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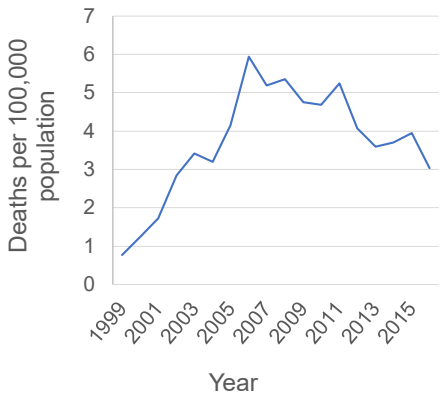
OREGON ACUTE OPIOID PRESCRIBING GUIDELINES

Oregon has seen a >30% decline in opioid prescribing since 2012, and a 50% decline in prescription opioid deaths since 2006 (Figure). Notwithstanding this progress, during 2017, >20% of Oregonians were prescribed an opioid. In 2016, to address the ongoing prescription opioid overdose epidemic, the Oregon Public Health Division (PHD) convened an Opioid Prescribing Guidelines Task Force, which approved adoption of Oregon-specific guidelines based on the *CDC Guideline for Prescribing Opioids for Chronic Pain*.[1] These guidelines include recommendations to improve patient safety for those with *chronic* pain; however, they do not address prescribing for acute pain in detail.

Figure. Presciption opioid mortality, Oregon 1999–2016



In the Summer of 2018, PHD convened a Task Force to develop statewide Oregon prescribing guidelines for acute pain. This *CD Summary* outlines the elements included in the acute guidelines; the full acute and chronic guidelines are in the footnote below.*

* www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SUBSTANCEUSE/OPIOIDS/Pages/index.aspx

NEED FOR GUIDELINES

Several factors support the need for acute pain guidelines. First, recent analysis by the CDC[2] demonstrates a linear association between the duration of an initial prescription and the likelihood of developing long-term opioid use: among those receiving an initial 30-day prescription, more than 30% remained on opioids a year later. Second, unused opioid medications increase the risk of misuse and abuse; Oregon ranks among the top 10 states for use of prescription pain killers for non-medical purposes.[3] An analysis of post-operative patients found that the majority did not use the quantities of opioids prescribed, resulting in left-over pills.[4] Finally, to avoid confusion, Oregon would benefit from a single document that clarifies expectations around opioid prescribing.

Opioids should NOT be considered as first line therapy for mild to moderate pain, which 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, then **prescribe the lowest effective dose of short-acting opioids for <3 days; in cases of more severe acute pain limit initial prescription to <7 days.**

GUIDELINE SCOPE

The goal of Oregon's acute prescribing guidelines is to improve patient safety while emphasizing effective and compassionate treatment of pain. The guidelines primarily address patients seen in:

- outpatient settings (e.g. primary care; urgent care; emergency departments);
- dental offices;
- post-procedure/post-surgical care.

While many of the principles may be relevant, the guidelines do not address acute pain from medical conditions requiring hospitalization (e.g. sickle cell crisis, pancreatitis, kidney stones). These guidelines are intended for patients who have had limited exposure to opioids, and not intended for those currently on opioids nor those with a history of substance use disorder (SUD). Similarly, pain in patients at the extremes of the age spectrum (e.g. young children, the elderly) are beyond the scope of these guidelines. (N.B. This guideline should be used when prescribing opioids to teens after dental procedures [e.g. wisdom teeth extractions], or sports-related injuries.) Importantly, these guidelines do not address pain treatment for cancer, palliative or end-of-life care.

ACUTE GUIDELINE OVERVIEW

The guidelines provide general recommendations for assessment, documentation, cautions, and prescribing limits for patients. Depending on the condition, 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.

EVALUATE THE PATIENT

- Identify cause and type of the acute pain (e.g. medical condition, post-op, injury). Determine if the pain is likely to be responsive to opioid or non-opioid therapies.
- Assess severity of pain.
- Determine likely period for recovery and duration of acute pain.
- Assess age and other medical considerations (e.g. patient's weight, metabolism, organ function) 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 potential drug interactions or toxic effects if taken with combination drugs, (e.g., Tylenol® #2–4).
- Document results of the patient evaluation and justification for prescribing an opioid.

ASSESS FOR LONG-TERM OPIOID USE AND SUBSTANCE USE DISORDER

- 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; and 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 painful condition, communicate with the primary clinician overseeing the long-term opioid / benzodiazepines use.
- 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'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 to understand the patient's prescription history before prescribing opioids.
- Note 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†

- Avoid prescribing opioids without a direct patient to prescribing clinician assessment (e.g. face-to-face, or telemedicine).
- Prescribe the lowest effective dose of short-acting opioids usually for <3 days; in cases of more severe acute pain limit initial prescription to <7 days.
- Do not recommend a more than 2-fold range of amount or timing of opioids. Never recommend dual ranges (i.e., 1–2 pills every 6 hours as needed for pain is appropriate, but 1–4 pills every 4–6 hours is not).
- Do not prescribe opioids and benzodiazepines simultaneously without a compelling justification.
- When pre-packaged opioids are dispensed in Emergency Departments, ensure that a system is in place to share information via Prescription Drug Monitoring Program.

PATIENT FOLLOW UP

- Recommend appropriate follow up for all patients, depending on condition (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 (ED), ensure follow up with an appropriate primary care medical or dental provider rather than providing 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 AND CLINIC RESPONSIBILITIES

- Endorse the Oregon guidelines for opioid prescribing.
- Adopt these guidelines as the standard of care for various practice settings.
- Implement the guidelines in health care systems and 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., <3 days).
- 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.

† Note: this guideline uses # days supply as a simple method to indicate amount; however, it is a given that different medications have differing strengths. The guidelines include a table with pill strengths.

RESOURCES

The Oregon Public Health's opioid web page has links to our opioid data dashboard and resources for clinicians. www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SUBSTANCEUSE/OPIOIDS/Pages/index.aspx

The Oregon Pain Management Commission recently updated its Pain Management Module that provides current understanding of the pathophysiology of pain and its treatment www.oregon.gov/oha/HPA/dsi-pmc/Pages/module.aspx).

The Centers for Disease Control opioid overdose web page has information for providers www.cdc.gov/drugoverdose/providers/index.html

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