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HEALing Communities Study
Kentucky



Rethinking Opioids

Best practices for dental pain management

A Guide for Dentists and Oral Surgeons



Helping to End Addiction Long-term

The HEALing Communities Study utilizes a community engaged process to develop a comprehensive, data-driven community response plan to deploy evidence-based practices across multiple sectors and reduce opioid overdose deaths within highly affected communities by 40% over 3 years.

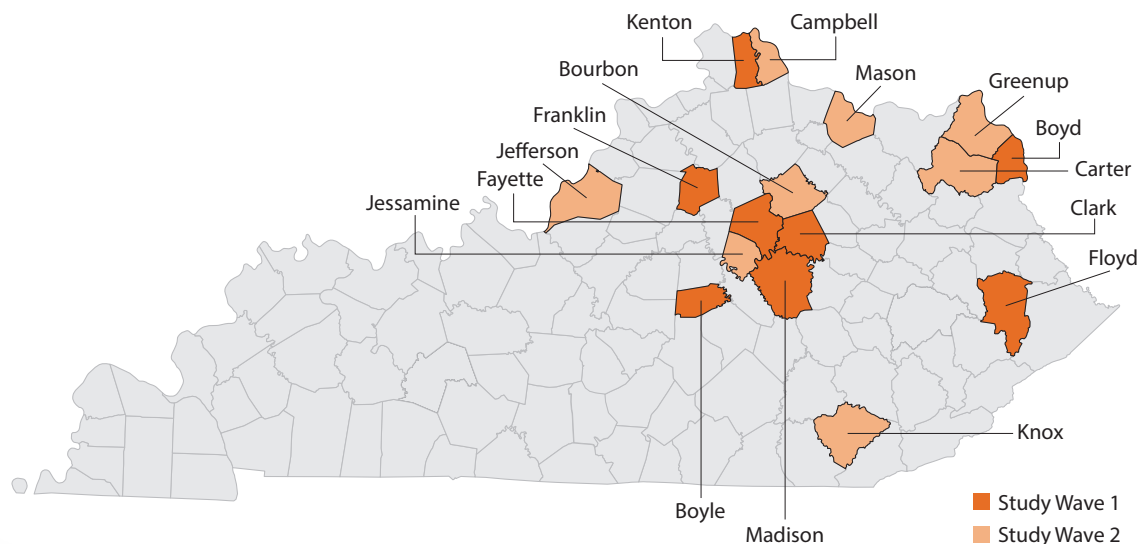
HEALing Communities Study

Ambitiously aiming to reduce opioid overdose deaths by 40 percent over three years

The HEALing Communities Study at the University of Kentucky is a 4-year, \$87 million project funded by the National Institute on Drug Abuse.

Researchers will work with 16 Kentucky counties to leverage existing resources and develop a collaborative model for ending the opioid overdose crisis. Intervention strategies focus on expanding treatment for opioid use disorder, ensuring naloxone availability, and improving prescription opioid safety.

As we implement an integrated set of evidence-based practices, we seek to better understand the unique needs of each community. What we learn will help guide efforts to increase support for patients and families and improve lives throughout Kentucky and across the country.



Learn more at www.healingcommunitiesstudy.org

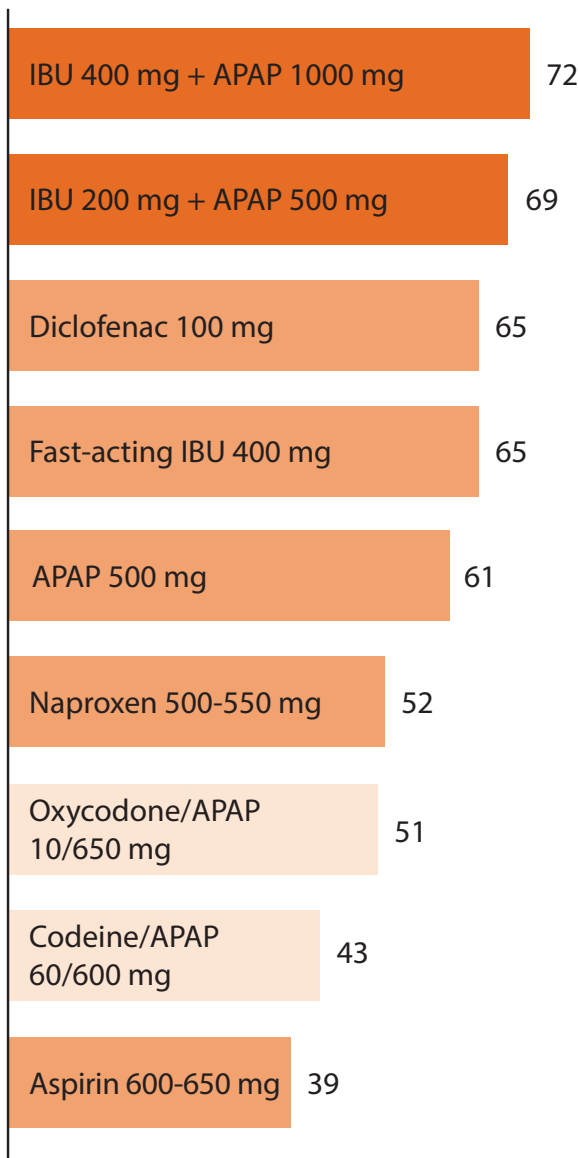


For acute postoperative dental pain, NSAIDs and acetaminophen are as effective as opioids with fewer adverse effects¹

An overview of systematic reviews examined the safety and efficacy of oral agents for acute postoperative dental pain and concluded that NSAIDs, with or without acetaminophen, offered the most favorable balance between benefits and harms. Most of the data in the systematic reviews came from studies of third-molar extraction.

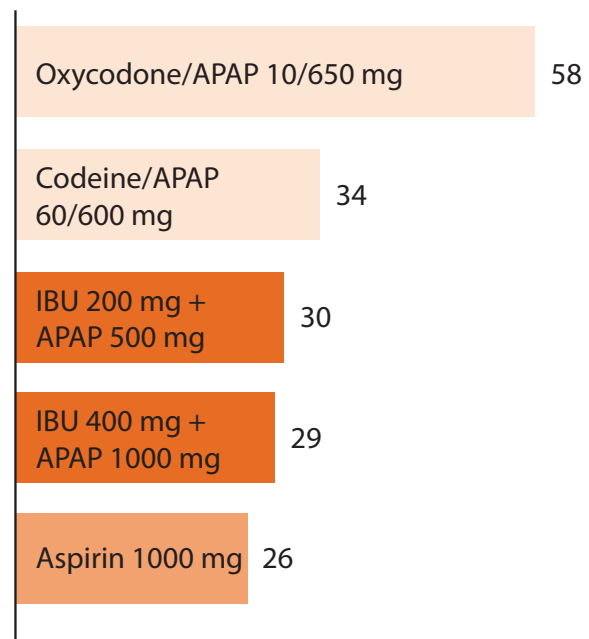
Use non-opioid treatment first line for pain management

Pain Relief



Percent attaining at least 50% maximum pain relief over 4 to 6 hours

Adverse Effects



Percent reporting acute adverse events

Adverse events for opioids included drowsiness, respiratory depression, nausea, vomiting, and constipation. Adverse events for NSAIDs included drowsiness, dizziness, nausea, and headache.

NSAID = Nonsteroidal anti-inflammatory drug
 IBU = Ibuprofen
 APAP = Acetaminophen

Graphs adapted from Moore, et al.¹



Recommended oral analgesics for acute dental pain

Anticipated Pain by Procedure		Recommendation by Pain Severity
Frenectomy Gingivectomy Routine endodontics Scaling/root planing Simple extraction Subgingival restorative procedures	MILD	Ibuprofen every 4 to 6 hours as needed Ibuprofen every 6 hours for 24 hours, then Ibuprofen every 4 to 6 hours as needed
Implant surgery Quadrant periodontal flap surgery w/bony recontouring Surgical endodontics Surgical extraction	MODERATE	Ibuprofen + Acetaminophen every 6 hours for 24 hours, then Ibuprofen + Acetaminophen every 6 hours as needed
Complex implant Partial or full bony impaction surgery Periodontal surgery	SEVERE	Ibuprofen + Acetaminophen every 6 hours + Hydrocodone w/Acetaminophen every 6 hours as needed for 24 to 48 hours, then Ibuprofen + Acetaminophen every 6 hours as needed

Dosing Recommendations for Adults and Adolescents:
 Ibuprofen 200 to 600 mg = 1 to 3 OTC tablets (depending on pain severity)
 Acetaminophen 500 mg = 1 OTC extra strength tablet (for all pain severities)
 Hydrocodone 5 mg w/Acetaminophen 325 mg = 1 Rx Hydrocodone-APAP 5-325 mg tablet (for severe pain only)

Adapted from American Dental Association and Indian Health Service^{2,4}

Additional recommendations for acute pain management

- A single dose of ibuprofen 400 mg and/or acetaminophen 500 mg taken 30–60 minutes before a procedure may delay and reduce post-procedural pain. (Not recommended if significant trauma or bleeding is expected.)
- Long-acting local anesthetics (e.g., bupivacaine) may reduce pain intensity and onset if given 5 minutes prior to procedure or immediately post-procedurally. (Use caution when combined with other local anesthetics.)
- Antiseptic mouthrinse (e.g., chlorhexidine gluconate) may promote healing, prevent infection, and reduce pain.
- Non-pharmacological strategies (e.g., ice or heat, rest, dietary considerations, smoking cessation for at least 24 hr) should be utilized.
- Antibiotics or antiseptic mouthrinse may be indicated to address pain related to infection.
- Corticosteroids (e.g., dexamethasone) may limit swelling and discomfort related to third-molar extractions.

Adapted from American Association of Oral and Maxillofacial Surgeons and Indian Health Service^{3,4}



2022 CDC Guideline Recommendations

The *CDC Clinical Practice Guideline for Prescribing Opioids for Pain* provides advice to all outpatient opioid prescribers, including dentists. Recommendations relevant to acute dental pain include:

Recommendation 1: Nonopioid therapies are at least as effective as opioids for many common types of acute pain. Clinicians should maximize use of nonpharmacologic and nonopioid pharmacologic therapies ... and only consider opioid therapy for acute pain if benefits are anticipated to outweigh risks to the patient.

Recommendation 3: When starting opioid therapy ... clinicians should prescribe immediate-release opioids instead of extended-release and long-acting (ER/LA) opioids.

Recommendation 4: When opioids are initiated for opioid-naïve patients ... clinicians should prescribe the lowest effective dosage.

Recommendation 6: When opioids are needed for acute pain, clinicians should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids.

Recommendation 9: When prescribing initial opioid therapy ... clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or combinations that put the patient at high risk for overdose.

Learn more at www.cdc.gov/opioids

Recommendations quoted from Dowell, et al.⁸

Other safety tips for opioid prescribing

- Educate patients on risks of opioids, storage and disposal, and prevention of misuse and abuse.
- Use screening tools to assess for history of opioid misuse or substance use disorder.
- Use extra caution when prescribing opioids to patients who are taking sedating medications such as benzodiazepines, gabapentinoids, hypnotics, or muscle relaxers.
- If the patient takes opioids for chronic pain or medications for opioid use disorder (e.g., methadone or buprenorphine), consult with their medical provider prior to prescribing additional opioids.

Adapted from American Association of Oral and Maxillofacial Surgeons and Indian Health Service^{3,4}

Special populations to consider

Drug Class	Populations of Concern
Opioids	Respiratory conditions Psychiatric conditions Substance use disorder Moderate to severe liver disease Renal impairment Older adults (e.g., ≥65 years)
NSAIDs	Clotting disorders or anticoagulant use Cardiovascular disease Peptic ulcer disease or GI bleeding Moderate to severe renal impairment History of gastric bypass Severe liver disease
Acetaminophen	Moderate to severe liver disease Alcoholic liver disease or consuming ≥ 3 drinks/day Severe renal impairment
Long-acting anesthetics	Heart disease Hyperthyroidism Seizures Severe liver disease History of aneurysm or stroke Older adults (e.g., ≥65 years)



Extra caution is warranted when considering opioids for younger patients



- Nearly one-quarter of all opioid prescriptions for patients 11 to 25 years old are dental-related.⁵
- Individuals who had an opioid prescription by 12th grade were, on average, 33% more likely to misuse prescription opioids after high school than those with no opioid prescription. Risk tripled in otherwise low-risk individuals.⁶
- A filled opioid prescription following wisdom tooth extraction nearly tripled the likelihood of persistent opioid use among opioid-naïve patients aged 13 to 30 years.⁷

Key features of Kentucky law for dentists prescribing opioids

- Dentists must be registered with the DEA and enrolled in KASPER.
- Acute pain prescriptions for schedule II or III controlled substances are limited to a 3-day supply unless ALL of the following are met:
 - The dentist believes more than a 3-day supply is medically necessary.
 - The dentist documents the medical condition and lack of alternative options.
 - The patient and dentist sign an attestation that non-opioid options were explained and that the risk of dependency is understood.
- Prior to initial prescribing, prescribers must:
 - Review KASPER for the preceding 12 months.
 - Perform and document a complete medical history and physical exam of the oral or maxillofacial area.
 - Make a written treatment plan.
 - Discuss risks and benefits with the patient.
 - Obtain the patient's signed consent for treatment.
- Prescribers may only provide 1 additional prescription within 30 days of the initial prescription without a clinical reevaluation. The additional prescription must be for the same drug or a lower scheduled drug and for the same amount or less.
- **Effective January 1, 2021 all controlled substances must be prescribed via electronic prescription, with limited exceptions.**

Follow state laws & regulations when prescribing opioids

201 KAR 8:540, KRS 218A.182

Need help with KASPER? Visit <https://ekasper.chfs.ky.gov> or call 502-564-2703



Establish *realistic expectations* and help every patient understand the pain management plan

Tips for communicating with patients about pain

Tip	Example Statement
Be honest	We do expect this procedure to cause [mild, moderate, severe] pain, which should improve over a few days. Medications can help, but some discomfort is normal. No medications can eliminate pain entirely.
Set realistic expectations	Our goal is to reduce your pain by about 30 to 50 percent compared to untreated pain. We also want less pain over time and expect you to be back to normal in about a week.
Explain the pain	Inflammation is the primary source of pain from dental procedures. Anti-inflammatories such as ibuprofen are more effective at treating the source of the pain and helping you heal than other pain medications.
Have a plan	I've planned a 3-day pain management regimen for you that works for most patients. However, if you find your pain is not subsiding after 3 days or you experience unbearable discomfort at any time, I can adjust your regimen over the phone, including sending a prescription to your pharmacy if needed.
Use reflective listening	It sounds like you've had a painful dental experience in the past, and that's made you anxious about pain with this procedure. Do I have that right?
Ask questions	What concerns do you have?
Use teach-back	I know I just gave you a lot of information. Can you describe your plan for pain management to me, so I can make sure I didn't forget to tell you anything?

Other tips

- **Take your time:** Avoid the perception that you are rushed or dismissive of the patient's concerns.
- **Stay neutral:** Avoid stigmatizing language about opioids and opioid use disorders (e.g., addict, drug-seeking, junkie).
- **Be empathetic to fear and anxiety:** Provide reassurance that you are focused on the patient's health, comfort, and safety.
- **Avoid confrontation and stay positive:** If a patient is combative or defensive, calmly emphasize your desire to provide safe and effective pain management.

Note: The information and recommendations throughout this document are intended for non-pregnant adolescent and adult patients only. Additional considerations and contraindications exist when treating patients younger than 13 years old.

Key Best Practices

- ✓ *Use non-opioid treatment first line for pain management*
 - ✓ *Follow state laws when prescribing opioids*
 - ✓ *Establish realistic expectations and help every patient understand the pain management plan*
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HEALing Communities Study Kentucky

The information in this document is intended to be general and educational in nature. Clinical decisions should be made by the treating provider based on an individual patient's condition. This document is not legal advice. Licensed providers are individually responsible for complying with all laws and regulations related to their practice. This publication was supported by the National Institutes of Health through the NIH HEAL Initiative under award number UM1DA049406. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health or its NIH HEAL Initiative.

References

1. Moore PA, Ziegler KM, Lipman RD, Aminoshariae A, Carrasco-Labra A, Mariotti A. Benefits and harms associated with analgesic medications used in the management of acute dental pain. *J Am Dent Assoc.* 2018;149(4):256-568. doi:10.1016/j.adaj.2018.02.012
2. American Dental Association. Oral Health Topics: Oral Analgesics for Acute Dental Pain. <https://www.ada.org/en/member-center/oral-health-topics/oral-analgesics-for-acute-dental-pain#>. Updated September 17, 2019. Accessed February 11, 2020.
3. American Association of Oral and Maxillofacial Surgeons. Opioid Prescribing: Acute and Postoperative Pain Management. 2017. https://www.aaoms.org/docs/govt_affairs/advocacy_white_papers/opioid_prescribing.pdf. Accessed February 11, 2020.
4. Indian Health Service. Recommendations for Management of Acute Dental Pain. <https://www.ihs.gov/doh/documents/Recommendations%20for%20Acute%20Dental%20Pain%20Management.pdf>. Revised July 2018. Accessed February 11, 2020.
5. Gupta N, Vujicic M, Blatz A. Multiple opioid prescriptions among privately insured dental patients in the United States: Evidence from claims data. *J Am Dent Assoc.* 2018;149(7):619-627.e1. doi:10.1016/j.adaj.2018.02.025
6. Miech R, Johnston L, O'Malley PM, Keyes KM, Heard K. Prescription opioids in adolescence and future opioid misuse. *Pediatrics.* 2015;136(5):e1169-1177. doi:10.1542/peds.2015-1364
7. Harbaugh CM, Nalliah RP, Hu HM, Englesbe MJ, Waljee JF, Brummett CM. Persistent opioid use after wisdom tooth extraction. *JAMA.* 2018;320(5):504-506. doi:10.1001/jama.2018.9023
8. Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022. *MMWR Recomm Rep.* 2022;71(No. RR-3):1–95. doi: <http://dx.doi.org/10.15585/mmwr.rr7103a1>