Michigan Quality Improvement Consortium Guideline

Opioid Prescribing in Adults Excluding Palliative and End-of-Life Care

This guideline is intended to apply to patients aged ≥ 18 years with acute or chronic pain outside of palliative and end-of-life care.

Key Components	Recommendation and Level of Evidence
Avoid starting opioids	Opioid Use Disorder (OUD) often begins with inital opioid exposure in treatment of acute pain and is associated with a substantial risk of chronic use in some patients. Treat pain with non-drug therapy (e.g., physical/behavioral modalities), and non-opioid medications (e.g., acetaminophen, NSAIDS), if possible. Opioids are rarely useful in chronic pain. Ask patient if they've signed a Nonopioid Directive. Consider opioid therapy only if expected realistic benefits for both pain and function are anticipated to outweigh risks to the patient.
Before starting opioids, assess risk of dependence, overdose or death	Review history of controlled substance use, mental health and substance misuse. Obtain a Prescription Drug Monitoring Program (PDMP) report, e.g. MAPS. Refer to local laws.[1] Screen for risk of OUD; consider using an instrument such as SOAPP-R or ORT. There is no safe lower limit of dose or duration for opioid use. After seven days of use, the risk of chronic use rises 3-4 fold. Discuss the risks of opioid use including physical dependency, overdose, OUD, addiction, drug and alcohol interactions, proper disposal of unused opioids, effects of fetal exposure/toxicity for females of reproductive age, and that diversion (sharing or selling) of a controlled substance is a felony in Michigan. Discuss lack of evidence of superiority to NSAIDs. **[B4]**
When starting opioids	Even when starting, strongly consider developing a formalized treatment plan[2], informed consent and/or an opioid treatment agreement (controlled substance agreement). **[B4]** In Michigan the Start Talking form is mandated, and when signed serves as attestation patient received education. Consider baseline drug screen, and random testing to follow. Obtain a urine or serum drug screen at the time of starting therapy if concerned about concurrent substance use. **[B4]** Prescribe the lowest effective dose of immediate-release opioids (not extended-release) and no greater quantity than needed for the expected duration of pain severe enough to require opioids; three days or fewer for acute pain; more than seven days will rarely be needed. **[A4]** Michigan limits initial prescription to seven (7) days. Use opioids as part of a pain management plan that includes instructions for tapering[3], non-opioid medications and non-drug therapy, as appropriate. Discuss realistic goals for pain and function, and how opioid therapy will be discontinued if benefits do not outweigh risks. Avoid concurrent use of opioids with benzodiazepines, muscle relaxants, hypnotics or alcohol **[A3]**, and educate patient about the dangers of mixing, due to the higher risk of death. Prescribe patient and family naloxone when risk factors for overdose are present; e.g., history of overdose or substance use disorder, higher opioid dosages (≥ 50 MME/day), concurrent benzodiazepine use, or risk to other household members. **[A4]** Educate patient and family on naloxone use. Call 911 immediately, give naloxone, then rescue breathing, followed by second dose of naloxone if no improvement. May need repeat doses. Patient should be seen immediately in a hospital Emergency Department.
If continuing opioids, or adjusting dose	Periodically re-evaluate pain and function (consider using an assessment tool such as PEG-3); recheck PDMP (MAPS) and urine drug screen. **[A4]** Continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety. **[A4]** Reassess known risks and realistic benefits throughout opioid therapy, including patient and clinician responsibilities for managing therapy. **[A3]** If benefits of therapy do not outweigh potential harms, optimize other therapies and work with patient to taper[3] to lower doses and discontinue. (**A4]** Use urine drug testing to assess for prescribed medications as well as other controlled or illegal substances. **[B4]** Absence of prescription medication may indicate diversion. An unexpected result may warrant an appropriate confirmatory test. Perform testing at least annually, more frequently (every 3-6 months) if warranted. When considering increasing dosage to ≥ 50 MME/day, reassess evidence of individual benefits and risks. Avoid increasing dosage to ≥ 90 MME/day, carefully justify and document the decision. **[A3]** Patients treated long-term with > 100 MME/day should slowly be tapered[3] to lower doses**.** Consider referral to a pain specialist. Avoid renewal without clinical reassessment. **[B4]**
Identify Substance Use Disorder[4]	Manage or refer based on: physician comfort treating substance use disorder, patient willingness to be referred, availability and coverage. Use evidence-based treatment, usually medication, plus behavioral therapy. **[B4]** (Medication for Opioid Use Disorder/Medication Assisted Treatment [MOUD/MAT]) See *MQIC Screening, Diagnosis and Referral for Substance Use Disorder guideline*

MME/day	Risk of death
20-49	1.3
50-99	1.9
100-199	2.0
≥ 200	2.9

MME=morphine milligram equivalents
(50 MME/day = 50 mg/day Hydrocodone = 33 mg/day Oxycodone)

[1] Michigan Opioid Resources Laws and Regulations

[2] NIH National Institute on Drug Abuse Sample Patient Agreement Forms

[3] CDC Pocket Guide: Tapering Opioids for Chronic Pain

[4] Michigan Opioid Collaborative

Recommendation categories: A = Applies to all persons; most patients should receive the recommended course of action; **B** = Individual decision making needed; different choices will be appropriate for different patients. Clinicians help patients arrive at a decision consistent with patient values and preferences and specific clinical situations.

Evidence type: 1-Randomized clinical trials or overwhelming evidence from observational studies; 2-Randomized clinical trials with important limitations, or exceptionally strong evidence from observational studies; 3-Observational studies or randomized clinical trails with notable limitations; 4-Clinical experience and observations, observational studies with important limitations, or randomized clinical trials with several major limitations.

This guideline lists core management steps. It is based on 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; and MI-OPEN Acute Care Opioid Treatment and Prescribing Recommendations: Summary of Selected Best Practices June 26, 2018. Individual patient considerations and advances in medical science may supersede or modify these recommendations.