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
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**Avoid starting opioids**<br>Initial opioid exposure is associated with a substantial risk of chronic use in some patients. Opioid dependency often begins with treatment of acute pain.<br>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.<br>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 dependence; 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 including dependency, overdose, permanent brain injury, and death. Discuss 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.

**When starting opioids**
Even when starting, strongly consider developing a formalized treatment plan², informed consent and/or an opioid treatment agreement (controlled substance agreement). [B4]
Document your discussion (in Michigan use the Start Talking form).
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] Michigan limits initial prescription to seven (7) days.
Use opioids as part of a pain management plan that includes instructions for tapering, 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.

**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 consider 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]
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. Any unexpected result should warrant a 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 to lower doses. 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

### Recommendations 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 trials with notable limitations; 4-Clinical experience and observations, observational studies with important limitations, or randomized clinical trials with several major limitations.

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1Michigan (michigan.gov/opioids)
2NIH National Institute on Drug Abuse Sample Patient Agreement Forms

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Approved by MQIC Medical Directors Nov. 2017, 2018MQIC.ORG