Opioid Prescribing Work Group: Post-Acute Pain Recommendations**DRAFT**

Prescribing Opioids in the Post-Acute Phase

The post-acute phase of pain is pain experienced between four and forty-five days following a severe injury, severe medical condition, or a major surgical procedure or trauma. This phase represents a critical period for secondary prevention of chronic opioid use and substance use disorder. Opioid use for acute pain is associated with long-term opioid use, and a greater amount of early opioid exposure is associated with greater risk for long-term use (Alam, 2012; Webster, 2007). In addition, because physical dependence on opioids is an expected physiologic response in patients exposed to opioids for more than a few days, it is imperative that a prescriber work with the patient to limit the days of opioids prescribed following an acute event.

Pain intensity and pain interference with normal function should decrease during the post-acute phase as part of the natural course of recovery following surgery or injuries. Patients may continue to experience acute pain induced by a severe injury or invasive procedure, and treatment should continue accordingly. Patients who experience sub-acute pain during this phase should receive aggressive, multi-modal pain treatment in order to improve function, manage pain, and prevent future transition to chronic pain and chronic opioid use. Avoid continued use of opioids to treat sub-acute pain, and plan to taper patients off opioids by 45 days after the acute event.

Clinicians must be aware that patients may become opioid-dependent within this timeframe, and transition to chronic opioid use. In addition, physiologic pain processes may begin to transition from acute to chronic mechanisms. Risk assessment is necessary to identify psychosocial risk factors that may predict chronic use, the development of opioid use disorders, and the transition from acute to chronic pain. Assessment of pain and function at each follow-up visit during this period is necessary to document changes over time. Assessment of mental health conditions and substance abuse risk is needed early and prior to any refill during the post-acute phase.

Note: Refer to OPWG Acute Pain Recommendations for patients who were initially prescribed opioids by another prescriber, or who because of the nature of the trauma, are still experiencing acute pain.

Clinical Recommendations

1. Pain and Function Assessment

   Pain

   Assess and document pain at each follow-up visit. Pain assessment and reassessment during the post-acute pain period can be valuable for tracking improvement and gauging whether healing and recovery is progressing normally. Documentation of pain should include use of any validated assessment instrument as a relative tool, and concordance of the patient’s assessment of his or her own pain with the provider’s objective observations. Validated tools include the Three Item PEG Assessment Scale (Krebs, 2009), the Pain Numeric Rating Scale (NRS) (Krebs, 2007), and the Brief

   1 See Minnesota Statutes 2015, section 256B.0638, subdivision 7.
Pain Inventory (BPI) (*Tan, 2004*). Consider the patient’s presentation of pain in relation to tissue damage and healing following an acute event, whenever possible. Patients with evidence of nociceptive process capable of causing the self-reported pain may require continued opioid therapy into the post-acute period.

**Function**

Assess and document function at each follow-up visit for pain management following an acute injury or trauma, or surgical procedure. Use functional assessments—in concordance with pain assessments—to guide patient-provider conversations about pain management and psychosocial factors that may contribute toward the experience of pain. Do not continue opioid therapy solely based on reports of improved physical function once the tissue healing is sufficient.

Evaluate whether changes in perceived pain and function demonstrate a trajectory of pain reduction and improved function at each follow-up visit during the post-acute period. Strongly consider reevaluation of the etiology of the pain for those patients who do not demonstrate expected improvements based on the nature of their injury or pathology.

Patients that report pain intensity or severity beyond the anticipated treatment duration, or functional limitations disproportionate to the nature of the injury or trauma, will require additional assessment. Clinicians should obtain additional contextual information from the patient regarding his or her experience and limitations with pain, and assess whether psychosocial issues are potentially affecting the pain experience (See Recommendation 6).

2. **Reevaluate patients who experience severe acute pain that continues longer than the expected duration of recovery.** Confirm or revise the initial diagnosis and adjust pain management accordingly.

3. **Patient Education and Reassurance**

Provide patient education about opioid use and pain management, recovery processes and prevention of future pain episodes as an adjunct to other treatment modalities. Clearly explain the diagnosis to the patient, and include the patient and/or his or her caregiver in decision-making about pain relief options. Address the following at each visit:

- Pain following an injury or surgery does not represent harm;
- Expected duration and severity of pain;
- Warning signs that require immediate medical attention;
- When the patient should be able to resume normal activities and return to work, if applicable;
- How to prevent future episodes of pain, especially for patients with back pain;
- The importance of actively participating in and being responsible for, his or her own pain control; and
- The patient’s questions, especially those related to concerns about the severity of the pain.
4. Basic Pain Education and Referral for Additional Pain Education

Emerging research suggests that patient education about the neurobiology and neurophysiology of pain reduces pain, disability, anxiety and stress associated with the pain experience (Louw, 2011). This type of education—often referred to as therapeutic neuroscience education (NE)—typically includes an educational session or sessions describing the neurobiology or neurophysiology of pain, and pain processing by the nervous system. The aim of this type of pain education is to teach patients to re-conceptualize their pain as the nervous system’s interpretation of the threat of injury, rather than an accurate measure of the degree of injury in their tissues.

Provide basic pain education during the post-acute period to all patients. Basic pain education resources include patient handouts and online resources.

Consider pain education—such as therapeutic neuroscience education--that involves education about the brain, spinal cord and descending pathway nature of pain for patients whose pain experience is disproportionate to the nature of the injury or pathology, or who are found to be at risk for chronicity or disability (See Recommendation 6). Refer patient to an appropriate clinician, such as a pain psychologist or a physical therapist.

5. Non-opioid and non-pharmacological therapies

Introduce multi-modal therapies to all patients in the post-acute period. Some types of acute and sub-acute pain are better managed with non-opioid and non-pharmacological therapies, such as acetaminophen and exercise for low back pain (Chou, 2007). Discuss evidence-based pain management options with the patient and provide risks and benefits of the options to guide discussion and support shared decision-making.

Non-Opioid Analgesics

Non-opioid analgesics and adjuvant analgesics may be equally or more effective than opioid analgesics, with potentially less risk for harm to the patient. Appropriate prescribing of non-opioid and adjuvant analgesics will depend on the patient’s diagnosis, symptoms, pain type, comorbid conditions, and overall risk for adverse drug events (AMDG, 2010). Non-opioid medications used to treat pain include non-opioid analgesics, NSAIDS, selected anticonvulsants, and selected antidepressants.

Non-pharmacological Therapy

Non-pharmacological therapies include, but are not limited to, physical modalities, behavioral approaches, interventional approaches and patient education. Examples include:

- Exercise Therapy
- Cognitive Behavioral Therapy
- Group Support Activities
- Spinal Manipulation, acupuncture or yoga
- Physical Therapy
- Multimodal integrative therapies
- Mindfulness and Stress Reduction
- Patient Education
6. Risk Assessment

Providers should continually assess the risk and benefit of opioid use for the patient through the post-acute phase. The risks and benefits of continued opioid use may change in accordance with the duration of the patient’s opioid exposure. Opioids and several mental health conditions may have a bidirectional relationship (Hooten, 2016). Therefore, it is important to assess both existing risk factors, and the emergence of risk factors if opioid therapy continues.

Assessment tools are an important component of risk assessment. A standardized approach to risk assessment allows providers to track outcomes, mitigate subjectivity, and document patient care. See the Post-Acute Pain Prescribing Guide for the recommended risk assessment screenings prior to prescribing additional opioids for pain management and during intervals in the post-acute period. Use screening tools in conjunction with clinical judgement, and inquiries about the patient’s unique circumstances, history, and potential protective factors.

a. Screen patients for depression using PHQ-9 and for anxiety using GAD-7 or other validated tools at each follow-up visit for pain management. If screening tools indicate an active mental health condition, provide aggressive treatment concomitant to analgesia strategies.

Screen patients for depression using PHQ-9 and for anxiety using GAD-7 or other validated tools at each follow-up visit for pain management, including use of opioids (Spitzer, 2006). Consider screening patients for posttraumatic stress disorder (PTSD) using the PC-PTSD if PHQ-9 or GAD-7 scores remain elevated during treatment. PTSD is a risk factor for chronic pain, and higher-risk opioid use (Spoont 2015; Seal 2012).

If screening tools indicate an active mental health condition, provide aggressive treatment and/or referral recommendations concomitant to analgesia strategies (See Recommendation 11). Consider whether the patient’s risk from continued opioid therapy outweighs the benefit, and discuss with the patient tapering off opioids in the outpatient setting (See Recommendation 10). If needed, include in the discussion supporting family members and/or caregivers identified by the patient.

b. Assess the patient’s level of risk for substance abuse using a validated, brief screening tool one week after the acute event, or at the first opioid refill request. If assessment indicates elevated risk for substance abuse, review and determine tapering strategy.

Assess and document the patient’s level of risk for substance abuse using a validated, brief screening tool one week after the acute event, or at the first opioid refill request. The National Institute for Drug Abuse (NIDA) Quick Screen is a single screening question that accurately identifies substance use in primary care patients (Smith, 2010). For patients with surgery or injury resulting in major tissue damage, assess substance abuse risk no later than 30 days after the acute event.

If the assessment indicates elevated risk for substance abuse, consider whether the patient’s risk from continued opioid treatment outweighs the benefit. Discuss with the patient tapering off opioids in the outpatient setting (See Recommendation 10). If needed, include in the discussion supporting family members and/or caregivers identified by the patient. If the assessment indicates an active substance abuse disorder, refer patient to an addiction specialist.
c. Assess the patient for fear avoidance tendencies or pain catastrophizing using a brief, validated tool. If assessment indicates presence of fear avoidance and elevated risk for chronicity, consider referring patient to a physical therapist or pain psychologist.

Assess and document whether the patient displays any fear avoidance tendencies or pain catastrophizing using a brief, validated tool. The fear avoidance model describes how individuals experiencing acute musculoskeletal pain may develop chronic pain as a result of avoidance behavior based on fear. The Keele’s STarT Back Screening tool is a brief, validated screening tool for patients in primary care (Hill, 2008). The Pain Catastrophizing Scale is a brief, validated screening tool for patients experiencing pain, and is not condition-specific (Sullivan, 1995).

If the assessment indicates the presence of fear avoidance or pain catastrophizing, consider whether the patient’s risk from continued opioid treatment outweighs the benefit and refer the patient to a physical therapist or pain psychologist. If needed, include in the discussion supporting family members and/or caregivers identified by the patient.

7. Check the Prescription Monitoring Program (PMP) prior to each refill during the post-acute pain period.

8. Prescribe opioids in multiples of 7 days, with no more than 200 MME per 7 day period, and no more dispensed than the number of doses needed. Prescribing should be consistent with expected tissue healing, with expected tapering.

Risk assessment should be performed consistent with recommended screenings (See Post-Acute Pain Prescribing Assessment Guide) when prescribing for multiples of 7 days.

9. Provide safety information about opioid use, storage and disposal with every refill during the post-acute period. Provide information, both oral and written, to patients, family members and caregivers, if appropriate. Advise patients, family members and caregivers to dispose of any opioids not used for a period of two weeks after discontinuation of therapy.

10. Patients should discontinue opioid therapy as tissue healing progresses. Consider a formal taper schedule if patient demonstrates withdrawal symptoms as he or she attempts dose reductions or based on his or her duration of use. If a taper regimen is required, tapering is generally accomplished over two weeks either to wean the patient off opioids completely or down to pre-surgical dose.

Patients exposed to opioids for a short period are not likely to need a formal taper regimen. Patients exposed to opioids for greater than two weeks following an acute event may require a formal taper. Explain to the patient that mild withdrawal symptoms are expected, and do not represent a need to adjust the taper. Discuss symptoms of withdrawal with the patient, and instruct the patient to contact you if he or she experiences any of these symptoms. Withdrawal signs and symptoms may include gastrointestinal symptoms, anorexia, yawning, lacrimation, salivation, rhinorrhea, piloerection, insomnia, anxiety, irritability, dysphoria and manifestations of sympathetic hyperactivity such as diaphoresis, tachycardia, fever, mydriasis or mildly elevated blood pressure (Farrell, 1994).
Decisions regarding a tapering schedule should be made on an individual basis, in consideration of the patient’s symptoms, and in conjunction with the patient and his or her caregivers, if appropriate. Patient education is essential to a successful taper. Provide clear written and verbal instructions to patients to educate them about the taper protocol, ways to minimize withdrawal symptoms, and the proper way to dispose of opioids. Consider adjuvant medications—antidepressants, NSAIDS, clonidine, anti-nausea and anti-diarrhea agents, as indicated—for patients experiencing withdrawal symptoms.

Seek consultation or refer a patient to a pain medicine specialist when the taper regimen is complex, when the patients fails to taper successfully in an outpatient setting, or when pain continues after tissue healing progresses (See Recommendation 11b).

*Patients receiving long-term opioid therapy (acute on chronic)*

Taper patient to the pre-surgical or pre-injury dose as tissue healing progresses. Patients receiving long-term opioid therapy who undergo surgery should have a coordinated pain management plan in place prior to surgery. Follow through with the agreed upon treatment plan.

11. **Consultation and Referral (VA/DoD, 2013)**

Health care providers who prescribe opioids—especially primary care providers, dentists and surgeons—should develop a referral network for mental health, substance use disorder, pain education, and pain medicine. Patients who require specialty care in these areas are at risk for opioid-related harm. When referring a patient to another provider, the referring physician should follow-up with the patient to assure that the appropriate care was received.

a. Consultation with or referral to an addiction specialist is indicated in the following situations:

- Patient has uncontrolled substance use disorder;
- Patient presents with behaviors suggestive of opioid abuse or addiction to either opioids or other drugs; or
- Patient requires additional evaluation for the risk of recurrent substance abuse, or assistance with ongoing management.

b. Consultation with or referral to a pain medicine specialist is indicated in the following situations:

- Patient has complex pain or polytrauma;
- Patient has significant medical comorbidities that may negatively impact opioid therapy;
- Patient continues to experience acute pain once tissue healing has resolved and the referring provider suspects centralized pain;
- When opioid-induced hyperalgesia or opioid tolerance is expected; or
- Patient is unable to tolerate increased pain or physical withdrawal symptoms that arise with the opioid taper.
c. Consultation with or referral to a mental health provider for evaluation and treatment is indicated in the following conditions:

- Patient continues to experience acute pain once tissue healing has resolved and the referring provider suspects centralized pain;
- Patient demonstrates high-risk behaviors suggestive of suicidal ideation or verbalization of suicidal thoughts;
- Exacerbation of underlying psychotic behavior;
- Patients has an uncontrolled, severe psychiatric disorder or emotional instability;
- Patient has psychosocial problems or comorbidities that may benefit from case management;
- Patient experiences adverse behavioral or cognitive effects of opioid therapy;
- Patient has co-occurring trauma related conditions; or
- Patient expresses interest in alternative approaches.

12. Naloxone

_Naloxone is sometimes indicated for patients receiving a prescription for opioids to treat acute pain._ Ask your patient whether he or she has already received a prescription for naloxone. Consider prescribing naloxone if the patient has not previously received it. Provide education to family members and caregivers about the safe use of naloxone, and appropriate storage.

All patients are potentially at risk for opioid-related overdose, however certain populations are known to have elevated risks of harm. Populations who are at high-risk for overdose include: 1) individuals with substance use disorder; 2) individuals concomitantly using benzodiazepines; 3) individuals on chronic opioids with an acute injury or major surgery taking over 100 MME/day; 4) individuals with a past overdose; 5) individuals with respiratory insufficiency, especially sleep apnea; 6) individuals who are morbidly obese; and 7) individuals who were recently incarcerated with a history of substance abuse. Consider prescribing naloxone to pediatric and geriatric populations.

Consider prescribing naloxone to individuals referred to addiction specialists, pain medicine specialists or mental health providers. These populations may be at elevated risk for opioid-related harm during the transition period to specialty care.

13. Diversion or Criminal Activity

Providers should consult their health system’s legal department or security department if they suspect that a patient is engaging in criminal activity, and they require assistance. The health system’s legal department can provide advice on the appropriate course of action.

Resources:
- HHS HIPAA website for professionals
- HHS Handout for Law Enforcement-related Questions
- The DEA Diversion website
- CMS “What is a Prescriber’s Role in Preventing the Diversion of Prescription Drugs” for Medicare and Medicaid
References:


