Minnesota Hospital Association

Opioid Prescribing for Acute Pain Road Map

In collaboration with the Minnesota Department of Human Services, MHA has created the Opioid Prescribing Road Maps to assist hospitals and health systems implement the Minnesota's Opioid Prescribing Guidelines (First edition, 2018). Like other MHA road maps, the prescribing guidelines were developed based on evidence-based recommendations and standards that reflect published literature and guidance from relevant professional organizations and regulatory agencies, as well as identified proven practices.

Each roadmap is tiered into fundamental and advanced strategies:

- **Fundamental strategies** should be prioritized for implementation, and generally have a strong evidence base in published literature in addition to being supported by multiple professional bodies and regulatory agencies.
- **Advanced strategies** should be considered in addition to fundamental strategies when there is evidence the fundamental strategies are being implemented and adhered to consistently and there is evidence that rates are not decreasing and/or the pathogenesis (morbidity/mortality among patients) has changed.

Operational definitions are included to assist organization teams with road map auditing and identifying whether current work meets the intention behind each road map element.

Resources linked within the road map include journal articles, expert recommendations, electronic order sets and other pertinent tools which organizations need to assist in implementation of best practices

Goals:

1. Reduce initiating opioid therapy for conditions not indicated for opioid analgesia. When opioid therapy is indicated for the patient, prescribe the lowest effective dose for the shortest period of time. Reduce initiating opioids at doses which are inappropriately high for the indication. Increase timely discontinuation of opioids once they are initiated in order to reduce the transition to long-term use.
2. Improve the consistency of decision making regarding opioid prescribing in the treatment of a painful condition.
3. Manage patients on COAT carefully through multidisciplinary pain treatment, improved safety monitoring and interventions to optimize the benefit to harm ratio.

This road map is intended for use in the outpatient setting where opioids are prescribed for take-home use. It is not intended for patients with cancer, sickle-cell anemia, hospice, or other end stage condition.

Road map sections	Road map questions (if not present at your hospital or answering no, please see next column for suggested resources)	If specific road map element is missing, consider the following resources:
Acute pain management	**FUNDAMENTAL** *(check each box if "yes")* ☐ Use multi-modal, non-opioid analgesia as the first line of drug therapy for acute pain management. (e.g., NSAIDS and acetaminophen) ☐ Document the patient's presentation of pain and diminished physical function. Documentation should include the use of the pain scale as a relative tool and concordance of the patient's assessment of pain with the prescriber's objective observations.	• Institute for Clinical Systems Improvement (ICSI). Pain: Assessment, Non-Opioid Treatment Approaches and Opioid Management. Eighth Edition. August 2017. [7] • Overview of Alternative Pain Treatment

Road map sections	Road map questions (if not present at your hospital or answering no, please see next column for suggested resources)	If specific road map element is missing, consider the following resources:
Acute pain management, cont.	☐ Avoid prescribing opioids for 1) fibromyalgia, 2) headache, including migraine, 3) self-limited illness, e.g., sore throat, 4) uncomplicated, acute neck and back pain and 5) uncomplicated, acute musculoskeletal pain. Complicated, acute back, neck or musculoskeletal pain is objectively verifiable and includes pain accompanied by severe or rapidly progressive neurological deficit, evidence of infection, new cancer diagnosis or metastasis or fracture. Provide appropriate non-opioid alternative pain management for conditions not indicated for opioid analgesic therapy.	• Acute Low Back Pain | Acute Pain (cdc.gov) • Treatments for Acute Pain: A Systematic Review | Effective Health Care Program (ahrq.gov)
Opioid prescribing for acute pain (0 to 4 days following an acute event)	**FUNDAMENTAL** *(check each box if "yes")* ☐ Know the status of your patient's risk factors for opioid-related harm. Consider any relevant risk factors not already documented in the patient's record. ☐ Query the Prescription Drug Monitoring Program (PMP) whenever prescribing an opioid for acute pain. ☐ Avoid prescribing more than 100 MME of low-dose short acting opioids. Limit the entire prescription to 100 morphine milligram equivalents (not 100 MME per day). ☐ Prescribe no more opioids than will be needed for initial tissue recovery following more extensive surgical procedures and traumatic injury. Patient-centered, procedure specific dosing whenever possible. Limit the initial prescription for acute pain following an extensive surgical procedure or major traumatic injury to no more than 200 MME, unless circumstances clearly warrant additional opioid therapy. ☐ Avoid providing concurrent prescriptions of opioids and benzodiazepines or other sedative-hypnotic medications. Use extreme caution when prescribing opioids to patients using benzodiazepines or other sedative-hypnotic medications on an on-going basis. Advise patients intermittently using benzodiazepines to stop use while taking opioids for acute pain. Frankly discuss the risks of concomitant use with the patient and conduct close follow-up during the period in which opioids are used. ☐ Non-dental providers use an appropriate non-opioid medication for pain management prior to examination and diagnosis by a dental provider ☐ Dental providers should avoid prescribing more than the recommended dose following a dental procedure	• PHQ-2/PHQ-9 • CAGE Alcohol Questionnaire • Generalized Anxiety Disorder (GAD-7) • MOPG, Appendix C: Morphine Milligram Equivalence • Oregon Conversion Calculator (online MME calculator) • MOPG, Appendix B: Acute and Post-acute Pain Prescribing and Assessment Guide • Institute for Clinical Systems Improvement (ICSI) Pain Assessment, Non-Opioid Treatment Approaches and Opioid Management Eighth Edition. August 2017 [7] • Minnesota Dental Association MDA Protocol for Assessment and Treatment of Oral/Facial Pain 2015 [8] • Postsurgical Pain, CDC 2020

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Prescribing opioids for children	**ADVANCED** *(check each box if "yes")* ☐ Acute opioid dosing for children should be proportional by weight to the acute pain dose and duration limit) ☐ Screen children over the age of 10 for a risk of opioid-related harm. ☐ Check the PMP for all children prescribed an opioid for acute pain, to confirm that the child is not at risk for care giver diversion. ☐ Avoid prescribing children codeine in any setting given the high risk posed to ultra-fast metabolizers.	• Minnesota Opioid Prescribing Guidelines, First edition 2018
Patient education	**FUNDAMENTAL** *(check each box if "yes")* ☐ Patient education includes the following: - Risks of opioid therapy - Safe and secure storage of opioids - Safe disposal of opioid analgesics in the home - Pain management rather than the elimination of pain as the goal of treatment. - The organization provides an appeal process for individual patients to have physician/APP decisions reviewed at patient request.	• CDC Patient educational materials [4] • Pain Management-Patient Education Intermountain Healthcare
Patients on long term opioid therapy with acute pain injury	**FUNDAMENTAL** *(check each box if "yes")* ☐ Use the recommended dose and duration limit for chronic pain patients with an identifiable, new injury or procedure i.e., 100 MME total prescription ☐ For patient who are already on COAT of ≥ 90 MME/day, manage new acute pain in collaboration with the COAT prescriber and acute pain prescriber (e.g., surgeon). **ADVANCED** *(check each box if "yes")* ☐ Do not increase opioid dosage for acute pain for COAT patients in the absence of a verifiable new injury.	• Opioid Prescribing Improvement Guide – In Partnership with DHS, ICSI

Road map sections	Road map questions (if not present at your hospital or answering no, please see next column for suggested resources)	If specific road map element is missing, consider the following resources:
Patients with history of or an active substance use disorder, including opioid use disorder	**FUNDAMENTAL** *(check each box if "yes")* ☐ Avoid prescribing opioids to patients with a history of substance use disorder and those with an active substance use disorder. Maximize appropriate non-opioid therapies. ☐ Use extreme caution, frankly discuss the risks and plan for close follow-up when opioids are necessary. Obtain a specific patient release to consult with a substance use disorder provider. ☐ Consult with a clinician trained in the pharmacology of buprenorphine or naltrexone when prescribing opioids to a patient receiving either medication for Opioid Use Disorder (OUD). ☐ The general dose and duration limit are appropriate for patients receiving methadone for OUD.	• Screening Tool for Addiction Risk (STARR) • Drug Use Questionnaire Test (DAST-20)
Women of childbearing age	**FUNDAMENTAL** *(check each box if "yes")* ☐ Pregnancy risk is assessed prior to prescribing opioids. ☐ Prescribing opioids to pregnant women is avoided. ☐ Pregnant women are educated about the known risks of opioids to both the mother and the fetus. ☐ Proper pain control is provided to lactating women experiencing acute pain following birth and surgical procedures. If opioids are prescribed, the lowest dose and duration are prescribed to adequately manage the pain. [11] **ADVANCED** *(check each box if "yes")* ☐ Following a cesarean section, the number of opioids prescribed is the minimum needed for initial tissue recovery. Consider prescribing 100 MME, total prescription, post-discharge.	• ACOG: Opioid Use and Opioid Use Disorder in Pregnancy [9] • Practice Advisory on Codeine and Tramadol for Breastfeeding Women [10]

References

1. National Institute on Drug Abuse. Benzodiazepines and Opioids. March 2018. Available at: https://www.drugabuse.gov/drugs-abuse/opioids/benzodiazepines-opioids

2. Agency for Healthcare Research and Quality, “Noninvasive Nonpharmacological Treatment for Chronic Pain: A Systematic Review”, June 11, 2018. Available at: https://effectivehealthcare.ahrq.gov/topics/nonpharma-treatment-pain/research-2018

3. Stratis Health (Collaboratively with Minnesota Managed Care Organizations). “A Provider Toolkit, Meeting the Challenges of Opioids and PAIN”. March 2018. Available at: https://www.stratishealth.org/pip/documents/Opioid-provider-toolkit.pdf

4. CDC, Helpful materials for patients. Available at: https://www.cdc.gov/drugoverdose/patients/materials.html

5. Substance Abuse and Mental Health Services Administration (SAMSHA) publications. Available at: https://store.samhsa.gov/

6. Future Directions… citation: Mackey S. Future Directions for Pain Management: Lessons from the Institute of Medicine Pain Report and the National Pain Strategy. Hand Clin. 2016;32(1):91–98. doi:10.1016/j.hcl.2015.08.012

7. Hooten M, Thorson D, Bianco J, Bonte B, Clavel Jr A, Hora J, Johnson C, Kirksson E, Noonan MP, Reznikoff C, Schweim K, Wainio J, Walker N. Institute for Clinical Systems Improvement. Pain: Assessment, Non-Opioid Treatment Approaches and Opioid Management. Updated August 2017

8. Minnesota Dental Association. MDA Protocol for Assessment and Treatment of Oral/Facial Pain. MDS Opioid task Force. 2015. Available at: https://www.mndental.org/files/MDA-Protocol-for-Assessment-and-Treatment-of-Oral-Facial-Pain-2015.pdf

9. Opioid Use and Misuse Disorder in pregnancy. Committee Opinion No. 711. American College of Obstetricians and Gynecologists. Obstet Gynecol 2017;130:e81-94. Available at: https://www.acog.org/-/media/Committee-Opinions/Committee-on-Obstetric-Practice/co711.pdf?dmc=1&ts=20190329T1833278386

10. American College of Obstetricians and Gynecologist, Society for Maternal-Fetal Medicine and Academy of Breastfeeding Medicine “Practice Advisory on Codeine and Tramadol for Breastfeeding Women”. April 27, 2017. Available at: https://s3.amazonaws.com/cdn.smfm.org/publications/238/download-f3b5696d35bb75e9b31bbb83981b2613.pdf