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>> Oregon **Acute** Opioid Prescribing Guidelines

Recommendations for patients with **acute pain**
not currently on opioids

Acknowledgments

Workgroup participants

Oregon Health Authority:

- State Health Officer: Katrina Hedberg, MD, MPH
- Chief Medical Officer: Dana Hargunani, MD, MPH
- Associate Medical Director of the Health Evidence Review Commission: Catherine Livingston, MD, MPH
- Dental Director: Bruce Austin, DMD

Co-author, CDC Guideline for Prescribing Opioids for Chronic Pain:

Roger Chou, MD

Local Public Health Authority:

- Multnomah County Health Officer: Paul Lewis, MD, MPH
- Jackson County Health Officer: Jim Shames, MD
- Clackamas County Federally Qualified Health Center: Andrew Suchocki, MD, MPH

Medical associations

- Oregon Medical Association: Andris Antoniskis, MD; Amy Kerfoot, MD; Courtni Dresser
- Oregon Academy of Family Physicians: Kathryn Kolonic, DO; Betsy Boyd-Flynn
- Oregon Primary Care Association: Danielle Sobel, MPH

Coordinated care organizations

- InterCommunity Health Network Medical Director: Kevin Ewanchyna, MD
- Health Share of Oregon Chief Medical Officer : Maggie Bennington-Davis, MD
- Care Oregon Chief Medical Officer: Amit Shah, MD
- Health Share of Oregon Medical Director: David Labby, MD, PhD

Emergency medicine

- Oregon Chapter of the American College of Emergency Physicians, Oregon Chapter: Michael Henstrom, MD, FACEP; Hans Notenboom, MD; Michelle Shaw, MD; Katy King

Surgery

- American College of Surgeons: Laurel Soot, MD
- Kaiser Permanente Department of Surgery: David Parsons, MD

Dental

- Oregon Oral Health Coalition: Gary Allen, DMD, MS
- CareOregon Dental Director: Alyssa Franzen, DMD
- Multnomah County Dental: William Runckel, DMD

Pharmacy

- Oregon State Pharmacy Association: Kevin Russell, RPh, MBA, BCACP
- Coordinated Care Organizations Pharmacy Directors: Caryn Mickelson, PharmD

Naturopathic medicine

- Oregon Association of Naturopathic Physicians: Patrick Chapman, ND

Oregon Health Leadership Council: Susan Kirchoff, MBA

Oregon Pain Management Commission: Catriona Buist, PsyD

Professional licensing boards

- Oregon Medical Board: Joe Thaler, MD
- Oregon Board of Dentistry: Stephen Prisby
- Oregon Board of Nursing: Helen Turner, DNP, PCNS
- Oregon Board of Pharmacy: Marcus Watt, RPh

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Background

Despite a greater than 30% reduction in opioid prescribing in Oregon since 2012, prescribing rates in Oregon remain high; during 2017, more than 20% of all residents received at least one opioid prescription. Recent analysis by the CDC (1) illustrates a linear association between the duration of an initial prescription and the likelihood of developing long-term opioid use. In addition, many patients who receive a prescription for opioids do not use all the medications, resulting in leftover pills that increase the risk of misuse and abuse. (2) These factors support the need for robust safety measures around prescribing opioids for acute, painful conditions. Opioids should only be prescribed when necessary for acute painful conditions due to the associated risks of long-term opioid use, misuse and overdose. Furthermore, the lowest effective dose and the shortest duration needed are important prescribing considerations to mitigate the risks.

The goal of these Oregon acute prescribing guidelines is to improve patient safety while emphasizing effective and compassionate treatment of acute pain. These statewide guidelines are intended for patients who have had limited exposure to opioids in the past. They are not intended for those who currently receive opioids nor for those with a history of substance use (or opioid use) disorder.

The guidelines address patients seen in the following domains of practice:

- Outpatient care (e.g., emergency departments; urgent care; primary care, including specialists who serve as primary care clinicians)
- Dental care
- Post-procedure/post-surgical care

While many of the principles will be relevant, the guidelines do not specifically address acute pain from medical conditions in patients requiring hospitalization (e.g., sickle cell pain crisis, pancreatitis, kidney stone, burn victims). Similarly, while some principles may be appropriate, pain in patients at the extremes of the age spectrum (e.g., young children, the elderly), new onset acute pain in patients with chronic persistent pain and acute pain in those with a substance use disorder (SUD) are beyond the scope of these guidelines. In addition, these guidelines do not address pain treatment for cancer or for palliative or end-of-life situations.

In general, opioids should *NOT* be considered as first line therapy for mild to moderate pain. Mild to moderate pain can often be treated without opioids by recommending over-the-counter medications, and physical treatments such as ice and immobilization. If non-opioid interventions are ineffective and opioids are appropriate, **prescribe the lowest effective dose of short-acting opioids for less than 3 days; in cases of more severe acute pain, limit initial prescription to less than 7 days.**

Rationale for Oregon guidelines

Several lines of evidence have recently emerged that make addressing acute opioid prescribing an urgent matter. Most compelling is the [2017 analysis](#) released by the CDC that demonstrated “the likelihood of chronic opioid use increased with each additional day of medication supplied starting with the third day.” Among those receiving an initial 30-day prescription, more than 30% remained on opioids a year later. Another analysis among post-operative patients found that the majority did not use the quantities of opioids prescribed. (2) These unused medications increase the potential for misuse and abuse. Finally, to avoid confusion, Oregon providers, healthcare systems and payers would benefit from a single document that clarifies expectations around opioid prescribing for acute pain.

Oregon’s efforts to promote safe prescribing

Opioids are a powerful class of medications used to treat pain. However, their use has inherent risks and prescribers are encouraged to remain up-to-date in current understanding of the pathophysiology of pain and its treatment. (See the Oregon Pain Management Commission’s updated Pain Management Module: <https://www.oregon.gov/oha/HPA/CSI-PMC/Pages/module.aspx>.)

In 2016, Oregon’s Opioid Prescribing Guidelines Task Force [approved adoption](#) of Oregon-specific opioid prescribing guidelines (3) based on the [CDC Guideline for Prescribing Opioids for Chronic Pain](#). (4) The guidelines include recommendations to improve patient safety for those with chronic pain and address the ongoing prescription opioid overdose epidemic. The chronic non-cancer pain guideline does not address prescribing for acute conditions in detail. In the absence of a national standard of care for acute opioid prescribing, a variety of specialty-specific guidelines have emerged from the dental, emergency medicine and surgical communities. All emphasize that, for acute pain, clinicians should first use non-opioid medication and then, if needed, judiciously prescribe opioids in small quantities with duration typically limited to less than a week.

Acute opioid guidelines

These Oregon opioid prescribing guidelines for acute pain provide general recommendations for assessment, documentation, cautions and prescribing limits for patients not currently or recently treated with opioids (i.e., opioid-naïve) across several practice settings. More detailed guidelines for specific conditions and procedures by practice setting (e.g., dental, emergency department, post-operative) are being developed as companion recommendations to these guidelines. These companion guidelines will include recommendations for maximum opioid prescription amounts by severity and anticipated duration of acute pain.

Children, the elderly and those with existing medical conditions require additional considerations (e.g., weight, metabolism, organ dysfunction) when prescribing opioids. While these acute pain guidelines cannot address every age group and medical condition, most of the principles are relevant for all patients. For example, these guidelines should be used when prescribing opioids to adolescents after dental procedures (e.g., after third molar [wisdom tooth] extractions) or sports-related injuries in adolescents.

Approach to acute pain

While pain is primarily a sensory response to physical tissue damage, there is a strong subjective component associated with the patient's experience of pain. When determining the most appropriate treatment for acute pain consider the type of pain (e.g., musculoskeletal, neuropathic), the severity and the expected duration. Depending on the acute condition, evidence-based non-opioid therapies may be the most effective. Always choose specific medications after reviewing precautions and contraindications and make schedule and dose adjustment as needed for each patient.

In general, opioids should not be considered first line therapy for mild to moderate pain in patients with limited past exposure to opioids (i.e., opioid naïve).

If other options are not appropriate or effective for acute pain, and the clinician deems that opioids will be effective, follow these recommendations before any new opioid prescription. Avoid prescribing opioids without a direct patient to prescribing clinician assessment (e.g., face-to-face or telemedicine).

Evaluate the patient

- Identify cause and type of the acute pain (e.g., medical condition, post-op, injury). Determine whether the pain is likely to be responsive to opioid or non-opioid therapies.
- Assess severity of pain.
- Determine likely period for recovery/duration of acute pain.
- Assess age and other medical considerations that might affect opioid dose.
- Review other medications patient may be taking for pain, such as acetaminophen and non-steroidal anti-inflammatory drugs (NSAIDs). Note that these may cause drug interactions or produce toxic effects if taken with combination drugs, such as Tylenol 3.
- Document the results of this patient evaluation and the justification for prescribing an opioid.

Assess history of long-term opioid use and/or substance use disorder

- Assess patient for history of substance use disorder (SUD). Opioids should be prescribed with great caution in patients with SUD. Include specific documentation of the indication for prescribing opioids in these patients.
- Assess patient for a history of long-term opioid treatment. Review records from other providers and be aware that, for a patient who could be tapering off opioids, a new opioid prescription could jeopardize this progress.
- Coordinate with other providers who have prescribed a controlled substance (e.g., opioids, benzodiazepines) to the patient. If a patient on long-term opioids or benzodiazepines presents for an acute condition causing pain, communicate with the primary clinician overseeing the long-term opioid/benzodiazepines use.
- Assess patient's use of alcohol or sedative medications. Be aware that these may exacerbate the sedative effects of opioids and prescribe opioids with caution in these patients.

Check the Prescription Drug Monitoring Program

- Check the Prescription Drug Monitoring Program (PDMP) to understand the patient's prescription history before prescribing opioids.
- Take note of chronic opioid use and any concurrent prescription for a benzodiazepine or other sedative hypnotics.

Provide patient education

- Counsel patient about pain and expected duration before procedures or after injuries.
- Review with patient the risks and side effects of opioids.
- Provide an opioid safety handout and review with patient before prescribing.
- Counsel patient to avoid alcohol and other sedative medications when taking opioids.
- Counsel patient that using opioid combination medications (e.g., Tylenol #2-4, Vicodin, Percocet) with over-the-counter medications (e.g., Tylenol) may lead to toxicity.
- Provide information on safe storage and disposal of unused opioid medications.

Amount and type*

- Use opioids with caution and only if necessary.
- Do not prescribe opioids without a direct patient to prescribing clinician assessment, or document reason for the exception.
- **Prescribe the lowest effective dose of short-acting opioids usually for a duration of less than 3 days; in cases of more severe acute pain limit initial prescription to less than 7 days.**
- Do not recommend a more than two-fold range of amount or timing of opioids. Never recommend dual ranges (e.g., 1–2 pills every 6 hours as needed for pain is appropriate, but 1–4 pills every 4–6 hours is not).
- If prescribing an opioid combination medication (e.g., Tylenol #3), assess patient’s use of over-the-counter medications (e.g., Tylenol) to identify and explain potential acetaminophen or NSAID toxicity.
- Do not prescribe opioids and benzodiazepines simultaneously unless there is a compelling justification.
- When pre-packaged opioids are dispensed in emergency departments, ensure that a system is in place to share information via the Prescription Drug Monitoring Program (PDMP).

* Note: These guidelines use # days’ supply as a simple method to indicate amount; however, it is a given that different medications have differing strengths. A table with recommended strengths of various medications is on page 7.

Patient follow-up

- Recommend appropriate follow-up for all patients, depending on condition for which patient has been seen (e.g., dental, post-op).
- Before providing a refill, re-assess the patient's pain, level of function, healing process and response to treatment. Explore other non-opioid treatment options. Do not prescribe a refill of opioids without a direct patient to prescribing clinician assessment (e.g., face-to-face, telemedicine).
- After visits to urgent care and/or the emergency department, ensure follow-up with an appropriate primary care medical or dental provider rather than providing additional opioid refills from the ED. Prescriptions opioids from the ED for severe acute injuries (e.g., fractured bones) should be in an amount that will last until the patient is reasonably able to receive follow-up care for the injury.

Health care systems/clinic responsibilities

- Endorse the Oregon guidelines for opioid prescribing, including the guidelines for chronic and acute pain.
- Adopt these guidelines as the standard of care for various practice settings.
- Implement the guidelines in the health care systems/clinic settings by ensuring they are included in work flow processes.
- For computerized provider order entry in an electronic health record (EHR), consider eliminating default amounts of opioids and make each opioid prescription an individualized, patient-centered decision. As an option, have clinic, hospital or health system pharmacy order systems update the default to reflect recommended minimum dose outlined in this document (e.g., <8 pills).
- Monitor the results of guidelines implementation, reviewing overall opioid prescribing by health system and practice setting and for individual clinicians.
- Perform quality review of guideline implementation; identify best-practices for clinical settings and implement across the health system.
- Consider providing individual clinicians with a report card on their opioid prescribing practices, comparison with other clinicians in similar practice settings and trends in prescribing over time.

WARNING:

USE OPIOIDS WITH CAUTION AND ONLY IF NECESSARY.

IF APPROPRIATE: OPIOID MEDICATION STRENGTH FOR ACUTE PAIN IN ADOLESCENTS AND ADULTS. IN MOST CASES, <3 DAYS' SUPPLY (<8 PILLS) WILL BE SUFFICIENT; FOR MORE SEVERE PAIN, <7 DAYS MAY BE NEEDED.

Codeine (e.g., Tylenol 3)	Oxycodone (e.g., Percocet)	Hydrocodone e.g., Vicodin)	Hydromorphone (e.g., Dilaudid)	Morphine sulfate	Tramadol (e.g., Ultram)
30 mg	5 mg	5 mg	2 mg	15 mg	50 mg

Endnotes

1. Shah A, Hayes CJ, Martin BC. Characteristics of initial prescription episodes and likelihood of long-term opioid use – United States, 2006–2015. MMWR 2017; 66: 265–9 [cited 2018 Oct 8]. Available from: <https://www.cdc.gov/mmwr/volumes/66/wr/mm6610a1.htm>.
2. Hill MV, McMahon ML, Stucke RS, Barth RJ Jr. Wide variation and excessive dosage of opioid prescriptions for common general surgical procedures. Ann Surg. 2017;265(4):709–714.
3. Oregon Health Authority. Oregon Chronic Opioid Prescribing Guidelines: Recommendations for the safe use of opioid medications for patients with chronic pain [cited 2018 Oct 8]. Available from: <https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SUBSTANCEUSE/OPIOIDS/Documents/taskforce/oregon-opioid-prescribing-guidelines.pdf>.
4. Dowell D, Haegerich TM, Chou R. CDC guideline for prescribing opioids for chronic pain — United States, 2016. MMWR Recomm Rep 2016; 65 (No. RR-1): 1–49 [cited 2018 Oct 8]. Available from: <https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6501e1.pdf>.



PUBLIC HEALTH DIVISION

Prescription Drug Monitoring Program

Phone: 971-673-0741

FAX: 971-673-0990

You can get this document in other languages, large print, braille or a format you prefer. Contact Oregon Prescription Drug Monitoring Program (PDMP) at 971-673-0741 or email pdmp.health@state.or.us. We accept all relay calls or you can dial 711.