Ohio's Prescribing Guidelines for Acute Pain

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Objectives

- Review the Governor's Cabinet Opiate Action Team process
- Discuss the Acute Pain guidelines
- Understand practical use of the guidelines

Governor's Cabinet Opiate Action Team

- Formed in 2011 by Governor Kasich to "attack the statewide opioid misuse, abuse, and overdose epidemic."

- Six working groups: Treatment, Professional Education, Public Education, Enforcement, Recovery Supports, and Opioids and Other Controlled Substances (OOCS)

- Various stakeholders represented

Guidelines

- Emergency and Acute Care Facilities (2012, 2014)
- Chronic pain and the 80mg Morphine Equivalent Dose (MED) “trigger point” (2013)
- **Acute pain** (2015)

Purpose of the guideline

- Provides a general approach to outpatient management of acute pain
- Not intended to replace clinical judgement that should always be used to provide the most appropriate care to meet the unique needs of each patient
- Provides key checkpoints to pause and consider additional factors

Acute Pain

Definition

- Fades with healing
- Related to tissue damage
- *Alters function significantly*
- Is expected to resolve in days to weeks, but certainly by 12 weeks

Management approach

History and physical exam

- PQRST, etc.
- Ask about psychological factors
- Make a specific diagnosis (“Acute pain” is not specific)

Develop a plan

- Plan flows from specific diagnosis and expectation management
- Set expectations and goals of therapy focusing on **function**, not degree of pain

General “Plan” guidelines

Partner with the patient to include

- Measurable goals for pain reduction
- Use of both nonpharmacologic and pharmacologic therapies
- Mutually understood expectations for degree and duration of pain therapy

Goal: Improvement of function to baseline or pre-injury status as opposed to complete pain resolution

Acute pain treatment

Non-pharmacologic options are first-line, within reason

- Ice/heat, positioning, stabilization, physical therapy
- Osteopathic neuromuscular care
- Biofeedback and hypnotherapy

Non-opioid treatment

Somatic and Visceral pain

- Acetaminophen
- Non-steroidal anti-inflammatory drugs (NSAIDs)
- Corticosteroids
- Also consider gabapentin/pregabalin, muscle relaxants, serotonin-norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs) and tricyclic antidepressants (TCAs)

Neuropathic pain

- Gabapentin/pregabalin
- SNRIs
- TCAs
- Also consider antiepileptics, baclofen, bupropion, capsaicin, SSRIs, topical lidocaine

Opioid treatment guidelines

- For pain associated with surgery or severe injuries
- Ideally, will be an adjunct to other therapies
- Screen for risk factors (high-risk psychosocial environment, personal or family history of substance use disorder, pregnancy)
- Use least potent opioid that will manage the pain; avoid long-acting

Opioid treatment guidelines

- Number of pills prescribed is guided by *expectations of healing* and *return to function* rather than a default number of pills
- Be mindful of potential interactions
- Discuss proper storage of medications
- Consider checking OARRS
- **Set expectations and ensure proper follow-up**

Follow-up

Key checkpoint: re-evaluate within 14 days (office visit or phone call)

- Pain characteristics (consider standardized tool, Oswestry Disability Index)
- Treatment methods used
- Expectation management (starting with correct diagnosis)
- Specialist consult needed?
- At 6 weeks, repeat checklist; refer to “Chronic” guidelines (not there yet, but suggestions offered)

Conclusion

- Use the guideline to support your decision-making and management plan
- Focus on function
- Partner with the patient and encourage self-management
- Set clear expectations