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	Initial opioid exposure is associated with a substantial risk of chronic use in some patients. Opioid dependency often begins with treatment of acute pain. Treat pain with non-drug therapy (e.g., physical/behavioral modalities), and non-opioid medications (e.g., NSAIDS), if possible. Opioids are rarely useful in chronic pain. 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	Review patient's history of controlled substance use. Obtain a Prescription Drug Monitoring Program report, e.g. MAPS. Screen for risk of dependence 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 with patient the risks including dependency, overdose and death, and lack of evidence of superiority to NSAIDs. **[B4]** Risk of death from overdose increases with daily dosage. Relative risk is almost 3x higher for high-dose vs. low-dose use. MME=morphine milligram equivalents
When starting opioids	Prescribe the lowest effective dose of immediate-release opioids 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]** Use opioids as part of a pain management plan, that includes 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 prescribing opioids with benzodiazepines, muscle relaxants or hypnotics **[A3]**, due to the high risk of death. Obtain a urine or serum drug screen at the time of starting therapy if concerned about concurrent substance use. **[B4]** Consider offering 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), or concurrent benzodiazepine use. **[A4]** Naloxone duration is less than an hour. Following any naloxone use, 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); consider re-checking 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 opioids to lower doses or to discontinue. (**A4]** Consider a formalized treatment plan[1] including informed consent and/or an opioid treatment agreement (controlled substance agreement). **[B4]** 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. 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]** Consider referral to a pain specialist. Avoid renewal without clinical reassessment. **[B4]**
Identify Substance Use Disorder	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]** See *MQIC Screening, Diagnosis and Referral for Substance Use Disorder guideline*

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

(50 MME/day = 50 mg/day Hydrocodone = 33 mg/day Oxycodone)

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

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. Individual patient considerations and advances in medical science may supersede or modify these recommendations.