Portland Metro Regional Safe Opioid 
Prescribing Standards  
December 2015

A collaborative effort of local government, hospitals, health systems, clinics and coordinated care organizations
Portland Metro Regional Safe Opioid Prescribing Standards

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

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

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

Two similar prescribing standards follow; one is for patients with chronic pain who are not currently receiving opioids, the second is for patients with chronic pain who are already on opioids. Each standard is a single page but an annotated version is appended.
The safe prescribing workgroup was chaired by Melissa Weimer, DO, Assistant Professor, OHSU. Participants in the safe prescribing workgroup included representatives from:

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

Coordinated Care Organizations
- FamilyCare Health
- HealthShare of Oregon

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

Public Health Departments
- Clackamas County
- Clark County, Washington
- Multnomah County
- Washington County

Professional Organizations
- Oregon Academy of Family Physicians
- Oregon Association of Naturopathic Physicians
- Oregon College of Emergency Physicians
- Oregon Section American College of Obstetrics and Gynecology
As of December 1, 2015, these Standards have been formally endorsed by the following institutions and organizations:

- Adventist Health
- CareOregon
- Central City Concern
- Clackamas County Health Centers
- FamilyCare Health
- HealthShare of Oregon
- Kaiser Permanente
- Multnomah County Clinics
- OHSU Health System
- Providence Health and Services
- Tuality Healthcare
- Virginia Garcia Memorial Health Centers
Standard for New Opioid Prescriptions for Patients with Chronic Non-Cancer/Non-Terminal Pain

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

2: Document initial and periodic functional evaluation.
   - Consider a physical and/or occupational therapy evaluation prior to opioid prescribing

3: Regularly monitor and document subjective pain measures.

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

5: Establish an opioid prescribing daily dosing limit.
   - Avoid a total opioid dose greater than 120mg MED in a 24 hour period without a qualified secondary review (i.e. pain specialist, internal opioid review process, etc.)

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

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

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

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

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

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

1: Perform a patient evaluation/history.
   • Obtain a detailed Pain History
   • Perform an appropriate physical exam including periodic evaluation of neurologic and musculoskeletal systems
   • Review and periodically update mental health and substance abuse history

2: Perform periodic functional evaluation.

3: Regularly monitor and document subjective pain measures.

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

5: Establish an opioid prescribing daily dosing limit.
   • Avoid a total opioid dose greater than 120mg MED in a 24 hour period without a qualified secondary review (i.e. pain specialist, internal opioid review process, etc.)

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

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

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

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

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