Opioid Prescribing Task Force Issues Matrix – Acute Pain

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Tech Experts:
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AMDG/CDC Recommendations:
AMDG—

- Explore non-opioid alternatives for treating pain and restoring function, including early activation.
- Check the PMP before prescribing.
- Help the patient set reasonable expectations about his or her recovery, and educate the patient about the potential risks and side effects of opioids.
- Assess function and pain at baseline and with each follow-up visit. Expect patients to improve and resume normal activities within days to weeks.
- Don't prescribe opioids for non-specific back pain, headaches, or fibromyalgia.
- Prescribe the lowest necessary dose for the shortest duration.
- Opioid use beyond the acute phase is rarely indicated. Consider tapering the patient off opioids as acute pain resolves; taper opioids by 6 weeks if pain is not improved or clinically meaningful functional improvement has not occurred.

CDC—

- Less than 3 days is usually sufficient, and more than 7 days is rarely needed.

1. What issues are there?	***2. How can we address these issues?***
How can we better regulate the use of opioids as a first-line treatment?	• Consider language in the rules around the use of alternative therapies and when they should be explored in lieu of opioids (e.g. front-line pain control or when opioids are no longer effective in controlling pain or improving function) • Guidelines for short term (3 days; 7 days) • Recommendations for smooth hand-off

	• Check PMP; initiation of opioid treatment plan; screening questions for addiction flags; alternatives to opioid treatment • Reference the BREE collaborative for acute management; specific to dental but applicable to overall
Prescribing for non-specific medical events or diagnoses.	• Enhance language in general provisions about history and examination of patient to require documentation of a specific diagnosis?
Excessive prescribing (number of pills and/or days).	• Consider dosage limits for acute pain control, time limits for opioid therapy for acute pain, or a combination of the two. • Take back or accountability process • WA state allows partial re-fill
Ensuring patients are appropriate candidates for opioid therapy and at minimal risk for addiction.	• Requiring, as part of the history and examination of patients, an evaluation of comorbid health issues including mental health issues, a history of past substance abuse, and other prescribing. • Consider requiring a PMP query at initial prescription.
Type of opioids prescribed (immediate release vs. long-acting)	• Consider requirement to prescribe immediate release in acute phase.
Appropriate time for follow-up examination.	• Consider an outer limit (e.g. 2/4/6 weeks) when patient should be re-examined and reducing or terminating opioid therapy should be evaluated.
No pain management specialist should be responsible for peri-operative treatment alone	Collaboration between surgeon and pain specialist
ER patient presentation as pain may have a different root cause such as opioid withdrawal	ER physicians without a waiver can prescribe a treatment program Education issue
Operative versus non-operative pain requirements	
Naïve users	
Limits on pills versus days	Guidelines for days with opportunity for extension
Adolescent patients	Special guidelines for young patients
Pregnant patients and those non-opioid naïve	
Methadone patients and tolerance	
In-patient or ED non-opioid naïve	Anesthesia provider consultation

Screening questions during in-take process	
Pain catastrophizing scale (patient intake)	Predictor for patients at risk

3. What concerns/ impacts are there?	***4. How might we mitigate these concerns?***
Will regulating use of other modalities before opioids create "artificial" expectations about the number or duration of modalities tried before opioid therapy?	• Consider what it means (and define, if possible) to exhaust other therapies.
Will limiting pill counts and/or days of prescriptions result in additional burden on patients and prescribers?	• Can exceptions to any prescribing limits be crafted to rely on specific and appropriate documentation in the patient's record?
Patients may experience some pain—what are reasonable expectations?	• As part of prescribing process, require that prescribers explain risks and benefits of opioids, along with establishing realistic expectations for patient's pain level.

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5. What further information do we need?
• AMDG Guidelines • CDC Guidelines • State of Ohio Guidelines for Management of Acute Pain Outside of Emergency Departments • Tedesco et al; "Opioid Abuse and Poisonings: Trends in Inpatient and Emergency Department Discharge"; Health Affairs; 36:10; October 2017.

6. <u>What is this group's recommendation?</u>