Opioid Prescribing Guidelines

MASSACHUSETTS GENERAL HOSPITAL

Purpose: The Massachusetts General Hospital/Massachusetts General Physicians Organization Opioid Task Force developed the following Opioid Prescribing Guidelines for the Mass General community. The guidelines support providers in delivering responsible, compassionate treatment for patients, while improving the safety and quality of care for patients with chronic or acute pain. We hope that the guidelines can inform the national conversation on opioid use.

ACUTE PAIN

1. Pain Assessment and Indications	• Consider opioid prescriptions based on the degree of tissue disruption, a strong consideration of alternatives, specialty specific published guidelines, the impact of pain upon function, and the risk/benefit ratio. • Opioids should only be prescribed after a clinical examination, diagnosis, review of medication and medical/psychiatric history, consideration of alternatives, and review of data from the Prescription Monitoring Program (PMP).
2. Non-Opioid Alternatives to Pain Management	• Opioids should be the last consideration for acute pain management. Do not prescribe without first considering non-opioid and non-pharmacological measures.
3. Risk Assessment	• All patients should be screened for risk of opioid misuse using a validated screening tool to determine whether it is appropriate to prescribe opioids based on diagnosis and risk. Recommended tool: Opioid Risk Tool (ORT). • Consider screening for family/personal history of substance use disorder and mental health problems before prescribing opioids.
4. Prescribing	• Opioids should be prescribed only for severe acute pain. • If opioids are necessary, they should be prescribed at the lowest effective dose and for a limited period. • For acute pain unrelated to surgery/major trauma, providers should prescribe no more than a 7-day supply. • Long-acting or extended-release opioids should not be used for the treatment acute pain. • Opioids should not be prescribed in excess of the expected duration of need. • Patients should not be prescribed longer courses of pain medications to avoid requests for refills or for "just in case" scenarios.
5. Patient Expectations	• Providers should counsel patients that pain medications will mange pain but not resolve pain. • When prescribing opioid analgesia, discuss side effects, addictive potential, and risks for overdose. Pain counseling should occur before the onset of pain and as part of pre-procedure education. • MGH providers should always: 1) Set the patient's expectations 2) Discuss alternatives to opioids 3) Discuss side effects 4) Review the duration of the therapy 5) Educate patients regarding practical storage and disposal methods of medication.
6. Communication	• Communication between providers of acute care and patients' primary care providers is essential for the coordinated management of acute pain. • For acute exacerbations of chronic pain, the acute provider should contact the primary provider before prescribing opioids. If unavailable, the acute provider should notify the patient's primary opioid prescriber of the visit and the medication prescribed.
7. Special Populations	• If a patient is currently on long-term opioid medications or opioid agonists/antagonists (i.e. Suboxone), any interruption in medications in the acute setting must be discussed with the prescribing clinician.
8. Reassessment of pain	• If opioids are prescribed for acute pain, close follow-up should be arranged with the primary surgeon/prescribing clinician and/or the primary care provider. • If a patient requires additional opioids prior to scheduled follow up, s/he should come for evaluation of complication or other possible cause of increased pain. • If a patient requires opioids for longer than expected without medical cause, the provider should consider: reevaluating cause of pain, rescreening for substance use disorder, toxicology screen if you have a concern of substance abuse or diversion, and/or referral to substance abuse specialist/pain service.

CHRONIC PAIN

1. Diagnosis, Screening, and Documentation	• History, physical exam, diagnosis, and plan must be documented before any opioid is prescribed. • All patients should be screened for risk of opioid misuse using a validated screening tool. • All patients on chronic opioid medications should receive, review, and sign an approved MGH Agreement and Informed Consent for Receiving Controlled Substances, which should be stored in the EMR. • All patients receiving chronic opioid medications for pain should have chronic pain documented as a problem in the problem list in the EMR, including indication, prescribing physician, and medication type.
2. Prescribing Opioids	• Prescribing opioids for chronic pain should only be pursued once all other options have been exhausted. • Non-pharmacologic and non-opioid pharmacologic options should be used as a first line for chronic pain unless otherwise contraindicated. • Providers should review side effects and discuss the risks of addiction and overdose with all patients on chronic opioid therapy. Providers should also counsel patients regarding safe storage and disposal of medications. • Providers should consider prescribing intranasal naloxone (Narcan) rescue kits to patients if appropriate.
3. Renewals	• Patients receiving chronic opioid medications from a practice must have regular clinical reassessments in order to receive refills. • Patients on chronic opioid medications should be clinically reevaluated by the prescriber/surrogate at least every 4 months. Patients should be seen at shorter intervals based upon the judgment of the prescribing clinician and care team. • Prescriptions should be limited to 28-day supplies unless mandated otherwise by insurance. • Renewals should not be given on evenings, holidays, or weekends.
4. Provider Monitoring	• Patients receiving opioids for chronic pain should have a regular clinical reassessment of pain, functional goals, treatment plan, and adherence. • All patients receiving chronic opioids should understand that pill counts and/or random toxicology screens (minimum yearly) are all part of a standard MGH protocol for care. • More frequent monitoring is appropriate for monitoring of symptoms or concerns of misuse. • Irregular findings should be addressed with the patient and documented in the EMR with the appropriate clinical and/or administrative response.
5. Discontinuing Opioids	• Clinicians are justified in discontinuing opioids if 1) there is evidence of harm 2) risks are not outweighed by clinical benefits 3) functional treatment goals are not being met 4) there is a high level of concern for non-adherence to mutually agreed upon treatment guidelines. • If discontinuing due to: Concern about opioid use disorder: Provide the patient with contact information for addiction treatment programs and/or provide an appropriate tapering schedule, consider referral to substance use disorder/pain management programs. High suspicion/confirmation of diversion: Do not taper the medication. Lack of clear benefit/not meeting functional goals: Outline taper/alternative pain plan/referral to pain program.
6. Special Populations	• If a patient is currently on long-term opioid medications or opioid agonists/antagonists, any interruption in medications in the acute setting must be discussed with the prescribing clinician.

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Jenna Berube, MPA| Senior Project Specialist
Strategic Communications and Physician Incentive Programs, MGPO
Phone: 617-724-9080 | jeberube@partners.org