Minnesota Hospital Association

Opioid Prescribing for Post-Acute Pain Road Map

In collaboration with the Minnesota Department of Human Services, MHA has created the Opioid Prescribing Road Maps to assist hospitals and health systems implement the Minnesota's Opioid Prescribing Guidelines (First edition, 2018). Like other MHA road maps, the prescribing guidelines were developed based on evidence-based recommendations and standards that reflect published literature and guidance from relevant professional organizations and regulatory agencies, as well as identified proven practices.

Each roadmap is tiered into fundamental and advanced strategies:

- **Fundamental strategies** should be prioritized for implementation, and generally have a strong evidence base in published literature in addition to being supported by multiple professional bodies and regulatory agencies.
- **Advanced strategies** should be considered in addition to fundamental strategies when there is evidence the fundamental strategies are being implemented and adhered to consistently and there is evidence that rates are not decreasing and/or the pathogenesis (morbidity/mortality among patients) has changed.

Operational definitions are included to assist organization teams with road map auditing and identifying whether current work meets the intention behind each road map element.

Resources linked within the road map include journal articles, expert recommendations, electronic order sets and other pertinent tools which organizations need to assist in implementation of best practices

Goals:

1. Reduce initiating opioid therapy for conditions not indicated for opioid analgesia. When opioid therapy is indicated for the patient, prescribe the lowest effective dose for the shortest period of time. Reduce initiating opioids at doses which are inappropriately high for the indication. Increase timely discontinuation of opioids once they are initiated in order to reduce the transition to long-term use.
2. Improve the consistency of decision making regarding opioid prescribing in the treatment of a painful condition.
3. Manage patients on COAT carefully through multidisciplinary pain treatment, improved safety monitoring and interventions to optimize the benefit to harm ratio.

This road map is intended for use in the outpatient setting where opioids are prescribed for take-home use. It is not intended for patients with cancer, sickle-cell anemia, hospice, or other end stage condition.

Road map sections	Road map questions (if not present at your hospital or answering no, please see next column for suggested resources)	If specific road map element is missing, consider the following resources:
Assessments prior to refill: pain and function	**FUNDAMENTAL** *(check each box if "yes")* ☐ 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.	• Institute for Clinical Systems Improvement (ICSI) Pain Assessment, Non-Opioid Treatment Approaches and Opioid Management. Eighth Edition. August 2017 [7] • Pain Assessment Scales/Tools, Pain Assessment and Management Initiative (PAMI) - Pain Assessment: Review of Current Tools, Practical Pain Management

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Assessments prior to refill: pain and function, cont.	- 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. 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.	- MN Opioid Prescribing Guidelines' (MPOG) list of screening tools Appendix D. Resources - Institute for Clinical Systems Improvement (ICSI) Pain: Assessment, Non-Opioid Treatment Approaches and Opioid Management Eighth Edition. August 2017 [7] - Evidence-Based Nonpharmacological Strategies for Comprehensive Pain Care 2018 [8] - Agency for Healthcare Research and Quality Noninvasive Nonpharmacological Treatment for Chronic Pain: A Systematic Review [2] - Stratis Health "A Provider Toolkit, Meeting the Challenges of Opioids and PAIN" March 2018 [3]
Assessments prior to refill: risk of chronicity	**FUNDAMENTAL** *(check each box if "yes")* ☐ 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. ☐ Screen patients for depression and anxiety using a brief, validated tool 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 substance use disorder using a brief, validated tool. Conduct a structured interviewing using the current Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria when the patient screens positive or refer to a specialist for diagnosis. - Screen patient for substance use disorders 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.	• MOPG, Appendix C Morphine Milligram Equivalence • MOPG, Appendix B Acute and Post-acute Pain Prescribing and Assessment Guide • PHQ-2/PHQ-9 • Generalized Anxiety Disorder (GAD-7) • Chronicity Tool (The Keele STarT Back Screening, TSK-11 or FABQ) • Opioid Risk Tool (ORT) • Screening Tool for Addiction Risk (STARR) • Drug Use Questionnaire Test (DAST-20) • Tobacco, Alcohol and Prescription medications and other illicit Substances use (TAPS) Tool, National Institute on Drug Abuse (NIDA) Clinical Trials Network (CTN)-recommended Common Data Elements (CDEs) of Substance Use Disorders

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Assessments prior to refill: risk of chronicity, cont.	**ADVANCED** *(check each box if "yes")* ☐ Assess patient for fear avoidance tendencies or pain catastrophizing using a brief, validated tool. If assessment indicates the presence of fear avoidance and elevated risk for chronicity, consider referring patient to a physical therapist or a pain psychologist. ☐ Assess patients for a history of trauma or abuse if depression or anxiety screening tool scores remain elevated during initial treatment. Refer patients with a history of trauma or abuse who have not been previously treated for appropriate psychotherapy. ☐ Discuss with the patient sources and/or targets of anger or injustice related to his or her pain. Consider using the Injustice Experience Questionnaire (IEQ) when a patient's pain is related to an occupational injury or motor vehicle accident.	• CAGE Alcohol Questionnaire • Screening Instrument for Substance Abuse Potential (SISAP) [11] • Prescription Drug Use Questionnaire (PDUQ) • Pain Medication Questionnaire (PMQ) *see Reference 3 • Current Opioid Misuse Measure (COMM) risk level tool • Future Directions for Pain Management: Lessons from the Institute of Medicine Pain Report and the National Pain Strategy (Mackey, 2016) [6] • Fear-Avoidance and Chronic Pain: Helping Patients Stuck in the Mouse Trap (Cosio, 2019) [9] • Brief Trauma Questionnaire (BTQ) • Injustice Experience Questionnaire (IEQ)
Opioid refills in the post-acute time frame	**FUNDAMENTAL** *(check each box if "yes")* ☐ 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. ☐ Query the PMP prior to each refill during the post-acute pain period. ☐ Prescribe opioids in multiples of seven days, with no more than 200 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. ☐ Avoid prescribing in excess of 700 MME (cumulative) in order to reduce the risk of chronic opioid use and other opioid-related harms.	• Minnesota Prescription Monitoring Program (MNPMP) Registration and Resources • National Institute on Drug Abuse. Benzodiazepines and Opioids. March 2018. [1] Available at: https://www.drugabuse.gov/drugs-abuse/opioids/benzodiazepines-opioids

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Assessments: mental health conditions	☐ Prescribing opioid therapy and benzodiazepines or other sedative hypnotics concurrently is avoided whenever possible. - Patients are advised to stop use while taking opioids for acute pain. ☐ Avoid prescribing opioids for 1) Fibromyalgia, 2) headache, including migraine, 3) self-limited illness, e.g. sore throat, 4) uncomplicated, acute neck and back pain and 5) uncomplicated acute musculoskeletal pain. - Provide appropriate non-opioid alternative pain management for acute conditions not indicated for opioid analgesic therapy. ☐ Monitor patients for opioid-related adverse outcomes, especially when opioid use continues for more than a couple of days. Adverse outcomes associated with longer-term use include central sleep apnea, endocrine dysfunction, opioid-induced hyperalgesia, opioid use disorder and signs of acute toxicity. ☐ 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. ☐ 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 COAT who undergo surgery should have a coordinated pain management plan in place prior to surgery. Follow through with the agreed upon treatment plan. ☐ Develop a referral network for mental health, substance use disorder, pain education and pain medicine.	
Additional considerations	**FUNDAMENTAL** *(check each box if "yes")* ☐ Verify patient understanding of how to use opioids ☐ Limit the number of prescribers ☐ Communicate plans across prescriber transitions ☐ Support consistent messages about pain from all staff ☐ Use scheduled acetaminophen and/or NSAIDs unless contraindicated ☐ Communicate plans during transitions to other facilities and across prescriber transitions	• Opioid Prescribing Improvement Guide – In Partnership with DHS, ICSI

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Patient education	**FUNDAMENTAL** *(check each box if "yes")* ☐ Provide patient education on an ongoing basis that addresses risks and benefits associated with opioid use, self-management of painful conditions, and safe use, safe storage and disposal. ☐ Considering co-prescribing naloxone to patients at elevated risk for overdose who receive opioids for pain management - Patients with substance use disorder (SUD), taking benzodiazepines, or history of overdose.	• CDC patient educational materials [4] • Stratis Health: Patient Education about Pain and Opioids • Substance Abuse and Mental Health Services Administration (SAMSHA) offers a series of free patient education fact sheets called Rx Pain Medications [5]
Women of childbearing age	**FUNDAMENTAL** *(check each box if "yes")* ☐ Pregnancy risk is assessed prior to prescribing opioids ☐ Prescribing opioids to pregnant women is avoided. - Pregnant women are educated about the known risks of opioids to both the mother and the fetus.	• Opioid Use and Opioid Use Disorder in Pregnancy ACOG Committee Opinion No. 711. American College of Obstetricians and Gynecologists.[8]

References

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