

Oregon Acute Opioid Prescribing Guideline
Recommendations for patients with acute pain not currently on opioids
DRAFT 8/27/18

Background

Despite a greater than 30% reduction in opioid prescribing in Oregon since 2012, prescribing rates in Oregon remain high; as of 2017, more than 20% of all residents received an opioid prescription annually. Recent analysis by the CDC¹ illustrates a linear association between the duration of an initial prescription and the risk of on-going opioid use demands prompt safety measures around prescribing opioids for acute, painful conditions.

The goal of this Oregon acute prescribing guideline is to improve patient safety while emphasizing effective and compassionate treatment of acute pain. This statewide guideline is not intended for patients who currently receiving short or long-term opioid therapy nor for patients with a history of substance use disorder. The guideline addresses patients seen in the following domains of practice:

- Primary care/urgent care/ emergency departments
- Dental care
- Post-procedure/post-surgical care

While many of the principles will be relevant, the guideline does not specifically address acute pain from medical conditions in patients requiring hospitalization (e.g. sickle cell pain crisis, pancreatitis, kidney stone). Similarly, while some principles may be appropriate, pain in young children, new acute pain in patients with chronic persistent pain, and acute pain in those with a Substance Use Disorder (SUD) are beyond the scope of this guideline. In addition, this guideline does not address pain treatment for cancer, palliative or end-of-life situations.

In general, opioids should NOT be considered first line therapy for mild to moderate pain. If non-opioid interventions and medications are ineffective, 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.

Rationale for an Oregon Guideline

Several lines of evidence have recently emerged that makes addressing acute opioid prescribing an urgent matter. Most compelling is the [2017 analysis](#) released by the CDC which 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 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 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 guidelines³ based on the CDC Guideline for Prescribing Opioids for Chronic Pain.⁴ The guideline includes recommendations to improve patient safety for those with chronic pain and also to 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 of opioids in small quantities with duration typically limited to less than a week.

Acute Opioid Guideline Overview

The Oregon opioid prescribing guideline for acute pain provides general recommendations for assessment, documentation, cautions, and prescribing limits for "opioid-naïve" patients across several practice settings. An opioid naïve patient is one who is not currently receiving opioids. More detailed guidelines for specific conditions and procedures by practice setting (e.g. dental, Emergency Departments, post-operative), are being developed as companion recommendations to this guideline. 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 this acute pain guideline cannot address every age group and medical condition, most of the principles are relevant for all patients. For example, this guideline should be used when prescribing opioids to adolescents after dental procedures (e.g. after 3rd molar [wisdom teeth] extractions) or sports-related injuries.

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. musculo-skeletal, 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 the opioid naïve patient.

Only if other options are not appropriate or effective for acute pain, follow these recommendations before any new opioid prescription.

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.
- 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 the patient could be tapering off opioids; a new opioid prescription could jeopardize this effort.
- 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 history of alcohol use or sedative medications. 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 opioid safety handout and review with patient before prescribing.

- Review other medications patient may be taking for pain, such as acetaminophen and non-steroidal anti-inflammatory drugs (NSAIDs). 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

- **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 2-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.
- Do not prescribe opioids for new acute pain without an in-person evaluation
- Eliminate pre-packaged opioids in Emergency Departments unless systems are in place to share information via Prescription Drug Monitoring Program (PDMP).
- 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. Alternatively have clinic, hospital or health system pharmacy order systems update the 'default' to reflect recommended maximum dose outlined in this document (e.g., <8 pills).

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, healing process, and response to treatment in a face-to-face visit and explore other non-opioid treatment options.
- After visits to urgent care and/or the Emergency Department, ensure follow up with an appropriate medical/ dental care provider rather than providing additional opioid refills. Prescriptions opioids from the ED for 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 their inclusion 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. Alternatively have clinic, hospital or health system pharmacy order systems update the 'default' to reflect recommended maximum dose outlined in this document (e.g., <8 pills).
- Monitor the results of guideline 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.

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.
<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 Opioid Prescribing Guidelines: Recommendations for the Safe Use of Opioid Medications.
<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.
<https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6501e1.pdf>