

**Oregon Health Authority**  
**Oregon Opioid Taper Guidelines Task Force**  
**MEETING NOTES**



**Oregon Opioid Taper Guidelines Task Force**  
Meeting Summary- June 14, 2019

**Welcome, goals, agenda review, introductions**

Diana Bianco, Principal of Artemis Consulting, welcomed the Task Force and asked Task Force members to introduce themselves. Diana reviewed the agenda.

**Updates**

Dana Hargunani, Chief Medical Officer of the Oregon Health Authority, announced that two new members with lived experience have been appointed to the Task Force: Amy Stocker and Connie Hunter. In addition, Dana shared the "Task Force Resource List" - materials that have been submitted by Task Force members. Task Force members aren't expected to read all the resources on the list - they are provided for reference. In addition, it is not the intent for these resources to be automatically included as part of the Guidelines. Members will have time at the end of the meeting to provide comments and highlights about resources that they provided.

**Work Plan**

Diana reviewed the work plan for the Task Force through September. Starting in July, the Task Force will begin reviewing draft guideline language for sections that we have discussed.

**Update: Patient Assessment/Evaluation Section**

Task Force members who volunteered to help create an algorithm weren't able to meet. Dr. Dogra drafted a model which will be shared with the small group. The group either will meet or consult via email and will bring a proposal to the Task Force in July.

**Content Review from May Meeting**

When to Consider Tapering Section

The Task Force reviewed changes to this section. The Task Force agreed to keep the MED range as "50-90." In addition, the group decided to remove "hyperalgesia" and replace it with "worsening pain despite increasing doses."

Approach to Tapering section: Patient Education, Setting Goals, Defining Success

The Task Force agreed that the May meeting summary represents the intended content for this section and that no further discussion was needed at this time. We will review draft content at a future meeting.

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## Task Force Discussions on New Sub-Sections

### Taper Plans

Task Force members agreed that the main points to make in this section are that providers should 1) have a taper plan and 2) the plan should be flexible. We agreed that we would offer examples of plans in an appendix. Examples might include those from local systems (e.g. Providence, OHSU, Legacy), OPG and the VA. Laura Heesacker and Lisa Whitmore volunteered to review examples and bring ideas for inclusion back to the full group.

We discussed the fact that no taper plan is evidence-based; for example, there hasn't been comparison in outcomes related to different taper speeds. The group does want the guidelines to identify situations when more rapid tapers might be indicated, such as in very high-risk situations (i.e., patient with history of recent overdose or, actively using heroin).

The Task Force discussed general language for this section. We agreed to the following approach:

- Adopt the CDC language in the discussion guide, but instead start with "if harms outweigh benefits."
- Add a sentence about BH, such as the last sentence in the OPG example language.
- Provide a link to ~ 3 taper plans with caveats regarding the need for individualization/flexibility in plans.

### OUD and MAT

Task Force members discussed the role that opioid dependence may play for patients for whom tapering is difficult, including those who may not meet all the criteria for opioid use disorder. Some members believe that the DSM-5 criteria, which removed the specific condition of opioid dependence, is limiting, and that reference to opioid dependence and the potential role of buprenorphine would be useful in the guidelines. We also discussed a concern with this approach, including the risk of creating a new diagnosis paradigm for people who may just actually have a mild OUD. We also want to be mindful of worsening the stigma of OUD by avoiding the diagnosis. The Task Force agreed to the following:

- Separate the content into two separate sections:
  1. Management of Opioid Use Disorder. In this section, the Task Force wants to reference the need for appropriate evaluation and treatment of OUD. In addition,

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- members recommended against use of the term MAT since it is becoming outdated. We will just reference “medications for OUD.”
2. Complicated tapers/people who get stuck. In this section, the Task Force wants to address the potential role of off-label use of buprenorphine as part of tapering, which may be a safer or more effective method based on the risk/benefit calculation. Task Force members noted that this is an emerging area; that this may require an X-waiver due to the complex regulatory landscape (X-waivers are required for treatment of OUD); and that there may be billing/reimbursement differences across payors with regards to the specific diagnosis codes used. It was also noted that there are challenges with how buprenorphine is currently captured in the PDMP when used for OUD vs. chronic pain.

#### Multidisciplinary Supports

For this section, Task Force members want to include the following information:

- Chronic pain and opioid use disorder are chronic conditions.
- Approaches to tapering for chronic pain must be trauma-informed.
- Treatment must include a focus on behavioral activation and behavioral therapy.
- Multidisciplinary supports need to be framed in line with the biopsychosocial model of chronic pain.
- Content in the following table as listed in the discussion guide: “Table 1. Cognitive Behavioral and Non-pharmacological Therapies for Chronic Pain.”

#### Cultural and Social Supports

Task Force members noted that the table referenced above includes cultural/social supports as well, so we might consider combining these two sub-sections. The group discussed how long-term, stable recovery depends on one’s social context: “treatment happens in the medical system; recovery happens in the community.” Additional recommendations from Task Force members for this section included:

- Consider referencing the role of peers.
- Consider pulling language from SAMSHA regarding a recovery-oriented system of care.
- Add “spiritual” to this heading.

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#### Monitoring and Reassessment

After review and discussion of the language in the discussion guide and member perspectives, the Task Force decided to adopt the following approach for completing this section of the guidelines:

- Adopt the CDC language; in the 3<sup>rd</sup> sentence, add a reference that this pertains to “if the goal is to taper completely off.” The Task Force also suggested possibly not keeping the language past that third sentence. Recommended changes to this section would read as follows:
  - *Adjust the rate and duration of the taper according to the patient’s response. Don’t reverse the taper; however, the rate may be slowed or paused while monitoring and managing withdrawal symptoms. Once the smallest dose is reached (if the goal is to taper completely off), the interval between doses can be extended and opioids may be stopped when taken less than once a day.*
- Pull from the VA tool regarding the goal of monitoring and reassessment: “reassess function, sleep, physical activity, personal goals, and stress levels.”
- The goal of reassessment should be an opportunity to shift to a safer medication sooner rather than later based on the risk/benefit assessment.

#### Managing Withdrawal

The Task Force agreed that the following points should be reflected in the guidelines pertaining to managing withdrawal:

- Withdrawal symptoms may be an indication that the taper is going too quickly; this is an opportunity to pause, rethink, and slow down.
- For individuals for whom a faster taper is indicated (i.e., diversion, use of illicit substance), there should be general information about treating and/or managing withdrawal.
- It should be explicitly stated that benzos should not be used for withdrawal.
- Other modalities in addition to medications should be considered for withdrawal treatment, such as acupuncture.
- Dr. Dogra will provide information on the VA Whole Health program.
- The Task Force proposed reviewing the UpToDate® table on managing withdrawal to consider whether it should be referenced in the guidelines.

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Harm Reduction

The Task Force discussed what they would like to include under this section. Members indicated that the goal of the guidelines is to ultimately reduce harms. This concept needs to be distinguished from traditional “harm reduction” methods that refer to programs such as clean needle exchanges. We may want to consider moving this discussion/framing up to the front of the document to inform the overall holistic approach/framework for the guidelines.

Special Populations

For this section, Task Force members suggested that the guidelines merely mention that “there are special populations that need to be considered uniquely” rather than trying to develop explicit guidelines for each subpopulation. One member cautioned that patients may seek or overstate the presence of a palliative care dx to avoid tapering, although this has not been substantiated.

**Task Force Resources List**

Task Force members were invited to share comments about the resources they submitted as part of the new Task Force Resource List included in meeting materials.

- Dana provided background on item #9 in the resource list. This is an evidence review completed by OHSU’s Center for Evidence-based Policy on behalf of the Health Evidence Review Commission as part of its recent consideration of coverage changes for five chronic pain conditions. The report, “Tapering or Discontinuing Opioid Use Among Patients with Chronic Noncancer Pain: Update Report,” is publicly available. While this report reviews a large amount of evidence, the strength of the evidence is overall weak.
- Laura Heesacker noted that items # 2 and 5 on the resource list informed the table, “Summary beliefs and perspectives on opioid tapering from people on chronic opioid prescriptions,” also included in the resource list.
- Several of the articles in the resource list will be helpful when the Task Force discusses the approach to shared decision-making within the context of opioid tapering. The group agreed that this topic deserves a deeper Task Force discussion and should be called out on the posted agenda given the expected broad interest.

**Public comment**

There was no public comment.

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**Next steps and summary**

The next three Task Force meetings have been confirmed:

- July 19 from 9 am – 12 pm (new date)
- August 27 from 1 pm - 4 pm (new date)
- September 23 from 1 pm – 4 pm (unchanged)

Staff will send out a Doodle Poll for a possible meeting in October in case it is needed.

Next meeting: July 19, 2019 from 9:00 a.m. – 12:00 p.m.

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#### 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)**
- **FDA statement** - new opioid analgesic labeling changes:  
<https://www.fda.gov/news-events/press-announcements/statement-douglas-throckmorton-md-deputy-center-director-regulatory-programs-fdas-center-drug-0>
- **No Shortcuts to Safer Opioid Prescribing** by Dowell, Haegerich, Chou (New England Journal of Medicine, 2019):  
<https://www.nejm.org/doi/full/10.1056/NEJMp1904190>

*Note: Resources included below are specific to the July 19, 2019 meeting agenda topic. Previous discussion guide content has been removed for brevity.*

#### Shared Decision-Making

1. **OPG:** For tapering to be successful, clinicians must approach the taper as an alliance with the patient with the goal of improving their safety and quality of life.
2. **VA/DoD:** Draw out their goals for life (not just being pain-free). 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. The goal of opioid tapering is to improve the balance of risks and clinically meaningful benefits for patients on LOT. (main goals of these focus group participants included returning to work, minimizing pain, maintaining a functional life, avoiding invasive medical procedures, and getting off opioids). Maintain focus on patient goals throughout treatment, including any changes in those goals over time. Uses SMART goals method for patient goal setting. The goals of the Stepped Care Model for Pain Management include functional rehabilitation, improvement in quality of life, and prevention of the pain becoming chronic and associated deterioration in function

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- 3. WA:** Clinically meaningful improvement is defined as an improvement in pain AND function of at least 30% as compared to the start of treatment or in response to a dose change. A decrease in pain intensity in the absence of improved function is not considered meaningful improvement except in very limited circumstances such as catastrophic injuries (e.g. multiple trauma, spinal cord injury, etc.). perioperative pain plan: Set expectations with them about realistic pain management goals, including functional recovery activities, need for multimodal treatment, limits of therapy, timely return to preoperative baseline opioid dose (if any) or lower, and the analgesic tapering timeline. Resource: Swedish STOMP Brochure is designed to help patient set health goals to alleviate pain and improve quality of life. It includes general information about pain, goal-setting ideas and steps to take to achieve those goals.

#### Long-term support and follow-up

*\*This content is related to chronic opioid therapy and not specific to long-term support and follow-up after tapering. Task Force members will need to identify what content to include in the guidelines related to tapering.*

- 1. CDC:** Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. therefore, follow-up earlier than 3 months might be necessary to provide the greatest opportunity to prevent the development of opioid use disorder. Consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs. At follow up, clinicians should assess benefits in function, pain control, and quality of life using tools such as the three-item “Pain average, interference with Enjoyment of life, and interference with General activity” (PEG) Assessment Scale (186) and/or asking patients about progress toward functional goals that have meaning for them (see Recommendation 2).
- 2. OPG:** Throughout the tapering process, it is very important to monitor the patient’s situation for changes in the risk benefit assessment at least quarterly. Evidence of diversion, doctor shopping, illicit substances in urine drug screening (UDS), would be cause for an immediate change in opioid prescribing.
- 3. VA/DoD:** The Work Group recommends follow-up at least every three months or more frequently (see [Recommendation 7](#) and [Recommendation 11](#)) due to the balance of benefits and harms associated with this recommendation. Frequency of visits should thereafter be based on risk stratification. Similarly, the CDC guideline for OT recommends re-evaluating harms versus benefits within one to four weeks of starting OT or at any dose change, and at least every three months or more frequently if needed.[132] At follow-up visits, a clinician should re-examine the rationale for continuing the patient on OT.

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Clinicians should take into account changes in co-occurring conditions, diagnoses/medications, and functional status when conducting the risk/benefit analysis for LOT. Alcohol use, pregnancy, nursing of infants, and lab abnormalities may change the risk/benefit calculus for LOT. Ongoing OT prescribing practice may include pharmacy review, informed consent, UDTs, and checking state PDMPs. A clinician should also be mindful of signs of diversion during follow-up (see [Risk Factors for Adverse Outcomes of Opioid Therapy](#)). The longer the patient is on opioids, the greater the potential for change in patient status and development of opioid-related harms. Follow-up should occur within a range of one week to one month after any opioid dosage change. Each follow-up interaction with the patient is an opportunity to provide education about self-management strategies and the risks associated with OT while optimizing whole person approaches to pain care and treatment of co-occurring medical and mental health conditions. Following discontinuation of opioids, consider continuing risk mitigation strategies. Tapering may unmask underlying OUD. Therefore, frequent assessment for OUD is recommended (for more information on diagnosis and treatment of OUD see the VA/DoD SUD CPG).<sup>12</sup>

4. **WA:** Patients who used opioids for at least 90 days were greater than 60% more likely to still be on chronic opioids in 5 years.<sup>1</sup> Evaluate function and pain using brief validated instruments at these critical decision-making phases:
  - a. At the end of the acute phase (6 weeks following an episode of pain or surgery), to determine whether continued opioid therapy is warranted.
  - b. At the end of the subacute or perioperative phase (12 weeks following an episode of pain or surgery), to determine whether non-opioid treatment will help or if prescribing COAT is warranted.
  - c. During chronic use with regular assessment and documentation of function and pain.

#### When to Refer

1. **CDC:** Patients with more entrenched anxiety or fear related to pain, or other significant psychological distress, can be referred for formal therapy with a mental health specialist (e.g., psychologist, psychiatrist, clinical social worker). If clinicians suspect opioid use disorder based on patient concerns or behaviors or on findings in prescription drug monitoring program data (see Recommendation 9) or from urine drug testing (see Recommendation 10)... clinicians can arrange for a substance use disorder treatment specialist to assess for the presence of opioid use disorder. Clinicians unable to provide treatment themselves should arrange for patients with opioid use disorder to receive care from a substance use disorder treatment specialist, such as an office-based buprenorphine or naltrexone treatment provider, or from an opioid treatment program certified by SAMHSA to provide supervised medication-assisted treatment for patients with opioid use disorder. Clinicians should assist patients in finding qualified treatment providers and should

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- arrange for patients to follow up with these providers, as well as arranging for ongoing coordination of care.
2. **OPG:** If the patient is diagnosed with OUD, the prescriber must either refer the patient to addiction treatment or can continue to treat the patient with buprenorphine if they have an X-waiver.
  3. **VA:** When there is concern for OUD or other SUD in a patient undergoing opioid tapering, clinicians should recommend SUD assessment and treatment to the patient in a setting that corresponds to the patient's level of risk and availability of services, while considering patient preferences (see the VA/DoD SUD CPG).<sup>1</sup> Additionally, underlying mental health disorders may be exacerbated by opioid use and/or opioid tapering and may require ongoing interdisciplinary care that includes mental health services.
  4. **WA:** Refer patient to a multidisciplinary rehabilitation program if s/he has significant, persistent functional impairment due to complex chronic pain.

#### Provider education

While this topic was identified by the Task Force for inclusion in the guidelines, staff did not identify related content among the resource documents. In review of past meeting notes, the Task Force wanted this section to include:

- Educating providers about the importance of patient-centeredness.
- Educating providers about the legal definition of abandonment

#### Patient Assessment/Evaluation

Patient assessment/evaluation to determine whether to taper (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

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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.

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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.
  - a. 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.<sup>3</sup>
  - b. 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®)
  - c. 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 (or “Protective and Risk Factors”)**
    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)

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- 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/DoD:** Screening for conditions that complicate pain management before initiating opioid taper. Mental health disorders, OUD, SUD, “Moral Injury”, Central sensitization, Medical Complications (lung disease, heart disease, renal disease, fall risk), Sleep Disorders. Assess for medical comorbidities that increase risk (for opioid use): 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.

Proposed content for the Patient Assessment Section by workgroup members: Drs. Dogra, Swanson and Mauer

It is important to perform an initial patient assessment using a combination of tools. Steps should include:

Assess and document efficacy of current chronic opioid therapy using the 4 A's

- Analgesia: effectiveness of pain control
- Activities: including activities of daily living and functional activities
- Adverse Effects: including side effects from medications, such as:
  - Sedation

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- Respiratory depression
- Constipation
- Aberrancy: must be assessed and documented in a consistent manner

#### Repeat a biopsychosocial assessment

- Clinical Interview & Patient Self Report
  - Patient centered interview and exploration of goals, questions, concerns, beliefs, expectations, fears relate to tapers
  - History of pain-duration of symptoms
    - Onset
    - Location(s)
    - Radiation
    - Previous episodes
    - Intensity
    - Patient perception of symptoms- examples of measures
    - *Examples* of patient paper and pencil measures include but are not limited to
      - PEG tool
      - DVPRS scale
      - BPI
      - Pain Numeric Rating Scale
      - Pain Catastrophizing Scale
  - Coexisting conditions, treatments (e.g., use of benzos or other sedating meds), effect on pain
  - Patient Personal History
    - Physical co-morbidities (e.g., Sleep apnea, diabetes)
    - Previous chronic pain related treatments and outcome
      - Surgery and procedures
      - Pharmacology
      - Non-pharmacological treatments (e.g., PT, TENS unit)
    - Personal Substance Use/Psychiatric History (examples)
      - Suicidality, history of self-injurious behavior, history of suicide attempts
      - History of taking medications for a psychiatric reason and outcome
      - Mood Disorders
      - Trauma History
      - Psychosis
      - ADHD
      - Substance use history including prescription medication (please include history of tobacco use as it is a predictor of opioid use/misuse/aberrancy/dependence)

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- \*Recommendation to formerly assess for cannabis use disorder using standardized paper and pencil screening measures e.g. the CUDIT-R (see cut off scores below)
- History of overdose
  - Lifestyle/Behavioral
    - Exercise
    - Nutrition
    - Leisure time
    - Time in nature
    - Sleep hygiene practices
- Social History
  - Social support
  - Family factors- e.g. family solicitousness (unintentional reinforcement of illness behaviors) versus positive support (reinforcement of wellness behaviors)
  - Employment/Disability Status
  - Living conditions
  - SES/Finances
  - Legal issues
- Family History
  - Family h/o chronic pain conditions pain
  - Family Psychological/psychiatric history
  - Family history of substance use disorders
  - Family history of suicide

#### Physical exam

This also includes:

- Diagnostic studies
- Additional consults if appropriate

#### Risks vs Benefits Assessment

- Urine drug screen
- Review the Prescription Drug Monitoring Program (PDMP)
- Examples of Paper & Pencil Self Report Measures
  - Opioid Risk Tool (ORT)
  - Screener & Opioid Assessment for Patients with Pain- Revised (SOAPP-R)

#### Considerations for tapering

*There is not a specific number of signs that need to be met. Providers should look at the whole picture and assess patients individually.*

- No reported improvement in analgesia on current opioid treatment regimen
- No reported improvement of function on current opioid treatment regimens

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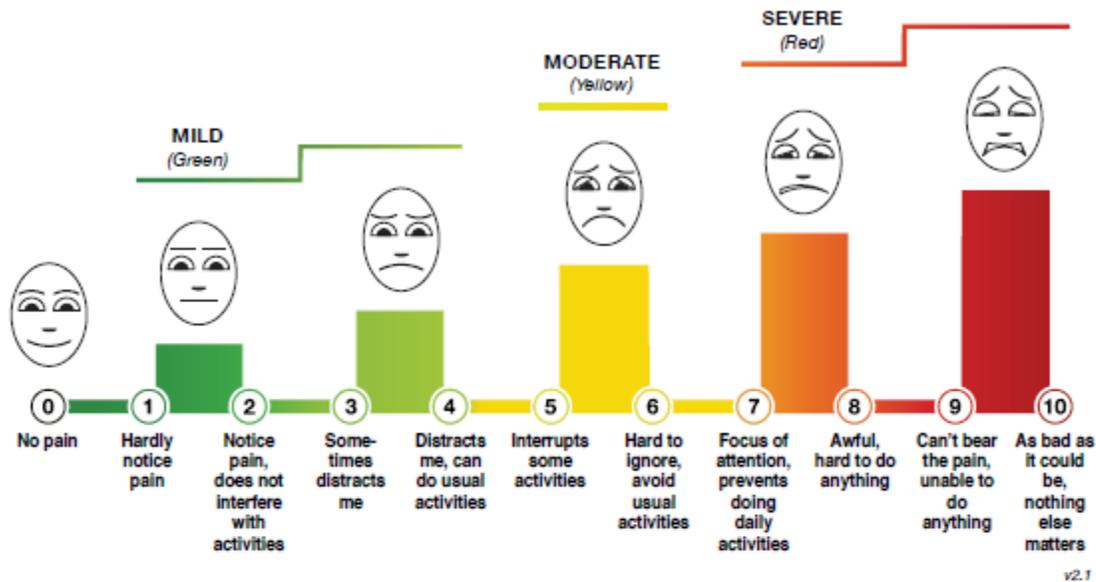
- Intolerable, life limiting, or health compromising adverse effects from current opioid regimen
- Signs of aberrancy, misuse, abuse, dependency or diversion
  - Positive or negative UDS, UDS reveals other substances (licit and illicit)
  - PDMP checks revealing multiple prescriptions, doctor shopping, frequenting the ED
- High risk score as evidenced on the ORT or SOAPP-R that are high risk
- High risk or dangerous behaviors
  - Suicidality/history of suicide attempts
  - Overdose event
  - Accidents, threats to providers-
  - Unstable or unsafe home situation
- Worsening of mental health conditions

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### Defense and Veterans Pain Rating Scale



### DVPRS SUPPLEMENTAL QUESTIONS

For clinicians to evaluate the biopsychosocial impact of pain

1. Circle the one number that describes how, during the past 24 hours, pain has interfered with your usual ACTIVITY:



2. Circle the one number that describes how, during the past 24 hours, pain has interfered with your SLEEP:



3. Circle the one number that describes how, during the past 24 hours, pain has affected your MOOD:



4. Circle the one number that describes how, during the past 24 hours, pain has contributed to your STRESS:



\*Reference for pain interference: Cleeland CS, Ryan KM. Pain assessment: global use of the Brief Pain Inventory. *Ann Acad Med Singapore* 23(2): 129-138, 1994. v 2.1

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PEG:

<b>1. What number best describes your <u>pain on average</u> in the past week:</b>										
0	1	2	3	4	5	6	7	8	9	10
No pain									Pain as bad as you can imagine	
<b>2. What number best describes how, during the past week, pain has interfered with your <u>enjoyment of life</u>?</b>										
0	1	2	3	4	5	6	7	8	9	10
Does not interfere									Completely interferes	
<b>3. What number best describes how, during the past week, pain has interfered with your <u>general activity</u>?</b>										
0	1	2	3	4	5	6	7	8	9	10
Does not interfere									Completely interferes	

<i>CUDIT- R Score</i>	<i>Risk</i>	<i>Intervention(s)</i>
0 - 7	Within Safe Cannabis Use limits (*unless pregnant where score should be 0)	<ul style="list-style-type: none"> <li>• Brief education</li> </ul>
8 - 9	Problematic/Hazardous	<ul style="list-style-type: none"> <li>• Brief education</li> <li>• Brief Intervention using Motivational Interviewing</li> <li>• Warm hand-over to embedded Behavioral</li> </ul>

**Oregon Opioid Taper Guidelines Task Force  
DISCUSSION GUIDE**

Last updated 7/15/2019

		Health Consultant
		<ul style="list-style-type: none"><li>• Consider referral to specialized chemical dependency treatment</li></ul>
$\geq 10$	Cannabis Use Disorder	<ul style="list-style-type: none"><li>• Brief Intervention using Motivational Interviewing</li><li>• Warm hand-over to embedded Behavioral Health Consultant</li><li>• Referral for Chemical Dependency Evaluation &amp; Treatment and/or Anonymous Programs</li></ul>

“Clinicians should taper opioids in patients who have developed physiologic dependence on opioids. This includes situations of post-operative pain or long-term use. Opioid tapers should be individualized to the specific patient situation and care should be taken to engage and provide support to the patient throughout the process. Clinicians should determine the length of time of an opioid taper based on the situation and the severity of risks associated with ongoing opioid prescription. The following are some recommendations on how to approach opioid dose reduction or discontinuation. [10]

- Gradual dosage reduction (appropriate for most patients): Reduce dose by 10-25% every 1-4 weeks, larger initial dose reductions (25-50%) can be used
- Rapid dosage reduction (medically dangerous situations): Decrease dose every 1-7 days as appropriate
- Stop immediately (clear signs of unsafe or high risk use)
- Use adjuvant medications during taper”

[http://ohsucancer.com/xd/health/who-we-are/upload/Safe-Opioid-Prescribing-Guideline\\_FINAL\\_12-6-18.pdf](http://ohsucancer.com/xd/health/who-we-are/upload/Safe-Opioid-Prescribing-Guideline_FINAL_12-6-18.pdf)

**OHSU HEALTH SYSTEM**  
**OFFICE OF CLINICAL INTEGRATION AND EVIDENCE-BASED PRACTICE**

*ADULT SAFE OPIOID PRESCRIBING GUIDELINE FOR CHRONIC, NON-END-OF-LIFE PAIN*  
*AND*  
*PRACTICE RESOURCES FOR CLINICAL IMPLEMENTATION*

**Background:** Opioids are commonly prescribed for pain. An estimated 20% of patients presenting to physician offices with non-cancer pain symptoms or pain-related diagnoses (including acute and chronic pain) receive an opioid prescription.<sup>[1]</sup> In 2012, health care providers wrote 259 million prescriptions for opioid pain medication, enough for every adult in the United States to have a bottle of pills.<sup>[2]</sup> Opioid prescriptions per capita increased 7.3% from 2007 to 2012, with opioid prescribing rates increasing more for family practice, general practice, and internal medicine compared with other specialties.<sup>[3]</sup> Rates of opioid prescribing vary greatly across states in ways that cannot be explained by the underlying health status of the population, highlighting the lack of consensus among clinicians on how to use opioid pain medication.<sup>[2]</sup>

**Prevalence of Chronic Pain and Prescription Opioids:**

Estimates of the prevalence of chronic pain vary, but it is clear that the number of persons experiencing chronic pain in the United States is substantial. The 1999–2002 National Health and Nutrition Examination Survey estimated that 14.6% of adults have current widespread or localized pain lasting at least 3 months.<sup>[4]</sup> Based on a survey conducted during 2001–2003<sup>[5]</sup>, the overall prevalence of common, predominantly musculoskeletal pain conditions (e.g., arthritis, rheumatism, chronic back or neck problems, and frequent severe headaches) was estimated at 43% among adults in the United States, although minimum duration of symptoms was not specified. Most recently, analysis of data from the 2012 National Health Interview Study showed that 11.2% of adults report having daily pain. On the basis of data available from health systems, researchers estimate that 9.6–11.5 million adults, or approximately 3%–4% of the adult U.S. population, were prescribed long-term opioid therapy in 2005.<sup>[6]</sup>

**Risks of Opioids:** Opioid pain medication use presents serious risks, including overdose and opioid use disorder. From 1999 to 2014, more than 165,000 persons died from overdose related to opioid pain medication in the United States. In the past decade, while the death rates for the top leading causes of death such as heart disease and cancer have decreased substantially, the death rate associated with opioid pain medication has increased markedly.<sup>[7]</sup> Sales of opioid pain medication have increased in parallel with opioid-related overdose deaths.<sup>[8]</sup> The Drug Abuse Warning Network estimated that >420,000 emergency department visits were related to the misuse or abuse of opioid pain relievers in 2011, the most recent year for which data are available.<sup>[9]</sup>

**Definitions:**

*Long-term opioid use:* use of opioids on most days for > 3 months

*Chronic pain:* pain conditions that typically last > 3 months or past the time of normal tissue healing

*LIP:* Licensed Independent Provider

*Non-cancer:* Pain caused by an entity that is not related to an active malignancy

*End-of-life:* a patient with an advanced, terminal, progressing illness, likely to result in death in < 6 months, where non-curative treatment is the goal

*Opioids:* Schedules II through V medications under the federal Controlled Substance Act, as modified by the Oregon State Board of Pharmacy (includes codeine, hydrocodone, hydromorphone, fentanyl, methadone, morphine, oxycodone, oxymorphone, tramadol, tapentadol, and buprenorphine)

NOTE: Buprenorphine is a partial opioid-agonist.

Morphine equivalent dose is not easily translatable for buprenorphine, so buprenorphine is not subject to morphine milligram equivalents/day dose exclusion.

Buprenorphine for the treatment of opioid use disorder is excluded from this guideline.

NOTE: Opioids administered through an intrathecal or epidural route has potent central nervous system effects and contributes powerfully toward a cumulative oral

morphine milligram equivalents/day dose. Conversion factors (multipliers) used in oral opioid morphine milligram equivalents conversion calculators do not apply to opioid administered through these routes and will underestimate the effective morphine milligram equivalents/day dose. Patients receiving opioid through intrathecal or epidural routes require close monitoring and, in an ambulatory setting, should receive continuous care by a pain specialist.

**Guideline Eligibility Criteria:** Adult and adolescent patients (>/= 15 years of age) being treated for chronic or

non-end-of-life pain not related to an active malignancy with long-term opioid prescriptions in any clinical setting (i.e., Emergency Department, outpatient, inpatient) throughout OHSU Health System

**Guideline Exclusion Criteria:**

- patients < 15 years of age
- patients at end-of-life
- patients with pain related to active malignancy
- patients with Sickle Cell Disease

**Clinical Practice Recommendations**

OHSU Health System fully endorses the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain.<sup>[10]</sup> The CDC guideline summary is listed below with specific aspects highlighted as they pertain to clinical practice throughout OHSU Health System.

**Determining When to Initiate or Continue Opioids for Chronic Pain**

Non-pharmacologic therapy and non-opioid 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 non-pharmacologic therapy and non-opioid pharmacologic therapy, as appropriate.<sup>[10]</sup>

- *Strong Recommendation; Low Quality Evidence*

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 opioid 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.<sup>[10]</sup>

- *Strong Recommendation; Very Low Quality Evidence*

Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.<sup>[10]</sup>

- *Strong Recommendation; Low Quality Evidence*

**PRACTICE IMPLICATIONS:**

- Prior to prescribing an opioid for long-term use for chronic pain, a pain focused history and examination should be performed. This evaluation should include the following elements. (See APPENDIX A for resources.)

- a. Subjective pain evaluation
- b. Functional capacity evaluation
- c. Mental health evaluation and history
- d. Substance use evaluation and history
- e. Opioid Risk evaluation including initial urine drug testing and review of the Oregon Prescription Drug Monitoring Program

- Prior to prescribing an opioid for long-term use for chronic pain, the following must be discussed with the patient and documented in the patient record. (See APPENDIX A for resources.)

- a. A specific pain diagnosis
- b. Set realistic goals for pain and function based on diagnosis (e.g., walk around block)

- c. Discuss benefits and risks (e.g., opioid use disorder, opioid withdrawal, overdose) with patient
  - d. Provide patient (and patient must read and sign) a Controlled Substance for Intractable Pain Notice and Consent Form (also known as Opioid Treatment Agreement and Material Risk Notice). The document will be part of the patient's medical record and should be renewed every year if opioids are continued
  - e. Set criteria for stopping or continuing opioids
- If cannabis is present on a urine drug test, the patient should be screened for cannabis use disorder prior to considering use of opioids for pain. OHSU Health System providers may not verbally prescribe or write a prescription for medical marijuana. OHSU Health System recognizes that new state policies regarding both medical and recreational use of marijuana have generated questions about potential therapeutic benefits as well as potential adverse health effects of marijuana, particularly as it relates to pain management involving opioids. Opioids should not be combined with ongoing marijuana use unless therapeutic benefit is determined to outweigh the risk for harm, and opioids should be avoided if cannabis use disorder is present. Some OHSU Health System clinics may choose to create additional clinic-specific policies regarding monitoring for cannabis use after initial screening or regarding the prescribing of opioids with concomitant use of cannabis.

### **Opioid Selection, Dosage, Duration, Follow-up and Discontinuation**

When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting opioids. <sup>[10]</sup>

- *Strong Recommendation; Very Low Quality Evidence*

When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to > 50 morphine milligram equivalents/day, and should avoid increasing dosage to > 90 morphine milligram equivalents/day or carefully justify a decision to titrate dosage to > 90 morphine milligram equivalents/day. <sup>[10]</sup>

- *Strong Recommendation; Low Quality Evidence*

#### **PRACTICE IMPLICATIONS:**

- An opioid dose > 90 morphine milligram equivalents/day must not be prescribed unless the benefit of dose escalation is determined to clearly outweigh the risk for harm, and without secondary review by another licensed independent provider (LIP), a clinic opioid review board, or a Comprehensive Pain Center. (See Appendix B for an example of a template for secondary review.)
- If a patient is already prescribed > 90 morphine milligram equivalents/day and has not yet had secondary review, an opioid taper attempt is generally recommended. For best results, it is recommended that this taper have an estimated completion date. Exceptions to taper should clearly document significant benefit and small harm, and should be substantiated by secondary review by another licensed independence provider, a clinic opioid review board, or a Comprehensive Pain Center. (See Appendix C for opioid taper resources.)
- Naloxone, opioid antagonist should be prescribed to patients whose opioid dose exceeds 50 morphine milligram equivalents/day. Patient and family education should accompany the prescription. (See APPENDIX A for instructions and additional resources.)

Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh the risks of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids. <sup>[10]</sup>

- *Strong Recommendation; Very Low Quality*

(See APPENDIX A for resources that list opioid associated harms.)

### **Assessing Risk and Addressing Harms of Opioid Use**

Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should complete the Opioid Risk Tool or another related risk assessment tool. (See APPENDIX A for Opioid Risk Tool.) 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 (> 50 morphine milligram equivalents/day), or concurrent benzodiazepine use, are present. <sup>[10]</sup>

- *Strong Recommendation; Very Low Quality Evidence*

**PRACTICE IMPLICATIONS:**

- Naloxone, opioid antagonist should be prescribed to patients whose opioid dose exceeds 50 morphine milligram equivalents/day. Patient and family education should accompany the prescription. (See APPENDIX A for instructions and additional information.)

Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for opioid overdose. Clinicians should review prescription drug monitoring program data when:

- a. starting opioid therapy for chronic pain,
- b. periodically ranging from every prescription to every three months for higher risk or new patients, and
- c. at minimum once per year during opioid therapy for chronic pain. <sup>[10]</sup>

- *Strong Recommendation; Very Low Quality Evidence*

**PRACTICE IMPLICATIONS:**

- Maintain a comprehensive treatment plan with agreed upon treatment goals.
  - a. Should review an informed consent and opioid agreement every 1 year
  - b. Should regularly review and discuss mutual treatment goals
  - c. Should regularly evaluate effectiveness and safety of opioid treatment
- Utilize the health maintenance registry to track periodic renewal of opioid agreement and monitoring of prescription drug monitoring program

When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and urine drug testing annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs. <sup>[10]</sup>

- *Weak Recommendation; Very Low Quality Evidence*

Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible. <sup>[10]</sup>

- *Strong Recommendation; Low Quality Evidence*

**PRACTICE IMPLICATIONS:**

- If the patient is already prescribed benzodiazepines, consider tapering benzodiazepines before prescribing opioids or do not start opioids. (See APPENDIX C for benzodiazepine taper resources.)
- Should avoid concomitant use of other medications with sedating effects and/or abuse potential (e.g., barbiturates, zolpidem, etc.)
- Should advise patients against concomitant use of alcohol and opioids
- Should provide patient counseling on the risks of combining the above substances with opioids

Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder. <sup>[10]</sup>

- *Strong Recommendation; Moderate Quality Evidence*

### Opioid Dosing Strategies for Acute Pain

Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed. <sup>[10]</sup>

- *Strong Recommendation; Very Low Quality Evidence*

#### PRACTICE IMPLICATIONS:

- Complex post-operative pain and significant trauma pain should follow the guideline to prescribe the lowest effective dose for the expected duration of pain, acknowledging that higher doses may be needed for a longer period of time
- For most other acute sources of pain such as dental pain, simple fracture, etc., the 3-7 day limit should be applied
- Opioid treatment for acute pain lasting longer than 2 weeks should have an exit strategy and taper plan in place (See the APPENDIX C for opioid taper recommendations.)

### Inpatient Referrals

In the hospital at OHSU, consider Acute Pain Service consultation if patient's pain is difficult to manage or if opioid dose is > 90 morphine milligram equivalents/day. Consider consulting OHSU Improving Addiction Care Team (IMPACT) if there is concern for an active substance use disorder that is complicating care in the hospital.

- *Consensus Statement*

### Outpatient Consults/Referrals

Consider specialty referral to internal opioid review process, pain specialist, or addiction medicine if:

- o The patient has ongoing severe pain with no significant improvement in pain and/or function despite opioid treatment
- o Presence of significant psychological and addiction issues
- o The provider is considering prescribing opiates in combination with other psychoactive drugs (i.e., benzodiazepines) with potential for abuse
- o There is aberrant drug-related patient behavior

- *Consensus Statement*

### Non-Opioid Pain Management Strategies

Alternatives to opioid prescribing should be considered in the management of patients with non-end-of-life pain, including: non-opioid medications (e.g., nonsteroidal anti-inflammatory drugs, tricyclic antidepressants, serotonin-norepinephrine reuptake inhibitors, anti-convulsants), physical treatments (e.g., exercise therapy, weight loss), behavioral treatment (e.g., cognitive behavioral therapy, mindfulness exercises), complementary and alternative medicine (e.g., chiropractic, acupuncture, massage). <sup>[10]</sup> (See APPENDIX A for additional resources.)

- *Consensus Statement*

### Safe Opioid Prescribing for Hospitalized Patients who are Prescribed Opioids Prior to Admission

At admission check the Prescription Drug Monitoring Program to confirm opioid dosing and prior opioid prescriber.

During the course of hospitalization to guide inpatient pain management, do the following:

- a. Establish if the patient has an opioid agreement with his or her primary care provider or other provider
- b. Contact the patient's primary care provider

Prior to hospital discharge, do the following:

- a. If prescribing opioids at discharge, prescribe only the amount appropriate to manage the acute pain episode with no refills. Chronic pain should be managed by the patient's primary care provider. Prepare tapering protocol prior to discharge
- b. Avoid concomitant prescription of benzodiazepines or other sedating medications at discharge
- c. Obtain Pain Service Consultation at OHSU if the patient's pain is difficult to manage or if opioid dose is > 90 morphine milligram equivalents/day.

- *Consensus Statements*

### **Patients in the Emergency Department**

The consensus statements below were informed by the 2016 CDC Opioid Prescribing Guideline for Chronic Pain<sup>[10]</sup> and the 2012 Prescribing of Opioids for Adult Pains in the Emergency Department Guideline from the American College of Emergency Physicians Opioid Guideline Writing Panel.<sup>[11]</sup>

At admission, check the prescription drug monitoring program to confirm opioid dosing and prior prescriber.

If opioids are prescribed at discharge:

- a. The prescription should be for the lowest practical dose for a limited duration (3-5 days), and the prescriber should consider the patient's risk for opioid misuse, abuse, or diversion
- b. The clinician should honor existing patient-physician pain contracts/treatment agreements and consider past prescription patterns from information sources such as prescription drug monitoring programs
- c. Establish if the patient has an opioid agreement with his or her primary care provider or other provider
- d. Avoid concomitant prescription of benzodiazepines or sedative hypnotics

- *Consensus Statements*

### **Opioid Tapering or Discontinuation**

Clinicians should taper opioids in patients who have developed physiologic dependence on opioids. This includes situations of post-operative pain or long-term use. Opioid tapers should be individualized to the specific patient situation and care should be taken to engage and provide support to the patient throughout the process. Clinicians should determine the length of time of an opioid taper based on the situation and the severity of risks associated with ongoing opioid prescription. The following are some recommendations on how to approach opioid dose reduction or discontinuation.<sup>[10]</sup>

- Gradual dosage reduction (appropriate for most patients): Reduce dose by 10-25% every 1-4 weeks, larger initial dose reductions (25-50%) can be used
- Rapid dosage reduction (medically dangerous situations): Decrease dose every 1-7 days as appropriate
- Stop immediately (clear signs of unsafe or high risk use)
- Use adjuvant medications during taper

- *Consensus Statements*

### **Patients with or Recovering from Substance Use Disorders**

The recommendations above apply to patients with or recovering from Substance Use Disorders.

The consensus statement below was informed by the 2012 Center for Substance Abuse and Mental Health Services Administration Guideline.<sup>[12]</sup>

Non-opioid pharmacological and non-pharmacological therapies, including complementary and alternative medicine, should be considered routine before opioid treatment is initiated. Opioids may be necessary and should not be ruled out based on an individual's having a history of substance abuse disorder.

- *Consensus Statement*

**Quality Measures:**

**Structure-**

- Prescription drug monitoring program link to EMRs

**Process-**

- Utilization of urine drug testing
- Percent of providers registered to use prescription drug monitoring program
- Utilization of prescription drug monitoring program
- Receipt of opioid agreement
- Prevalence of patients treated with opioids and mean dose
- Prevalence of concomitant use of opioids and benzodiazepines
- Referrals to IMPACT/Acute Pain Service/Comprehensive Pain Clinic/Addiction Medicine
- Utilization of naloxone in patients prescribed > 50mg morphine milligram equivalents/day

**Outcome-**

- Patient satisfaction with pain management
- Patient functional status

## References

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### **Guideline Preparation**

This guideline was prepared by the Office of Clinical Integration (CI) and Evidence-Based Practice (EBP) in collaboration with content experts at Oregon Health and Science University, Salem Healthcare, and Tuality.

### **Adult Safe Opioid Prescribing for Chronic, Non-End-of-Life Pain Content Expert Team**

Michael Aziz, MD, Anesthesiology, OHSU  
Sarah Jean Baptiste, PA-C, Orthopaedics, OHSU  
Catriona Buist, PsyD, Pain Psychology, OHSU  
Joseph Bubalo, PharmD, MBA, Oncology Pharmacy, OHSU  
Kathleen Buhler, MSN, Nursing, OHSU  
Roger Chou, MD, General Medicine/PNW EPC, OHSU  
Tiffany Culbertson, MSN, Nursing, OHSU  
Stuart Currie, MD, Family Medicine/CMO, Tuality Healthcare  
Lynn Eastes, RN-MS, Trauma Surgery, OHSU  
Lori Ellingson, MSN, Surgical and Oncology Division Director, OHSU  
Darin Friess, MD, MPH, Orthopaedics, OHSU  
Erik Fromme, MD, Palliative Care, OHSU  
Nicholas Gideonse, MD, Family Medicine  
Walter Hardin, DO, Family Medicine, Tuality Healthcare  
Seth Hartman, PhD, Inpatient Pharmacy Services, OHSU  
Brandon Hayes-Lattin, MD, Hem/Onc, OHSU  
Daniel Haupt, MD, Psychiatry, OHSU  
Michael Lieberman, MD, MS, General Medicine/Informatics, OHSU  
Kim Mauer, MD, Anesthesiology, OHSU  
Long Ong, MSN, ACNP-BC, Anesthesiology, OHSU  
Lee Paton, RN, PhD, Nursing, OHSU  
Mary Pickett, MD, Internal Medicine  
Jonathan Robbins, MD, Internal Medicine  
Bruin Rugge, MD, MPH, Family Medicine, OHSU  
Scott Sallay, MD, Hospital Medicine/Informatics, OHSU  
Troy Schmit, MHA, Quality and Safety, OHSU  
Jackie Sharpe, PharmD, Clinical Pharmacy, OHSU  
Christine Slusarenko, RN, Regulatory Affairs, OHSU  
Mary Tanski, MD, MBA, ED, OHSU  
Helen Turner, MSN, Anesthesiology, OHSU  
Angela Vinti, PharmD, Clinical Pharmacy, OHSU  
Jennifer Watters, MD, Surgery, OHSU  
Melissa Weimer, DO, MCR, General Medicine, OHSU  
Daisuke Yamashita, MD, Family Medicine, OHSU

### **Clinical Integration and EBP Team**

Elizabeth Crabtree, MPH, PhD (c) Director of Clinical Integration and EBP  
Honora Englander, MD, Clinical Integration Medical Director/Hospital Medicine  
Andrew Hamilton, MS/MLS, Liaison Librarian  
Stephanie Halvorson, MD, Clinical Integration Medical Director/Hospital Medicine

### **Development Process**

This guideline was developed using the process outlined in the CI and EBP Manual (2016). The review summary documents the following steps:

1. Review Preparation
  - PICO questions established
  - Evidence search confirmed with content experts
2. Review of Existing Internal and External Guidelines
  - Literature Review of Relevant Evidence
3. Critically Analyze the Evidence
4. Summarize the Evidence by preparing the guideline, and order sets

### **Evaluating the Quality of the Evidence**

Published clinical guidelines were evaluated for this review using the **University of Pennsylvania's Trustworthy Guideline Rating Scale**. The summary of these guidelines are included in the evidence summary. The rating scale is based on the Institute of Medicine's "Standards for Developing Trustworthy Clinical Practice Guidelines" (IOM), as well as a review of the AGREE Enterprise and Guidelines International Network domains. This scale evaluates a guideline's transparency, conflict of interest, development group, systematic review, supporting evidence, recommendations, external review and currency and updates. The purpose of this scale is to focus on the weaknesses of a guideline that may reduce the trust a clinical user can have in the guideline, and distinguish weaknesses in documentation (e.g. guideline does not have a documented updating process) from weaknesses in the guidance itself (e.g., recommendations are outdated).

The **GRADE (Grading of Recommendations, Assessment, Development and Evaluation)** criteria were utilized to evaluate the body of evidence used to make clinical recommendations. The table below defines how the quality of the evidence is rated and how a strong versus

weak recommendation is established. The evidence summary reflects the critical points of evidence.

Recommendation	
<b>STRONG</b>	Desirable effects clearly outweigh undesirable effects or vice versa
<b>WEAK</b>	Desirable effects closely balanced with undesirable effects
Quality	Type of Evidence
<b>High</b>	Consistent evidence from well-performed RCTs or exceptionally strong evidence from unbiased observational studies
<b>Moderate</b>	Evidence from RCTs with important limitations (e.g., inconsistent results, methodological flaws, indirect evidence, or imprecise results) or unusually strong evidence from unbiased observational studies
<b>Low</b>	Evidence for at least 1 critical outcome from observational studies, from RCTs with serious flaws or indirect evidence
<b>Very Low</b>	Evidence for at least 1 critical outcome from unsystematic clinical observations or very indirect evidence

**Recommendations**

Recommendations for the guidelines were directed by the existing evidence, content experts, and consensus.

Patient and family preference were included when possible. When evidence is lacking, options in care are provided in the guideline and the order sets that accompany the guideline.

**Approval Process**

Guidelines are reviewed and approved by the Content Expert Team, Office of CI and EBP, Knowledge Management and Therapeutics Committee, Professional Board, and other appropriate hospital committees as deemed appropriate for the guideline’s intended use. Guidelines are reviewed and updated as necessary every 2 to 3 years within the Office of CI and EBP at OHSU. Content Expert Teams will be involved with every review and update.

**Disclaimer**

Guideline recommendations are made from the best evidence, clinical expertise and consensus, in addition to thoughtful consideration for the patients and families cared for within the Integrated Delivery System. When evidence was lacking or inconclusive, content experts made recommendations based on consensus. Expert consensus is implied when a reference is not otherwise indicated.

The guideline is not intended to impose standards of care preventing selective variation in practice that is necessary to meet the unique needs of individual patients. The physician must consider each patient and family’s circumstance to make the ultimate judgment regarding best care.

## APPENDIX A: GENERAL RESOURCES

### OHSU HEALTH SYSTEM POLICY STATEMENTS AND PRACTICE DOCUMENTS

Oregon Sample Material Risk Notice

<https://www.oregon.gov/omb/OMBForms1/material-risk-notice.pdf>

### OTHER GUIDELINES:

CDC Guideline for Prescribing Opioids for Chronic Pain

<https://www.cdc.gov/drugoverdose/prescribing/guideline.html>

Oregon Opioid Prescribing Guidelines

<https://public.health.oregon.gov/PreventionWellness/SubstanceUse/Opioids/Documents/taskforce/oregon-opioid-prescribing-guidelines.pdf>

Washington State Agency Medical Directors' Guideline

<http://www.agencymeddirectors.wa.gov/Files/OpioidGdline.pdf>

### PRACTICE RESOURCES

Oregon Pain Guidance Resource

<http://portlandprofessional.oregonpainguidance.org/tools-for-professionals/>

[http://www.oregonpainguidance.org/wp-content/uploads/2014/04/OPG\\_Guidelines.pdf](http://www.oregonpainguidance.org/wp-content/uploads/2014/04/OPG_Guidelines.pdf)

My Top Care – practical resources on how to implement changes to prescribing for providers, patients and pharmacists

<http://mytopcare.org/prescribers/>

Documentation Templates – The Pain Assessment and Documentation Tool

<http://mytopcare.org/wp-content/uploads/2013/07/Passik.pdf>

Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain

<http://www.agencymeddirectors.wa.gov/Files/OpioidGdline.pdf>

Oregon Pain Guidance Website – useful information for patients and providers about managing pain, risks, preventing overdose, and real stories

<http://portlandmetro.oregonpainguidance.org/>

CDC Guideline Resources: Clinical Tools

<https://www.cdc.gov/drugoverdose/prescribing/clinical-tools.html>

Urine Drug Testing Resources

<http://mytopcare.org/prescribers/about-urine-drug-tests/>

OHSU Comprehensive Pain Center

<http://www.ohsu.edu/xd/health/services/pain-center/about/our-team.cfm>

## **PROVIDER EDUCATION**

Providers' Clinical Support System for Opioid Therapy (PCSS-O)

<http://pcss-o.org/>

Providers' Clinical Support System for Medication Assisted Treatment (PCSS-MAT)

<http://pcssmat.org/>

CDC's Clinician Outreach and Communication Activity (COCA)

<https://www.cdc.gov/drugoverdose/prescribing/trainings.html>

Boston University Safe and Competent Opioid Prescribing (SCOPE)

<https://www.scopeofpain.com/>

My Top Care

<http://mytopcare.org/prescribers/>

## **NALOXONE**

Oregon Pain Guidance Naloxone Site

<http://portlandprofessional.oregonpainguidance.org/overdose-naloxone/information-for-pharmacists/>

Naloxone for overdose prevention/treatment

<https://public.health.oregon.gov/ProviderPartnerResources/EMSTraumaSystems/Pages/epi-protocol-training.aspx>

Naloxone

<http://prescribetoprevent.org/prescribers/palliative/>

## **COLLEAGUE SUPPORT/MENTORING**

[http://pcss-o.org/?portfolio\\_category=oregon](http://pcss-o.org/?portfolio_category=oregon)

[http://pcssmat.org/?portfolio\\_category=oregon](http://pcssmat.org/?portfolio_category=oregon)

## **PATIENT EDUCATION**

CDC Patient and Partner Tools

<https://www.cdc.gov/drugoverdose/prescribing/patient-tools.html>

Opioid Information, Side, Pain Relief, etc

<http://mytopcare.org/patients/>

**APPENDIX B: SECONDARY REVIEW TEMPLATE**

Patient Name:

Chronic opioid indication (be specific):

Current morphine equivalent dose (MED):

Has patient ever attempted an opioid taper?

Other current non-opioid medications (if none or failed attempts, document reason):

Last Urine Drug Test result and date:

Prescription Drug Monitoring Program check result and date:

Last opioid agreement date with current provider:

History of Aberrant Drug Related behavior? If so, describe.

Based on the above information and face to face conversation with patient/provider, the above named patient does/does not appear to meet criteria for an exception to our general practice of prescribing less than 90mg MED per day of an opioid. The benefits/risks appear to outweigh the benefits/risks in this case at this time.

As a secondary review of the pain treatment for this patient, I recommend the following treatment plan and follow up: \*\*\*

## APPENDIX C: OPIOID AND BENZODIAZEPINE TAPER RESOURCES

Oregon Pain Guidance

<http://www.oregonpainguidance.org/app/content/uploads/2016/05/Opioid-and-Benzodiazepine-Tapering-flow-sheets.pdf>

## How to Approach an Opioid Taper/Cessation

Indication	Recommended Length of Taper	Degree of Shared Decision Making about Opioid Taper	Intervention/Setting
Substance Use Disorder	No taper, immediate referral	None – provider choice alone	<b>Intervention:</b> Transition to medication assisted treatment (buprenorphine or methadone) maintenance therapy, Naloxone rescue kit <b>Setting:</b> Inpatient or Outpatient Buprenorphine (OBOT) or methadone
Diversion	No taper*	None – provider choice alone	Determine need based on actual use of opioids, if any
At risk for immediate severe harms	Weeks to months	Moderate – provider led & patient views sought	<b>Intervention:</b> Supportive care Naloxone rescue kit <b>Setting:</b> Outpatient opioid taper
Therapeutic failure	Months	Moderate – provider led & patient views sought	<b>Intervention:</b> Supportive care Naloxone rescue kit <b>Setting:</b> Outpatient opioid taper <b>Option:</b> Buprenorphine (OBOT)
At risk for smaller harms	Months to Years	Moderate – provider led & patient views sought	<b>Intervention:</b> Supportive care Naloxone rescue kit <b>Setting:</b> Outpatient opioid taper <b>Option:</b> Buprenorphine (OBOT)

Table by Melissa Weimer, DO, 2016.

## Tapering Dose Example: Providence Health System Example

Provided by Ruben Halperin, September 2018, for OPG Guideline

### Consider the following patient:

- 48 year old male on Oxycodone for 16 years since a motor vehicle crash
  - Dose: Oxycodone 30 mg four times daily = 120 mg of oxycodone = 180 mg MED
  - Pain: Still rates his pain as a 10, wants to increase to 40 mg four times daily
  - Function: Hasn't worked since crash. Divorced 9 years ago. Lives alone. On bed or couch 20 hours daily
  - Co-morbid conditions: sleep apnea, diabetes 2, hypertension, depression, osteoarthritis of knees
- After a long discussion he admits that the oxycodone doesn't help him much, but he's afraid of how bad his pain will be on less of it or without it. He reluctantly agrees to the taper when you explain that his dose is unsafe and you don't feel comfortable continuing to prescribe it.

How to taper? Make sure other **ongoing** strategies are in place before you begin. He goes to a pain education class, watches several videos and meets with the behaviorist in clinic. The behaviorist encourages him to join a pain group where he will have a chance to learn and share experiences with other patients in a similar situation.

Week	Dose 1	Dose 2	Dose 3	Dose 4	Total daily dose	MED
0	30 mg	30 mg	30 mg	30 mg	120 mg	180 mg
1	30 mg	25 mg	30 mg	30 mg	115 mg	172.5 mg
2	same					
3	30 mg	25 mg	25 mg	30 mg	110 mg	165 mg
4	same					
5	30 mg	25 mg	25 mg	25 mg	105 mg	157.5 mg
6	same					
7	25 mg	25 mg	25 mg	25 mg	100 mg	150 mg
8	same					
At the end of 8 weeks you have decreased the oxycodone by about 16%. He's had mild withdrawal symptoms, but nothing intolerable						
Week	Dose 1	Dose 2	Dose 3	Dose 4	Total daily dose	MED
9	25 mg	20 mg	25 mg	25 mg	95 mg	142.5 mg
10	same					
11	25 mg	20 mg	20 mg	25 mg	90 mg	135 mg
12	same					
13	25 mg	20 mg	20 mg	20 mg	85 mg	127.5 mg
14	same					
15	20 mg	20 mg	20 mg	20 mg	80 mg	120 mg
16	same					
At the end of 16 weeks you have decreased the oxycodone by about 33%. Withdrawal symptoms mild. He has noticed that his pain isn't any worse. Even so, he tells you he is afraid to keep going, but agrees that everything you told him has been correct.						
Week	Dose 1	Dose 2	Dose 3	Dose 4	Total daily dose	MED
17	20 mg	20 mg	15mg	20 mg	75 mg	112.5 mg
18	same					
19	20 mg	15 mg	15 MG	20 MG	70 MG	105 MG
20	same					

*Taper Examples Providence 2*

21	20 mg	15 mg	15 mg	15 mg	65 MG	97.5 90
22	same					
23	15 mg	15 mg	15 mg	15 mg	60 MG	90 MG
24	same					
At 24 weeks he is on 50% of his starting opioid dosing. He admits that his pain is no worse. He also tells you his mind feels less foggy and he's been using some of the relaxation techniques when he does feel pain. He began physical therapy a few weeks back and is now walking 15 – 20 minutes daily						
Week	Dose 1	Dose 2	Dose 3	Dose 4	Total daily dose	MED
25	15 mg	15 mg	10 mg	15 mg	55 mg	82.5
26						
27	15 mg	10 mg	10 mg	15 mg	50 mg	75 mg
28						
29	15 mg	10 mg	10 mg	10 mg	45 mg	67.5 mg
30						
31	10 mg	10 mg	10 mg	10 mg	40 mg	60 mg
32	same					
At 32 weeks he is on 30% of his starting opioid dosing. Pain is not worse, in fact he thinks it might be a little better. He's now walking up to an hour daily. He says, I think I want to go to 10 mg 3 times daily and then cut down from there.						
Week	Dose 1	Dose 2	Dose 3		Total daily dose	MED
33	10 mg	10 mg	10 mg		30 mg	45 mg
34	Same: he has a little more withdrawal and asks to stay on 10 mg TID for another 2 weeks					
35	10 mg	10 mg	10 mg		30 mg	45 mg
36	same					
37	10 mg	5 mg	10 mg		25 mg	37.5 mg
38	Same: he wants to cut the morning dose before evening dose because he is worried he won't sleep well					
39	5 mg	5 mg	10 mg		20 mg	30 mg
40	5 mg	5 mg	5 mg		15 mg	22.5 mg
At 40 weeks he is on 12.5% of his starting opioid dosing. He cut down a little faster in last 2 weeks. He is excited by the prospect of getting off completely but still feels like he needs to keep tapering and can't just stop at this dose						
Week	Dose 1	Dose 2	Dose 3		Total daily dose	MED
41	5 mg	2.5 mg	5 mg		12.5 mg	18.25 mg
42						
43	5 mg	5 mg			10 mg	15 mg
44						
45	2.5 mg	5 mg			7.5 mg	11.25 mg
46						
47	X	5 mg			5 mg	7.5mg
48	0				0 mg	0 mg
It took 48 weeks – almost a year, but he successfully came off of a high dose opioid he had been on for 16 years. He admits that his pain is minimal. He is more active than he has been in years, has lost 18 lbs. and he is contemplating going back to work.						

Example Tapers for Opioids <sup>5-9</sup>			
<p><b>Slowest Taper (over years)</b></p> <p>Reduce by 2 to 10% every 4 to 8 weeks with pauses in taper as needed</p> <p><i>Consider for patients taking high doses of long-acting opioids for many years</i></p>	<p><b>Slower Taper (over months or years)</b></p> <p>Reduce by 5 to 20% every 4 weeks with pauses in taper as needed</p> <p><b>MOST COMMON TAPER</b></p>	<p><b>Faster Taper (over weeks)<sup>****</sup></b></p> <p>Reduce by 10 to 20% every week</p>	<p><b>Rapid Taper (over days)<sup>****</sup></b></p> <p>Reduce by 20 to 50% of first dose if needed, then reduce by 10 to 20% every day</p>
<p>Ex: morphine SR 90 mg Q8h = 270 MEDD</p> <p><b>Month 1:</b> 90 mg SR qam, 75 mg noon, 90 mg qpm [5% reduction]*</p> <p><b>Month 2:</b> 75 mg SR qam, 75 mg noon, 90 mg qpm</p> <p><b>Month 3:</b> 75 mg SR (60 mg+15 mg) Q8h</p> <p><b>Month 4:</b> 75 mg SR qam, 60 mg noon, 75 mg qpm</p> <p><b>Month 5:</b> 60 mg SR qam, 60 mg noon, 75 mg qpm</p> <p><b>Month 6:</b> 60 mg SR Q8h</p> <p><b>Month 7:</b> 60 mg SR qam, 45 mg noon, 60 mg qpm</p> <p><b>Month 8:</b> 45 mg SR qam, 45 mg noon, 60 mg qpm</p> <p><b>Month 9:</b> 45 mg SR Q8h**</p>	<p>Ex: morphine SR 90 mg Q8h = 270 MEDD</p> <p><b>Month 1:</b> 75 mg (60 mg+15 mg)SR Q8h [16% reduction]</p> <p><b>Month 2:</b> 60 mg SR Q8h</p> <p><b>Month 3:</b> 45 mg SR Q8h</p> <p><b>Month 4:</b> 30 mg SR Q8h</p> <p><b>Month 5:</b> 15 mg SR Q8h</p> <p><b>Month 6:</b> 15 mg SR Q12h</p> <p><b>Month 7:</b> 15mg SR QHS, then stop***</p>	<p>Ex: morphine SR 90 mg Q8h = 270 MEDD</p> <p><b>Week 1:</b> 75 mg SR Q8h [16% reduction]</p> <p><b>Week 2:</b> 60 mg SR (15 mg x 4) Q8h</p> <p><b>Week 3:</b> 45 mg SR (15 mg x 3) Q8h</p> <p><b>Week 4:</b> 30 mg SR (15 mg x 2) Q8h</p> <p><b>Week 5:</b> 15 mg SR Q8h</p> <p><b>Week 6:</b> 15 mg SR Q12h</p> <p><b>Week 7:</b> 15 mg SR QHS x 7 days, then stop***</p>	<p>Ex: morphine SR 90 mg Q8h = 270 MEDD</p> <p><b>Day 1:</b> 60 mg SR (15 mg x 4) Q8h [33% reduction]</p> <p><b>Day 2:</b> 45 mg SR (15 mg x 3) Q8h</p> <p><b>Day 3:</b> 30 mg SR (15 mg x 2) Q8h</p> <p><b>Day 4:</b> 15 mg SR Q8h</p> <p><b>Days 5-7:</b> 15 mg SR Q12h</p> <p><b>Days 8-11:</b> 15 mg SR QHS, then stop***</p>

\*Continue the taper based on Veteran response. Pauses in the taper may allow the patient time to acquire new skills for management of pain and emotional distress while allowing for neurobiological equilibration.

\*\*Continue following this rate of taper until off the morphine or the desired dose of opioid is reached.

\*\*\*May consider morphine IR 15 mg ½ tablet (7.5 mg) twice daily.

\*\*\*\*Rapid tapers can cause withdrawal effects and patients should be treated with adjunctive medications to minimize these effects; may need to consider admitting the patient for inpatient care. If patients are prescribed both long-acting and short-acting opioids, the decision about which formulation to be tapered first should be individualized based on medical history, mental health diagnoses, and patient preference. Data shows that overdose risk is greater with long-acting preparations.

## Communicate the opioid taper plan to the Veteran

Example: Veteran is currently taking morphine SR 60 mg, 1 tablet every 8 hours. Goal is to reduce dose of morphine to SR 30 mg every 8 hours using a slow taper. Dose will be reduced by 15 mg every 10 days.

Using **morphine SR 15 mg tablets**, follow the schedule below:

	Morning	Afternoon	Evening
<b>Days 1 to 10</b>	4 tablets = 60 mg	3 tablets = 45 mg	4 tablets = 60 mg
<b>Days 11 to 20</b>	3 tablets = 45 mg	3 tablets = 45 mg	4 tablets = 60 mg
<b>Days 21 to 30</b>	3 tablets = 45 mg	3 tablets = 45 mg	3 tablets = 45 mg

### Scenario 1: Veteran is tolerating the taper



**1.** Follow up in the first 1 to 4 weeks of taper

**2.** If Veteran feels supported and is adjusting to the dose reduction

**3.** Continue strategy of reducing to morphine SR 30 mg every 8 hours

**4.** Follow up in 1 to 4 weeks to determine the next step in the taper

## Working Draft: Oregon Opioid Tapering Guidelines

**Note: this document represents a working draft. Nothing in this document has been finalized and all language is subject to change.**

### Background

From 1999 to 2006, Oregon experienced a sharp increase in prescription opioid abuse, overdose, hospitalization and death. Much of the increase was attributed to increased opioid prescribing for chronic non-cancer pain. While the rate of prescription opioid overdose deaths peaked in 2006 and have been declining gradually, at the end of 2018 the rate was still 3 times higher than in 1999.

In 2015, the Oregon Health Authority (OHA), in collaboration with stakeholders (e.g., health care systems, providers, payers, licensing boards, policy makers, local health departments, community-based organizations, law enforcement), implemented the Oregon “Opioid Initiative” to facilitate a coordinated response to the prescription opioid crisis. The Opioid Initiative aims to reduce deaths, non-fatal overdoses, and harms to Oregonians from prescription opioids, and lays out a strategic framework with four goals:

1. improving access to non-opioid pain treatment;
2. supporting medication-assisted treatment and naloxone access for people taking opioids;
3. implementing opioid prescribing guidelines;
4. using data to inform and evaluate policies.

### Existing Oregon opioid prescribing guidelines

In an effort to change the conversation on pain management and improve patient safety, the Oregon Health Authority convened experts from across the state to develop clinical guidelines on opioid prescribing. In 2016, Oregon's Opioid Prescribing Guidelines Task Force [approved adoption](#) of Oregon-specific opioid prescribing guidelines<sup>1</sup> based on the [CDC Guideline for Prescribing Opioids for Chronic Pain](#).<sup>2</sup> The guideline includes recommendations to improve patient safety for those with chronic pain. It also presents specific recommendations to evaluate the benefits and harms of long-term opioid therapy, and if the harms of long-term opioid use outweigh the benefits, taper opioids to safer doses.

In addition to the chronic opioid prescribing guidelines, Oregon has developed guidelines to address opioid prescribing for acute pain; in dental settings; and to assist clinicians in addressing opioid use in pregnant women (refs). All existing guidelines explicitly call out the need to balance patient safety with the need for compassionate care.

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## Opioid tapering guideline overview

The Oregon Opioid Tapering Guidelines provide recommendations that are intended to complement the Opioid Prescribing Guidelines for Chronic Pain to help patients and prescribers approach opioid tapering with best practices in mind. The goal of the tapering guidelines is to ultimately reduce harms to patients associated with opioid use.

These Oregon Opioid Tapering Guidelines are intended to lay out general principles for opioid tapering, potential indications for and approaches to tapering, reasons for referral, and important long-term supports. The guidelines stress the need to provide compassionate care, access to non-opioid therapies for chronic pain, as well as education and psycho-social supports for patients. [Note: these guidelines do not address opioid prescribing in the context of managing pain associated with cancer or for palliative or end-of-life situations.]

## Principles

- The overarching goals for opioid tapering are to improve patient safety and provide compassionate care.
- The process should be patient-centered, trauma-informed and anchored to pain science.
- The tapering guidelines are intended to encourage conversations between clinicians and patients; promote patient engagement and shared decision-making; support informed consent; and apply easily to different practice settings.
- Tapering plans should be clear, flexible, and include individualized, realistic goals.
- Health systems must support an integrated approach to the tapering process and ensure access to non-opioid and non-pharmacologic pain therapies, including broad multidisciplinary supports as needed.

## Definitions

Providers and patients should understand the following relevant definitions when approaching these guidelines:

**Tapering:** Collaborating with a patient to achieve a reduced opioid dosage or reducing dosage and discontinuing opioid therapy (CDC). Although discontinuing opioid therapy may be a desired goal, it may not be achievable for all patients.

**Opioid Tolerance:** Defined by either of the following:

1. Need for markedly increased amounts of opioids to achieve desired effect whether therapeutic or recreational;
2. Markedly diminished effect with continued use of the same amount of opioid. (DSM-5)

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**Opioid Withdrawal syndrome:** The DSM-V defines opioid withdrawal syndrome by Criteria A and B. Patients must have:

- A. Either of the following:
- a. Cessation of (or reduction in) opioid use that has been heavy and prolonged (several weeks or longer),
  - b. 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. (DSM-5)

**Opioid Withdrawal:** Defined by either of the following:

3. Characteristic opioid withdrawal syndrome;
4. Same (or closely related) substance is taken to relieve or avoid withdrawal symptoms. (DSM-5)

**Opioid Use Disorder (OUD):** 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 the definition of OUD for individuals taking opioids solely under appropriate medical supervision):

- Opioids are often taken in larger amounts or over a longer period than was intended.
- There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
- A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
- Craving, or a strong desire or urge to use opioids.
- Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
- Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
- Important social, occupational, or recreational activities are given up or reduced because of opioid use.
- Recurrent opioid use in situations in which it is physically hazardous.
- 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.
- The patient exhibits tolerance.
- The patient exhibits withdrawal.

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Severity of OUD is specified as: Mild (2-3 criteria), Moderate (4-5 criteria), or Severe (6 or more criteria). (DSM-5) Note: Opioid Dependence) is no longer a separate category from Opioid Use Disorder within the DSM-5.

**Patient Abandonment:** The legal definition of abandonment is “a medical professional’s discontinuation of an established provider-patient relationship before the patient’s necessary treatment has ended and without arranging for continuing treatment or care. It is a form of medical malpractice.” (Black’s Law Dictionary 10th Edition, 2015). This legal definition is more specific than a patient’s perception of abandonment by their health care provider.

## Recommendations

### I. Assessing the patient

*Content TBD*

### II. Determining when to taper opioids

Opioid tapering\* should be considered when:

- Opioids are no longer needed
- The patient experiences no reduction in pain, no improvement in function, or requests to discontinue opioid therapy
- The patient experiences unmanageable adverse effects (e.g., drowsiness, constipation, cognitive impairment, worsening pain despite increasing doses)
- The dosage indicates high risk of adverse events (e.g., doses of 50-90 MED and higher)
- The patient does not adhere to their treatment plan or exhibits unsafe behaviors (e.g., early refills, lost/stolen prescription, buying or borrowing opioids, failure to obtain or aberrant urine drug test)
- The patient’s history indicates an increased risk for substance use disorder (SUD) (e.g., SUD-related behaviors, age <30, family or personal history of SUD)
- The patient experiences an overdose event involving opioids
- The patient has medical risk factors that can increase risk of adverse outcomes including overdose (e.g., lung disease, sleep apnea, liver disease, renal disease, fall risk, medical frailty)
- Patient is taking other medications (e.g., benzodiazepines, other sedative-hypnotics, and poly-pharmacy) that increase risk of opioid overdose

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\* For both full and partial opioid agonists when they are used for the treatment of chronic pain

- The patient has mental health risk factors that can develop or worsen with opioid therapy (e.g., post-traumatic stress disorder [PTSD], depression, anxiety)

### III. Approaches to opioid tapering

#### Patient engagement and education

Discussions with patients about tapering may be challenging. This is especially true for patients who are anxious or fearful of withdrawal symptoms or of worsening pain. For a taper to be successful, it is important to educate the patient about what to expect during the taper, have realistic goals for the taper and a shared understanding of what constitutes success.

- Providers should explore the patient's concerns in a non-judgmental fashion and should utilize motivational interviewing techniques to explore patient goals. Providers should address common beliefs and learn the patient's perspectives.
- The patient and provider should set realistic expectations for the treatment plan, informed by a risk-benefit assessment and based in compassion.
- Providers should utilize both oral (ideally face-to-face) and written communication (i.e., a written taper plan).
- Providers should emphasize that tapering opioids is part of standard clinical practice. While the patient may feel that they are being abandoned, the provider should reassure the patient that they will continue to provide care throughout the process.
- Provide education about what to expect during the taper and the potential for opioid withdrawal. Let patients know that most people have improved function without worse pain after tapering opioids. Some patients even have improved pain after a taper, even though pain might briefly get worse at first [CDC].
- Reassure patients that withdrawal symptoms will be monitored for and addressed. Expectations should be set that treating withdrawal symptoms does not mean prescribing potentially harmful replacement medications.
- Provide patient education on safekeeping of opioids and other controlled substances.

#### Shared decision making

*Content TBD*

#### Tapering plan

If harms outweigh benefits of continued opioid therapy during patient assessment, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

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- Tapering should be approached as an agreement between provider and patient with the goal of improving the patient’s safety and quality of life. The patient and provider should determine whether the goal is a dose reduction or complete discontinuation of opioids
- Tapering plans should be individualized and should minimize symptoms of opioid withdrawal, while maximizing pain treatment with nonpharmacologic therapies and nonopioid medications (CDC), and should include possible referral to behavioral health or other specialists (OPG)
- For tapering to be most successful, it is important to have a plan (i.e., written taper plan) in place that is understood by both patient and their health care provider. It is important that the plan be flexible and re-evaluated on a routine basis.
- The rate of taper should be established based on individual factors and safety considerations. There is no evidence basis to recommend a particular taper rate or length.
- Example taper plans have been created by various health organizations but should always be approached with flexibility to meet individual patient needs and circumstances. *Note: Provide links to ~ 3 taper plans here.*
- Situations when more rapid tapering is indicated based on safety considerations may include but are not limited to: patients with a history of recent overdose, evidence of diversion, or those who are actively using heroin.
- It is important to coordinate with any other providers who have prescribed a controlled substance (e.g., opioids, benzodiazepines) to the patient to ensure that all prescribers are aware and supportive of the tapering plan.

### Managing opioid use disorder

Patients should be evaluated for opioid use disorder or other substance use disorders prior to initiating a taper. For patients meeting criteria for opioid use disorder, clinicians should offer or arrange for patients to receive evidence-based treatments for opioid use disorder such as buprenorphine or methadone maintenance therapy in combination with behavioral therapies. (CDC). Providers should care for their patients experiencing opioid use disorder with compassion and be aware of and address any stigma that their patients may face with this diagnosis.

### Handling complicated tapers

While some patients are able to taper their opioid medications with minimal or manageable symptoms, other patients experience more challenges during opioid tapering.

- Providers might want to consider prescribing buprenorphine (off-label) as part of tapering, which may be a safer or more effective method based on the risk/benefit calculation. *Note: this is an emerging area and likely requires that the provider obtain an “X-waiver” (ref) (as*

required for treatment of OUD) due to the complex regulatory landscape. In addition, there may be billing/reimbursement differences across payors with regards to the specific diagnosis codes used.

- *\*Still needed: reference to evidence that supports this off-label use of buprenorphine\**

### Addressing special populations

These taper guidelines do not address important considerations for all populations. There are special patient populations for whom opioid tapering may be more complex, including but not limited to: cancer patients, those receiving palliative or hospice care, pregnant women, and children. In addition, patients with another substance use disorder (SUD) and/or dual diagnoses of mental illness and SUD will have unique needs that must be considered individually.

## IV. Providing multidisciplinary supports to address cultural, social, spiritual and other patient needs

Multidisciplinary supports should be offered to patients throughout opioid tapering in alignment with the biopsychosocial model of addressing pain. Recommendations for ensuring that these supports are in place include:

- Address the importance of team-based care and approach chronic pain and opioid use disorders as chronic conditions using a trauma-informed approach.
- Include treatment approaches that focus on behavioral activation and behavioral therapy.
- Recognize that long-term, stable recovery depends on one’s social context: “treatment happens in the medical system; recovery happens in the community.”
- Offer patients with the opportunity to connect with peer-delivered services when available
- When desired by the patient, include social, cultural and spiritual supports or best practices as part of the treatment plan.

**Table 1. Cognitive Behavioral and Non-pharmacological Therapies for Chronic Pain**

<b>Cognitive</b>	Address distressing negative cognitions and beliefs, catastrophizing (pain coping characterized by excessively negative thoughts and statements about the future)
<b>Behavioral approaches</b>	Mindfulness, meditation, yoga, relaxation, biofeedback
<b>Physical</b>	Activity coaching, graded exercise
<b>Spiritual</b>	Identify existential distress, seek meaning and purpose in life
<b>Education (patient and caregivers):</b>	Promote patient efforts aimed at increased functional capabilities

Adapted from Argoff, 2009 & Tauben, 2015

*\*Still to consider: add additional language from SAMSHA regarding a recovery-oriented system of care*

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## V. Patient follow-up, monitoring and reassessment

The tapering plan should include frequent follow-up and assessment of progress, which may vary (i.e., daily, weekly or monthly) based on the rate of the taper. During follow-up and reassessment, providers should address or consider the following:

- Regularly assess patient function including pain intensity, sleep, physical activity, personal goals, and stress levels.
- Based on the patient's response to the taper, the provider should adjust the rate and duration of the taper. Do not reverse the taper; however, the rate may be slowed or paused while monitoring and managing withdrawal symptoms. Once the smallest dose is reached, the interval between doses can be extended and, if the goal is to taper off completely, opioids may be stopped when taken less than once a day. (CDC)
- The provider should remain alert to signs of anxiety, depression, and opioid use disorder that might be unmasked by an opioid taper and arrange for prompt management of these co-morbidities.
- Throughout reassessment, providers should assess for the need to shift to safer medications based on the ongoing risk/benefit reassessment.

## VI. Managing withdrawal

- Providers should regularly assess for withdrawal symptoms during an opioid taper.
- Withdrawal symptoms may be an indication that the taper is going too quickly; this is an opportunity to pause, rethink, and slow down.
- For individuals for whom a faster taper is indicated (i.e., diversion, use of illicit substance, recent overdose), active management of withdrawal symptoms should be provided including appropriate medications and multidisciplinary approaches (*\*consider reference/link to resource on withdrawal management here\**)
- Providers should not use benzodiazepines or other high-risk medications to treat withdrawal.

## VII. When to refer

## VIII. Long-term support and follow-up

## IX. Provider education

## X. Organizational supports

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## XI. Resources/ 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](#))
- April 9, 2019 FDA statement - new opioid analgesic labeling changes: <https://www.fda.gov/news-events/press-announcements/statement-douglashrockmorton-md-deputy-center-director-regulatory-programs-fdas-center-drug-0>
- No Shortcuts to Safer Opioid Prescribing by Dowell, Haegerich, Chou (New England Journal of Medicine, 2019): <https://www.nejm.org/doi/full/10.1056/NEJMp1904190>

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<sup>1</sup>. Oregon Health Authority. Oregon opioid prescribing guidelines: Recommendations for the safe use of opioid medications [cited 2018 Oct 8]. Available from: <https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SUBSTANCEUSE/OPIOIDS/Documents/taskforce/oregon-opioid-prescribing-guidelines.pdf>.

<sup>2</sup>. Dowell D, Haegerich TM, Chou R. CDC guideline for prescribing opioids for chronic pain — United States, 2016. MMWR Recomm Rep 2016; 65 (No. RR-1): 1–49 [cited 2018 Oct 8]. Available from: <https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6501e1.pdf>.