MINNESOTA

Post-acute pain phase prescribing recommendations

The post-acute pain prescribing interval is between **four and 45 days** following a severe injury, severe medical condition, or a major surgical procedure or trauma. This timeframe 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; Deyo, 2016, Guy, 2017)*. 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.

Clinical recommendations

1. Assess and document pain and function at each follow-up visit. Pain assessment and reassessment during the post-acute pain period is valuable for tracking improvement and gauging whether healing and recovery is progressing normally.
    - Consider the patient's presentation of pain in relation to **tissue damage** and healing following an acute event, whenever possible.
    - 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.
2. 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. 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. Assess and document risk factors for opioid-related harm and chronic opioid use during the post-acute pain phase, including depression, anxiety, substance abuse, fear avoidance and pain catastrophizing. Refer to the Acute and Post-Acute Pain Prescribing and Assessment Guide (https://mn.gov/dhs/assets/mn-opioid-prescribing-guidelines_tcm1053-337012.pdf#page=57) for the recommended risk assessment screenings prior to prescribing additional opioids for pain management during the post-acute pain period.
4. Introduce **multi-modal therapies** to all patients in the post-acute period. 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.
5. Prescribe opioids in multiples of seven days, with no more than 200 morphine milligram equivalents (MME) per seven-day period and no more dispensed than the number of doses needed. Prescribing should be **consistent with expected tissue healing**, with expected tapering.
6. Avoid prescribing in excess of 700 MME (cumulative) in order to reduce the risk of chronic opioid use and other opioid-related harms.

7. 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.
8. For patients receiving chronic opioid analgesic therapy and additional opioid therapy for acute pain, **taper patient to the pre-surgical or pre-injury dose** as tissue healing progresses. Patients receiving chronic opioid analgesic therapy (COAT) who undergo surgery should have a coordinated pain management plan in place prior to surgery. Follow through with the agreed upon treatment plan.
9. **Develop a referral network** for mental health, substance use disorder, pain education and pain medicine.

Post-acute pain discussion

Pain intensity and pain interference with normal function should decrease during the post-acute pain 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 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 post-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. Physiologic pain processes may begin to transition from acute to chronic mechanisms. Assessment of pain and function at each follow-up visit during this period is necessary to document changes over time. Early and ongoing 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.

Pain, function and quality of life assessments

Continued assessment of pain interference and functional status in the post-acute period can be valuable for tracking improvement and gauging whether healing and recovery is progressing normally. Use functional assessments—in concordance with pain assessments—to guide patient-provider conversations about pain management and psychosocial factors that may contribute to the experience of pain.

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 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.

Risk assessment

Refer to the Acute and Post-Acute Pain Prescribing and Assessment Recommendations Guide (https://mn.gov/dhs/assets/mn-opioid-prescribing-guidelines_tcm1053-337012.pdf#page=57) for recommended screenings and timing of the screenings in the post-acute pain interval, as well as Biopsychosocial Assessment and Risk Assessment (/dhs/opip/opioid-guidelines/factors-in-treatment/biopsychosocial-assessment.jsp) for discussion and additional recommendations about assessments.

Dose and duration

Opioid prescribing patterns in the post-acute pain interval present challenges to monitoring utilization and safety. The patient may obtain prescriptions from a number of different prescribers based on the nature of the acute event. Prescribers may be located in different medical groups, or separated by significant geographic distance. Prescriptions written with intended tapering may appear larger than the intended use. On the other hand, patients may not understand how to gradually discontinue their dosage. Checking the PMP every time a refill is requested in the post-acute pain interval provides the prescriber with a history of the patient's past opioid and other medication use.

Experts agreed that a standard dosage and duration recommendation is helpful in this interval, despite the nuances related to dose reduction and discontinuation. The work group members also agreed that prescribers should understand the cumulative morphine equivalence exposure of the patient since the initial prescription for acute pain. Two recent studies suggest significant risk points related to cumulative morphine equivalence exposure. One study found that the largest increment in probability of continued use was observed at 700 MME cumulative dose. *(Guy, 2017)* The other study found that opioid naïve patients who received a cumulative dose of 400 – 799 (versus ≤ 120) MME in the first month of use were 2.3 and 3.0 times as likely to become chronic opioid users *(Deyo, 2016)*.

Discontinuing opioids during the post-acute pain period

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 (/dhs/opip/opioid-guidelines/tapering-opioids/index.jsp). 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

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