Opioid Discharge Prescribing Guidelines

Origination: 6/2022 **Applicability: SCOR, SCV, SGH, SMB, SMH, SMV**

Purpose: These guidelines are intended to support safe prescribing of opioid medications on discharge from Sharp Health Care hospitals with the understanding that there will be patient variation.

Definitions:

1) Acceptable Pain Intensity: The pain intensity, on a self-report pain scale, identified by the patient, at which the patient is able to perform expected necessary and desired activity. It should be appreciated that this is often a dynamic process and will vary depending upon the experience with interventions attempted, post-procedural goals, etc.
2) Opioid naïve: a person who has not recently taken opioids on a regular basis and is not tolerant to the effects of an opioid
3) Opioid tolerant: Patients who are taking opioid. Opioid tolerance is variable but is generally associated with both total dose and duration of opioid exposure. With the full appreciation that this does not capture all patients who may require a opioid escalation for acute pain, the FDA in opioid product labeling defines opioid tolerance as those patient who are taking opioids for 1 week or longer, at least 60 mg oral morphine/day, 25 µg transdermal fentanyl/hour; 30 mg oral oxycodone/day, 8 mg oral hydromorphone/day, 25 mg oral oxymorphone/day, or an equianalgesic dose of any other opioid.
4) Acute pain: Follows injury to the body and generally disappears when the body heals (e.g. post-operative, post-trauma). Usually associated with objective clinical signs of autonomic nervous system activity, e.g., tachycardia, hypertension, diaphoresis, mydriasis, and pallor. Autonomic signs are similar to, and frequently accompanied by, anxiety. Acute pain has an endpoint.
5) Chronic pain: Pain lasting longer than several months without an endpoint. It is less commonly accompanied by autonomic signs. Chronic pain may be accompanied by changes in personality, lifestyle, and functional abilities and by symptoms and signs of depression – hopelessness, helplessness, loss of libido and weight, and sleep disturbances. Often relentlessly increases with time.
6) Multimodal pain management: The use of more than one method or modality of controlling pain (e.g., drugs from two or more classes, drug plus nondrug treatment) to obtain additive beneficial effects, reduce side effects or both. These modalities may operate through different mechanisms or at different sites (e.g., peripheral vs. central actions).

Guidelines:

1) Non-opioid medications (e.g., acetaminophen, NSAIDs, lidocaine patches) and non-pharmacological therapies (e.g., ice/heat, integrative therapies, repositioning) are considered first line for the management of acute pain.
2) Opioid discharge prescriptions for acute pain should be considered only after first line therapy has been optimized and the patient's acceptable pain intensity has not been or is likely not to be achieved after discharge.

   The patient's likelihood of achieving their acceptable pain intensity shall be assessed using patient specific criteria including but not limited to type of surgery, opioid use history, pain history, behavioral health conditions and inpatient medication use.

3) Hypnotic [barbiturate, benzodiazepine, and non-benzodiazepine] and opioid co-prescribing at discharge is discouraged. If the prescriber determines that the benefit of prescribing both at discharge outweigh the risk:
   a) the discharge prescriptions shall be for the lowest therapeutic dose and the shortest duration.
   b) The patient shall be educated about the increased risk of oversedation and respiratory depression.
4) A naloxone prescription shall be provided to the patient when opioids are prescribed
   a) with a benzodiazepine
   b) for a dose equal to 90 or more morphine milligram equivalents of an opioid per day or
   c) for a patient that presents with an increased risk for overdose
5) Long-acting opioids shall not be prescribed at discharge for acute pain.
6) For patients with acute pain requiring opioids at discharge, initial prescriptions for opioids shall be limited to the minimum dose and quantity to meet the patient's needs.
   a) Patient specific criteria including inpatient medication use, pain history (opioid naïve v tolerant), risk for side effects and risk for dependency shall be used to determine the minimum dose and quantity.
   b) Consider lower discharge quantities for
      i) Patients at risk for side effects: less-than 60 kg, elderly, renal or hepatic dysfunction, morbid obesity, OSA, COPD or potential drug-drug interactions
      ii) Patients at risk for dependency or misuse: prior history of drug or alcohol abuse, teenagers, younger adults (18 to 25 years) or mental health disorders (depression, anxiety, post-traumatic stress disorder).
   c) In general, initial opioid discharge prescriptions quantities should be limited to three days and not exceed seven days of therapy.
7) Recommended discharge prescriptions for post-surgical patients
   a) Start with scheduled multi modal analgesics (e.g., acetaminophen 1 gram TID with ibuprofen 400 mg TID), if not contraindicated.
   b) Add Opioid discharge prescription if needed.
      i) In addition to patient history, and risk factors; consider surgery type, opioid use during the 24 hours prior to discharge, expected recovery duration and current evidence-based recommendations to determine discharge prescription strength and quantity.
8) Sharp Health Care will review discharge opioid prescriptions for opportunities for improvement (e.g., discharge quantities, co-commitment prescribing of opioids with benzodiazepines).

References:

- Opioid Prescribing Engagement Network (OPEN) Prescribing Recommendations updated February 25, 2020. Prescribing Recommendations Table
- Prescribing Surgical Guidelines | Center for Opioid Research and Education (solvethecrisis.org)
- Pain and Opioid Prescribing | Bree Collaborative (qualityhealth.org)

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Review - Approvals:

- **SMH:** Pharmacy & Therapeutics Committee, Surgery Supervisory, Orthopedic Supervisory, Cardio Thoracic Surgery, MEC
- **SGH:** Pharmacy & Therapeutics Committee, Orthopedic Supervisory, Surgery Supervisory, Cardio Thoracic Surgery Supervisory, OB Surgery Supervisory, MEC
- **SCVM:** Pharmacy & Therapeutics Committee, Surgery Supervisory, OB Surgery Supervisory, MEC
- **MBHWN:** Pharmacy & Therapeutics Committee, OB GYN, MEC
- **SCOR:** Pharmacy & Therapeutics Committee, Surgery Supervisory, MEC
- **SMV:** Pharmacy & Therapeutics Committee, MEC
- **System:** Controlled Substance Stewardship Steering Committee, System Clinical Pharmacy Practice Council, Sharp Drug Formulary Committee, Emergency Department IS Steering, Ortho Physician Advisory, Hospitalist's System Meeting