NWFMR Policy #13: Prescription Opioid Guideline

The intent of this guideline is to provide a standardized approach for usage of opioid/narcotic medications within our Family Medicine Practice. While this document is based upon “best practices” according to CDC Guidelines, Washington State Guidelines, and the Six Building Blocks for Safe and Effective Opioid Prescribing, every physician, nurse practitioner, and physician assistant should exercise her/his clinical judgment during patient care. When deviation(s) from the guideline occur, it is incumbent upon the prescriber to provide justification for such deviation...demonstrating need for an approach to care outside the guideline.

Physicians, Nurse Practitioners, and Physician Assistants within Northwest Washington Family Medicine Residency Practice:

1. **Should Not** prescribe opiate medications at a “new-patient” visit.
2. **Should Not** prescribe opiates for any residency employee unless that employee is the empanelled patient of the prescriber.
3. **Should Not** use long-acting opioids for treatment of acute pain.
   a. MS Contin, OxyContin, Opana, XTampa, and Fentanyl Transdermal are examples of “long-acting opioids.”
4. **Should Not** initiate treatment with opiate medications without reviewing the Washington State Prescription Monitoring Program report for her/his patient.
5. **Should Not** prescribe long-term opioid therapy in patients with substance use disorders.
6. **Should Not** prescribe opiate and benzodiazepine medications concurrently.
7. **Should** initiate taper to discontinue one, or both, medications if patients ARE using benzodiazepine and opiate medications concurrently.
8. **Should** use non-opioid medications and therapies as first-line treatment for mild and moderate acute pain.
   a. NSAIDs, Acetaminophen, Physical Therapy Referral, Massage Therapy Referral, Sports Medicine Referral, Behavioral Health Referral, and Physical Medicine Referral are examples of such treatments.
9. **Should**, when opioids are indicated for acute pain, initiate therapy at the lowest effective dose for no longer than a 3 day duration.
10. **Should** reassess the patient if pain persists beyond the 3 day duration and document rationale for continued opioid therapy.
11. **Should** prescribe self-management strategies, non-pharmacologic treatments, and non-opioid medications as the preferred treatment for chronic pain.
12. **Should** avoid initiation of Long-Term Opioid Therapy for most patients with non-cancer chronic pain.
   a. “Long-Term Opioid Therapy” is defined as treatment with scheduled opiate medication > 30 days
   b. “Long-Term Opioid Therapy” includes usage of either short-acting or long-acting medication preparations.
13. **Should** prescribe opiates at the lowest possible dose and for the shortest possible time if Long-Term Opiate Therapy is required.

14. **Should** document informed consent which includes the risks of opioid use, options for alternative therapies, and therapeutic boundaries for patients maintained on long-term opioid therapy.

15. **Should** review annually with patients the risks, benefits and alternatives to treatment with Long-Term Opioid Therapy.
   - The NWFMR Prescription Opioid Agreement should be re-signed.
   - The patient’s presence on the Chronic Opioid Treatment Registry should be verified.

16. **Should** limit opiate prescriptions to <50 Morphine Equivalents Daily.

17. **Should** refer patients to a Pain Management Specialty Clinic if therapy ≥90 Morphine Equivalents Daily.

18. **Should** discuss reproductive plans, contraceptive options, and the risk of neonatal abstinence syndrome when using Opioid Therapy for women of reproductive age.

19. **Should**, at face-to-face visits, document re-evaluation of patients on long-term opioid therapy at least every 90 days for functional improvements, substance use, high-risk behaviors, PDMP checks, and performance of urine drug tests.

20. **Should** assess and treat appropriately co-morbid mental health conditions contributing to opioid misuse risk.
   - Treatment may include initiation of therapy with medication, referral for evaluation/treatment with NWFMR Behavioral Health, and/or referral for evaluation/treatment with an outside Mental Health Specialist.
## Functional Improvement Symptom Tracker

### Pain Intensity
0. My pain is mild to moderate; I do not need painkillers.  
1. My pain is severe, but I manage without taking painkillers.  
2. My pain is severe, and painkillers give me complete relief.  
3. My pain is severe, and painkillers give me some relief.  
4. My pain is severe, and painkillers give me no relief.

### Personal Care
0. I can look after myself normally.  
1. I can look after myself normally, but it causes additional pain.  
2. I need some help to manage some personal care.  
3. I need help every day to manage most aspects of my self-care.  
4. I cannot get dressed. I wash with difficulty and stay in bed.

### Lifting
0. I can lift weights of 15-20 pounds without causing pain.  
1. I can lift weights of 15-20 pounds, but it causes more pain.  
2. I cannot lift weights of 15-20 pounds off the floor.  
3. I cannot lift weights of 5-10 pounds.  
4. I cannot lift or carry anything at all.

### Walking
0. I can walk as far as I wish without extra pain.  
1. Pain prevents me from walking more than 1 mile.  
2. Pain prevents me from walking more than ½ mile.  
3. Pain prevents me from walking more than ¼ mile.  
4. I cannot walk without a cane, a walker, or crutches.  
5. I cannot walk and spend most days in bed or a chair.

### Sitting
0. I can sit in any chair for as long as I like without extra pain.  
1. I can sit in my favorite chair only, but for as long as I like.  
2. Pain prevents me from sitting more than 1 hour.  
3. Pain prevents me from sitting more than ½ hour.  
4. Pain prevents me from sitting more than 10 minutes.  
5. Pain prevents me from sitting at all.

### Standing
0. I can stand as long as I want without extra pain.  
1. I can stand as long as I want, but it causes extra pain.  
2. Pain prevents me from standing for more than 1 hour.  
3. Pain prevents me from standing for more than ½ hour.  
4. Pain prevents me from standing for more than 10 minutes.

### Sleeping
0. Pain does not prevent me from sleeping well.  
1. I sleep well, but only when taking medication.  
2. Even when I take medication, pain keeps me from sleeping more than 8 hours.  
3. Even when I take medication, pain keeps me from sleeping more than 4 hours.  
4. Even when I take medication pain keeps me from sleeping more than 2 hours.  
5. Pain keeps me from sleeping at all.

### Social Life
0. My social life is normal and causes me no extra pain.  
1. My social life is normal but causes me extra pain.  
2. Pain affects my social life by limiting some activities like dancing, sports, etc.  
3. Pain affects my social life, and I do not go out often.  
4. Pain has restricted my social life to home.  
5. I have no social life because of pain.

Updated 5/17/2018
Traveling
(0) I can travel anywhere without extra pain.
(1) I can travel anywhere, but it gives me extra pain.
(2) Pain limits my travel time to about 2 hours.
(3) Pain limits my travel time to about 1 hour.
(4) Pain limits my travel time to less than ½ hour.
(5) Pain prevents travel except to the doctor/hospital.

Changing Degree of Pain
(0) My pain is getting better quickly.
(1) My pain changes from day to day, but overall is getting better.
(2) My pain seems to be getting better but improvement is very slow.
(3) My pain is no better and no worse.
(4) My pain is gradually getting worse.
(5) My pain is quickly getting worse.

Side Effects
(1) In the past 2 weeks, my pain medications have caused me to lose interest in usual activities.
(1) In the past 2 weeks, my pain medications have caused me to have trouble concentrating.
(1) In the past 2 weeks, my pain medications have caused me to feel slow or sluggish.
(1) In the past 2 weeks, my pain medications have caused me to feel depressed, down, or anxious.
(1) In the past 2 weeks, my pain medications have caused problems with my family, work, or social life.

Total Score: ____________