroxyzine) might be useful.

- › Patient empowerment is key to success. Involve them in the planning from the beginning. Elicit suggestions from patients for healthful activities that can replace reliance on medications.
- › Certain therapies, CBT and trauma-focused care, for example, can be quite helpful in supporting patients through the tapering process and beyond.
- › The last part of the dosage reduction is the most difficult for patients. This is a phenomenon that is true for many psychoactive drugs. Prescribers and patients should anticipate this, and utilize supports that are meaningful to patients. In motivated patients, a slow-down of the tapering process may be necessary toward the end. Liquid forms of medication can be helpful for more precise dosing and can be obtained from a compounding pharmacy.

Discontinuation Strategies

Here are two strategies that can be used to taper off of benzodiazepines:

- 1 Switching to a long-acting benzodiazepine (or phenobarbital) and taper (slow taper).
- 2 Simultaneous treatment with an anti-epileptic drug during taper (allows for a more rapid taper).

Special Circumstances

Consider inpatient/medical residential treatment in patients with significant substance abuse history, history of benzodiazepine overdose, seizure disorder, or illicit benzodiazepine use. Modified CIWA evaluation or MSSA (withdrawal scoring systems), can be used in such circumstances to determine the total 24-hour dose needed to begin the taper and provide safe medical monitoring of the taper process.

Slow-Taper Method

See Ashton Manual (www.benzo.org.uk/manual) for more detailed instruction on this method of reduction.

- 1 Calculate the dose equivalence of the current benzodiazepine into clonazepam, diazepam, or phenobarbital long-acting drug: (www.benzo.org.uk/bzequiv.htm). Provide behavioral support to the patient during the tapering process above (see General Considerations concerning opioid tapering).
- 2 Switch the patient from the short-acting drug to the longer-acting drug. Be conservative in estimating the long acting dose since variation in metabolism may create safety issues. Consider a reduction of 25–50% of the calculated dose for initiation of tapering.
- 3 See the patient for a return visit a few days after initiating the taper to be sure your dose equivalency is appropriate.
- 4 Reduce the total dose of the long-acting agent by 5–10% per week in divided doses.
- 5 Consider slowing the taper to 5% or less per week when the dose has been reduced to 25–50% of the starting dose.
- 6 Consider adjunctive agents to help with symptoms: trazodone, buspirone, antidepressants, hydroxyzine, clonidine, neuroleptics, and alpha blocking agents, have all been found useful.

BENZODIAZEPINE EQUIVALENCY CHART

Drug	Action Onset	Peak Onset (hrs)	Half-life (hrs)	Eliminator	Dose Equivalent
Long-Acting					
Chlordiazepoxide (Librium)	Int	2–4	5–30 (parent); 3–100 (metab)	Oxidation	10mg
Diazepam (Valium)	Rapid	1	20–50 (parent); 3–100 (metab)	Oxidation	10mg
Flurazepam (Dalmane)	Rapid	0.5–2	47–100 (metab)	Oxidation	30mg
Intermediate-Acting					
Alprazolam (Xanax)	Int	0.7–1.6	6–20 (parent)	Oxidation	0.5mg
Clonazepam (Klonopin)	Int	1–4	18–39 (parent)	Oxidation	0.5mg
Lorazepam (Ativan)	Int	1–1.5	10–20 (parent)	Conjugation	1mg
Oxazepam (Serax)	Slow	2–3	3–21 (parent)	Conjugation	15mg
Temazepam (Restoril)	Slow	0.75–1.5	10–20 (parent)	Conjugation	30mg
Short-Acting					
Triazolam (Halcion)	Int	0.75–2	1.6–5.5 (parent)	Oxidation	0.5mg

Onset of Action: Rapid = within 15 min; Intermediate = 15–30 min; Slow = 30–60 min.

Rapid-Taper Method

- 1 Pre-medicate 2 weeks prior to taper with valproate 500mg BID or carbamazepine 200mg every AM and 400mg every HS. Plan to continue this medication for 4 weeks post-benzodiazepines. Follow all the usual safeguards (lab testing and blood levels) when prescribing these medications.
- 2 Utilize concomitant behavioral supports.
- 3 Discontinue the current benzodiazepine treatment and switch to diazepam 2mg BID x 2 days, followed by 2mg every day x 2 days, then stop. For high doses, may begin with 5mg BID x 2 days and then continue as described.
- 4 Use adjuvant medications as mentioned above for rebound anxiety and other symptoms.

SPECIAL ISSUES

Special Issues and Populations

Patients with Cancer and Other Painful, Terminal Conditions (Palliative Care)

Many of the recommendations in these guidelines are not necessary or appropriate for patients dying from painful, progressive conditions. The goal for treatment of CCNP is to improve function. The goal of treatment for cancer pain, however, is to improve comfort. Escalating doses and high MEDs are not unusual in these circumstances. Care must still be taken to ensure that your medication is going to your patient, but the risk/benefit balance is not the same as it would be in a patient with the expectation of years of productive life.

Treatment of Acute Pain

Unlike chronic pain which has a large non-nociceptive component, acute pain is primarily driven by tissue injury. Adequate analgesia is the goal of acute pain treatment, but should be time limited. Experienced clinicians can judge the average length of time that an acute injury should require opioids, and a step-down approach to nonopioid analgesics is recommended after that time. The WHO analgesic ladder is a helpful guideline, and can readily be found at various Internet sites.

Opioid Use During Pregnancy

Opioid withdrawal during pregnancy is to be avoided. Keep in mind that pregnant women often feel guilty about their drug use and may under-identify the amounts being used. In these cases, the risk of withdrawal may be greater than the woman acknowledges. All women should be screened during pregnancy with UDSs as well as questionnaires such as 5Ps Screening (to assess substance abuse during pregnancy). If there is any question about opioid dependency, a professional evaluation should be undertaken. Methadone and buprenorphine are the preferred treatment options for opioid dependency during pregnancy. Be sure to ask patients about other substance abuse (such as benzodiazepines) that may require specific treatment modalities.

Metabolic changes may occur during pregnancy, so women on methadone treatment regimens may find they need a higher dose, and/or a split dose, to maintain sobriety during pregnancy.

Neonatal Abstinence Syndrome (NAS) is common after delivery when a woman is on methadone maintenance during pregnancy. Buprenorphine is associated with reduced risk of NAS, but has a somewhat lower acceptance rate for pregnant women. The use of medications during pregnancy must be individualized for each woman in terms of efficacy and safety.



Managing Patients in the Emergency Department

The Oregon Chapter of the American College of Emergency Physicians has created a set of guidelines regarding the use of opioids in a hospital emergency department (ED). Emergency medical providers (EMPs) should be supported and should not be subject to adverse consideration when respectfully adhering to these guidelines.

- 1 Only one medical professional should provide all opioids to treat a patient's chronic pain, to the extent possible.
- 2 The administration of intravenous and intramuscular opioids in the ED for the relief of acute exacerbations of chronic pain is discouraged.
- 3 EMPs should not provide replacement prescriptions for controlled substances that were lost, destroyed, or stolen.
- 4 EMPs should not provide replacement doses of methadone for patients in a methadone treatment program.
- 5 Long-acting or controlled-release opioids (e.g., oxycodone [OxyContin], fentanyl patches, and methadone) should not be prescribed by EMPs.
- 6 EMPs are encouraged to access the online Oregon PDMP.
- 7 EMPs should exercise caution when considering prescribing opioids for patients who present to the ED without a government-issued photo ID.
- 8 Primary care and pain-management physicians should make patient pain agreements accessible to local EDs and work to include a plan for pain treatment in the ED.
- 9 EDs should coordinate the care of patients who frequently visit the ED, using an ED care coordination program, to the extent possible.
- 10 EDs should maintain a list of clinics that provide primary care for patients of all payer types and should refer patients with chronic pain to primary care.
- 11 EDs should perform screening, brief interventions, and treatment referrals for patients with suspected prescription opiate abuse.
- 12 The administration of meperidine (Demerol) in the ED is discouraged.
- 13 For exacerbations of chronic pain, the EMP should contact the patient's primary opioid prescriber or pharmacy, if possible. If prescribing, the EMP should prescribe only enough pills to last until the patient is reasonably able to follow up with his or her primary opioid prescriber.
- 14 Prescriptions for opioid pain medication from the ED for acute injuries, such as fractured bones, should be in an amount that will last until the patient is reasonably able to receive follow-up care for the injury. In most cases, this should not exceed 30 tablets.
- 15 ED patients should be asked about past or current substance abuse prior to the EMP prescribing opioid medication for acute pain. Opiates should be prescribed with great caution in the context of substance abuse.
- 16 EMPs are required by law to evaluate an ED patient who reports pain to determine whether an emergency medical condition is present. If an emergency medical condition is present, the EMP is required to stabilize the patient's condition. The law allows the EMP to use his or her clinical judgment when treating pain and does not require the use of opioids.

Medication-Assisted Treatment (MAT)

- › Methadone and buprenorphine/Suboxone are provided under direct medical supervision at federally sanctioned treatment programs. MAT programs operate under strict governmental oversight allowing higher doses than would be considered safe in a providers office setting.
- › Buprenorphine/Suboxone is offered by a number of specially trained physicians. Training may be acquired online at www.buprenorphine.samhsa.gov/training. General information can be obtained at www.buppractice.com.
- › Naltrexone by injection can be prescribed by providers without special licensure requirements.

Managing Patients on Opioids and Benzodiazepines

Managing New Patients Who Are Already on Opioids

These patients present a unique challenge as well as a unique opportunity. All of the guidelines described earlier apply to these patients, with an emphasis on evaluating prior records before prescribing. You should determine the reason why the patient left the previous practice and confirm relevant facts with the previous provider. The PDMP and a UDS will also be helpful to determine the risk of abuse or misuse. In any event, you should rarely prescribe opioids for such a patient or any other patient on the first visit. This should be part of your office policy, and your receptionist should alert patients to this when appointments are made.

Prescribing opioids for chronic pain is a long-term therapeutic commitment, so be sure you are following the right course of action at the outset.

Concomitant Benzodiazepine (All Sedative Hypnotics) and Opioid Use

Most experts advise against concomitant use of benzodiazepines (BZPs) and opioids because of the synergistic effect of those drugs, resulting in respiratory depression. In addition, the anterograde amnesia that is inevitable with benzodiazepines can lead to inadvertent overdose for predisposed individuals. Whatever the reason, 50 percent of Jackson County opioid overdoses have been associated with concomitant benzodiazepine use. It is strongly recommended that the prescriber check for BZP use by UDS as well as observe for impairment or sedation. Intensive therapy, often requiring inpatient treatment, may be necessary to achieve cessation. Many patients who are dependent on benzodiazepines have a difficult time abstaining from these drugs. Other sedative hypnotic substances (such as alcohol, barbiturates, and carisoprodol) have similar risks.

Concomitant Marijuana and Opioid Use

Medical marijuana is legal in Oregon and many other states. It is still illegal, however, under federal law. Marijuana is clearly a mind-altering drug, and though it may provide mild to moderate pain relief, it does have associated risks and side effects, such as altered response times, perceptual changes, and mood changes. In some circumstances, marijuana use may be associated with other illicit or risky drug use.

Some providers do not prescribe chronic opioids when marijuana is used (the patient has to choose which treatment modality to use). Others decide not to include THC in their UDS so as not to create a conflict with their patients. Others believe that marijuana may provide appropriate additional pain relief. Most providers in southern Oregon have chosen not to prescribe opioids for CCNP in patients who also use marijuana. (See Tapering section.)

Medications of Special Merit

Sleeping pills (“Z” drugs)

The “Z” drugs (zolpidem/Ambien, zaleplon/Sonata, eszopiclone/Lunesta) are indicated for the short term treatment of insomnia. These medications are not benzodiazepines (benzos) but they do act on the same receptors as benzos, and yet have a somewhat different risk profile (reduced seizure risk with withdrawal for example). Many of the adverse effects of benzos are true for the “Z” drugs as well: drowsiness, memory impairment, reduced coordination, depression, and sleep disturbances. Like benzodiazepines, there is an increase in all of these effects with elderly and pediatric patients. There is an increased risk of impairment and overdose when these drugs are combined with other CNS depressants like alcohol, benzos, or opioids.

It is easy to become dependent on these medications, and it can be difficult to return to normal unaided sleep when discontinuing use. There are safer medical alternatives as well as non-pharmacological options that can be explored.

When considering prescribing “Z” drugs:

- › Avoid use in patients already on benzodiazepines, opioids, or stimulants.
- › Use the lowest dose possible:
 - Avoid prescribing these for children and adolescents
 - Use cautiously and at the lowest doses in the elderly
- › Prescribe for only short intervals

Tramadol (Ultram)

This is an opiate-like analgesic, used to treat moderate to severe pain. Many of the risks associated with opioids (respiratory depression, synergy with sedative-hypnotics) are true for tramadol. In addition, there is the risk of precipitating a seizure with this drug. Despite the fact that this is a non-scheduled drug, it can cause physical and psychological dependency with numerous reports of abuse. Here is a direct quote from the DEA:

Tramadol hydrochloride may induce psychic and physical dependence of the morphine-type (μ -opioid). Dependence and abuse, including drug-seeking behavior and taking illicit actions to obtain the drug are not limited to those patients with prior history of opioid dependence. The risk in patients with substance abuse has been observed to be higher. Tramadol hydrochloride is associated with craving and tolerance development. Withdrawal symptoms may occur if tramadol hydrochloride is discontinued abruptly.

We recommend that tramadol be treated as other true opioids when evaluating risks and benefits of opioid treatment.

Carisoprodol (SOMA)

A muscle relaxant with properties and risks similar to benzodiazepines, with similar habit forming properties. Although not previously scheduled, it is now a schedule IV drug, and should be used cautiously, especially in combinations with opioids. It has been removed from the market a number of countries worldwide, and the EU recommends it not be used for the treatment of low back pain. For the purposes of these guidelines consider carisoprodol the equivalent of benzodiazepines.

Recommended Opioid Policy for Dentists

Pain management is routinely required for some dental procedures. Patients must receive respectful care and appropriate management of dental pain. Most often, dental pain management is for acute or episodic situations, requiring short-term prescribing. For many conditions, ibuprofen, acetaminophen, or a combination of the two will suffice for dental pain. In other circumstances, a very small amount of narcotic medications followed by OTCs will provide appropriate pain relief.

General Guidelines

- 1 Prescribe opioids cautiously to those with a substance abuse history.
- 2 Ask if patients are getting medications from other doctors, and use the PDMP prior to prescribing opioids whenever possible.
- 3 Do not prescribe opioids to patients in substance abuse treatment programs without consulting the program's medical staff.
- 4 Do not offer prescriptions with refills. Use caution if replacing prescriptions that were lost, destroyed, or stolen.
- 5 Prescribing over the phone is discouraged, especially with patients you have not met, except in rare cases involving known invasive surgery.
- 6 The use of non-combination opioids is discouraged.
- 7 If prescribing opioids, prescribe pills only in small dosages, which in most cases should not exceed 16 tablets.
- 8 When prescribing an antibiotic with the opioids, stipulate that the narcotic must be filled with the antibiotics at the pharmacy.
- 9 Inform patients how to secure medication against diversion and how to dispose of leftover medication.
- 10 Narcotics should not be prescribed more than seven days after the last appointment. It is strongly recommended that the patient be assessed in the clinic prior to providing narcotic (same or different narcotic) refills.
- 11 A second refill (same or different narcotic) request should require that the patient be assessed in the dental clinic and only be provided once a supporting diagnosis to continue with narcotic pain management is established.
- 12 Third refills are strongly discouraged (except in unusual clinical circumstances that are well documented, such as osteonecrosis management); consider need for chronic pain management by physician.
- 13 Prolonged pain management (while awaiting specialty care) should be managed by and/or coordinated with the patient's primary care provider.

DIFFICULT CONVERSATIONS

Questions to Use with Patients

Consider questions like these when evaluating patients being considered for Chronic Opioid Treatment (COT) or monitoring patients already receiving COT.

Assessment/Monitoring Questions

In the past month:

- › In general, how would you say your health has been? (On a scale of poor, fair, good, very good, or excellent.)
- › How much has pain interfered with your daily activities?
- › Use a scale from 0 to 10, where 0 is “no interference” and 10 is “unable to do any activities.”
- › On average, how would you rate your pain?
- › Use a scale from 0 to 10, where 0 is “no pain” and 10 is “pain as bad as could be.”

Assessing Goals for Pain Management

- › Other than reducing pain, what is the most important goal (or goals) you hope to achieve to improve your quality of life?
- › To what extent have you reached this goal (or these goals)? (0-100%.)

Assessing Medication Effects and Expectations

- › How well has the opioid pain medicine worked to relieve your pain?
- › Have you been bothered by any side effects?
- › How long do you expect to continue using this medicine?

Assessing Patient Problems and Concerns

Problems with Opioids	Concerns about Opioids
Have opioid pain medicines caused you to: Lose interest in your usual activities? Have trouble concentrating or remembering? Feel slowed down, sluggish, or sedated? Feel depressed, down, or anxious? Have difficulty thinking clearly? Have side effects that interfered with work, family, or social responsibilities? Be sleepy or less alert when driving, operating machinery, or doing things when you needed to be alert?	Have you been preoccupied with or thought constantly about using opioid pain medicine? Have you felt you could not control how much or how often you used the medicine? Have you needed to use a higher dose of the medicine to get the same effect? Have you worried that you might be dependent on or addicted to the medicine? Have you wanted to stop using the medicine or to cut down on the amount that you use? Has the medicine caused you to have problems with family, friends, or co-workers? Have family members or friends thought you might be dependent on or addicted to this medicine?

Source: Group Health, Chronic Opioid Therapy for Chronic Non-Cancer Pain Guideline, 2010.

Assessing Patient Psychological Well-Being

Over the last two weeks, how often have you been bothered by:

- › Little interest or pleasure in doing things?
- › Feeling down, depressed, or hopeless? (Not at all, several days, more than half the days, nearly every day.)

Recommendations for Approaching and/or Responding to Potentially Challenging Patient Interactions

It is understandable and predictable for patients to express concern when they are presented with the information that they may need to reduce or eliminate opioids for the treatment of their pain. Sometimes, their reactions become more desperate as the conversation persists. Consider:

Instead of feeling “responsible” for your patient’s pain and suffering, do all you can do to remain “response-able” and show your patient you care about his or her health.

Common Patient Responses to the Request to Change Their Treatment Regimen

I First-line negotiations:

- “You are telling me to _____ (exercise, go to therapy, etc.), and I am telling you that without the pills I can’t even get out of bed.”
- “You know this means I won’t be able to go to work. Is that what you want for me, to lose my job?”
- “Taking these pills is the only way I can manage to take care of my children. You do understand that you are taking their mother/father away from them?”

II Second-line negotiations:

- “Are you saying you are just going to let me suffer?”
- “You have no idea how much pain I am in. You are not in my body.”
- “This isn’t fair. You promised you wouldn’t reduce my medications, and you are going back on your word.”

III Final desperation negotiations/threats:

- “Do you want me to go get drugs from the street?”
- “Well, I am just going to go to the ER.”
- “I will be finding nother provider, who believes me and cares!”

Such patient reactions can be very challenging for healthcare providers to manage. This area of medicine is often highly anxiety-provoking, and providers are often not sure what is the right thing to do. It is even possible for highly confident providers to begin to second guess themselves when it comes to making decisions that patients won’t like, but are in their safest and best interest.

Suggestions on How to Compassionately Manage Patients Who Are Confronting These Situations

I. Before going into the patient room

- 1 Pause and consider what value this challenging conversation will be in the service of: Perhaps it is related to your commitment to practice safe medicine, “Primum Non Nocere,” to follow “best practices”, to be in alignment with your colleagues, community, and/or practice in this area?
- 2 Be clear on the outcome you hope to reach. If possible, come up with at least three choices you can live with.
- 3 Decide if you will “hold the line” with your goal. Flexibility is valuable as long as it adheres to safety principles.
- 4 If the patient senses any hesitation and/or ambivalence from the provider, the patient is likely to move into “negotiation,” which is lengthy and frustrating for all involved.

II. While in the room with the patient

- 1 Elicit patient perspective on how their chronic pain care is going.
- 2 Share your concerns, framed around safety (consider having a prepared and practiced, concise description of the new and safe opioid prescribing guidelines for CCNP).
- 3 Ask the patient to relay back understanding and clarify misconceptions.
- 4 Identify a shared goal, if possible, and/or agree to disagree on course of treatment.
- 5 Set limits/Clarify boundaries. Focus on what you are willing to do, rather than on what you refuse to do.

III. Helpful hints

- 1 Speak slowly and keep it simple. Brief explanations are usually preferred, at least for initial conversations. Avoid the temptation to overexplain or get into rationalizing/negotiating/arguing with the patient about anything.
- 2 If your intent is to take something away (e.g., a taper or remove a medication), consider what you will offer your patient. It may be as simple as, “I will continue to be your healthcare provider as you move through these changes.” You may want to have some preprinted non-opioid treatment suggestions to give to the patient at the end of the visit. In particular, behavioral strategies such as CBT or peer-directed counseling can be very effective adjunctive treatments. It is common for patients to state that they have tried all such treatments to no avail and are not interested. The patient can have this response, and you can give the patient the information at the same time.
- 3 When a patient becomes highly emotional (angry, desperate, tearful, etc.) it is unreasonable that you will be able to talk the patient into being okay with the changes you are proposing. Be prepared to leave the visit with the patient who is not agreeing to the changes and/or continuing to be highly emotional. As the medical provider, it is your charge to make the changes in the name of safe medicine.
- 4 Suggest early on that no changes need to be made that day, allowing the patient to adjust to information and consider what supports they may need in order to embark upon the treatment changes.
- 5 It is highly recommended that you schedule a follow-up appointment before the patient leaves the office. The patient may state they plan to find another provider but it is still recommended that an appointment be set and that a member of the medical team call the patient the following day to check in on the patient and remind them of his or her follow-up appointment.

- 6 Don't be defensive, as it escalates emotion. Instead, make a statement about the patient's experience, e.g., "The look on your face tells me you are afraid. Is that the right emotion?"
- 7 Share control. It models collaboration and empowers patients to make changes. This is why offering three options is a good place to start, as it gives the patient control over which option to choose.
- 8 Focus on function not pain. This permits progress despite ongoing pain.
- 9 Although it may seem obvious, it is very helpful to state how much you care for your patient and that you have confidence in his or her capacity to make the changes being proposed (even if you don't have high confidence right now, it will increase the more you make these changes and see the resilience of your patient).

Examples of What You Might Want to Say to Your Patients

I. Deal with the patient's emotions by making the following types of statements:

Reflection: "You seem _____ (upset, anxious, fearful, scared), by what I have said."

Validation: "It is understandable that you feel _____ in regard to me not prescribing narcotics when that is the main reason you came in."

"This is a lot of information; it would be understandable if you were experiencing _____ (anger, fear, betrayal, anxiety, hopelessness). As your provider, it is important for me to practice within safe guidelines. Therefore, some treatment adjustments need to be made."

"I hear that you are in real pain and you have every right to _____ (find a new provider, go to the ER, get your Rx from the streets, neighbor, etc.). I hope that you will continue to let us care for you."

You don't have to agree to express understanding.

Support: "I'm sure it has been difficult to keep going to your provider and repeatedly have these tug-o-wars about a prescription"

"I am certain I do not want you to suffer. I care about your health a great deal. I am confident that you are capable of making the adjustments I have outlined."

Or, for example, instead of speaking, hand the crying patient a tissue.

II. Identify the Impasse

"It seems as though we have reached an impasse."

"You and I have very different views on how to best manage your pain."

"At this point, maybe we can agree to disagree. Why don't you take some time to consider the three options we have discussed, and next week when you come in we will start with the adjustments."

III. Clarify boundaries

What you will do: “I’d like to be your provider and continue to help you with your pain, despite our disagreement.”

“I certainly do not want you to _____ (stay in bed, not go to work, neglect children), and due to the safety reasons I have outlined, it is important for us move forward with treatment adjustments.”

What you won’t do: “Prescribing more of this medicine is something that is not in your best, long-term interest. It is something I feel uncomfortable with and cannot do.”

“Unfortunately, I will not be able to _____ (raise the dose, give you a prescription, etc.). I would like you to consider the non-narcotic treatment options we discussed. I hear you have tried them in the past with no success, but I am asking you to consider trying them again.”

IV. Manage your reactions

When you say “no,” you may:

- › Question your judgment, and if you are doing the right thing
- › Feel you have failed as a provider
- › Feel your behavior is unethical
- › Feel mean, unsupportive, and uncaring

Consider looking at your patient’s behavior through the lens of “physical dependence”:

- › It is normal for patients to have heightened emotional reactions, fear of the pain and other physical symptoms when they face opioid withdrawal.
- › It is the role of the provider to take charge and safely guide the patient’s treatment.

V. Learn to soothe yourself

Breathe. Self-talk. Talk to a colleague who shares your philosophy of pain management.

Gather strength from your core beliefs.

Let your values and core principles of practicing good and safe medicine guide your practice. This will ease your way as you embark on these challenging conversations with your patients.

Potentially Challenging Conversations

As OPG guidelines are implemented, potentially challenging patient conversations may arise.

1 Introducing the new guidelines to new and existing patients.

- a “After having reviewed your medical record and gathering some further information, let me start by telling you about some of the things we can offer you (non-opioid treatments).”
- b “For safety reasons, I rarely prescribe controlled substances on the first visit (or on the first appointment when a patient has a new request for controlled substances).
- c “I would like to offer you some new information we have about treating complex, chronic pain with opioids. Would that be okay with you?” (If patient refuses, suggest that you do so on the next visit. Let the patient have some control over this scary situation for them.)

d. After evaluating a patient and finding some risk of opioid misuse: “Your level of risk limits our treatment choices. We still have some good options and I would like to share some of the things we can offer you for your chronic pain. Would now be a good time?”

2 Compassionate refusal of opioid prescriptions to new patients and existing patients requesting an increase in dose.

- a. “Would you be interested in learning some new information about using opioids for chronic complex pain?”
- b. “Due to recent information on the safety and effectiveness of using opioids for treating chronic pain, unfortunately, I am not able to offer that medication at this time.”

3 The need to reduce or stop opioids (with the intent of keeping the patient in the practice):

- a. “I have just shared with you a lot of information. It would be understandable if you were having a strong reaction...(pause)... can you tell me what you are the most concerned about right now?” (You may be surprised by the answer: Don’t assume you know.)
- b. “It has come to my attention that these medications (or these doses of medications) are not a safe choice for you at this time. Would this be a good time to discuss ways we could work together to begin reducing your dose safely?”

Further Resources

Below are links to websites that offer ideas on how to effectively talk to your patients on this topic:

www.scopeofpain.com/tolls-resources

www.agencymeddirectors.wa.gov/guidelines.asp

www.cdc.gov/primarycare/materials/opioidabuse/index.html

www.supportprop.org/index.html

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OPIOID RISK TOOL (ORT)

MARK EACH BOX THAT APPLIES	Female	Male
Family history of substance abuse		
Alcohol	<input type="checkbox"/> 1	<input type="checkbox"/> 3
Illegal drugs	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Prescription drugs	<input type="checkbox"/> 4	<input type="checkbox"/> 4
Personal history of substance abuse		
Alcohol	<input type="checkbox"/> 3	<input type="checkbox"/> 3
Illegal drugs	<input type="checkbox"/> 4	<input type="checkbox"/> 4
Prescription drugs	<input type="checkbox"/> 5	<input type="checkbox"/> 5
Age between 16 and 45 years	<input type="checkbox"/> 1	<input type="checkbox"/> 1
History of preadolescent sexual abuse	<input type="checkbox"/> 3	<input type="checkbox"/> 0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	<input type="checkbox"/> 2	<input type="checkbox"/> 2
Depression	<input type="checkbox"/> 1	<input type="checkbox"/> 1
Scoring Totals		

ADMINISTRATION

- › On initial visit
- › Prior to opioid therapy

SCORING (RISK)

- 0–3 = low
- 4–7 = moderate
- ≥8 = high

PHQ-4: THE FOUR-ITEM PATIENT HEALTH QUESTIONNAIRE FOR ANXIETY AND DEPRESSION

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
TOTALS				

Total score is determined by adding together the scores of each of the 4 items.

Scores are rated as normal (0-2), mild (3-5), moderate (6-8), and severe (9-12).

Total score ≥ 3 for first 2 questions suggests anxiety.

Total score ≥ 3 for last 2 questions suggests depression.

Reprinted with permission from Kroenke K, Spitzer RL, Williams JB, Löwe B. An ultra-brief screening scale for anxiety and depression: the PHQ-4. *Psychosomatics*. 2009;50(6):613-21. From *Principles of Neuropathic Pain Assessment and Management*, November 2011.

S T O P B A N G

Screening for Obstructive Sleep Apnea

Ask your patient to answer the following questions to determine if he or she is at risk of obstructive sleep apnea.

S (snore)	Have you been told that you snore?	YES	NO
T (tired)	Are you often tired during the day?	YES	NO
O (obstruction)	Do you know if you stop breathing, or has anyone witnessed you stop breathing while you are asleep?	YES	NO
P (pressure)	Do you have high blood pressure, or are you on medication to control high blood pressure?	YES	NO

If the patient answered *yes* to two or more questions on the STOP portion, he or she is at risk of obstructive sleep apnea.

To find out if the patient is at moderate to severe risk of obstructive sleep apnea, he or she should complete the BANG questions below.

B (BMI)	Is your body mass index greater than 28?	YES	NO
A (age)	Are you 50 years old or older?	YES	NO
N (neck)	Are you a male with a neck circumference greater than 17 inches, or a female with a neck circumference greater than 16 inches.	YES	NO
G (gender)	Are you a male?	YES	NO

The more questions the patient answers *yes* to, the greater his or her risk of having moderate to severe obstructive sleep apnea.

URINE DRUG SCREENINGS (UDS) FAQ

Using UDS to Monitor Opioid Therapy for Complex Chronic Non-Cancer Pain

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. The frequency of such testing can be determined by risk stratification based upon screening tools already mentioned in this document (page 19 and Appendix A). 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.

Q Drug screening implies that I don't trust my patients. How do I get around this?

A A self-report of drug use has limited validity, and monitoring behavior alone can fail to detect problems revealed by UDTs. Creating a UDS policy in advance and applying it consistently to all patients on opioids may help de-stigmatize the testing. Inform patients that drug testing is a routine procedure for all patients starting or maintained on opioid therapy and it is an important tool for monitoring the safety of opioid therapy.

Possible language for explaining to patient includes:

- › Ensures my capacity to provide treatment for your pain while balancing the need for safety.”
- › Provides critical information needed to assess the success of your therapy.”
- › Prescription medications are a common form of treatment for chronic pain. However, each person reacts differently to them. UDS enables us to identify individual risks related to your medications and avoid problems.”
- › Our clinic uses ‘universal precautions’ in opioid prescribing, which includes UDS. This is the same as wearing gloves on all patients when drawing blood.”

Q Can I tell whether my patient has taken the dose of opioid(s) I prescribed?

A No. It is very difficult to correlate urine drug concentration with a patient's dose. UDS can detect the parent drug and/or its metabolite(s) and demonstrate recent use of prescribed drugs and illegal substances. However, it CANNOT determine the amount of drug used and when the last dose was taken, nor can it identify the source of the drug.

Q My patient says he is a “high metabolizer” and that is why the expected drug is not found in the urine. Is this possible?

A A small percentage of persons are ultrarapid metabolizers. They metabolize specific drugs more rapidly than typical patients. It would be rare to take an opioid as prescribed and have a totally negative UDS. It is important that you use testing that is specific to the medication of interest and with cutoff thresholds that are extremely low.

Q How do I deal with marijuana?

A This is a complex issue. Marijuana is currently classified as a Schedule I drug by the DEA. For that reason, many providers will not prescribe opioids to patients using cannabis. Other providers reference State “Medical Marijuana” laws (<http://apps.leg.wa.gov/RCW/default.aspx?cite=69.51A&full=true>) and feel comfortable prescribing opioids to cannabis users. Some providers adopt a “don’t ask, don’t tell” policy, and request the lab to remove marijuana from the UDS so that positive results are not seen. Do your homework and create an office policy. Then disclose this policy to your patients.

Q Would short-acting opioids show up in UDS?

A Urine testing typically has a 1- to 3-day window of detection for most drugs depending on dose and individual differences in drug metabolism. Short-acting opioids can be detected if the lab removes the cutoff concentration so that the presence of lower concentrations is detected. If the laboratory uses LC/MS/MS, then it will have a lower limit of detection (LOD) with less interference.

Q Why confirm results?

A Immunoassays used in drug screening can cross-react with other drugs and vary in sensitivity and specificity. Thus, confirmation with a more accurate method may be required for clinical decision making. Confirmatory drug testing (GC/MS or LC/MS/MS) of the original specimen is recommended for unexpected results, or in cases where patients are known to be high risk. However, on occasion, even confirmatory testing requires expert assistance for interpretation. Consider consultation with the lab before discussing/confronting the patient with unexpected test results and discontinuing opioid therapy.

Q Should I use temperature and adulteration strips?

A It depends. Drug testing for clinical compliance, unlike employment testing, does not require a strict “chain-of-custody” However, if tampering is a concern, the specimen should be monitored for temperature and/or adulterants. Normal human urine should have a temperature between 90°F – 100°F, pH between 4.5 – 8.5 and creatinine >20 mg/dL. Be aware that there are multiple websites and devices devoted to getting a “clean” urine drug screen.

Q Should I perform a drug screen on every visit for patients using opioids for chronic pain?

A No. Random screening based on the frequency recommended in the guideline should suffice for most patients. Those patients who you feel require drug screening on every visit, are perhaps not candidates for chronic opioid therapy.

Risk Category	UDS Frequency	Recommended Drug Panel to Test
Low Risk by ORT (1 or more/year)	Periodic (e.g. up to 1/year)	Drug you are prescribing if not listed
Moderate Risk by ORT (2 or more/year)	Regular (e.g. up to 2/year)	Amphetamines Opiates Cocaine
High Risk by ORT (3 or more/year) or opioid doses >120 mg MED/d	Frequent (e.g. up to 2+/year)	Benzodiazepines Alcohol
Aberrant Behavior (lost prescriptions, multiple requests for early refills, opioids from multiple providers, unauthorized dose escalation, apparent intoxication, etc.)	At time of visit (Address aberrant behaviors in person, not by telephone)	Barbiturates Oxycodone Methadone Fentanyl Marijuana Testing for all drug classes may not be necessary, depending on clinical situation.

Consideration

Typically, the initial (screening) drug test uses an immunoassay method to identify the presence of a drug (presumptive positive). Because of cross reactivity and different sensitivity and specificity between immunoassays, a second confirmatory test is required unless result is expected or the patient has disclosed drug use. Confirmatory drug tests use gas chromatography/mass spectrometry or liquid chromatography/tandem mass spectrometry (GC/MS or LC/MS/MS) to verify a presumptive positive result.

Contact the laboratory director, toxicologist or a certified Medical Review Officer (MRO) in your area for questions about drug testing or result.

If a point of care (POC) test is used, contact technical support from the manufacturer for questions.

UDS Results

Interpreting UDS results can be challenging, especially when the parent drug can be metabolized to other commonly prescribed drugs. The table on the next page may aid prescribers when interpreting UDS results. The following UDS results should be viewed as a “red flag,” requiring confirmation and intervention:

- › Negative for opioid(s) you prescribed
- › Positive for drug (benzodiazepines, opioids, etc) you did NOT prescribe or have knowledge of
- › Positive for amphetamine or methamphetamine
- › Positive for alcohol
- › Positive for cocaine or metabolites

If a confirmatory drug test substantiates a “red flag” result AND is positive for prescribed opioid(s):

- › Prescriber should consider a controlled taper and a referral to an addiction specialist or drug treatment program depending on the circumstances.
- › Prescriber should consider extraneous circumstance such as duration of action of the drug and timing of last dose. Consultation with your laboratory’s pharmacologist may be useful. Discontinuing prescribing and substance abuse referral should be considered. Prescriber should stop prescribing opioid(s) and consider a referral to an addiction specialist or drug treatment program depending on the circumstances.

PRESCRIPTION DRUG MONITORING PROGRAM (PDMP)

Health Information
Designs Inc.

Oregon
Query Report

Date: 02/06/13
Page#: 1

Patient Rx History Report

PURPLE LARA

Search Criteria: Last Name 'purple' and First Name 'lara' and D.O.B. = '06/17/32' and Address = '' and Request Period = '06/01/11' to '02/06/13' - 1 out of 1 Recipients Selected.

Patients that match search criteria

00000234 PURPLE LARA, DOB 06/17/32; 111-9090 COMMODO ST, DONALD OR 97020

Fill Date	Product, Str, Form	Qty	Pt ID	Prescriber	Written	RX#	Pharm
06/30/2011	LORAZEPAM 0.5 MG TABLET	3.000	00000234	0006	02/28/2011	4004882	0001
06/30/2011	ACETAMINOPHEN-COD #3 TABLET	90.000	00000234	0007	04/15/2011	4005028	0001
06/30/2011	ALPRAZOLAM 0.25 MG TABLET	90.000	00000234	0008	06/16/2011	4005208	0001
06/30/2011	ZOLPIDEM TARTRATE 5 MG TABLET	36.000	00000234	0009	02/28/2011	4004882	0001
06/30/2011	HYDROCODON-ACETAMINOPH 7.5-500	360.000	00000234	0010	03/30/2011	4005247	0001
06/29/2011	HYDROCODON-ACETAMINOPH 7.5-750	180.000	00000234	0011	04/15/2011	4005015	0001
06/29/2011	ZOLPIDEM TARTRATE 10 MG TABLET	135.000	00000234	0012	06/18/2011	4005244	0001
06/28/2011	HYDROCODON-ACETAMINOPHEN 5-500	120.000	00000234	0013	07/19/2011	4005128	0001
06/27/2011	ZOLPIDEM TARTRATE 10 MG TABLET	90.000	00000234	0014	04/16/2011	4005027	0001
06/25/2011	ZOLPIDEM TARTRATE 10 MG TABLET	90.000	00000234	0015	04/16/2011	4005027	0001
06/24/2011	HYDROCODON-ACETAMINOPH 7.5-750	180.000	00000234	0001	06/23/2011	4005229	0001

Prescribers for prescriptions listed

0001	KNOPF, GREGORY M MD; GRESHAM TROUTDALE FAM. MED. CTR., 1700 SW 257TH AVENUE, PO BOX 730, TROUTDALE OR 97060
0002	LOVATO, KIMBERLY K; 641 SE MILLER AVE, DALLAS OR 97338
0003	BEAMAN, DOUGLAS NEAL MD; 501 NORTH GRAHAM, SUITE 200, PORTLAND OR 97227
0004	THOMAS, STEPHEN JOHN MD; 17600 SW ALEXANDER, GRESHAM OR 97006
0005	HILL, TIMOTHY A MD; CENTER FOR ORTHOPEDIC, 2000 NEW ROAD, SUITE 200, BEND OR 97701
0006	VRANNA, LEE E MD; 1135 WHISKEYTOWN COURT, REDDING OR 96001
0007	COLLINS, DAVID MCAVLEY MD; SHERIDAN MEDICAL CENTER, 222 S.E. JEFFERSON, SHERIDAN OR 97378
0008	MA, HAIYUN E (MSN); JUNCTION CITY MEDICAL CENTER, 355 WEST THIRD AVE., JUNCTION CITY OR 97448
0009	SHORTZ, ROGER WILLIAM MD; 3065 RICHMOND PARKWAY, SUITE 102, RICHMOND CA 94806

Pharmacies that dispensed prescriptions listed

0001	AMERIPHARM, INC; DBA MEDVANTX PHARMACY SERVICES, 2503 E 54TH ST. N, SIOUX FALLS SD 57104,
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Patients that match search criteria

00000234	PURPLE LARA, DOB 06/17/32; 111-9090 COMMODO ST, DONALD OR 97020
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Report Disclaimers:

The Oregon PDMP makes no claims, promises, or guarantees about the accuracy, completeness, or adequacy of the contents of this report, and expressly disclaims liability for errors and omissions in the contents of this report. The records herein are based on information submitted by pharmacies. Records in this report should be verified with the patient before any clinical decisions are made or actions are taken. Access to the record of an individual who is not a patient under the care of the person accessing the record is not permitted by law.

PATIENT TREATMENT AGREEMENTS

Sample 1. Controlled Substance Agreement

Why an agreement? The medication we are prescribing has the potential to provide much benefit, but it also can do harm to you or others. Misuse of pain medications is becoming a large problem in our community. We are doing our part to ensure that our prescriptions are taken as directed. We also want to protect you and inform you concerning the uses and abuses of this medication.

What are the Benefits of opiate treatment? Opiates, also called opioids, provide relief from pain and a sense of well-being. They can allow you to perform activities that you might otherwise find limiting due to pain.

What are the risks of opioid treatment? Opioids produce physical dependency with prolonged use. That means that you may experience discomfort if you discontinue these medications abruptly after taking them for over a few weeks. Some individuals have a hard time remaining medication free after being on long term opioids for that reason.

Opioids may decrease your ability to breathe deeply. This is especially true when they are combined with other sedating drugs like alcohol and some tranquilizers. This can lead to accidental overdose deaths.

Less serious side effects may include: constipation, decrease in sexual interest and performance, weight gain, sleepiness, urination difficulties, and itchiness. As with any medication, there is the rare possibility of a severe allergic reaction.

Some people are at risk of abusing these medications and may feel compelled to take them for their pleasurable effect. Therefore we are obliged to provide safeguards to protect you from these potential risks.

What are those safeguards? Our clinic has the following regulations for all patients taking long-term opioids; we will not prescribe these medications for chronic use without first:

- › Obtaining all pertinent medical records
- › Obtaining a urine drug screening (UDS)
- › Reviewing your medical condition and past history
- › Having a signed agreement between a clinician and yourself outlining the expectations of both parties.

What can I expect from the clinic? Our clinic agrees to provide you with appropriate doses of medication in a timely fashion and on an ongoing basis as long as there are no contraindications. You will be treated respectfully and professionally.

What does the clinic expect from me? The clinic expects all patients will agree to the following:

- › Agree to have only one prescriber of opioids and use only one pharmacy.
- › Bring their pill bottles to every clinic visit.
- › Have a valid phone number available to our staff, and to respond within 24 hours to the clinic if asked.
- › Agree to random urine drug screenings and random pill counts.
- › Agree to a chemical dependency or other specialist consultation should your provider feel that would be appropriate.
- › Allow open communication between this clinic and other providers concerning the use of these medications.
- › Advise other treatment providers of the medication you are taking and to inform this clinic of any health care emergencies requiring pain or anxiety treatment.
- › Agree to treat our staff respectfully and courteously.

Suggestions for safely handling your prescription: These medications can be dangerous if combined with other sedating substances. These medications are sought after by drug abusers. Therefore we ask that you follow these suggestions to provide safety for you and your medications:

- › Keep all medicines in a safe, preferably locked container, out of sight and out of the reach of children.
- › Never share these medicines with others. Never take other people's pain medications.
- › Avoid drinking alcohol while taking these medicines.
- › Never combine these medications with other opioids or benzodiazepines (tranquilizers like Ativan, Xanax, Valium or Klonopin) unless advised to by your provider.
- › Never use illicit drugs while using these medications.
- › Be aware that opioids may affect your judgment and driving skills, particularly when your dose is increasing.

How will I obtain my refills? The clinic's policy on refills is:

- › Refill prescriptions will only be written at a clinic visit. Therefore refills will not take place over the phone, through the mail, or by calling the pharmacist.
- › All dosage changes will occur at the next clinic visit.
- › Lost or stolen medications may not be refilled until the next scheduled visit.

Will this medication relieve my pain? It is unrealistic to expect opioids to relieve all discomfort. We hope to reduce your pain so that you can regain function; that is to allow you to enjoy activities that you participated in prior to the onset of your pain. We will continue to ask that you participate in activities that improve your ability to perform daily activities. We may, in the course of your treatment, ask you to exercise, attend classes, or see a specialist of our choosing.

What are the consequences of not following these agreements? Your clinician has agreed to provide you with these medications as long as necessary, but also has the obligation to protect you and the community from abuse of these substances. In the event of suspected misuse, your provider may insist on a referral to a specialist in the assessment and treatment of drug dependency, or may immediately discontinue prescribing. Lack of improvement in function or to achieve adequate pain control may also necessitate the discontinuing of opioid medications.

I will receive my prescriptions at the following pharmacy only:

Name and phone: _____

I agree to allow the following health care facilities to share information (including any pertinent mental health, drug or alcohol history or conditions) with my provider, and to allow my health care provider to freely share pertinent health care information with these facilities for the purpose of coordinating my medical care.

Facility: _____

Facility: _____

Facility: _____

Facility: _____

By signing below I am agreeing to abide by the conditions of this agreement.

Patient's signature: _____ **Date** _____

Person obtaining the consent: _____ **Date** _____

Sample 2. Patient/Clinic Agreement for the use of Controlled Substances

Your provider has prescribed _____ for _____ (diagnosis).

To continue receiving this medication from your provider, you are expected to follow the policies below. If you do not follow them, your provider may decide to stop prescribing the medication for you.

- 1 You are expected to take the medication as directed by your clinician, and to make your medication last until the next scheduled appointment. We expect our patients to be responsible for their prescriptions. You should never give any of your medications to someone else. We will not fill requests for lost or stolen prescriptions or medications.
- 2 Refills for controlled substances will only be done by appointment at the clinic. We will not fill requests for controlled substances by phone, after hours, or on weekends. We expect our patients to plan ahead to upcoming vacations, weekends and holidays and make a timely appointment if a prescription will need to be filled early.
- 3 By signing below you agree to submit urine or blood as requested by your provider for random drug screens. You also agree to have a working phone number where clinic staff can reach you within 24 hours. That number is _____. You agree to update the clinic anytime you move or change your phone number.
- 4 You agree to bring your pill bottles to each regular visit.
- 5 Any patient who receives controlled substances from La Clinica on an ongoing basis is expected to receive these prescriptions only from our organization. If you receive additional medicines for an unanticipated injury or condition, and these are not prescribed by a La Clinica provider, you are required to call the clinic the next business day, advise us of the situation and release records of the encounter to La Clinica.
- 6 While taking narcotics or other controlled substances you are expected to refrain from misusing or abusing other drugs which could alter consciousness, impair judgment, or cause addiction, including, alcohol, marijuana, methamphetamine, or other illegal drugs. If you in any way use these medications to harm yourself, you will no longer receive them at this clinic.
- 7 You may be required to seek treatments or consultations you have to pay for yourself.
- 8 In addition to taking pain relief medication, you are expected to comply with your clinician's other recommendations for improving your pain relief, or ability to function.
- 9 We require you to use only one pharmacy for your refills. Your pharmacy is _____. If you decide to change pharmacies you must advise us immediately.
- 10 You authorize, by your signature below, any employee of La Clinica to call any other health care provider, including Emergency Department staff and pharmacies, to obtain information regarding the prescription of any substance.

Your signature acknowledges you have received a copy of this agreement.

Patient Signature _____ Date _____

Print Name _____ Medical Record Number _____

The use of narcotics poses risks to patients. By prescribing _____ to you, we expect the following improvements:

- _____ Increased ability to exercise
- _____ Lose weight
- _____ Increased ability to participate in family activities
- _____ Able to go shopping
- _____ Increased ability to do housework
- _____ Able to return to work

OR _____

Alternatives to taking _____ include: _____

In addition to taking _____ to reduce your chronic pain, you are expected to:

Your allergies are: _____

The following is not necessarily a complete list of the side effects of pain medicines, but common side effects include:

BRAIN Sleepiness, difficulty thinking, confusion, slow reflexes. It is possible to be convicted of driving under the influence (DUI) if you drive while using prescribed medication.

LUNG Difficulty breathing or slowed breath rate to the point you stop breathing.

STOMACH Nausea, vomiting. Constipation can be severe.

SKIN Itching, rash.

GENITO-URINARY Difficulty urinating. These drugs reduce interest in and ability to perform sexual activities.

ALLERGY Potential for allergic reaction.

TOLERANCE With long term use, an increasing amount of the same drug may be needed to achieve the same effect.

PHYSICAL DEPENDENCE/WITHDRAWAL: Physical dependence develops within 3-4 weeks when taking these drugs. If they are stopped abruptly, symptoms of withdrawal may occur. Withdrawal can be extremely difficult and last a long time. Use of all controlled substances needs to be slowly tapered off under the direction of your prescriber.

ADDICTION: This refers to the abnormal behavior directed toward acquiring or using drugs in a non-medically necessary manner. People with a history of alcohol or drug abuse are at increased risk.

Avoid medications or substances which increase drowsiness or limit the ability to think clearly, react quickly, or which decrease your rate of breathing. Talk to your provider before taking any of these medications, even if you can buy them over the counter.

I understand these risks and agree to accept them. I will let my prescriber know of any problems or side effects I am having with this medication.

Name (print) _____ Signature _____ Date _____

Sample 3. Patient Treatment Agreement

I, _____ (patient receiving chronic pain medications), agree to correctly use pain medications prescribed for me as part of my treatment for chronic pain. I understand that these medications may not get rid of my pain but may decrease the pain and increase the level of activity that I am able to do each day. I understand that the Pain Management Clinic will deal with my chronic pain and will not deal with any of my other medical conditions.

I understand that _____ (name) will be my pain management provider and the only provider who will be ordering medications for my chronic pain.

I understand that I have the following responsibilities (initial each item you agree to):

- _____ I will only take medications at the amount and frequency prescribed.
- _____ I will not increase or change how I take my medications without the approval of my pain management provider.
- _____ I will not ask for refills earlier than agreed. I will arrange for refills ONLY during regular office hours. I will make the necessary arrangements before holidays and weekends.
- _____ I will get all pain medications only at one pharmacy. I will let my pain management provider know if I change pharmacies. **Pharmacy** _____ **Phone Number** _____
- _____ I will allow my pain management provider to provide a copy of this agreement to my pharmacy.
- _____ I will not ask for any pain medications or controlled substances from other providers and will let my pain management provider know of all medications I am taking, including non-legal drugs.
- _____ I understand that other physicians should not change doses of my pain medications made by another provider.
- _____ I will notify the Pain Management Clinic of any changes to my pain medications made by another provider.
- _____ I will let my other health care providers know that I am taking these pain medications and that I have a pain management agreement.
- _____ In event of an emergency, I will give this same information to emergency department providers.
- _____ I will allow my pain management provider to discuss all my medical conditions and treatment details with pharmacists, physicians, or other health care providers who provide my health care for purposes of care coordination.
- _____ I will inform my pain management provider of any new medications or medical conditions.
- _____ I will protect my prescriptions and medications. I understand that lost or misplaced prescriptions will not be replaced.
- _____ I will keep medications only for my own use and will not share them with others. I will keep all medications away from children.

In addition, I will do the following (initial each box):

- _____ I must make an appointment with a drug and alcohol counselor and bring proof of following my treatment plan. Contact number is 1-800-562-1240).
- _____ I must take a drug test _____ (frequency).
- _____ I agree to pill counts to prove I am using my medications correctly.
- _____ If I fail a drug test, I will take the drug test _____ (frequency).
- _____ If I fail a drug test, I will be referred to Medicaid's Patient Review and Coordination Program that restricts me to certain providers, such as a primary doctor. (<http://maa.dshs.wa.gov/PRR>)
- _____ If I sell my narcotics, my name will be referred to the DSHS fraud unit.
- _____ If I fail all of the above, I will be discharged from your care with no notice.

Should any of the above not show good faith efforts and my providers feel they can no longer prescribe my pain medications in a safe and effective way, I may be notified and discharged from their care.

I agree to use only the following providers. I will notify my physician of any changes in my health care and/or changes in my providers.

Provider: _____ **Clinic:** _____ **Phone:** _____

Provider: _____ **Clinic:** _____ **Phone:** _____

Patient Signature: _____ **Provider Signature:** _____

MATERIAL RISK NOTICE

This will confirm that you, _____, have been diagnosed with the following condition(s) causing you chronic intractable pain: _____.

I have recommended treating your condition with the following controlled substances: _____.

In addition to significant reduction in your pain, your personal goals from therapy are: _____.

Alternatives to this therapy are: _____.

Additional therapies that may be necessary to assist you in reaching your goals are: _____.

Notice of Risk: The use of controlled substances may be associated with certain risks such as, but not limited to:

Central Nervous System: Sleepiness, decreased mental ability, and confusion. Avoid alcohol while taking these medications and use care when driving and operating machinery. Your ability to make decisions may be impaired.

Cardiovascular: Irregular heart rhythm from mild to severe.

Respiratory: Depression (slowing) of respiration and the possibility of inducing bronchospasm (wheezing) causing difficulty in catching your breath or shortness of breath in susceptible individuals.

Gastrointestinal: Constipation is common and may be severe. Nausea and vomiting may occur as well.

Dermatological: Itching and rash. Endocrine: Decreased testosterone (male) and other sex hormones (females); dysfunctional sexual activity.

Urinary: Urinary retention (difficulty urinating).

Pregnancy: Newborn may be dependent on opioids and suffer withdrawal symptoms after birth.

Drug Interactions: With or altering the effect of other medications cannot be reliably predicted.

Tolerance: Increasing doses of drug may be needed over time to achieve the same (pain relieving) effect. Physical dependence and withdrawal: Physical dependence develops within 3-4 weeks in most patients receiving daily doses of these drugs. If your medications are abruptly stopped, symptoms of withdrawal may occur. These include nausea, vomiting, sweating, generalized malaise (flu-like symptoms), abdominal cramps, palpitations (abnormal heartbeats). All controlled substances (narcotics) need to be slowly weaned (tapered off) under the direction of your physician.

Addiction (Abuse): This refers to abnormal behavior directed towards acquiring or using drugs in a non-medically supervised manner. Patients with a history of alcohol and/or drug abuse are at increased risk for developing addiction.

Allergic reactions: Are possible with any medication. This usually occurs early after initiation of the medication. Most side effects are transient and can be controlled by continued therapy or the use of other medications.

This confirms that we discussed and you understand the above. I asked you if you wanted a more detailed explanation of the proposed treatment, the alternatives and the material risks, and you (Initial one):

_____ was satisfied with that explanation and desired no further information.

_____ requested and received, in substantial detail, further explanation of the treatment, alternatives and material risks.

_____ DATE _____

PATIENT SIGNATURE

Explained by me and signed in my presence.

_____ DATE _____

PHYSICIAN SIGNATURE

MEDICAL RISKS OF LONG-TERM OPIOID USE

Medical risk	How common?	Description and information
Respiratory depression		
Opioid overdose	< 1% per year	<ul style="list-style-type: none"> • Caused by severely slowed breathing, which you may not notice • Severe cases are treated in the hospital • Can cause death
Breathing problems during sleep	25%	<ul style="list-style-type: none"> • Can cause or worsen sleep apnea • You may not notice breathing problems
Falls, fractures		
Falls causing hip & pelvis fractures	1%-2% per year	
Gastrointestinal		
Constipation	30%-40%	<ul style="list-style-type: none"> • It helps to use stool-softeners or medicines that stimulate bowel movements
Serious intestinal blockage	<1% per year	<ul style="list-style-type: none"> • Caused by severe constipation • Severe cases are treated in the hospital
Hormonal effects		
Hypogonadism, impotence, infertility, osteoporosis	25%-75%	<ul style="list-style-type: none"> • Hypogonadism=lowered sex hormones, which can worsen sexual function • Osteoporosis can make you more likely to fracture
Cognitive and neurophysiologic effects		
Sedation	15%	<ul style="list-style-type: none"> • Can cause difficulty driving and thinking clearly
Disruption of sleep	25%	
Hyperalgesia	Not known	<ul style="list-style-type: none"> • Hyperalgesia = being more sensitive to pain
Psychosocial		
Depression, anxiety, deactivation, apathy	30%-40%	<ul style="list-style-type: none"> • Can cause loss of interest in usual activities, which can lead to depression. Depression can worsen pain, just as pain can worsen depression.
Addiction, misuse and diversion	5%-30%	<ul style="list-style-type: none"> • Misuse or overdose can occur if others—including children and teens—gain access to the medicine. • Your pharmacist can tell you how to dispose of unused medicines safely.
Other		
Dry mouth that may cause tooth decay	25%	<ul style="list-style-type: none"> • Brush your teeth and rinse your mouth often • Chew sugarless gum and drink water or sugarfree, non-carbonated fluids
Myoclonus	Not known	Myoclonus = muscle twitching

Source: Group Health, Chronic Opioid Therapy for Chronic Non-Cancer Pain Guideline, 2010.

GRADED PAIN AND FUNCTION SCALE

Pain Intensity and Interference

In the last month, on average, how would you rate your pain? Use a scale from 0 to 10, where 0 is “no pain” and 10 is “pain as bad as could be”? (That is, your usual pain at times you were in pain.)

No Pain										Pain as bad as could be
0	1	2	3	4	5	6	7	8	9	10

In the last month, how much has pain interfered with your daily activities? Use a scale from 0 to 10, where 0 is “no interference” and 10 is “unable to carry on any activities”?

No Interference										Unable to carry on any activities
0	1	2	3	4	5	6	7	8	9	10

OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE

The Oswestry Disability Index (also known as the Oswestry Low Back Pain Disability Questionnaire) is an extremely important tool that researchers and disability evaluators use to measure a patient's permanent functional disability. The test is considered the "gold standard" of low back functional outcome tools.¹

SCORING INSTRUCTIONS

For each section the total possible score is 5: If the first statement is marked, the section score = 0; if the last statement is marked, it = 5. If all 10 sections are completed, the score is calculated as follows:

Example: 16 (total scored)
 50 (total possible score) x 100 = 32%

If one section is missed or not applicable, the score is calculated:

 16 (total scored)
 45 (total possible score) x 100 = 35.5%

Minimum detectable change (90% confidence): 10% points (Change of less than this may be attributable to error in the measurement.)

INTERPRETATION OF SCORES

0% to 20%: minimal disability	The patient can cope with most living activities. Usually no treatment is indicated apart from advice on lifting, sitting and exercise.
21%-40%: moderate disability	The patient experiences more pain and difficulty with sitting, lifting and standing. Travel and social life are more difficult, and they may be disabled from work. Personal care, sexual activity and sleeping are not grossly affected, and the patient can usually be managed by conservative means.
41%-60%: severe disability	Pain remains the main problem in this group, but activities of daily living are affected. These patients require a detailed investigation.
61%-80%: crippled	Back pain impinges on all aspects of the patient's life. Positive intervention is required.
81%-100%	These patients are either bed-bound or exaggerating their symptoms.

INSTRUCTIONS

The following questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply, but please check only the box that indicates the statement which most clearly describes your problem.

1. Fairbank JC, Pynsent PB. The Oswestry Disability Index. Spine 2000 Nov 15;25(22):2940-52; discussion 52.

SECTION 1—PAIN INTENSITY

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

SECTION 2—PERSONAL CARE (WASHING, DRESSING, ETC.)

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of self-care.
- I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3—LIFTING

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed, eg. on a table.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift very light weights.
- I cannot lift or carry anything at all.

SECTION 4—WALKING

- Pain does not prevent me walking any distance.
- Pain prevents me from walking more than 1 mile.
- Pain prevents me from walking more than ½ mile.
- Pain prevents me from walking more than 100 yards.
- I can only walk using a stick or crutches I am in bed most of the time.

SECTION 5—SITTING

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me sitting more than one hour.
- Pain prevents me from sitting more than 30 minutes.
- Pain prevents me from sitting more than 10 minutes.
- Pain prevents me from sitting at all.

SECTION 6—STANDING

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it gives me extra pain.
- Pain prevents me from standing for more than 1 hour.
- Pain prevents me from standing for more than 3 minutes.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

SECTION 7—SLEEPING

- My sleep is never disturbed by pain.
- My sleep is occasionally disturbed by pain.
- Because of pain I have less than 6 hours sleep.
- Because of pain I have less than 4 hours sleep.
- Because of pain I have less than 2 hours sleep.
- Pain prevents me from sleeping at all.

SECTION 8—SEX LIFE (IF APPLICABLE)

- My sex life is normal and causes no extra pain.
- My sex life is normal but causes some extra pain.
- My sex life is nearly normal but is very painful.
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents any sex life at all.

SECTION 9—SOCIAL LIFE

- My social life is normal and gives me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g., sports).
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted my social life to my home.
- I have no social life because of pain.

SECTION 10—TRAVELLING

- I can travel anywhere without pain.
- I can travel anywhere but it gives me extra pain.
- Pain is bad but I manage journeys over two hours.
- Pain restricts me to journeys of less than one hour.
- Pain restricts me to short necessary journeys under 30 minutes.
- Pain prevents me from travelling except to receive treatment.

ADDITIONAL ASSESSMENT TOOLS

Specific Psychosocial Assessment	Tools to Evaluate
Substance abuse history	ORT, CAGE, Audit, Dast. SOAPP-R
Psychiatric/Mental health history	PHQ, PMQ, DIRE, GAD-7, PCL-C
ADLs/self-care	Oswestry, SF-36 or 12, pain log/diary, ACPS QOL
Self-perception of disability	DIRE, COMM, SF-36 or 12
SI/SA history	Roland-Morris Low-Back Pain and Disability Questionnaire

- ORT** Opioid Risk Tool. Very simple, evidence-based and widely used.
- CAGE** Four-item self-test for identifying usage patterns that may reflect problems with alcohol.
- PHQ** Patient Health Questionnaire, a 2-, 4-, or 9-item depression scale; tool for assisting in diagnosing depression.
- DIRE** Diagnosis, intractability, risk, efficacy tool that assesses the risk of opioid abuse and the suitability of candidates for long-term opioid therapy.
- COMM** Current Opioid Misuse Measure. A 17-item self-assessment to identify patients with chronic pain who are taking opioids and have indicators of current aberrant drug-related behaviors.
- SBIRT** Screening, brief intervention, and referral to treatment. An effective, evidence-based method to intervene in alcohol and drug misuse.
- OSWESTRY** The Oswestry Low-Back Pain Disability Questionnaire, a tool that researchers and disability evaluators use to measure a patient's permanent functional disability. The test is considered the gold standard of low back functional outcome tools.
- SOAPP-R** The Screener and Opioid Assessment for Patients with Pain-Revised. Predicts possible opioid abuse in chronic pain.

CHRONIC PAIN TREATMENT CHECKLIST

This checklist may be useful as a means to ensure compliance with these guidelines.

- Hx and Px with assessment of baseline function and pain.
- Review all relevant prior records.
- Has there been a prior unsuccessful attempt to treat with non-opioid modalities?
- Is the diagnosis appropriate for opioid treatment?
- Psychosocial and risk assessment: risk of medication abuse (ORT), psychiatric co-morbidity PHQ-4 or other validated tools, evidence of existing abuse (PDMP).
- Are there co-prescribed drug interaction risks? Benzodiazepines are generally contraindicated.
- Sleep risk assessment (S I O P B A N G or equivalent).
- UDS: Any unexpected results?
- Have you checked the PDMP for prescriptions of which you were unaware?
- Create a treatment plan that emphasizes patient self-management.
- Are there appropriate referrals?
- Have you explored all reasonable non-opioid treatment options: medical, behavioral, physiotherapy, and lifestyle changes?
- Have you considered partnering with a substance abuse treatment program?
- Check women of child-bearing age for pregnancy.

If prescribing opioids, proceed with caution:

- Obtain a signed Material Risk Notice.
- Establish treatment goals with periodic review of goals over time.
- Monitor compliance (UDSs, pill counts, PDMP, call-backs).
- Monitor improvement in pain and function, including overall well-being.
- Obtain consultation as needed: mental health, substance abuse, pain management, specialty care, pregnant women.
- Have you considered partnering with a behavioral health specialist (CBT counselor, peer-to-peer coordinator, Living Well with Chronic Disease facilitator, substance abuse counselor)?

METABOLISM DATA FOR COMMON MEDICATIONS

Drugs or Drug Classes	Detection Time in Urine*	Urine Drug Screening to Order	Expected Results	Consideration
Opioids or "opiates" – Natural (from opium)				
Codeine (Tylenol #2/3/4)	1-3 days	Opiates Immunoassay + GC/MS or LC/MS/MS Opiates	Opiates Immunoassay –positive GC/MS or LC/MS/MS – codeine, possibly morphine & hydrocodone	Immunoassays for "opiates" are responsive for morphine and codeine but do not distinguish which is present. Confirmatory testing is required to reliably identify drug(s) present. Since codeine is metabolized to morphine and small quantities to hydrocodone, these drugs may be found in the urine. Also, morphine may metabolize to produce a small amount (<10%) of hydromorphone.
Morphine (Avinza, Embeda, MS Contin, Kadian)	1-3 days		Opiates Immunoassay –positive GC/MS or LC/MS/MS – morphine, possibly hydromorphone	
Opioids – Semisynthetic (derived from opium)				
Hydrocodone (Lorcet, Lortab, Norco, Vicodin)	1-3 days	Opiates Immunoassay + GC/ MS or LC/MS/MS Opiates	Opiates Immunoassay –positive GC/MS or LC/MS/MS – hydrocodone, possibly hydromorphone	"Opiates" immunoassays may also detect semisynthetic opioids depending on their cross-reactivity pattern. However, a negative result does not exclude use of semisynthetic opioids. Confirmatory testing (GC/MS or LC/MS/MS) is required to verify compliance with the prescribed semisynthetic opioid(s).
Hydromorphone (Dilaudid, Exalgo)	1-3 days	Opiates Immunoassay + GC/ MS or LC/MS/MS Opiates	Opiates Immunoassay –positive GC/MS or LC/MS/MS –hydromorphone	Since hydrocodone is metabolized in small amounts to hydromorphone, both may be found in the urine. Likewise, oxycodone is metabolized to oxymorphone, so these may both be present in the urine of oxycodone users. However, the reverse is not true. In other words, hydromorphone and oxymorphone use does not result in positive screens for hydrocodone and oxycodone, respectively.
Oxycodone (Roxicet, OxyContin)	1-3 days	Oxycodone Immunoassay + GC/MS or LC/MS/MS Opiates	Opiates Immunoassay –positive GC/MS or LC/MS/MS – oxycodone possibly oxymorphone	
Oxymorphone (Opana)	1-3 days	Opiates or Oxycodone Immunoassay + GC/MS or LC/MS/MS Opiates	Opiates or Oxycodone Immunoassay –positive GC/MS or LC/MS/MS – oxymorphone	
Opioids – Synthetic (man-made)				
Fentanyl	1-3 days	GC/MS or LC/MS/MS Fentanyl	GC/MS or LC/MS/MS – fentanyl & norfentanyl	Current "opiates" immunoassays do not detect synthetic opioids. Thus confirmatory testing (GC/MS or LC/MS/MS) is needed to identify these drugs. If the purpose is to document compliance with treatment, the laboratory can be instructed to remove the cutoff concentration so that the presence of lower concentrations can be identified.
Meperidine (Demerol)	1-3 days	GC/MS or LC/MS/MS Meperidine	GC/MS or LC/MS/MS – normeperidine, possibly meperidine	

Drugs or Drug Classes	Detection Time in Urine*	Urine Drug Screening to Order	Expected Results	Consideration
Opioids – Synthetic (man-made) - continued				
Methadone (Methadose)	3-7 days	Methadone Immunoassay + GC/MS or LC/MS/MS Methadone	Methadone Immunoassay – positive GC/MS or LC/MS/MS – methadone & EDDP	
Propoxyphene (Darvon, Darvocet)	1-3 days	Propoxyphene Immunoassay + GC/MS or LC/MS/MS Propoxyphene	Propoxyphene Immunoassay – positive GC/MS or LC/MS/MS – propoxyphene & norpropoxyphene	
Others				
Alcohol	Up to 8 hours	Alcohol	Alcohol – see Consideration	Additional testing for alcohol metabolites, ethyl glucuronide (EtG) or ethyl sulfate.
Amphetamines	2-3 days	Amphetamines, Methamphetamines or MDMA Immunoassay + GC/MS or LC/MS/MS Amphetamines	Amphetamines, methamphetamines or MDMA Immunoassay – see Consideration GC/MS or LC/MS/MS – amphetamine, methamphetamine or MDMA	Amphetamines immunoassays are highly cross-reactive so results should be interpreted cautiously, and may require consultation with the lab. They may detect other sympathomimetic amines, such as ephedrine, pseudoephedrine or selegiline. Confirmatory testing can identify which amphetamine is present.
Barbiturates	1-3 days w/short-acting; up to 30 days w/long acting	Barbiturates Immunoassay	Barbiturates Immunoassay – see Consideration	The clearance half-life of intermediate-acting barbiturates averages 24 hours. It takes about 5 to 7 half-lives to clear 98% of a drug dose. Thus, the presence of an intermediate-acting barbiturate indicates exposure within 5-7 days.
Benzodiazepines	1-3 days w/short-acting; up to 30 days w/long acting	Benzodiazepines Immunoassay	Benzodiazepines Immunoassay – see Consideration GC/MS or LC/MS/MS – alprazolam, diazepam, clonazepam, lorazepam, etc.	Immunoassays for benzodiazepines have a 28% overall false negative rate and vary in cross-reactivity. Certain benzodiazepines (clonazepam and alprazolam) have limited detectability by most available immunoassays. Confirmatory testing is needed when use is expected or suspected.
Cocaine or benzoylecgonine	2-4 days	Cocaine Metabolites Immunoassay	Cocaine Metabolites Immunoassay – see Consideration	Cocaine immunoassays do not cross-react with other topical anesthetics that end in “caine” (e.g. lidocaine) and are highly specific for cocaine use.
Marijuana	2-4 days; up to 30 days w/ chronic heavy use	Cannabinoids (THC) Immunoassay	Cannabinoids Immunoassay – see Consideration GC/MS or LC/MS/MS – THC	THC may be an indicator of the patient’s risk category. Prescribers should have an office policy, discuss with the patients reason for use and adjust monitoring plan accordingly.

*Agency Medical Directors Group, Interagency guideline on Opioid dosing for Chronic Non-cancer Pain, 2010.

BEHAVIORAL HEALTH RISKS SCREENING TOOL



For Pregnant Women and Women of Childbearing Age

Patient/Client Name _____ Date _____

Screeener Name _____ Date _____

Reviewed by Qualified Provider _____ Date _____

Women and their children’s health can be affected by emotional problems, alcohol, tobacco, other drug use and violence. Women and their children’s health are also affected when these same problems are present in people who are close to them. Alcohol includes beer, wine, wine coolers, liquor and spirits. Tobacco products include cigarettes, cigars, snuff and chewing tobacco.

APPENDIX N

1. Have you smoked any cigarettes or used any tobacco products in the past three months?	TOBACCO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Did any of your parents have a problem with alcohol or other drug use?	PARENTS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. Do any of your friends have a problem with alcohol or other drug use?	PEERS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4. Does your partner have a problem with alcohol or other drug use?	PARTNER	<input type="checkbox"/> YES	<input type="checkbox"/> NO
5. In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?	PAST	<input type="checkbox"/> YES	<input type="checkbox"/> NO
6. Check YES if she agrees with any of these statements. – In the past month, have you drunk any alcohol or used other drugs? – How many days per month do you drink? _____ – How many drinks on any given day? _____ – How often did you have 4 or more drinks per day in the last month? _____	PRESENT	<input type="checkbox"/> YES	<input type="checkbox"/> NO
7. Over the last few weeks, has worry, anxiety, depression, or sadness made it difficult for you to do your work, get along with other people, or take care of things at home?	EMOTIONAL HEALTH	<input type="checkbox"/> YES	<input type="checkbox"/> NO
8. Are you feeling at all unsafe in any way in your relationship with your current partner?	VIOLENCE	<input type="checkbox"/> YES	<input type="checkbox"/> NO

PROVIDER USE ONLY

Brief Intervention/Brief Treatment	Y	N	NA
Did you State your medical concern?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you Advise to abstain or reduce use?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you Check patient’s reaction?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you Refer for further assessment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you Provide written information?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Review risk.

Refer to tobacco cessation program or addictions and recovery programs.

Refer to domestic violence prevention.

Refer to mental health program.

Develop a follow-up plan with patient.

Moderate drinking for non-pregnant women is one drink per day. Women who are pregnant or planning to become pregnant should not use alcohol, tobacco, illicit drugs or prescription medication other than as prescribed.

Developed by the Institute for Health and Recovery (IHR), Massachusetts, February, 2007. Adapted by the Southern Oregon Perinatal Task Force in partnership with AllCare Health Plan, Oregon, May 2013.

COMPARISON OF CURRENT OPIOID GUIDELINES

Clinical Issue	ACOEM Guidelines	American Pain Society Guidelines	Canadian Pain Guidelines	Colorado Guidelines	California MTUS Guidelines	Washington Guidelines
Screen all patients for opioid risks, using a questionnaire?	Yes, all patients; SOAPP is suggested	Yes. Questionnaire "likely" to help; suggest SOAPP, PADI, or COMM	Consider using questionnaire; suggest Opioid Risk Tool (ORT)	No recommendation	CAGE, SOAPP, Opioid Risk Tool (ORT), others suggested	PO9, CAGE-AID
Initiate opioids only after treatment failure?	Yes	No. Start chronic opioids when benefits are likely to outweigh risks	Physician should document "comprehensive knowledge of the patient's pain condition"	Yes	Yes	N/A
Urine drug screen on all patients on chronic opioids?	Yes	Urine drug screens recommended "periodically" in patients at high risk for drug abuse. "Consider" urine drug screens in low risk patients	No recommendation for routine urine drug screenings	Yes	Consider	Yes
Urine drug screen only for high risk with acute pain?	Yes	Recommended	No recommendation for routine urine drug screenings	Yes	Consider	Yes
Frequency of urine drug screen?	2 to 4 times a year, random	Could be as often as weekly in "very high risk" patients; no other recommendation for frequency	No recommendation for routine urine drug screening at all	At least annually	Random	Frequency of urine drug screening depends on both MED and ORT risk score (range from 1 to 4 times a year)
Pain agreements for ALL patients on chronic narcotics?	Yes	Recommend written informed consent when starting chronic opioids. Sample "Pain Agreement"	Consider in patients at high risk for abuse; no recommendation for routine use of pain agreements	Yes	Optional	Yes
Pain agreements for "high risk" patients?	Yes	No recommendation; sample "Pain Agreement" included in Appendix	No recommendation for routine use of pain agreements	Yes	Optional	N/A
Discontinue/wean opioids if no functional improvement	Yes	Yes	No recommendation	No recommendation	Yes	Yes
Increase dose of meds if additional functional improvement obtained?	Yes	Yes	Yes	No recommendation	Yes	Yes
Maximum morphine-equivalent dose before additional screening?	N/A	200 MEQ (morphine equianalgesic dose)	200 MEQ (morphine equianalgesic dose)	N/A	N/A	120 MEQ (morphine equianalgesic dose)
Consultation with pain specialist recommended?	Yes. PRN	Primary care physician should continue to manage. Consider consult, at clinician's judgment	No	Required	Yes, as per Washington	Yes, suggested if >100 MEQ, but required if > than 120 MEQ
Attempt periodic wean of opioids if functional improvement?	Yes	No recommendation	No recommendation	No recommendation	Yes	Yes
Attempt periodic wean of meds for ALL patients on chronic opioids?	Yearly	Yes	No recommendation	No recommendation	N/A	N/A
Psychiatry consult recommended?	Yes, especially during wean	Consider, at clinician's judgment	Referral to pain management specialist recommended for certain high risk conditions	Yes	Yes	Yes. Must have psych eval if combining narcotics with benzodiazepines, sedatives, etc.
PT recommended?	Yes, especially during drug wean and to establish HEP.	No recommendation	No recommendation	No recommendation	Yes	N/A
Physician to consult PDMP (Prescription Drug Monitoring Program) regularly	N/A	N/A	N/A	Yes	N/A	N/A
Other clinical advice			Discontinue or taper benzodiazepines before initiating chronic opioids	Requires the physician to prepare a written Treatment Plan. Supplemental Fee Schedule for extra documentation		Urine drug screen-first use immunoassay (less expensive); if needed after a positive result, confirmatory test (GC/MS or other)
Advice about driving?		No evidence to suggest that chronic opioid use impairs driving; warn patients not to drive if they "feel impaired"	Advise not to drive until opioid dose stabilized			

WOEMA wishes to thank the following members who compiled this poster: Paul Papanek, MD, MPH, FACOEM, Scott Levy, MD, MPH, FACOEM, and Steven Feinberg, MD.

PATIENT AND COMMUNITY RESOURCES

	Inpatient care, residential	Populations served	Chronic pain services	Sliding scale	Payment options
Adapt Josephine County-Recovery Services					
418 NW 6th St., Grants Pass, OR 97526 541-474-1033 Fax: 541-474-0770 www.adaptoregon.org	✓	Adults and adolescents	✓	✓	OHP, commercial insurance
The Addictions Recovery Center					
111 Genesee St., Medford, OR 97504 541-779-1282 Fax: 541-779-2081 www.addictionsrecovery.org	✓	Adults and children	✓	✓	OHP, commercial insurance
Allied Health-Recovery Services					
777 Murphy Road, Medford, OR 97504 541-772-2763 Fax: 541-734-3164		Adults	✓ (for those with addiction only. Methadone and Suboxone.)	✓	OHP, commercial insurance
Choices Josephine County-Recovery Services					
109 Manzanita Ave Grants Pass, OR 97526 541-479-8847 Fax: 541-471-2679		Adults and adolescents	✓		OHP
Jackson County Mental Health					
1005 E Main St., Medford, OR 97503 541-774-8201 www.co.jackson.or.us	✓	Adults and families	✓	✓	OHP
Kolpia-Recovery Services (offices in Medford and Talent)					
10 S Bartlett St, Ste 204 Medford, OR 97503 541-227-6729 Fax: 541-482-0964 www.kolpiacounseling.com		Adults and adolescents	✓ (including Suboxone)		OHP, commercial insurance
On Track-Recovery Services (offices in Medford, Grants Pass, White City, and Ashland)					
221 W Main St., Medford, OR 97501 541-772-1777 Fax: 541-734-2410 www.ontrackrecovery.org	✓	Adults and children	✓	✓	OHP, Medicare, commercial insurance
Options for Southern Oregon, Inc.					
1215 SW G St., Grants Pass, OR 97526 541-476-2373 Fax 541-476-1526 www.optionsonline.org	✓	Adults and families		✓	OHP
Phoenix Counseling Center-Recovery Services					
153 S Main St., Phoenix, OR 97520 541-535-4133 Fax: 541-535-5458 www.phoenixcounseling.org		Adults and adolescents	✓	✓	OHP, commercial insurance

LINKS

Group Health: Principles for More Selective and Cautious Opioid Prescribing

www.ghinnovates.org/?p=3573

University of Washington: Pain Medicine Provider Toolkit

<http://depts.washington.edu/anesth/education/pain/index.shtml>

Center for Disease Control

www.cdc.gov/primarycare/materials/opoidabuse/index.html

Washington State Agency Medical Directors

www.agencymeddirectors.wa.gov

ADDITIONAL REFERENCES

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Standridge JB, Adams SM, Zotos AP. Urine drug screening: a valuable office procedure. *American Family Physician*. 2010;81(5):635-40.

Notes

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OREGON PAIN GUIDANCE

www.oregonpainguidance.org



Your Community Health Plan

www.jacksoncareconnect.org



My community. My health plan.

www.allcarehealthplan.com

Produced by Oregon Pain Guidance of Southern Oregon