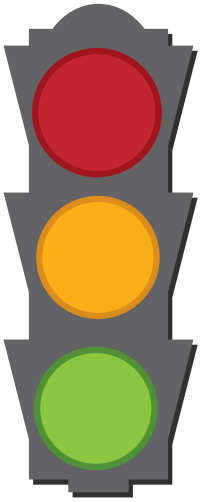
Intermountain® Healthcare

CLINICAL GUIDELINE JANUARY 2017

# Acute Pain Opioid Prescribing Guidelines

## ACUTE PAIN MANAGEMENT GUIDELINES

The following guidelines and algorithm (on page 2) address the complexity of treating patients who are suffering from pain with opioid medication. These recommendations align with current Utah and CDC prescribing guidelines (note resources in sidebar at right).



### STOP

**AVOID PRESCRIBING:**

- Long-acting or extended-release opioids for acute conditions.
- Opioids in doses ≥ 50 mg morphine equivalent/day (MME) Refer to iCentra or to page 12 of Intermountain's CPM, *Prescribing Opioids for Chronic Non-Cancer Pain*.

### CAUTION

For elderly patients and those at risk for OIRD (see page 3), **REDUCE** dose and frequency when opioid prescribing is unavoidable.

### GO

- **PRESCRIBE**:
  - The lowest effective dose
  - Low-dose, immediate-release, short-acting opioids only
  - No more than the number needed for usual pain duration associated with the condition, usually for 3 days and rarely for more than 7 – 10 days
- **INTEGRATE** non-opioid therapies to reduce overall opioid consumption (e.g., multimodal therapies, regional analgesia, massage, etc.)
- **RE-EVALUATE** any severe acute pain that continues beyond the anticipated duration
  - Confirm or revise initial diagnosis
  - Appropriately adjust pain management plan
- **FOLLOW UP** with primary care within 3 – 5 days post-discharge
- **EDUCATE** patient and caregiver pre-therapy & post-discharge — PROVIDE patient education (*Prescription Opioids: What You Need to Know* fact sheet), and INITIATE shared-decision-making conversations about:
  - Risks and benefits of opioid therapy.
  - Proper use, storage, and disposal.
  - Use of naloxone.
    **NOTE:** Consider prescribing naloxone for all patients at risk for opioid-induced respiratory depression (ORID), if discharged on opioids (**see guidance on assessing ORID risk on page 3**).

### INTERMOUNTAIN RESOURCES

- *Prescribing Opioids for Chronic Non-Cancer Pain Care Process Model*
- *Assessment and Management of Substance Use Disorder Care Process Model*
- *STOP-BANG@ Assessment*

### GUIDELINES AND OTHER RESOURCES

- http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf
- http://www.aspmn.org/documents/GuidelinesonMonitoringforOpioid-InducedSedationandRespiratoryDepression.pdf
- https://www.icsi.org/_asset/dyp5wm/opioids.pdf
- http://health.utah.gov/prescription/pdf/guidelines/final.04.09opioidGuidlines.pdf
- http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm
- https://www.utahmed.org/docs/CS_Resources/4/Pain%20Treatment%20Recommendations.pdf
- http:/www.fda.gov/downloads/drugs/drugsafety/postmarketdrugsafetyinformationforpatientsandproviders/ucm311290.pdf

These guidelines apply to common clinical circumstances, and may not be appropriate for certain patients and situations. The treating clinician must use judgment in applying guidelines to the care of individual patients.

**(a) Common acute pain conditions rarely indicated for opioids (non-inclusive)**

- Fibromyalgia/Neuropathic pain
- Headache
- Self-limited illness, i.e., sore throat
- Uncomplicated back and neck pain
- Uncomplicated musculoskeletal pain

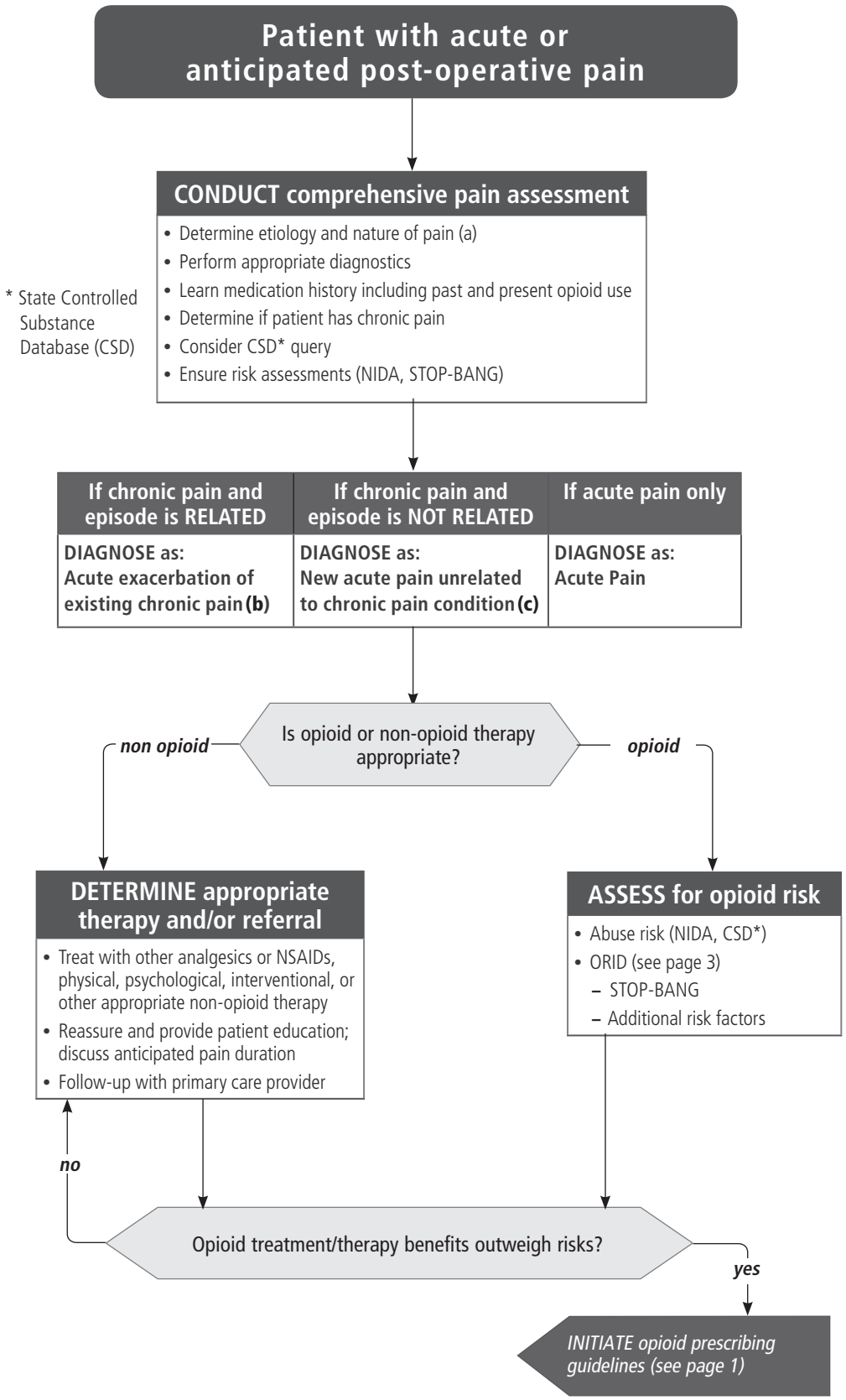
**(b) Acute exacerbation of existing chronic pain diagnosis**

- Consult patient's pain care plan prior to prescribing any medications.
- Refer to chronic pain and opioid prescribing guidelines.
- Check for existing Medical Management Agreement (MMA).
- Consider collaborating with the primary pain care provider, acute pain service, or teleservices resources to provide appropriate chronic pain management.
- Check CSD*.
- Ensure appropriate monitoring for ORID

**(c) New acute pain unrelated to chronic pain condition**

- Consult patient's pain care plan prior to prescribing any medications.
- Consider collaborating with the primary pain care provider, acute pain service, or teleservice resources for appropriate chronic pain management.
- For optimal safety (after establishing a baseline), consider only prescribing opioids in similar dosages and number as for patients not on chronic opioids.

## ALGORITHM



## ASSESSING OPIOID-INDUCED RESPIRATORY DEPRESSION RISK (OIRD)

Prior to administration of opioids, inpatients should be assessed for the following OIRD risk factors (in addition to administering the STOP-BANG):

1. Recurrent respiratory event (non-stimulated patients) — Evaluate for repeated occurrence of:
   - $O_2$ saturation < 90 %
   - Bradypnea < 8 bpm
2. Home opioid use for chronic pain — Perform Controlled Substance Database (CSD) screen on those patients who:
   - Take opioids at home (opioid tolerant — taking opioids ≥ 60 mg oral morphine equivalent for ≥ 1 week)
   - Are on the chronic pain registry
   - Have a Controlled Substance Medication Management Agreement (MMA) on file
   - Have a known substance use disorder (see also the Substance Use Disorder CPM)
3. Inpatient medication considerations such as:
   - Opioid naïve (or tolerance not established)
   - Increased opioid dose requirement (≥ 90 mg morphine equivalency)
   - On other sedating medication such as benzodiazepines
   - Any continuous opioid infusion ordered
4. Other factors such as:
   - Age > 80 years
   - Previously diagnosed OSA
   - History of previous naloxone administration
   - Thoracic or other large, incision surgeries that may interfere with adequate ventilation
   - Known reduction in cognitive abilities
   - Pre-existing pulmonary, neuromuscular, or cardiac disease/dysfunction

### MONITORING

For patients with additional risk factors, close observation is strongly recommended with $ETCO_2$ (or "acoustic") monitoring where available. If $ETCO_2$ unavailable:

- Require pulse oximetry
- Increase frequency of respiratory and sedation assessments

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