Screen the patient for opioid use and substance use before surgery to identify those at risk for poor pain and opioid use outcomes

- Consider using the TAPS Screening Questionnaire, a validated way to screen patients for risk before surgery
- Identify patients at increased risk of respiratory depression: Concurrent medication use (e.g., prior opioid prescriptions, sleep aids, benzodiazepines), obstructive sleep apnea, obesity, neurological disorder, oxygen desaturation prior to discharge
- Use language that respects individuals with substance use disorder to mitigate stigma

Prescribe based on OPEN's acute care prescribing guidelines

<table>
<thead>
<tr>
<th>DO</th>
<th>AVOID</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ Prescribe acetaminophen and NSAIDs, unless patients have contraindications or high-risk adverse effects</td>
<td>☒ Prescribing codeine or tramadol. Due to pharmacogenetic differences, codeine and tramadol are poor choices for pain management and should not be prescribed</td>
</tr>
<tr>
<td>- Giving families a prescription helps them understand these are the first-line medications for pain management</td>
<td></td>
</tr>
<tr>
<td>- Refer to the OTC Quick Reference Sheet</td>
<td></td>
</tr>
<tr>
<td>☑ If prescribing opioids is indicated, then follow OPEN's Acute Care Opioid Prescribing Recommendations</td>
<td>☒ Prescribing fentanyl or long-acting opioids (e.g. OxyContin®)</td>
</tr>
<tr>
<td>☑ Access the prescription drug monitoring program (PDMP) prior to prescribing controlled substances schedules 2-5, in compliance with state law</td>
<td>☒ Prescribing opioids that contain acetaminophen (e.g. Norco®, Vicodin®, Percocet®) to minimize risk of acetaminophen overdose</td>
</tr>
<tr>
<td>☑ Consider co-prescribing naloxone to patients on high doses of opioids or Medication for Opioid Use Disorder</td>
<td>☒ Prescribing opioids with other sedative medications (e.g., benzodiazepines, skeletal muscle relaxants)</td>
</tr>
</tbody>
</table>

Educate patients and families about the following:

- Acetaminophen and NSAIDs should be used together as first-line medications for postoperative pain in surgical patients, unless patients have contraindications or high risk of adverse effects
- Use of prescription opioids ONLY to manage severe breakthrough pain that is not relieved by acetaminophen and NSAIDs
- Pain expectations and how to taper opioid use as pain improves
  - Pain usually peaks and then improves after the first 2-3 days following surgery
- The risks and side effects of opioid medications (sedation, respiratory depression, dependence, withdrawal, addiction, overdose)
- How to safely store and dispose of opioids
- Appropriate use of naloxone, if prescribed
  - For additional information about naloxone, refer to https://michigan-open.org/resource/learn-the-facts-naloxone/

Coordinate postoperative pain management plan

- Coordinate with anesthesia, and consider nerve block, local anesthetic catheter or an epidural when appropriate
- Provide primary care providers or usual prescriber with information about their patient's operative procedure and the plan for management of acute postoperative pain
  - Allows for better communication, consistent messaging, and improved patient monitoring after surgery
- If the patient screens positive for risk of SUD, consult an addiction medicine specialist

Scan to access OPEN's Resources, or visit michigan-open.org