

Executive Summary: Use of Opioid Therapy for Acute, Non-malignant Pain at Brigham and Women's Hospital

Purpose/Definition: The purpose of this document is to support BWH healthcare providers in delivering compassionate, evidence-based, responsible care while improving the quality and safety of care that we deliver to our patients experiencing acute pain. 'Acute pain' is defined as pain provoked by a specific disease or injury, or subsequent to surgery, and is self-limited, lasting no longer than 90 days.

Pain Assessment and Indications: In acute situations, 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 given the provider's knowledge of the individual patient.**

- Opioids may only be prescribed after a clinical examination, diagnosis, review of medication and medical/psychiatric history, consideration of alternatives as well as the risk to the individual patient of opioids, and review of data from the Massachusetts Prescription Awareness Tool (MassPAT).

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.

Risk Assessment: **All patients should be screened for opioid misuse.** Consider using a validated screening tool to determine whether it is appropriate to prescribe opioids based on diagnosis and risk.

- The recommended risk screening tool at BWH is the SOAPP-R. You may also use other validated tools such as [Opioid Risk Tool \(ORT\)](#).
- Screen for family/personal history of substance use disorders (SUDs) and mental health problems before prescribing opioids.
- If a patient is at high risk for opioid abuse, then consider very close follow up and evaluation. For surgical patients, develop a pain management plan before elective surgery and as soon as feasible for urgent surgery.

Prescribing: For acute pain, opioids should be prescribed only when alternative pain treatment modalities are not expected to be sufficient.

- Opioids should never be prescribed for treatment of mild pain where non-opioid over the counter pain relievers or alternative therapies can be used effectively to treat mild 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.
- Be aware of the stigma associated with opioids and approach each patient with respect. It's crucial to communicate why the measures are being taken and to be mindful of not undertreating pain.

Patient Expectations:

- Providers should counsel patients that pain medications will manage pain and, ideally improve function, but not resolve pain.
- When prescribing opioid analgesia, **discuss side effects, addictive potential and risks for overdose**. If pain is anticipated as an outcome of a medical or surgical procedure, counseling should occur **before the onset of pain and as part of pre-procedure education**.

- **As a rule, BWH 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; and 5) Educate regarding practical storage and disposal methods of medication.

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 patient's primary provider before prescribing opioid analgesics. If unavailable, the acute provider should notify the patient's primary opioid prescriber of the visit and the medication prescribed.

Special Populations: If a patient is currently on long-term opioid medications or opioid agonists/antagonists (i.e. buprenorphine), any interruption in medications in the acute setting must be discussed with the primary prescribing clinician and addiction psychiatry should be consulted.

- Patients with an active opioid use disorder but not in treatment would benefit from an addiction psychiatry consultation. Those with IV-drug use related endocarditis, epidural abscess, cellulitis, or spinal abscess or related condition should be referred to addiction psychiatry as soon as identified in the hospital.

Hospitalization and Discharge Planning: When opioids are considered or started in the hospital, we encourage the following:

- Use of a risk calculator and documentation of risk before starting opioids
- Communication between inpatient team and outpatient provider around opioids
- Use and documentation of the MassPAT at least once during the hospital stay

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 then the provider should consider:** reevaluating cause of pain, rescreening for alcohol/drug abuse, toxicology screen if concern of other substance abuse or diversion, and/or referral to substance use disorder specialist/pain service.

Clinical Strategy: Use of Opioid Therapy for Acute, Non-malignant Pain

Date Updated: March 25, 2017

Brigham Health

1. Introduction: Overview and Intent

In 2014, Massachusetts was among the top ten states for prescribing prescription opioids with 4.6 million Schedule II and III medications prescribed for a total of 255 million pills. Yet, only 36% of Massachusetts residents report being warned about risks of addiction by their prescriber, compared to 61% of those receiving prescriptions nationally. The rising prevalence of prescription opioids across the country has been associated with the increased prevalence of opioid use disorder and overdose death. In Massachusetts, there has been a three-fold increase in opioid-related overdose deaths from 2000 to 2015, and over 1500 residents across the Commonwealth died from overdose in 2015. Additionally, the DEA has estimated that up to one-third of opioid prescriptions in Eastern Massachusetts are diverted (given to or sold to other users).

At BWH, an estimated 25,000 prescriptions for controlled substances are prescribed monthly. The BWH and BWPO recognized the need to develop a thoughtful and comprehensive strategy to support physicians in the prescribing of opioids for acute and chronic non-malignant pain, while ensuring the safety of our patients and our communities. The intent of this document is to offer a unified approach to guide physicians in the appropriate initiation of opioids for acute non-malignant pain, in all clinical settings except for hospice and palliative care.

2. Scope and Audience

This clinical strategy applies to all opioid prescribers within the BWPO. For the purposes of this strategy, acute pain is defined as pain that is provoked by a specific disease or injury, or occurs subsequent to surgery, and is self-limited, lasting no longer than 90 days. There is an accompanying document for the treatment of chronic pain. This clinical strategy does not apply to patients with active cancer and malignancy associated pain or patients receiving hospice or palliative care.

Within the overall category of acute pain, this strategy includes and recognizes three distinct sub-classes of patients:

- Opioid naive individuals
- Patients on opioid therapy for chronic pain with an unrelated and new acute pain issue
- Patients with an opioid use disorder with a new acute pain issue

This strategy does not apply to individuals with an acute exacerbation of an existing chronic pain condition.

3. Pain Assessment and Indications

In acute situations (including acute exacerbation of chronic pain and acute pain unrelated to other chronic pain problems), prescribing clinicians should consider opioid prescriptions based on:

- the known or anticipated degree of tissue disruption
- a **strong** consideration of non-medication and non-opioid alternatives
- specialty specific published guidelines
- the functional impact of pain on the individual patient
- the risk/benefit ratio given the known risks and potential benefits for the individual patient
- state and federal regulation requirements

Prior to prescribing opioids for a patient in acute pain, or when acute pain is anticipated, the following steps should be taken and when appropriate, documented:

- A comprehensive clinical examination with appropriate tests and imaging studies as necessary
- A definitive diagnosis or where that is not possible a differential diagnosis
- A review of the patient's medication and medical/psychiatric history
- Consideration or trial of alternative non-opioid and non-pharmacological measures appropriate to the clinical situation ([Section 4](#))
- Check the patient's Prescription Monitoring Program (PMP, MassPAT) record in accordance with both federal and state regulations
- An assessment of their reduced functional capacity as a result of acute pain
- If opioids are appropriate, assess risk using a Risk Stratification tool ([Section 5](#))

Pain Assessment:

- Traditionally pain is assessed on a visual analog scale or verbal scale from 0-10. These correlate well and provide an accurate assessment of the individual patient's current pain but not of their pain experience over time. Other scales have been devised which address this added dimension.
- Functional pain assessment ([Acute Pain Management](#), page 39—See [Appendix C](#) for references):
 - No limitation. Patient is able to undertake the activity without limitation due to pain. The pain intensity is typically 0-3.
 - Mild limitation. Patient is able to undertake the activity but experiences moderate pain. Pain intensity is 4-10.
 - Significant limitation. Patient is unable to perform the function due to pain or the adverse effects of treatment for pain.

4. Non-Opioid Alternatives to Pain Management

Opioid analgesics should be the last consideration for acute and chronic pain management. A thorough clinical evaluation is necessary prior to institution of any treatment strategy. Prescribing clinicians should pay close attention to red flags ([Washington State Guidelines](#), table 2, page 15—See [Appendix C](#) for references).

Prior to starting opioid treatment for any pain, the following should be considered:

- Optimize co-morbid illnesses—these could increase severity of pain and the need for opioids
 - Sleep problems
 - Depression
 - Anxiety
- Non-pharmacologic strategies—have shown low to moderate efficacy in reducing acute pain. These strategies include:
 - Exercise
 - Cognitive-behavioral intervention
 - Relaxation therapy
 - Cutaneous stimulation
 - Distraction therapy
 - Acupuncture
 - Education
 - Bio-feedback
 - Imagery
 - Music and art therapy
 - Hypnosis
 - Touch, massage, electrical current
 - Physical therapy
 - Heat/ice and elevation to decrease swelling
- Non-opioid pharmacologic agents—strong evidence that the use of these agents can reduce acute pain and the need for opioids. Consider risks/side effects for each patient prior to use.
 - NSAIDs
 - Acetaminophen
 - Gabapentin
 - Clonidine
 - Topical lidocaine
- Regional Techniques:
 - Consider consulting a pain specialist.
 - Continuous peripheral nerve blocks or continuous epidural anesthesia are far superior to systemic opioids in managing acute pain (strong evidence).

5. Risk Assessment

- 1) Providers should follow the legal requirements on the use of Massachusetts Prescriptions Awareness Tool (MassPAT) before initiating opioid treatment ([Massachusetts Online PMP](#)—See [Appendix C](#) for references).
- 2) Prescribers should consider screening patients for family or personal history of substance use disorders and mental health problems before initiating opioid treatment. Individuals with substance use and/or psychiatric disorders are more likely to have complications from opioid use, such as misuse, addiction, or overdose.
- 3) Risk assessment should respect patient privacy and be done without accompanied friends or family unless desired by the patient.
- 4) Preferred Screening Tool before starting opioid medication:
 - The [SOAPP-R](#) is the preferred screening tool at the Brigham. It's a 24 question, Likert scale instrument with internal validation that helps determine the patient's level of risk of aberrant behavior and categorizes them into low and high risk. It also correlates with high preoccupation with pain (catastrophizing) and decreased likelihood of adhering to other rehabilitative suggestions.
 - While there are no true hard stops on prescribing, a high risk score should be documented in the record, and the prescribing clinician should consider the following:
 - Reducing the amount of opioids initially prescribed
 - Increasing caution when prescribing refills
 - Increasing counseling (risks and overdose) and monitoring
 - Prescribing naloxone (e.g. Narcan) if appropriate
 - Referring to pain management specialists and substance use disorder resources
 - Additional screening tools are located in [Appendix C](#).
- 5) Females of childbearing age should be screened for pregnancy before initiating opioid treatment. Pregnant women require counseling regarding maternal, fetal and neonatal risks before initiating opioids.
- 6) Individuals with toxicology screen test results revealing illicit drugs, alcohol or non-prescribed controlled substances should be considered screened for SUDs and/or a consultation should be sought. (See [Appendix C](#) for Additional Screening Tools and Addiction Treatment Resources)
- 7) Individuals with an active or suspected opioid use disorder should be referred to addiction psychiatry for assistance with management of their acute pain, treatment planning and disposition. All individuals diagnosed with IV-drug use related endocarditis, epidural abscess, cellulitis, or spinal abscess or related condition should be referred to addiction psychiatry for consultation as soon as identified in the hospital.
- 8) Screening for Risk of Overdose and Overdose Reversal
 - Prescribers should consider prescribing take-home nasal naloxone if the patient has one or more of the following risk factors:
 - Psychiatric condition
 - Current or prior history of substance use disorder
 - Medical condition that could increase sensitivity to opioid-related side effects (e.g. impaired respiratory function, sleep apnea, high fall risk, altered drug metabolism related to advanced age or impaired renal, hepatic and/or cardiac function)
 - Concurrent use of benzodiazepines
 - Tobacco use
 - Anyone taking >50 mg morphine equivalents daily
 - Previous history of opioid overdose

(Additional overdose resources located in [Appendix C](#))

9) Risk Assessment After Opioid Overdose

- Prescribers should use extreme caution initiating opioid treatment for individuals who have a reported or documented history of overdose with opioids. Clinicians should strongly consider referral for pain consultation and will require close follow up.

6. Prescribing

For acute pain, opioids should be prescribed only when alternative pain treatment modalities are not expected to be sufficient. For mild to moderate acute pain, a trial of non-opioid therapies (e.g., acetaminophen, NSAIDs, muscle relaxants, rest and ice) should be tried before considering opioids ([Section 4](#)).

If opioid therapy is necessary, it should be prescribed at the **lowest effective dose** and for a **limited period**, corresponding to the expected duration of severe pain.

- Limiting the strength and duration of opioid therapy for acute pain may decrease the risk that patients progress to chronic use or abuse. It also decreases the amount of potential leftover medication that is available for misuse or diversion.

For acute pain (in patients not on chronic opioid therapy) unrelated to surgery or major trauma, providers should prescribe no more than a [7-day](#) supply.

- This generally corresponds to between 10 and 20 tablets to be used as needed. Patients should also have other pain control options as noted above.
- For significant pain 5 mg of oxycodone or 5/325 hydrocodone/acetaminophen is likely appropriate. Consideration should be given to tramadol 50mg, with appropriate review for drug interactions, before using a schedule II opioid.
- A smaller dose (e.g., 2.5 mg) may be appropriate for patients expected to be more sensitive to the effects of opioids (e.g., the elderly, patients that are co-prescribed benzodiazepines).

For acute pain related to trauma or surgery, or for pain that is expected to be persistent (i.e. kidney stones), the amount and duration should be guided by the extent of the surgical insult/traumatic injury.

- Departments/divisions caring for surgical and trauma patients should define by consensus the amount and duration of opioids that should be prescribed for different procedures/injury types.
- The quantity prescribed should again be defined by the expected duration of pain severe enough to require opioid therapy. It is recognized that close monitoring is important as is titration of medication, especially in opioid naive patients.

For acute pain in patients with co-morbid opioid use disorder, the Addiction Psychiatry team should be consulted for management, possible use of buprenorphine or methadone, and safe disposition and transition to ongoing substance use disorder treatment. Education of and coordination of care with family members and outpatient providers are both critical for the safe management of acute pain for patients with opioid use disorders.

Justifications for any prolonged prescriptions should be documented and clearly communicated to the patient and to his or her primary physician.

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 requirement to avoid the need for refills or “just in case.”

Co-prescribing of benzodiazepines and opioids is discouraged due to the increased risk of unintentional overdose.

7. Patient Consent/Expectations for Pain Management

It is crucial that physicians counsel their patients about pain and pain management and clearly discuss the side effects, including potential for addiction. Below provides a best practice structure for counseling:

When/Where: Counseling should occur as soon as possible, preferably before the onset of pain if such onset can be predicted (e.g. scheduled surgery), whether it is for a patient with new onset back pain in the Emergency Department, a trauma patient with rib fractures in the Intensive Care Unit, or a preoperative patient being scheduled from clinic for surgery next week.

What: Specifically, physicians should aim to:

- 1) Set the patient's expectations: Pain control expectations should be discussed as soon as possible. According to experts that studied pain, the goal should be improvement in overall functioning, which does not necessarily correlate with the pain score. In other words, the patient's expectation should be reaching a tolerable level of pain and improvement in function, NOT a zero level of pain.
- 2) Discuss alternatives for opioids: Not all pain requires opioids, and some does not respond well to opioids. Alternatives to opioid therapy exist and are effective in either eliminating or decreasing the need for opioids. These alternatives, such as acetaminophen, NSAIDs, SNRIs, or GABA-based medications should be the first line of therapy.
- 3) Discuss duration of therapy: Even though the extent of pain depends on the patient's perception, physiology and the etiology of the pain, most acute pain resolves within a few days and tapering the doses should be discussed explicitly. A large number of opioid pills dispensed at once without reassessment of the needs should be discouraged.
- 4) Discuss practical methods to store medications and dispose of any extra pills: Patients should be made aware of the risk of pills being potentially used by family members, roommates, children, or strangers. Recommend that patients store any controlled substances in locked containers/cabinets and away from other household members' medications. Because the leading cause of prescription medications on the street is diversion, patients should dispose of any extra pills according to the label or patient instructions (See [Appendix B](#) for Medicine Disposal Card). Any pills can also be brought to the bin at the BWH outpatient pharmacy. A plan should be made and documented for administration of these medications at home to patients with history of substance abuse who absolutely need opioids for a short time.

8. Communication

Communication between providers of acute care and patients' primary care providers is essential for the coordinated management of acute pain. This is true regardless of therapeutic modality chosen, but is especially important when treatment involves the prescription of opioid analgesics.

- Acute care providers (e.g., those in the ED, Medical walk-in, Urgent Care Centers, etc.) should document the specific treatment modalities discussed with and recommended to patients they treat in the patient chart (non-pharmacologic strategies as well as non-opioid and opioid medications).
- Any opioid medications prescribed should be for the duration and at the doses discussed above and clearly noted as new prescriptions in the patient chart.
- The record should be made available either during or immediately after the patient visit so that it can be readily accessed within the electronic medical record system when the patient follows up with their primary provider.
- For acute exacerbations of chronic pain, the acute provider should attempt to contact the patient's primary opioid prescriber or primary care provider before prescribing opioid analgesics. If the primary provider is not available, the acute provider should notify the patient's primary opioid prescriber/primary care provider of the visit and the medication prescribed. This communication should be within the electronic medical record "Inbox."
- At any time that any provider is concerned about misuse potential, addiction, or diversion, they should make every effort to communicate with the patients care team, especially the primary provider.

9. 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 and/or addiction psychiatry should be consulted for guidance.
- For people who are in recovery from drug or alcohol addiction, we recommend clear communication with the patient, their family, and their primary care clinicians, and pre-op assessment and evaluation as deemed necessary. It may be helpful to consult the addiction psychiatry service or pain service in advice of the treatment.
- The initial prescribing clinician of these medications should anticipate communications from providers in the acute settings and provide the appropriate guidance and/or support.

10. Hospitalization and Discharge Planning

Communication during transitions of care is essential, especially when opioids are started on patients in the hospital who will be transitioned to the care of outpatient providers. While it is not a legal requirement, we recommend the following for starting opioids on inpatients.

- Use a risk calculator, either the SOAPP-R or the ORT to help you assess the patient's risk.
- If the patient is at high or moderate risk, it's a good idea to speak to their outpatient clinicians, family members, and other supports (with patient consent) about your plan.
- Check the MassPAT. It may inform your decision. Document the results of both your risk assessment and MassPAT search.
- Discuss the plan for continued prescribing (if necessary) with the responsible outpatient clinicians.
- If you write a prescription for more than a 7 day supply, you must write in the chart: "patient requires management greater than 7 days for an acute medical condition."

11. Reassessment of Pain & Follow up

If opioids are prescribed for acute pain, close follow up should be arranged with the primary surgeon/prescribing clinician and the primary care provider. Contact information for routine and emergency care should be provided.

- Each department should create guidelines for routine follow up and emergency reevaluation for their most common procedures or medical complications causing acute pain.
- Patients with one or more of the following risk factors need earlier follow up:
 - Chronic opioid user along with follow up with their chronic opioid prescriber
 - History of prior substance use disorder
 - Psychiatric or medical conditions increasing risk of opioid related problems
 - Current use of other medication potentiating risk of opioids such as benzodiazepines
 - People who have a moderate or high risk assessment score.
 - Aberrant urine tox screens
- If patient requires additional opioids prior to their scheduled follow up they should come for evaluation of complication or other possible cause of increased pain.
- If patient requires opioids for longer duration than expected or larger quantity or for longer than expected, consider:
 - Looking for medical or surgical cause of continued pain
 - Screening/rescreening for alcohol/drug use and psychiatric conditions ([Section 5](#))
 - Toxicology screen if there is concern of other substance abuse or diversion (see appendix)
 - Referral to substance abuse specialist or pain service if indicated
 - Again encourage use of non-opioid alternatives to aid in taper and overall wellbeing ([Section 4](#))
 - Re-discuss benefits of weaning off opioids including:
 - Resumption of normal activities without sedation
 - Ability to drive or operate complex machinery
 - Side effects such as constipation and erectile dysfunction
 - Decreased risk of long-term disability
 - Fewer follow up appointments
 - Decreased risk of withdrawal
 - Less risk of analgesic tolerance
 - Decreased risk of developing opioid abuse, higher risk with higher doses and longer duration
- **Only after all reasonable and safe alternatives to long term use of opioid medications have been considered and exhausted should chronic use of opioid analgesia be considered. Chronic opioid therapy is rarely the best approach for the treatment of chronic pain.**
- At all follow up visits ask about any unused medication and discuss importance of safe disposal and provide safe medication disposal flyer ([Appendix B](#))
- Please see BWH guidelines for management of chronic pain.

12. Monitoring Best Practice Trends

Regular opioid prescribing reporting helps prescribers, practices, and clinical leaders to identify opportunities to improve prescribing practices, including:

- Assessing adherence to best practices, guidelines and policies
- Benchmarking prescribing rates and exploring inter-prescriber variations
- Reviewing utilization to detect and secure against diversion

BWH/BWPO will develop and securely distribute prescriber reports. Prescribers should:

- Review reports in a timely manner
- Investigate unfavorable or unanticipated findings
- Make practice changes where appropriate
- Report potential data errors to the report's author
- Report unexplained results to clinical leadership
- Feel comfortable asking questions and seek education and training to improve their prescribing practices.

Both the State and DEA will continue to monitor through periodic audits of the PMP.

Appendix A: How to order a urine tox screen in Epic

New Orders

Toxicology screen, urine

P STAT, Once First occurrence Today at 0953



Qualitative screen for PCP, Barbiturates, THC, Amphetamines, Benzodiazepines, Opiates, and Cocaine. Drugs NOT tested include Oxycodone, Buprenorphine, Methadone, Meperidine, LSD, and Propoxyphene. Providers wishing to test for Oxycodone, Buprenorphine, or Methadone should order the Pain Management Profile in addition to or instead of the Drugs of Abuse (urine) test. In the Pain Management Profile testing is performed for Buprenorphine, Oxycodone, Methadone, and 6-Monoacetyl morphine. Please note that the Pain Management Profile is not a stat test; testing is performed daily, M-F. Contact the laboratory for other information at 6-3636.

Appendix B: MGH Medicine Disposal Card

Did You Know?

- ◆ Prescription medication abuse is a serious public health issue
- ◆ Over half of heroin users admit to starting with opioids, which are prescription pain medications
- ◆ Most people admit to taking prescription medications from their relative's or friend's medicine cabinets
- ◆ The best option for disposal is to return unused opioids to a special medication disposal unit; most police stations, and some pharmacies, now have disposal or "take-back" units available. To find a disposal site near you, please visit: <https://www.deadiversion.usdoj.gov/pubdispsearch>
- ◆ Drug "take-back" events are held so that prescription and over-the-counter medications can be collected at a central location for proper disposal. Call your city or county government's household trash and recycling service and ask if a drug take-back program is available in your community
- ◆ As a last resort, opioid medications should be flushed down the toilet for disposal. To find out more information, please consult the patient information leaflet, or look up the medication at: <http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm101653.htm>



MGH NAS COMMITTEE 11/2015

If no medication "take-back" program is available in your community, follow these simple steps to get rid of them in your household trash. Please NOTE: For safety reasons, some medications should be flushed down the toilet.*

1. Mix medication (do NOT crush tablets or capsules) with kitty litter, dirt or used coffee grounds
2. Place the mixture into a container that can be closed, such as an empty margarine tub, a coffee can or a sealable plastic bag
3. Before throwing out your empty pill bottle, remember to scratch out all personal information, such as name, date of birth and RX number
4. Throw the container in your household trash

* For more information on which medications are recommended for disposal by flushing, please visit <http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm101653.htm> OR read the disposal instructions on the medication label or the accompanying patient information leaflet



- Rx Med Disposal Flyer in ENGLISH (pk of 100) 87453
- Rx Med Disposal Flyer in SPANISH (pk of 50) 87453SP

Appendix C: References

BWH Pain Policy

<https://hospitalpolicies.ellucid.com/documents/view/2523/17884>

CDC Opioid Prescribing Guidelines

Prescribing Opioids for Chronic Pain, 2016

<http://www.cdc.gov/drugoverdose/prescribing/guideline.html>

Institute for Clinical Systems Improvement

Acute Pain Assessment and Opioid Prescribing Protocol

https://www.icsi.org/_asset/dyp5wm/Opioids.pdf

Massachusetts Hospital Association

Guidelines for Emergency Department Opioid Management

<https://www.mhalink.org/AM/Template.cfm?Section=Newsroom&Template=/CM/ContentDisplay.cfm&ContentID=49021>

Massachusetts Online PMP - MassPAT

Massachusetts Online Prescription Monitoring Program

<http://www.mass.gov/eohhs/gov/departments/dph/programs/hcq/drug-control/pmp/>

Washington State Agency Medical Directors' Group (AMDG)

Interagency Guideline on Prescribing Opioids for Pain

<http://www.agencymeddirectors.wa.gov/files/opioidgdline.pdf>

Preventing Overdose, Nasal Narcan

How to Assemble Nasal Narcan

Massachusetts Opioid Overdose Statistics

<http://www.mass.gov/chapter55>