These prescribing recommendations, developed by Michigan OPEN for patients with no preoperative opioid use, were informed by patient-reported data from our Collaborative Quality Initiative (CQI) partners, published studies and expert opinion.

tinyurl.com/OPEN-RX

Download prescribing recommendations in PDF or Excel, sign up for notifications of updated recommendations and additional procedures.

*No opioid use in the year prior to surgery

Michigan-OPEN.org

Counseling

patients about **pain** & **opioid** use after surgery

- ❑ Set pain expectations in relation to procedure
- ❑ Focus on post-operative functional goals. Ability to:
  - eat
  - move
  - breathe deeply
  - sleep
- ❑ Focus on non-opioid pain management alternatives
  - NSAIDs, acetaminophen
  - physical therapy
  - acupressure
  - meditation/mindful breathing
- ❑ Discuss appropriate use
  - only for acute surgical pain
- ❑ Discuss adverse effects
  - nausea, vomiting, constipation
  - risk of dependence
  - addiction
  - potential overdose
  - diversion
- ❑ Educate on safe storage and disposal
  - Find a local medication drop box at: Michigan-OPEN.org/takebackmap

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4

evidence-based

reasons

to change opioid prescribing practices

OPEN

OPIOID PRESCRIBING ENGAGEMENT NETWORK

The evidence found

6-10%

of surgical patients become new persistent opioid users

(A significant surgical complication)

NO correlation

between probability of refill and amount of opioid prescribed

Greater than

70%

of prescribed opioids go unused

NO correlation

between patient satisfaction scores and amount of opioid prescribed

Q: Why are prescribers being asked to change their opioid prescribing practices?

- Postoperative opioid prescribing varies significantly.[1]
- Greater than 70% of prescribed pills went unused by patients.[1,2]
- Patients who were prescribed fewer opioids reported using fewer opioids with no change in pain scores.[3]
- Evidence-based opioid prescribing guidelines for the perioperative period are needed to enable tailored prescribing and reduce the excess of opioid pills within patients' communities.[4]
- Prescription size was the strongest predictor of patient consumption.[5]

Q: Will patient satisfaction scores be impacted by prescribing fewer opioids?

- No correlation was found between HCAHPS pain measures and postoperative opioid prescribing.[6]
- Prescribers can feel empowered to reduce their initial opioid prescription without impacting patient satisfaction.[6]

Q: How likely is persistent opioid use after surgery?

- Approximately 6–10% of opioid naïve (before surgery) patients continue to use opioids more than three months after surgery.[7,8,9]
- Many patients continue to use their opioids for reasons other than surgical pain.[7,9]
- New persistent opioid use after surgery is an underappreciated surgical complication that warrants increased attention.[7,8,9]

Q: Will patients request more prescription refills if initially prescribed fewer opioids?

- The probability of a patient refilling a postoperative opioid prescription was not correlated with their initial prescription amount.[10]
- Prescribers could prescribe smaller opioid prescriptions without influencing the probability of a refill request.[10]
- Implementation of evidence-based prescribing guidelines reduced post-laparoscopic cholecystectomy opioid prescribing by 63% without increasing the need for medication refills.[3]

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