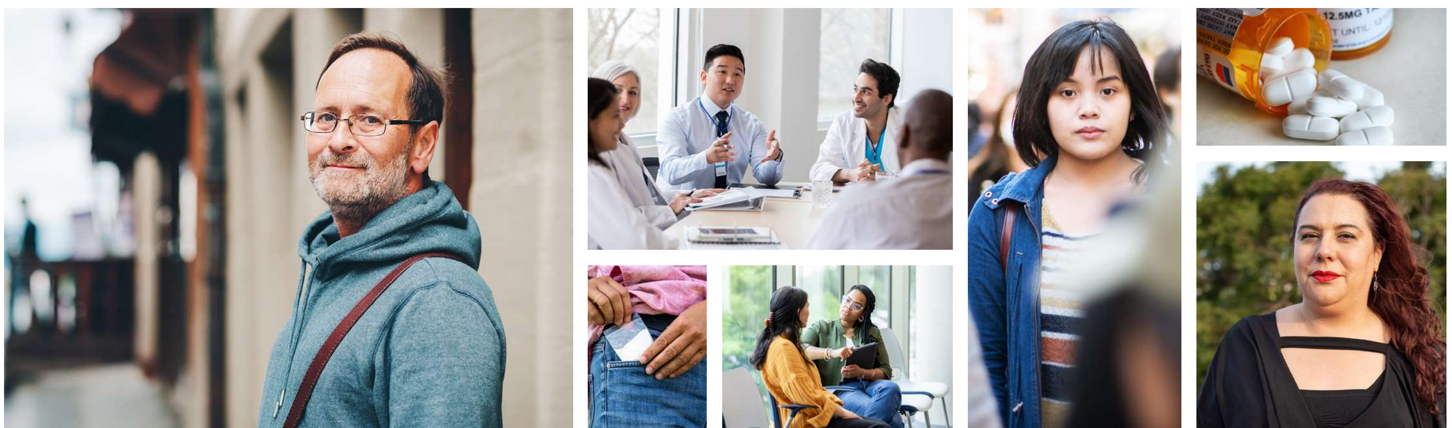
July 2024

Oregon Opioid Prescribing Guidelines:

Recommendations for the Safe Use of Opioid Medications



Approved by Oregon Opioid Prescribing Guidelines Task Force members on November 18, 2016

Updated July 2024 to reflect updated CDC Clinical Practice Guideline for Prescribing Opioids for Pain

Oregon Health Authority
PUBLIC HEALTH DIVISION

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Background

At the start of the 21st century, Oregon and the nation experienced a dramatic increase in overdose deaths and hospitalizations due to prescription opioid pain medications. The key to reversing prescription opioid overuse and associated adverse effects (e.g., increases in heroin use, non-medical use of prescription opioids, opioid use disorder, etc.,) is addressing opioid prescribing practices that lead to misuse, overdose, and death. In a March 2016 response, the Centers for Disease Control published the *CDC Guideline for Prescribing Opioids for Chronic Pain*.

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

Task force members met from April through November of 2016, relying on expert review from varied organizational perspectives to consider endorsement of the CDC Guideline and Oregon-specific additions. Four workgroups formed and met separately to develop recommendations for these additions and for future work to communicate and implement the Oregon Guidelines. The task force adopted the CDC Guideline as the foundation for opioid prescribing for Oregon and developed a brief addendum to address Oregon-specific concerns. The task force encouraged more discussion at state, regional and organizational levels on how the guidelines should be disseminated, communicated to patients and providers, and implemented.

In 2022, CDC released an updated CDC Clinical Practice Guideline for Prescribing Opioids for Pain, a clinical tool intended to help clinicians and patients make shared, informed, patient-centered decisions about pain care. The updated recommendations are intended to be flexible, voluntary, and support, not supplant, individualized, person-centered care. This update targets a broader clinical audience spanning from primary care to outpatient settings and has expanded guidance on acute and subacute pain, maximizing nonpharmacologic and nonopioid treatment, as well as specific implementation considerations.

In Oregon, opioid prescriptions dispensed from retail pharmacies have declined nearly 40% since peaking in 2013. The number of people dying each year from overdoses related to prescription opioids declined between 2010 and 2019 and has remained at a consistent level since then, even as the number of people dying

from overdoses from illicit opioids and other drugs has risen sharply. In addition to ongoing efforts to address overdoses related to illicit drugs, continuing attention to practice guidelines for opioid prescribing remains an essential means of addressing the overdose crisis.

Summary of the recommendations

In 2022, CDC released an updated Clinical Practice Guideline for Prescribing Opioids for Pain. The full CDC Guideline can be found at: https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm

The Oregon Pain Management Commission (OPMC) recognizes that the 2022 CDC Guideline update provides vital advice for healthcare professionals as they navigate the complexities of pain management. OPMC endorses CDC's 2022 Clinical Practice Guidelines for Prescribing Opioids for Pain in a Position Statement available here: https://www.oregon.gov/oha/HPA/dsi-pmc/Resources/2022-CDC-Guidelines-Update-Position-Statement_February_draft_final.pdf.

Below are 12 CDC Guideline abbreviated recommendations including 2022 revisions, with Oregon additions in shaded text. The 2016 Oregon additions are unchanged.

I. Determining when to initiate or continue opioids for pain

1. Nonpharmacologic therapy and nonopioid therapy are at least as effective as opioids for many types of acute pain. Clinicians **should maximize use of nonpharmacologic and nonopioid pharmacologic therapies** as appropriate for the specific condition and patient and only consider opioid therapy for acute pain if benefits are anticipated to outweigh risks to the patient.

   Before prescribing opioid therapy for acute pain, clinicians should discuss with patients the potential benefits and harms of opioid therapy.

2. **Nonopioid therapies are preferred for subacute and chronic pain**. Clinicians should maximize use of nonpharmacologic and nonopioid pharmacologic therapies as appropriate for the specific condition and patient and only consider initiating opioid therapy if expected benefits for pain and function are anticipated to outweigh risks to the patient.

   Before starting opioid therapy for chronic pain, clinicians should discuss with patients the potential benefits and harms of opioid therapy, should work with patients to establish treatment goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks.

II. Selecting opioids and determining dosage

3. When starting opioid therapy for acute, subacute, or chronic pain, clinicians should **prescribe immediate-release** opioids instead of extended-release/long-acting (ER/LA) opioids.

4. When opioids are started for opioid-naïve patients with acute, subacute, or chronic pain, clinicians should **prescribe the lowest effective dosage**. If opioids are continued for subacute or chronic pain, clinicians should use caution when prescribing opioids at any dosage, carefully evaluate individual potential benefits and harms when considering increasing dosage and avoid increasing dosage above levels likely to yield diminishing returns in benefits relative to risks to patients.

5. For patients already receiving opioid therapy, clinicians should **carefully weigh potential benefits and harms and exercise care when changing opioid dosage**. If the benefits outweigh the harms of continued opioid therapy, clinicians should work closely with patients to optimize non-opioid therapies while continuing opioid therapy. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work closely with patients to gradually taper opioids to lower dosages or, if warranted based on the individual circumstances of the patient, appropriately taper, and discontinue opioids.

   Unless there are indications of a life-threatening issue such as warning signs of impending overdose (e.g., confusion, sedation, or slurred speech), **opioid therapy should not be discontinued abruptly**, and clinicians should not rapidly reduce opioid dosages from higher dosages.

   - Clinicians should strongly consider additional evaluation of the potential benefits and harms of higher dose opioid therapy, document clinical justification for the higher dose in the medical record and obtain and document pain management consultation. Options for consultation could include: 1) having a colleague evaluate the patient, 2) presenting and discussing the case to a clinician peer group or multi-disciplinary pain consultation team, 3) referring the patient to a pain specialist who has experience tapering patients off of opioids, or 4) referring the patient to a mental health provider specializing in care for people with chronic pain and/or addictions. (See CDC narrative under recommendation 8.)
   - Refer to Oregon Medical Board Material Risk Notice (required in Oregon when prescribing opioids for chronic pain.): https://www.oregon.gov/omb/OMBForms1/material-risk-notice.pdf
   - Refer to the *Oregon Medical Board Winter 2024 Report* for information on inheriting transferred patients on opioids and other controlled prescriptions. "The Board wishes to reassure and encourage licensees to assume the prescribing

responsibilities for such patients, regardless of MME level, at least temporarily, in order to avoid patients going into withdrawal or turning to illicit sources." Read the report here: https://www.oregon.gov/omb/Newsletter/Winter%202024.pdf

- Task force members emphasized the need for compassionate and nondiscriminatory treatment for established (including transferred) patients currently taking higher doses, echoing specific suggestions found in the CDC Guideline narrative supporting this recommendation.

III. Deciding duration of initial opioid prescription and conducting follow-up

6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should **prescribe no greater quantity than needed** for the expected duration of pain severe enough to require opioids.

7. Clinicians should **evaluate potential benefits and harms with patients within one to four weeks** of starting opioid therapy for subacute or chronic pain or of dose escalation. Clinicians should regularly re-evaluate the potential benefits and harms of continued opioid therapy, with a suggested interval of every three months or more frequently for most patients.

IV. Assessing risk and addressing potential harms of opioid use

8. Before starting and periodically during continuation of opioid therapy, clinicians should **evaluate risk for opioid-related harms and discuss risk with patients**. Clinicians should incorporate strategies into the management plan to mitigate risk including co-prescribing naloxone. Clinicians should consider asking patients about their drug and alcohol use and use validated tools or consult with behavioral specialists to screen for and assess mental health and substance use disorders.

9. When prescribing initial opioid therapy for acute, subacute, or chronic pain, and periodically during opioid therapy for chronic pain, clinicians **should review the patient's history of controlled substance prescriptions** using state Prescription Drug Monitoring Program (PDMP) data to determine whether the patient is receiving opioid dosages or combinations that put the patient at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every three months.

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

10. When prescribing opioids for subacute or chronic pain, clinicians should consider the potential benefits and harms of **toxicology testing to assess for prescribed medications as well as other prescribed and nonprescribed controlled substances**.

    - If clinicians suspect their patient might be sharing or selling opioids and not taking them, or intentionally misusing opioids, clinicians should consider 1) urine drug testing to consider whether opioids can be discontinued abruptly or tapered, and 2) referral to substance use disorder (SUD) treatment.
    - Urine drug testing is a tool that can be used to assist providers in assessing whether patients are using opioids as prescribed, using other substances, or potentially diverting opioids.

11. Clinicians should **use particular caution when prescribing opioid pain medication and benzodiazepines concurrently** and consider whether benefits outweigh risks of concurrent prescribing of opioids and other central nervous system depressants.

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

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

12. Clinicians should **offer or arrange treatment** with evidence-based medications to treat patients with opioid use disorder, such as buprenorphine or methadone, in combination with behavioral therapies (see Resources for list of county Behavioral

Health Resource Networks (BHRNS)). **Detoxification on its own**, without medications for opioid use disorder, **is not recommended** ffor opioid use disorder because of increased risks for resuming drug use, overdose, and overdose death.

- Oregon Board of Pharmacy issued a Statement on Access to Buprenorphine for Patients Requiring Medication-Assisted Treatment for Opioid Use Disorder (OUD). The Board of Pharmacy recognizes the significant role of buprenorphine in supporting individuals with OUD. Pharmacies, particularly those in rural and underserved communities, are critical access points for all patients. The Board of Pharmacy has a call to action for community pharmacies to make buprenorphine available to patients seeking treatment for OUD. Recognizing the importance of accessible and convenient care, the Board of Pharmacy encourages all wholesale distributors and pharmacies to maintain adequate supplies of buprenorphine to minimize barriers for patients. The full Board of Pharmacy Statement is available here: https://content.govdelivery.com/accounts/ORBOP/bulletins/377308c

V. Additional considerations: cannabis (marijuana) and safe storage and disposal

1. **Cannabis**

With Oregon's legalization of recreational use of cannabis in 2014, its use is relatively prevalent. Current data are limited on the interactions between opioids and cannabis products.

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

2. **Safe storage and disposal**

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

Resources

Resources for prescribers

1. The full version of the CDC Guideline includes specific details and tools for each of the 12 recommendations: https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm
2. Oregon Pain Management Commission Position Statement for the 2022 CDC Guidelines: https://www.oregon.gov/oha/HPA/dsi-pmc/Resources/2022-CDC-Guidelines-Update-Position-Statement_February_draft_final.pdf
3. Oregon Medical Board Winter 2024 Report: https://www.oregon.gov/omb/Newsletter/Winter%202024.pdf
4. Safe and Competent Opioid Prescribing Education: https://www.scopeofpain.org/
5. Providers' clinical support system for opioid therapies: http://pcss-o.org/
6. Oregon ECHO Network for health care providers: https://www.oregonechonetwork.org/
7. HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics: https://www.hhs.gov/system/files/Dosage_Reduction_Discontinuation.pdf
8. Oregon Pain Management Commission pain training course for health care providers: https://oregonpainmodule.org/regApp/regForm.asp
9. Oregon Prescription Drug Monitoring Program: http://www.orpdmp.com/
10. List of county Behavioral Health Resource Networks (BHRNS)
11. Oregon Board of Pharmacy Statement on Access to Buprenorphine for Patients Requiring Medication-Assisted Treatment for Opioid Use Disorder https://content.govdelivery.com/accounts/ORBOP/bulletins/377308c

Resources for patients

1. Heal Safely, a campaign to empower people to heal safely after injury or surgery: https://healsafely.org/
2. University of Washington Tele-Pain for health care providers: http://depts.washington.edu/anesth/care/pain/telepain/

3. Oregon Pain Education Toolkit: https://www.oregonpainguidance.org/paineducationtoolkit/

4. OHA naloxone training protocol: http://public.health.oregon.gov/ProviderPartnerResources/EMSTraumaSystems/Pages/epi-protocol-training.aspx

5. Oregon Public Health Division's website: www.healthoregon.org/opioids

6. SAMHSA's MAT website: http://www.samhsa.gov/medication-assisted-treatment

7. SAMHSA opioid treatment program directory: http://dpt2.samhsa.gov/treatment/directory.aspx

8. Oregon Addictions and Mental Health Services: http://www.oregon.gov/oha/amh/Pages/gethelp.aspx

9. Oregon substance use helpline: 1-800-923-4357

Safe disposal and drug take back programs

1. Oregon Drug Take-Back and Disposal: https://public.health.oregon.gov/HealthyEnvironments/DrinkingWater/SourceWater/Pages/takeback.aspx

2. Rx Disposal for Pharmacists and Clinics: http://orcrm.oregonpainguidance.org/rx-disposal/rx-disposal-pharmacists-clinics/

3. FDA – How to dispose of unused medicines: http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm101653.htm

Cannabis information

1. Oregon Medical Marijuana Prescribing Guidelines: https://public.health.oregon.gov/DiseasesConditions/ChronicDisease/MedicalMarijuanaProgram/Pages/Physicians.aspx

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact Lisa Shields at 971-673-1036 or email LISA.M.SHIELDS@oha.oregon.gov. We accept all relay calls.

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