Rationale: The overprescribing of opioids post-operatively, places patients at risk of becoming new persistent users, a significant surgical complication. Among opioid-naïve patients undergoing common surgical procedures, 6-10% continue filling opioid prescriptions 3-6 months after surgery. Surgeons overprescribe opioids for many common surgical procedures with 72% of opioids prescribed to surgical patients going unused. Excessive, unused prescription opioids have devastated our communities by creating an opportunity for misuse and diversion. Among patients who misused prescription opioids, over 50% obtained them for free from a friend or relative. Implementation of a pain control optimization pathway, leveraging multi-modal analgesic management and patient education and engagement, can potentially transform post-operative surgical care.

The Care Processes

Patient selection:

• **Patient Inclusions:**
  - Uncomplicated, elective surgery
  - Opioid naïve patients (i.e., No opioid use within one year of procedure).
  - Patients in active recovery from Opiate Use Disorder (OUD) and intermittent opioid users may be considered, upon surgeon’s discretion.

• **Patient Exclusions:**
  - History of multiple comorbidities, in whom surgery is not straightforward.
  - Patients currently utilizing opioids for chronic pain or with a Controlled Substance Agreement from their pain specialist or usual prescriber.
  - Those with allergies, medical conditions, or personal reservations contraindicating acetaminophen and/or ibuprofen use.

Preoperative optimization: Discuss risks/benefits of the Pain Control Optimization Process (POP) ideally at the surgical consult, or preoperative screening thus informing shared decision-making.

• **Patients receive education regarding:**
  - Post-operative pain expectations including usual opioid consumption
  - Non-opioid pain medication instructions
  - Opioid safe use and disposal instructions
Operative management: The perioperative pain management plan should be reinforced with the patient, attending anesthesiologist, CRNA, RNs and surgeon.

- Anesthesia will maintain standard intraoperative analgesia to ensure safe and optimal anesthetic management.

- Post Anesthesia Care Unit (PACU) RNs will maintain ASPAN standards, however nursing is encouraged to administer oral opioids sparingly with appropriate rationale to patients.

Discharge post-operative pain management:

- All patients should receive:

  - Clear messaging regarding normal pain expectations specific to their surgery.

  - Communication options (e.g., patient portal, phone numbers) for any unforeseen pain questions or concerns, including during off hours.

  - Instructions for scheduled acetaminophen and ibuprofen to be taken around-the-clock, while awake during the first 72 hours postop.

  - Education regarding the efficacy and use of non-opioid pain management options (i.e., acetaminophen and ibuprofen) and other adjuncts (e.g., splinting, elevating, ice or heat packs prn, ambulation) for optimal pain management.

  - A prescription for a limited number of opioids. (See medication chart pg. 3.)

  - Explicit instructions on reserving the opioids only for breakthrough pain and only during the first 24-48 hours postop.6

  - Education on safe opioid storage while in use and safe disposal instructions for any unused opioids.
    - Consider providing an in-home drug disposal product
    - Minimally, provide printed information on local authorized collectors, in their community.
      Visit: http://michigan-open.org/takebackmap/
    - As a last resort, provide instructions on safe disposal of excess opioids using household trash. http://michigan-open.org/patient-resources/
Pain Control Optimization Pathway - POP

Opioid Medication Summary

Michigan OPEN Recommendations

<table>
<thead>
<tr>
<th>PROCEDURE</th>
<th>RX: OXYCODONE 5mg TABLETS</th>
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<tbody>
<tr>
<td>Adrenalectomy</td>
<td>12</td>
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<tr>
<td>Appendectomy – Adult</td>
<td>4</td>
</tr>
<tr>
<td>Appendectomy – Pediatric</td>
<td>0</td>
</tr>
<tr>
<td>Carotid Endarterectomy (CEA)</td>
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</tr>
<tr>
<td>Carpal Tunnel Release</td>
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</tr>
<tr>
<td>Endovascular Aneurysm Repair (EVAR)</td>
<td>4</td>
</tr>
<tr>
<td>Functional Endoscopic Sinus Surgery (FESS)</td>
<td>8</td>
</tr>
<tr>
<td>Hernia Repair – Inguinal</td>
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</tr>
<tr>
<td>Hernia Repair – Ventral and Umbilical</td>
<td>8</td>
</tr>
<tr>
<td>Laparoscopic Cholecystectomy</td>
<td>4</td>
</tr>
<tr>
<td>Parathyroidectomy</td>
<td>5</td>
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<td>Sleeve Gastrectomy</td>
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<td>Thyroidectomy</td>
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<td>Ureteroscopy</td>
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<tr>
<td>Vasectomy</td>
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</tr>
</tbody>
</table>

*May substitute (5) Tramadol 50mg tablets, per surgeon’s discretion.

NOTE: Oxycodone allows the adjuvant use of IBU/APAP while eliminating concerns of exceeding APAP’s maximum daily dose.

Over-the-counter medication discharge instructions:

Acetaminophen 650mg q 6h, alternating with ibuprofen 600mg q 6h.
  - Emphasize this is scheduled dosing of OTC
  - Ensures pain meds q 3h, while maintaining 6 hours between each dose of APAP and IBU.
  - CONSIDER a prescription for IBU 600mg to decrease confusion.
References: