

**Oregon Health Authority**  
**Oregon Opioid Taper Guidelines Task Force**  
**AGENDA**



**Oregon Opioid Taper Guidelines Task Force**

April 12, 2019

2:00 p.m. - 4:30 p.m.

Portland State Office Building

800 NE Oregon, Room 1A

Conference Line: 1-888-278-0296

Public Meeting ID: 843163

**Goals**

- Finalize principles for guidelines
- Determine outline for guidelines
- Begin discussion of content

**Agenda**

- **Welcome, goals, agenda review, introductions** - Dana Hargunani, Chief Medical Officer, Oregon Health Authority; Diana Bianco, Principal, Artemis Consulting
- **Principles for guidelines**
  - Review and revise principles
- **Key components for inclusion in the guidelines**
  - Review and revise outline
- **Guideline content**
  - Definitions
  - Patient assessment/evaluation
  - When to consider tapering
- **Public comment** (approx. 4:15)
- **Next steps and summary**
  - Resource library
  - Next meeting

## **Oregon Opioid Taper Guidelines Task Force**

March 12, 2019

1:30 p.m. - 4:00 p.m.

Portland State Office Building

800 NE Oregon, Room 1B

Conference Line: 1-888-278-0296

Public Meeting ID: 843163

### **Welcome, Task Force purpose and outcomes, agenda review**

Dana Hargunani, Chief Medical Officer of the Oregon Health Authority, welcomed the Task Force and outlined the goals for the work over the next few months – the outcome will be statewide opioid taper guidelines.

Diana Bianco, Principal of Artemis Consulting, reviewed the agenda and asked Task Force members to introduce themselves, share the perspective they bring to the work and describe their goals for the Task Force.

The Task Force reviewed communications processes and ground rules for how the group wanted to work together. Ground rules included: respectful communication; lean in to differences of opinion; listen to each other; step up and step back; be present and participate. Diana will bring a set of ground rules to the next meeting.

### **Background on formation of the Task Force**

Katrina Hedberg, State Health Officer and State Epidemiologist for the Oregon Health Authority, provided information on the scope of the opioid problem in Oregon, as well as background on related, existing statewide guidelines (chronic opioid taper guidelines, acute prescribing guidelines, and dental prescribing guidelines). She provided context that guidelines are a reference for providers in the community and were developed with the input of multiple groups, including, but not limited to, providers, health associations, health boards, community opioid regional collaboratives, and leadership of CCOs.

Dana provided an overview of the need for opioid tapering guidelines in Oregon. She also discussed the current work of Oregon's Health Evidence Review Commission (HERC) pertaining to Medicaid coverage for five chronic pain conditions. Dana will continue to update the Task Force on the HERC's work so the groups are aware of the other's work.

## Principles for guidelines

The Task Force brainstormed principles that should underlie the guidelines:

- Patient-centered
- Compassionate
- Flexible
- Trauma-informed
- Promote patient engagement and shared decision-making
- Support informed consent
- Focus on harm reduction
- Medically realistic
- Data driven
- Evidence-based
- Focus on pain science
- Promote an integrated approach
- Practical
- Accessible/Clear

## Key components for inclusion in the guidelines

We discussed topics that we should consider for inclusion in the guidelines:

- a. Definitions
  - i. Dependency
  - ii. Addition
  - iii. Abandonment
  - iv. Imminent harm
- b. Assessment
  - i. MH Screening
  - ii. Co-morbid conditions
- c. Psychosocial considerations
- d. Education
  - i. Need a script
  - ii. How to talk to patient
  - iii. Clarity on goal for patient
- e. Evidence
- f. When to consider tapering
- g. Supported tapers
- h. Considerations for tapering
- i. Considerations in integrity
- j. What is the goal/how to define success
- k. What to do when failure
- l. Risks vs. benefits – balance
- m. Other resources for when you are tapering/supporting materials
- n. After taper -> then what
  - i. What to expect during/after taper
- o. Reassessment/dialogue/shared decision-making
- p. Rationale and context

- q. Approach
- r. Evaluation
- s. PH education
- t. How to approach highlight ambivalent patience/providers/families
- u. AMT
- v. Follow-up
- w. Organizational supports for tapering
- x. Risky drugs/resilience/vulnerable people
- y. Patient Supports
  - i. Family
  - ii. Peers
  - iii. Community
  - iv. Tribal/cultural
  - v. Ex waiver – Buprenorphine
- z. Resources

### **Resources**

We discussed the list of resources shared as part of meeting materials. If Task Force members have additional resources, they will send them to Lisa Bui. Preliminary additional resources include OHSU's opioid prescribing guidelines and the Veteran's Administration's opioid guidelines and tools. The planning team will discuss how to best catalog and share resources with the Task Force.

### **Public comment** (approximately 3:30)

None

### **Next steps and summary**

- Task Force members will complete conflict of interest forms.
- The planning team will organize the principles and topics for inclusion in the guidelines and will bring back to the group for additional discussion.

Next meeting: April 12, 2019 from 2:00 p.m. – 4:30 p.m.

### **Ground Rules for Task Force Meetings**

- Be present and participate.
- Listen actively -- respect others when they are talking and avoid interrupting.
- Respect the group's time -- keep your comments concise and to the point.
- Speak with authenticity and grace.
- Step up/Step Back: If you tend not to talk, challenge yourself to participate more. If you tend to dominate the conversation, step back and give space for others.
- Varied and opposing ideas are welcome. Challenge ideas, not people.
- Consider, and be considerate of, perspectives that are different than yours.
- Propose solutions.
- Strive to meet the stated purpose and expected outcomes of the meeting.
- Everyone is responsible for following and upholding the ground rules.

## Oregon Health Authority

# Oregon Opioid Taper Guidelines Task Force

### Draft Principles for Opioid Taper Guidelines (from 3/12/19 Task Force meeting)

1. Patient-centered
2. Compassionate
3. Flexible
4. Trauma-informed
5. Promote patient engagement and shared decision-making
6. Support informed consent
7. Focus on harm reduction
8. Medically realistic
9. Data driven
10. Evidence-based
11. Focus on pain science
12. Promote an integrated approach
13. Practical
14. Accessible/Clear

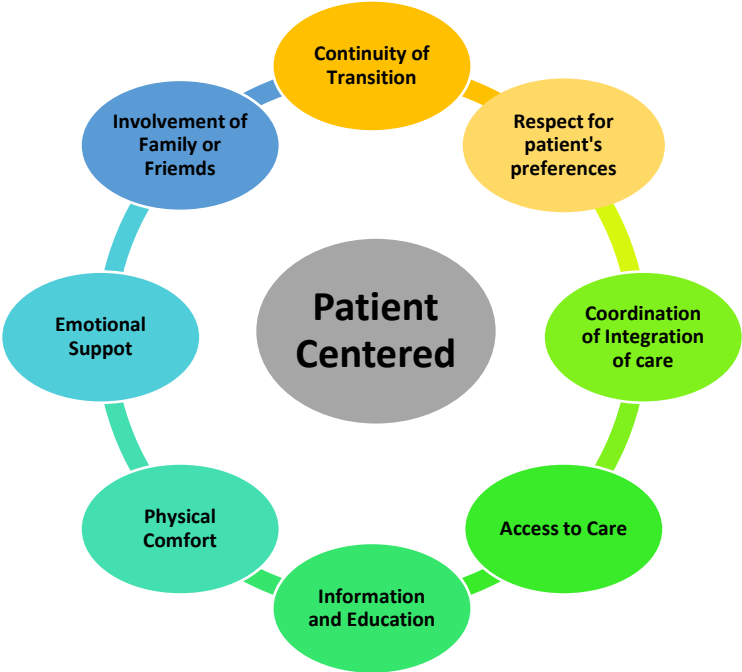
### HHS Pain Management Practices Inter-Agency Task Force

- Balanced
- Individualized
- Multi-disciplinary
- Multi-modal approach
- Access to care
- Empathy and non-judgmental
- Innovative pain management solutions

### Competencies for Pain Management

- Patient Centered
- Empathy and Compassion
- Inter-professional teamwork
- Comprehensive care across continuum
- Ethical treatment
- Cultural inclusiveness and health disparities
- Evidence based practice

**Harvard's Picker Institute Principles of Patient Centered Care**



**Oregon Opioid Taper Guidelines Task Force**  
**Oregon Opioid Taper Prescribing Guidelines**  
**Draft Outline**  
**4/6/19**

- I. Acknowledgements
  - a. Task Force membership
- II. Background
- III. Principles
- IV. Definitions
  - a. Tapering
  - b. Opioid tolerance
  - c. Opioid withdrawal
  - d. Opioid Withdrawal Syndrome
  - e. Opioid Use Disorder
  - f. Opioid dependence
  - g. Abandonment
- V. Patient assessment/evaluation
  - a. Pain
  - b. Opioid use, Substance Use Disorder
  - c. Psychosocial environment
  - d. Co-occurring conditions
- VI. When to consider tapering
- VII. Approach to tapering
  - a. Patient education
  - b. Setting goals and defining success
  - c. Taper plans
    - i. Role of medication-assisted therapy (MAT)
  - d. Multidisciplinary supports
  - e. Social and cultural supports
  - f. Monitoring and reassessment
- VIII. Long-term support and follow-up
- IX. Provider education
- X. Organizational supports
- XI. Resources
  - a. References
  - b. Sample scripts



# Oregon Opioid Tapering Prescribing Guidelines

## Discussion Guide for 4/12/19 Task Force Meeting

### REFERENCE DOCUMENTS

- **Centers for Disease Control & Prevention (CDC):** [Pocket Guide: Tapering](#); [Training Module 5: Assessing and Addressing Opioid Use Disorder](#); [Guideline for Prescribing Opioids for Chronic Pain](#)
- **Oregon Pain Guidance (OPG):** [Tapering Guidance & Tools](#); [Pain Treatment Guidelines](#)
- **Veteran's Health Administration/Dept. of Defense (VA/DoD):** [Opioid Taper Decision Tool](#); [Transforming the Treatment of Chronic Pain: Moving Beyond Opioids](#)
- **Washington Agency Medical Director's Group (WA):** [AMDG 2015 Interagency Guideline on Prescribing Opioids for Pain](#)
- **Diagnostic and Statistical Manual of Mental Disorders (DSM-5)**

### DEFINITIONS

#### **Tapering definition**

1. **CDC:** Tapering to a reduced opioid dosage or tapering and discontinuing opioid therapy
2. **OPG:** Opioid dose reduction
3. **VA/DoD:** Determine if the initial goal is a dose reduction or complete discontinuation. If initial goal is determined to be a dose reduction, subsequent regular reassessment may indicate that complete discontinuation is more suitable.
4. **WA:** Reducing or discontinuing chronic opioid analgesic therapy

#### **Opioid tolerance definition**

1. **DSM-5:** Defined by either of the following:
  - a. Need for markedly increased amounts of opioids to achieve intoxication or desired effect
  - b. Markedly diminished effect with continued use of the same amount of opioid

#### **Opioid withdrawal definition**

1. **DSM-5:** Defined by either of the following:
  - a. Characteristic opioid withdrawal syndrome
  - b. Same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms

#### **Opioid withdrawal syndrome definition**

1. **DSM-5:** Defined by Criteria A and B:
  - a. Either of the following: 1) Cessation of (or reduction in) opioid use that has been heavy and prolonged (several weeks or longer), or 2) administration of an opioid antagonist after a period of opioid use.
  - b. Three (or more) of the following, developing within minutes to several days after Criterion A: dysphoric mood; nausea or vomiting; muscle aches; lacrimation or rhinorrhea; pupillary dilation, piloerection, or sweating; diarrhea; yawning; fever; or insomnia.

## Opioid Use Disorder/Addiction definition

1. **DSM-5:** Opioid Use Disorder (OUD) is defined as a problematic pattern of opioid use leading to clinically significant impairment or distress. To confirm a diagnosis of OUD, at least two of the following should be observed within a 12-month period (the last two diagnostic criteria, related to tolerance and withdrawal, are not considered to meet OUD for individuals taking opioids solely under appropriate medical supervision):
  - a. Opioids are often taken in larger amounts or over a longer period than was intended.
  - b. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
  - c. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
  - d. Craving, or a strong desire or urge to use opioids.
  - e. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
  - f. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
  - g. Important social, occupational, or recreational activities are given up or reduced because of opioid use.
  - h. Recurrent opioid use in situations in which it is physically hazardous.
  - i. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
  - j. Exhibits tolerance (discussed in the next section).
  - k. Exhibits withdrawal (discussed in the next section).

Severity of OUD is specified as: Mild (2-3 symptoms), Moderate (4-5 symptoms), or Severe (6 or more symptoms).

## Opioid dependence definition

1. **DSM-5:** term no longer utilized
2. **OPG:** Complex Persistent Opioid Dependence (CPOD)
  - **Complex:** Dependence is complicated by desire to continue taking opioid for the treatment of pain. Withdrawal is complicated by anhedonia and hyperalgesia which, unlike classic 'physical' symptoms, may not reverse within days.
  - **Persistent:** Tapering is poorly tolerated. Tapering, therefore, may fail, or is highly protracted (takes months or years).
    - **What distinguishes CPOD from OUD:**
      - No craving
      - No compulsive use
      - No harmful use that is not medically directed (patient takes opioid exactly as prescribed)
      - Social disruption is attributed to pain and not to OUD
3. **WA:** The term "opioid dependence," while often acceptable to patients, is best avoided due to possible confusion with its outdated formal definition in DSM-IV.

### **Patient Abandonment language** (use to develop definition?)

1. **CDC:** Let patients know that most people have improved function without worse pain after tapering opioids. Some patients even have improved pain after a taper. Tell patients "I know you can do this" or "I'll stick by you through this"
2. **OPG:** The prescriber's job is to remain empathic, yet resolute, and communicate to patients that a careful risk–benefit assessment informed by experience and compassion has led to this treatment plan and that to continue opioids under these circumstances would be to cause the patient further harm. Tapering down the opioid dose or not prescribing opioids doesn't mean you aren't taking care of the patient. Reassure each patient that supportive adjunctive treatment of withdrawal will be provided as needed, and may be quite helpful, but set expectations that this will not include dangerous replacement medications.
3. **VA/DoD:** When a decision is made to taper, special attention must be given to ensure that the Veteran does not feel abandoned. Prior to any changes being made in opioid prescribing, a discussion should occur between the Veteran, family members/caregivers, and the provider either during a face-to-face appointment or on the telephone. Listen to the Veteran's story; let the Veteran know that you believe their pain is real; include family members or other supporters in the discussion; acknowledge the Veteran's fears about tapering.
4. **WA:** Patients on COAT can be reluctant to change, and many who agree to try will have difficulty as the dose is reduced. Such reluctance and difficulty in tapering often reflect anxiety. There may be apprehension about worsening of pain and withdrawal symptoms or, if there is opioid use disorder, about reduced access to the drug. Exploring each of these possibilities in a non-judgmental manner helps the provider understand the patient's perspective and helps the patient have realistic expectations. This, in turn, strengthens the therapeutic relationship and supports future strategies.

### **PATIENT ASSESSMENT/EVALUATION** *example components to include but not limited to:*

- **Pain assessment/evaluation**
  1. **CDC:** Focus on functional goals and improvement, engaging patients actively in their pain management. Assess pain using validated instruments such as the 3-item (PEG) Assessment Scale.  
***Determining When to Initiate or Continue Opioids for Chronic Pain*** (CDC Guideline)  
**Recommendation 1.** Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.  
**Recommendation 2.** Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
  2. **OPG:** Specific review of symptoms related to Central Sensitization spectrum, physical exam, past medical and psychiatric history, pain and, most important,

functional assessment to evaluate progress with treatment over time: Oswestry, Low Back Pain Intensity, Visual Analog Scale, PEG 3-item scale for pain tracking.

3. **VA/DoD:** Assess pain and functional treatment goals and adherence to treatment plan (no specific assessment)
4. **WA:** Perform a thorough history and physical examination at initial visit for pain management. Do not pursue diagnostic tests unless risk factors or “red flags” indicate the need for further evaluation. Assess and document function and pain using validated tools at each visit where opioids are prescribed (3-item PEG, 2-item Graded Chronic Pain Scale to assess pain intensity and pain interference, STarT Back to assess risk of transitioning to chronic pain)

▪ **Assessing and addressing opioid/other substance use and opioid use disorder/substance use disorder**

1. **CDC: *Assessing Risk and Addressing Harms of Opioid Use (CDC Guideline)***

Recommendation 8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms.

Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages ( $\geq 50$  MME/day), or concurrent benzodiazepine use, are present.

Recommendation 9. 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 dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

Recommendation 10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

2. **OPG:** Query the PDMP, UDS POC in-office will provide results at the time of the visit, substance-abuse risk screening. If patient has OUD, transition to MAT; if patient has Complex Persistent Opioid Dependence, transition to Buprenorphine off-label for pain, or slow down taper and re-assess quarterly.
3. **VA/DoD:** If patient has OUD, use a shared decision-making approach to discuss options for OUD treatment. First-line is MAT, preferred buprenorphine/naloxone; alternative is injectable naltrexone. Ensure screening and treatment is offered for conditions that can complicate pain management before initiating opioid taper. The lifetime prevalence for OUD among patients receiving long-term opioid therapy is estimated to be about 41%: approximately 28% for mild symptoms, 10% for moderate symptoms and 3.5% for severe symptoms of OUD.
  - I. Patients with chronic pain who develop OUD from opioid analgesic therapy need to have BOTH pain and OUD addressed. Either tapering the opioid analgesic or continuing to prescribe the opioid without providing OUD

treatment may increase the risk of overdose and other adverse events. Refer to DSM 5 criteria for OUD.3

- m. Use a shared decision-making approach to discuss options for OUD treatment: First-line: Medication Assisted Therapy (MAT)
    - i. **PREFERRED:** Opioid Agonist Therapy (OAT)—  
buprenorphine/naloxone (Suboxone®) or methadone maintenance\*
    - ii. **ALTERNATIVE:** Extended Release (ER) Injectable Naltrexone (Vivitrol®)
  - n. MAT can be provided in a variety of treatment settings including: residential SUD treatment, intensive outpatient SUD treatment, regular SUD specialty care clinic, primary care or general mental health clinic, or federally regulated opioid treatment program.
4. **WA:** Assess the patient behaviors that may be suggestive of SUD; address increased pain with use of non-opioid options; evaluate patient for mental health disorders. Opioid Risk Tool (ORT), CAGE Adapted to Include Drugs (CAGE-AID), Screener and Opioid Assessment for Patients with Pain – Revised (SOAPP-R), Current Opioid Misuse Measure (COMM), DIRE, Alcohol Use Disorders Identification Test (AUDIT).

▪ **Psychosocial environment**

- 1. **CDC:** Because psychological distress frequently interferes with improvement of pain and function in patients with chronic pain, use validated instruments such as the Generalized Anxiety Disorder (GAD)-7 and the Patient Health Questionnaire (PHQ)-9 or the PHQ-4 to assess for anxiety, post-traumatic stress disorder, and/or depression.
- 2. **OPG:** Mental health screening, for co-occurring mental health disorders related to trauma, depression, anxiety, depression, ACES, and PTSD.
- 3. **VA/DoD:** Ensure screening and treatment is offered for conditions that can complicate pain management before initiating opioid taper:
  - a. Mental health disorders (PTSD, anxiety disorders, depressive disorders)
    - i. If suicidal, then activate suicide prevention plan
    - ii. If high suicide risk or actively suicidal, consult with mental health provider before beginning taper
- 4. **WA:** Use validated instruments to assess predictors of suboptimal recovery such as depression, fear avoidance, and catastrophizing, which can lead to persistent pain and functional limitation (PHQ-9, GAD-7, PC-PTSD).

▪ **Co-occurring conditions**

- 1. **CDC:** Certain risk factors are likely to increase susceptibility to opioid-associated harms and warrant incorporation of additional strategies into the management plan to mitigate risk, such as sleep-disordered breathing, pregnant women, renal or hepatic insufficiency, patients aged 65 and older, mental health conditions, substance use disorder, and prior nonfatal overdose.
- 2. **OPG:** Co-morbid conditions can increase the risks from opioids: respiratory disease (COPD, sleep apnea, etc.), abnormalities in the endocrine system (depressed testosterone, hypoxemia), cardiac arrhythmias, obesity, dementia,

fibromyalgia, depression, anxiety, substance use disorder, history of drug overdoses.

3. **VA/DD:** Assess for medical comorbidities that increase risk: lung disease, sleep apnea, liver disease, renal disease, fall risk, advanced age;
4. **WA:** Screen for medical conditions that could increase sensitivity to opioid-related side effects such as comorbid mental health disorders (especially PTSD and major depressive disorder), and COPD, CHF, sleep apnea, advanced age, or renal or hepatic dysfunction.

## WHEN TO CONSIDER TAPERING

*Various elements can be included (none specifically identified by the TF yet)*

- **Patient request**
    1. **CDC:** Patient requests dose reduction
    2. **OPG:** *none*
    3. **VA/DoD:** Patient requests to discontinue therapy
    4. **WA:** Patient requests opioid taper
  - **Treatment progress**
    1. **CDC:** Patient does not have clinically meaningful improvement in pain and function
    2. **OPG:** Thorough and systematic risk benefit assessment reveals that benefits outweigh risks, e.g., continued pain and dysfunction
    3. **VA/DoD:** No pain reduction, no improvement in function. Consider tapering opioids in Veterans where the risk of continuing the opioid outweighs the benefit of continuing the opioid.
    4. **WA:** Patient is maintained on opioids for at least 3 months, and there is no sustained clinically meaningful improvement in function, as measured by validated instruments
2. **High dose/ co-prescribing**
    1. **CDC:** Patient is on dosages  $\geq 50$  MME/day without benefit or opioids are combined with benzodiazepines
    2. **OPG:** Dose over 90 MED; co-prescribed sedative hypnotics
    3. **VA/DoD:** Dosage indicates high risk of adverse events (e.g., doses of 90 MEDD\* and higher); Concomitant use of medications that increase risk (e.g., benzodiazepines)
    4. **WA:** At increased risk for opioid-related toxicity from concurrent drug therapy or comorbid medical conditions
  3. **Substance use disorder**
    1. **CDC:** Patient shows signs of SUD
    2. **OPG:** Patient meets criteria for Opioid Use Disorder or Complex Persistent Opioid Dependence
    3. **VA/DoD:** Concerns related to an increased risk of SUD\*\*\*\* (e.g., behaviors, age  $< 30$ , family history, personal history of SUD†)
    4. **WA:** Patient has a SUD (except tobacco) or exhibits aberrant behaviors

#### 4. Adverse events or warning signs

1. **CDC:** Patient experiences overdose or other serious adverse event; or patient shows early warning signs for overdose risk such as confusion, sedation, or slurred speech
2. **OPG:** Risk assessment reveals mental health disorder, co-morbid conditions, opioid adverse effects, diversion, or other aberrant behavior
3. **VA/DoD:** Severe unmanageable adverse effects (e.g., drowsiness, constipation, cognitive impairment); Non-adherence to the treatment plan or unsafe behaviors\*\* (e.g., early refills, lost/stolen prescription, buying or borrowing opioids, failure to obtain or aberrant UDT\*\*\*); Overdose event involving opioids
4. **WA:** Patient's risk from continued treatment outweighs the benefit; patient has experienced a severe adverse outcome or overdose event