WINTER 2024

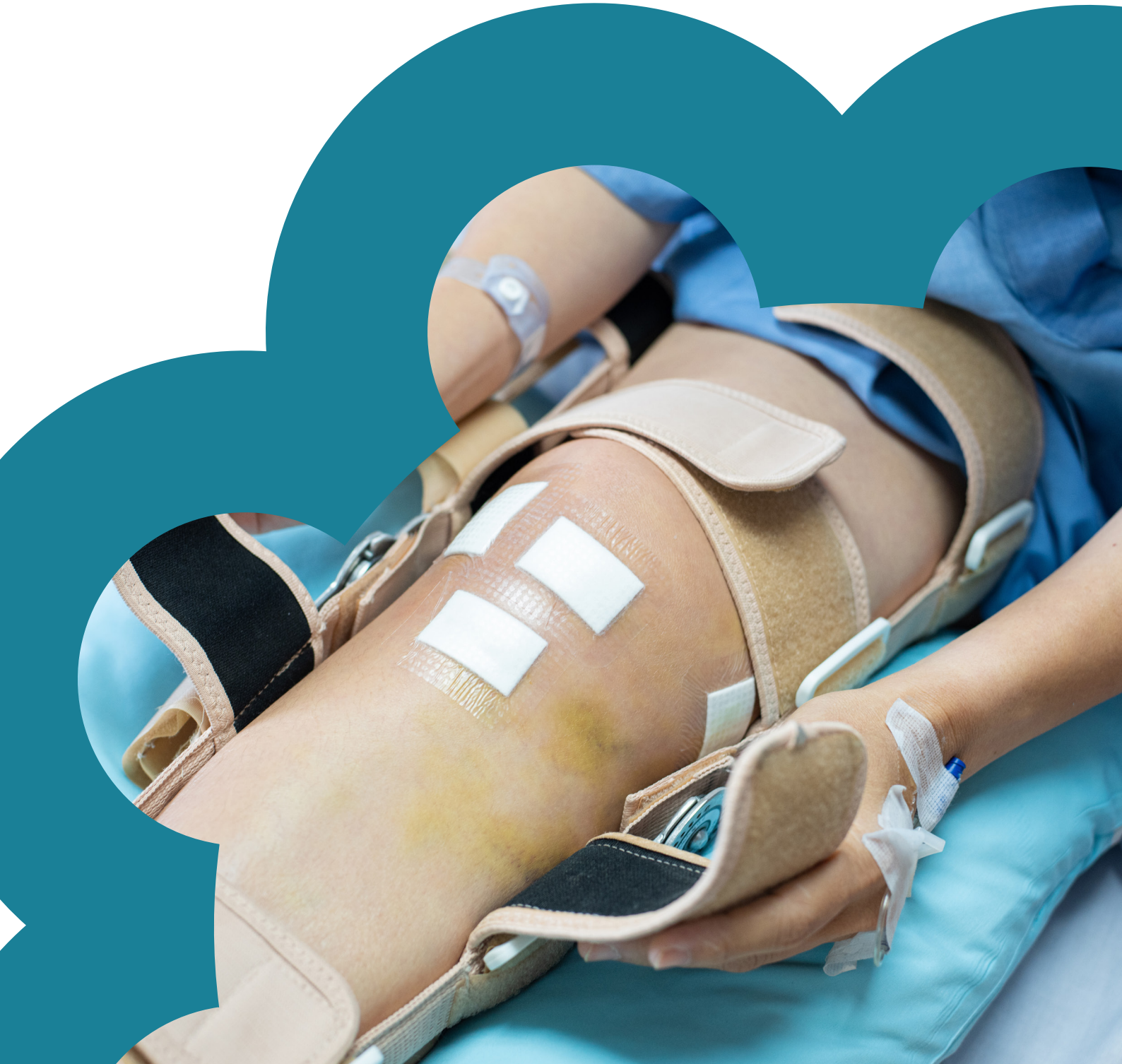
Persistent Pain

Medicines Advice Initiative Australia

CATAG
Council of Australian Therapeutic Advisory Groups

Preventing progression to persistent pain

CATAG Practice Tool



Key Points

Increasing people's understanding of pain and how thoughts, emotions and behaviours influence their physical functioning and experience of pain, leads to improved outcomes.

Use the term 'persistent pain' rather than 'chronic pain' when communicating with people.

Use collaborative multidisciplinary approaches to pre-emptively provide pain management education when pain is anticipated, to improve outcomes and reduce the risk of persistent pain.

Analgesia should include multimodal therapies, the judicious use of opioids and management of potential risks associated with analgesics used in pain management pathways.

Medicines and Therapeutics Advisory Committees are advised to promote:

- → opioid analgesic stewardship programs within hospitals
- → effective communication of pain medicine discharge plans (PMDPs) to clinicians, people and carers by embedding tools into electronic medicines management systems, and frameworks into policies and procedures.

Background

Persistent pain can reduce physical functioning and the quality of a person's life, and is associated with high levels of psychological distress, anxiety, depression and opioid use.[1,2] One-third of Australians with persistent pain take an opioid medicine, despite limited evidence for benefit in this indication, and clear evidence of potential harm.[2]

Why use the term peristent pain rather than chronic pain?

Persistent pain implies that pain lasts longer than expected or desired, allowing the possibility for change. The term 'chronic' suggests pain that is 'unchangeable' or more severe, which can be less helpful for people experiencing pain.[2]

Purpose

The Council of Australian Therapeutic Advisory Groups (CATAG) developed this practice tool to raise awareness of best practice recommendations for the management of acute pain in hospital settings to prevent progression of acute to persistent pain through prolonged opioid use. It promotes the review of existing systems at a governance level and in individual practice.

CATAG has developed this practice tool to promote change in policy by Medicines and Therapeutics Advisory Committees* for:

- integrating the neuroscience behind pain experience into clinical practice
- recognising the role of hospital prescribing in prolonged opioid use and persistent pain
- the safe and judicious use of opioids
- implementing local opioid analgesic stewardship programs
- improving communication of pain management plans at transitions of care.

Implementation of these recommendations, including evidence demonstrating regular auditing of opioid prescriptions and pain management processes at discharge, may be used as evidence towards achievement of The National Safety and Quality Health Service (NSQHS) Standards: Clinical Governance, Partnering with Consumers, Medication Safety, Comprehensive Care, Communicating for Safety, and Recognising and Responding to Acute Deterioration Standard, as well as the Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard.

Integrate findings from neuroscience in pain management

Pain is a complex biopsychosocial condition involving physical, psychological, social and environmental factors, which can strongly influence a person's experience of pain and their ability to function.[2,3] Increasing people's understanding of persistent pain and how thoughts, emotions and behaviours can influence both their experience of pain and their physical functioning leads to improved outcomes.[2]

In addition to increased understanding of pain, people can be empowered with pain management strategies such as:[1,3]

- exercise with a focus on strength and movement, as appropriate for the individual
- relaxation techniques
- mindfulness
- emotional awareness
- distraction
- cognitive behavioural therapy
- adequate sleep
- healthy eating
- other treatments such as acupuncture or massage.

For further information on persistent pain, read the Medicines Advice Initiative Australia (MAIA) Therapeutic Brief: Pathways out of persistent pain.

*Examples of Medicines and Therapeutics Advisory Committees include drug and therapeutics committees, medicines advisory committees or equivalent, medication safety committees.

Therapeutic Brief: Pathways out of persistent pain

Educate people before opioids are needed

Hospital clinicians are well placed to proactively educate and counsel people anticipated to experience pain; for example early in a cancer diagnosis and before painful procedures, childbirth, or surgery. Managing expectations and providing pain education are effective strategies for improving postoperative pain control, reducing postoperative opioid use, decreasing complications and re-admissions, and increasing postoperative function and quality of life.[4, 5] Education should include an individualised discussion of:

- expected severity and duration of postoperative pain to create realistic goals about pain management
- how pain will be assessed
- available analgesic options including multimodal analgesia, as appropriate.

Multimodal analgesia

Multimodal analgesia combines analgesic agents and techniques with different mechanisms of action, and may include non-pharmacological modalities, non-opioid analgesics, adjuvants and local or regional (central and peripheral) anaesthetic techniques.[5,6]

Multimodal analgesia, including the judicious use of opioids, is recommended when pain is anticipated, preferably using a multidisciplinary approach, by inclusion in policy and standard practice.

Opioid analgesic stewardship programs

Opioid analgesic stewardship programs facilitate best possible use of opioids and other analgesics to optimise outcomes across health services.[5, 7, 8]

Hospital-based opioid analgesic stewardship programs should promote:[6]

- non-pharmacological and pharmacological interventions
- realistic expectations for pain management, including the aim to improve function rather than remove pain entirely
- multimodal analgesia appropriate for the type and severity of pain
- paracetamol as the first-line analgesic in adults and children for acute nociceptive pain
- Real Time Prescription Monitoring programs prior to opioid prescribing and dispensing
- regular assessment of pain severity and impact on function, and monitoring for analgesic-related adverse effects
- early identification of people at risk of persistent pain (see Table 1), and systems and referral pathways for the assessment and management of pain
- tapering and stopping plans when analgesia is initiated
- comprehensive and timely communication of the individual's pain management plan at transitions of care.

Real Time Prescription Monitoring programs

Table 1: Risk factors associated with the transition from acute to persistent pain

Category	Risk factor	
Individual characteristics and comorbidities	• Female • Low socioeconomic status • Low educational attainment • Younger age (adults) • Receiving compensation for a work-related injury or illness	• Genetic predisposition • Disability • Severe or numerous comorbidities • Postoperative chemotherapy
Psychological	• Anxiety • Catastrophising • Depression • Psychological vulnerability	• Stress • Low self-efficacy • Poor coping skills

Pain	• Pre-existing pain condition associated with:
	  ◦ Chronic pain
	  ◦ Regular opioid use (eg hyperalgesia)
		• Acute postoperative pain that is:
		  ◦ Neuropathic
		  ◦ Associated with secondary hyperalgesia
		  ◦ Severe

Surgical technique	• Longer duration of surgery • Nerve injury • Traumatic approaches (eg open versus laparoscopic)	• Type of surgery • Need for repeated revisions • Radiotherapy to surgical area

Reproduced with permission from 'The transition from acute to chronic pain' [published 2020 Dec]. In: Therapeutic Guidelines. Melbourne: Therapeutic Guidelines Limited. www.tg.org.au [accessed 29 May 2024].

It is important to note that several resources discuss possible risks for progression to persistent pain, however there is currently no validated, universally accepted assessment tool for the prevention of persistent postoperative pain.[9]

To assist with implementation of an opioid stewardship program see the CATAG Guiding Principles for Medicines Stewardship Programs and toolkit.[8] The NSQHS Standards for Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard guide the appropriate use and review of opioid analgesics for the management of acute pain in acute settings, to optimise outcomes and reduce the potential for opioid-related harm in Australia. This clinical care standard supports health service organisations to monitor how well they are implementing the care recommended in the standard, and should inform local quality improvement activities.[10]

Effective communication at discharge

Opioid prescribing requires careful planning due to potentially serious adverse outcomes, including dependence and overdose.
To reduce this risk:

- prescribe opioids at the lowest effective dose for the shortest possible duration[11]
- discuss and document the PMDP with the person or their carers
- provide a PMDP to the person's general practitioner and other relevant clinicians to ensure safe ongoing management and care.

Recent data suggest that only 7 to 13% of Australians discharged with opioids have a discharge summary that includes a PMDP.[11] PMDPs are critical for communicating information to general practitioners regarding indication, dosing and intended duration of treatment. A PMDP embedded in an electronic medicines management system has been shown to improve communication at the transition from acute to community care.[11]

In one facility, incorporation of an electronic PMDP into routine workflows significantly increased rates of PMDP completion and My Health Record documentation for people issued an opioid prescription in emergency departments, orthopaedic wards and other surgical units.[11] CATAG recommends Medicines and Therapeutics Advisory Committees promote implementation of standardised PMDPs and embed electronic PMDPs at their site, where possible.
An example implementation framework is available at Design and implementation of an electronic opioid management plan to support consistent communication of opioid analgesia prescribing intentions to patients and general practitioners.[11]

Individualised PMDPs should include:[6,10]

- all pain management strategies, including non-pharmacological strategies and the anticipated outcomes of the pain management regimen
- why the medicine was prescribed
- how many times a day to take, use or apply the medicine, including if it is to be used regularly or as needed, and if the medicine should be taken with food
- when to take "as needed" medicines and the preferred order
- if the medicine may affect other medicines
- the potential adverse effects and how to manage them
- when to seek urgent care for adverse effects of the medicine or lack of pain relief
- details of how to reduce the medicine and stop the medicine (tapering and stopping plan)
- how to safely store and dispose of the medicine.

Examples of individualised PMDPs can be found at Pain Medicine Discharge Plans[12#] and Patient guide to managing pain and opioid medicines.[13] These should be tailored to local medicines formulary and prescribing guidelines. Toolkits related to medicines use require endorsement by the local Medicines and Therapeutics Advisory Committee prior to implementation.

Design and implementation of an electronic opioid management plan to support consistent communication of opioid analgesia prescribing intentions to patients and general practitioners

Pain Medicine Discharge Plans

#It is important to note that the development of the Resources for Opioid Stewardship Implementation (ROSI) from the Australian and New Zealand College of Anaesthetists were supported by an unrestricted educational grant from the manufacturer of tapentadol and any materials in the ROSI toolkit should be considered in this light and endorsed by local Medicines Governance Committees before implementation.

Patient guide to managing pain and opioid medicines

Next steps

For Medicines and Therapeutics Committees

Review relevant local guidelines, policies and procedures, and consumer resources to include the term persistent pain rather than chronic pain.

Promote a local opioid analgesic stewardship program.

Support a perioperative care model that incorporates a multidisciplinary approach to provide patient-centred education and manage pain expectations and perceptions.

Review relevant policies to encourage multimodal pain management, such as safe use of regional anaesthesia to reduce opioid requirements.

Promote systems and referral pathways for the assessment of people at risk of persistent postoperative pain and opioid use.

Promote, via inclusion in local policy, the use of a consumer-tested and approved PMDP. Consider embedding into electronic medical records wherever possible.

Measure performance of hospital-based pain management processes using indicators such as the Australian Commission on Safety and Quality in Health Care Opioid Analgesic Stewardship in Acute Pain Indicators and the QUM Indicators in Australian Hospitals 4.1 and 4.2.

For Clinicians

Use Real Time Prescription Monitoring programs prior to prescribing opioid analgesia. Document findings.

Communicate PMDP to the person or carer, and document this in the medical records, including the discharge summary for timely communication to the clinician(s) taking over care e.g. general practitioner.

Refer people at high risk for progression to persistent opioid use or persistent pain to transitional pain clinics or other pain services for follow-up and review after an acute inpatient admission.

Resources

Tools and further information for implementation:

Opioid Stewardship

CATAG Guiding Principles for Medicines Stewardship Programs

CATAG Guiding Principles for Medicines Stewardship toolkit

Safe use of opioids in acute pain – NPS MedicineWise

From the Australian and New Zealand College of Anaesthetists (ANZCA) and Faculty of Pain Medicine

Acute Pain Management: Scientific Evidence Fifth Edition 2020

Resources for Opioid Stewardship Implementation: How do you measure?

Position statement on acute pain management 2023

Opioid Dose Equivalence Calculation Table

Discharge communication

Pain Medicine Discharge Plan – Australian Society of Anaesthetists

Patient guide to managing pain and opioid medicines – Choosing Wisely

Deprescribing

Deprescribing guide for regular long-term opioid analgesic use in older adults – NSW Therapeutic Advisory Group

Guidelines for Deprescribing Opioid Analgesics – The University of Sydney

Persistent pain

Electronic Persistent Pain Outcomes Collaboration (ePPOC) – (membership fee required to access program)

Chronic Pain | Pain Management Network – Agency for Clinical Innovation

Individualised pain management plan form – Agency for Clinical Innovation

Chronic pain management video resource – Brainman

Indicators for surveillance and monitoring:

Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard

National QUM Indicators for Australian Hospitals Set 4: Pain Management

Appendix 1: How this was developed

CATAG has developed this practice tool as part of the Medicines Advice Initiative Australia (MAIA); Supporting quality use of medicines consortium. This practice tool aims to assist good governance and decision-making for health service organisations, medicines governance committees and health professionals.

This guidance was developed in consultation with the CATAG member organisations listed below:

ACT Health

Clinical Excellence Commission, NSW Health

NSW Therapeutic Advisory Group (NSW TAG)

Northern Territory Drug and Therapeutics Committee

Queensland Health Medicines Advisory Committee (QHMAC)

South Australian Medicines Advisory Committee (SAMAC)

Tasmanian Medicines Access and Advisory Committee (TMAAC)

Victorian Therapeutics Advisory Group (Vic TAG)

Western Australian Therapeutics Advisory Group (WATAG)

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