Oregon Opioid Taper Guidelines Task Force
Meeting Summary- July 19, 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, shared that we've scheduled a Task Force meeting for October 25, 2019 from 9:00 a.m. to noon which we will use if necessary. Dana acknowledged that we have Task Force members on vacation in July and August, but that we need to continue discussing guideline content. We'll make sure members have an opportunity to provide feedback via email and/or as we continue to review the draft guidelines.

Discussion Guide Section Review
Shared Decision Making
The Task Force agreed that shared decision making is fundamental and central to the guidelines. We want to include in the guidelines key principles underlying and supporting shared decision making: establishing trust; ensuring patient education; allowing pauses; allowing patients to direct the focus of tapering; and understanding and incorporating patient values and belief systems. We can use the OPG language as framing and include the bullet points above as principles.

The Task Force also discussed the importance of patient safety. We can make a statement about the importance of assessing whether there is an imminent threat to patient safety and determining what that means for shared decision making. If there is an imminent threat to patient safety, providers should convey their concern to the patient, ensure the patient understands the risks; and consider referral to a specialist (where available).

We should call out the exceptional cases where there are significant risks to patient safety that might limit the appropriateness of shared decision making: evidence that opioids are being diverted to other users; overdose; high-risk, poly-pharmacy use; known active illicit drug use; signs of sedation or intoxication during office visit; bowel obstruction or other emergent and significant side effect. Providers should rely on objective data in making an assessment of

patient safety, including PDMP check; urine drug screen; drug reconciliation; and patient history. Providers should consider risk-mitigating strategies in consultation with the patient.

Finally, we should be mindful of not repeating what is stated elsewhere in the guidelines, while also highlighting the importance of shared decision making (which is why it requires its own section).

Long-term support and follow up after taper

The Task Force discussed that long-term support should include the following:

- Continual assessment of pain (e.g. PEG);
- Ongoing assessment of withdrawal symptoms;
- Ongoing assessment and education on opioid use disorder/substance use disorder and discussing patient interest level in addiction treatment, if relevant;
- Discussion with the patient on functional goals;
- Mental health assessments;
- Alternative therapy consideration and discussion;
- Social supports discussion.
- Discuss potential risks associated with new opioid starts (i.e., if offered in the ED)

We should be mindful of where this section overlaps with discussion on patient assessment and evaluation.

When to Refer

The Task Force made a distinction between establishing a team-based model of care vs. referring to providers/specialists, outside the clinic. A provider may refer to another member of the internal, clinical team (when the need is outside the provider scope of practice) or a provider may refer to an outside entity/provider when the need is outside the clinic's scope of practice. We also discussed that a team approach is important to ensure the resources are available to facilitate a taper plan.

The following types of key resources could be provided within a team-based model of care or provided to the patient via a referral to an outside entity: behavioral health, peer support specialists, support groups, pain specialists and addiction medicine specialists.

Provider Education

The Task Force discussed a variety of resources for provider education. The provider education section should highlight the opportunity to convey to providers that opioid tapering is an opportunity to learn more about the patient and their values and to help them understand and manage their pain.

Areas for provider education we might include in the guidelines include:

- Definitions of patient centeredness; legal definition of abandonment
- Resources for patient centered approaches
- Opioid risks beyond overdose symptoms
    - Patient safety and not causing harm
- Pain
    - Central pain syndrome
    - Hyperalgesia
    - Oregon Pain Management Commission education modules
- Addiction medicine
    - Addictive risk of high dose opioids
- Why a taper may fail
- Types of medication
- Community resources (e.g. OPG, Project ECHO, OPAL-K, Synergy)
- Education tools for patients
    - Pain education models for patients
- Training for X Waiver
- Trauma-informed care

Patient Assessment

The Task Force agreed that patient assessment is not about running through a check list. Successful assessment requires a comprehensive understanding of the patient. We distinguished between the initial global assessment necessary when first considering tapering and the ongoing reassessment and evaluation of progress to ensure the efficacy of the current approach. One edit to the existing outline is to change the “4As” to the “5As” and add “Affect: mood, sleep” and move analgesia to the end of the list.

The Task Force thought the patient assessment outline was long and had concerns about how that would work for providers. We had general agreement on the areas to cover for patient assessment but continue to be challenged about what to include in the guideline so that it isn't very long. We discussed and will review the DIRE tool at the August meeting.

Taper Plan Examples

The Task Force had no objections to the examples reviewed. Examples can be referenced in the guideline, but we must explicitly state that each plan should be individualized.
The guidelines can state: 1) this is a rapidly evolving field; 2) on a population basis 10% taper per month can be a helpful guide; 3) every taper is individualized; and 4) examples provided are current as of the date of publication of the guideline.

Updated research

The Task Force discussed information provided by Drs. Shames and Coehlo about the population-level risk of high-dose opioids, focused on families and communities. The Task Force agreed to include a one-page attachment to the guideline for community-level interventions (e.g. safe storage, safe disposal, community education).

Draft Guideline Content Review

The Task Force reviewed the draft guideline. We agreed that it was important to highlight that the goal of the guidelines is for individualized patient care for opioid tapering that emphasizes both safety and quality of life. Additional edits to each section noted below:

Background

Move the language stating that the guidelines do not address cancer and end-of-life care to earlier in the document.

Existing Oregon Opioid Prescribing Guidelines

No edits.

Opioid Tapering Guideline Overview

Add language to note that not all patients on opioids need to be tapered.

Definitions

- Tapering definition: reword, including suggestions to either remove “achievable” from the last sentence or to remove last sentence altogether.. Discussion about whether we needed to define tapering since the entire guideline is about tapering.
- Include definition for trauma-informed care. Kim will work on updated language.
- Add definition language for opioid dependence and patient centeredness

Public comment

Seven public comments provided in person.
Twenty-six written public comments submitted prior to the meeting and shared with Task Force members.

Next steps and summary

The next three Task Force meetings have been confirmed:

- August 27 from 1 pm - 4 pm (new date)
- September 23 from 1 pm – 4 pm (unchanged)
- October 25 from 9 am to 12 pm (hold; depending on meeting progress)

Oregon Opioid Taper Guidelines Task Force: Talking Points
Draft – 8/19/19

The Oregon Opioid Taper Guidelines Task Force was convened to inform the development of guidelines to assist patients and providers when considering opioid tapering. The final guidelines will lay out principles for opioid tapering, potential indications for and approaches to tapering, reasons for referral, and long-term supports and more. The Task Force meetings are open to the public and public comment is welcome. The guidelines are expected to be completed in October 2019.

The Oregon Opioid Taper Guidelines Task Force was convened to build on the work of previous task forces that developed statewide opioid guidelines for acute pain, chronic pain, in dental settings, and for pregnant women. The final taper guidelines will support existing guidelines, which have been built on available evidence, other federal and state guidelines, expert opinion, and public comment.

The Task Force was assembled with experts and community members around the state who are developing a useful framework that promotes trusting dialogue, shared decision-making, competent care and patient safety.

The Task Force started their work by identifying key principles that will inform the guideline develop and future best practices. These principles include:

- Improve patient safety, reduce risks of harm and improve quality of life through compassionate care.
- Process should be patient-centered, trauma-informed and anchored to pain science.
- Promote patient engagement and shared decision-making
- Tapering plans should be clear, flexible, and include individualized, realistic goals.
- Support a team-based, integrated approach to the tapering process and ensure access to non-opioid and non-pharmacologic pain therapies, including broad multidisciplinary supports as needed.

1. Drug Alcohol Dependence. (2010) Risks for Opioid Abuse and Dependence Among Recipients of Chronic Opioid Therapy: results from the TROUP Study. (submitted by Paul Coehlo) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2967631/pdf/nihms-214364.pdf

2. The Journal of Pain. (2017) "I'm Not Gonna Pull the Rug out From Under You": Patient-Provider Communication About Opioid Tapering. (submitted by Laura Heesacker) https://www.jpain.org/article/S1526-5900(17)30631-4/fulltext

3. Pain Medicine Journal. (2016) Patients' Perspectives on Tapering of Chronic Opioid Therapy: A Qualitative Study. (submitted by Laura Heesacker) https://academic.oup.com/painmedicine/article/17/10/1838/2270351?searchresult=1

4. Substance Abuse. (2017) A chronic opioid therapy reduction policy in primary care. (submitted by Paul Coehlo) https://www.tandfonline.com/doi/full/10.1080/08897077.2015.1129526?scroll=top&needAccess=true

5. JAMA Intern Medicine. (2018) Patient-Centered Prescription Opioid Tapering in Community Outpatients with Chronic Pain. (submitted by Laura Heesacker) https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2672574

6. Pain Med. (2016) Patients' Perspectives on Tapering of Chronic Opioid Therapy: A Qualitative Study. (submitted by Paul Coehlo) https://academic.oup.com/painmedicine/article/17/10/1838/2270351

7. Journal Pain. (2017) Prescription Opioid Taper Support for Outpatients with Chronic Pain: A Randomized Controlled Trial. (submitted by Paul Coehlo) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5337146/

8. Eur J Pain. (2018) Tapering off long-term opioid therapy in chronic non-cancer pain patients: A randomized clinical trial. (submitted by Paul Coehlo) https://www.ncbi.nlm.nih.gov/pubmed/29754428

9. Medicaid Evidence-based Decisions Project. (2018) MED report: Tapering or Discontinuing Opioid Use Among Patients With Chronic Noncancer Pain: Update Report. https://www.oregon.gov/oha/HPA/DSI/QHOCMeetingDocuments/Opioid-Tapering-Update-Report-2019.pdf (submitted by OHA)

10. PEG-3: Pain Screening Tool and PEG Demonstration Video- https://www.oregonpainguidance.org/resources/difficult-conversations/ (submitted by Laura Heesacker - attached)

11. VA/DoD. Stratified Tool for Opioid Mitigation: STORM. (submitted by Meenakshi Dogra – attached)

12. VA/DoD. Pain Scale. (awaiting from Meenakshi Dogra)

13. Heal Safely media campaign (submitted by OHA)

14. Pain education toolkit for patients and providers; includes guidance on tapering medication (submitted by OHA)

15. Link to just the medication decrease handout for patients: https://www.oregonpainguidance.org/wp-content/uploads/2018/10/Tapering_DecreasingPainMedication_FINAL_EN.pdf?x91687 (submitted by OHA)

16. Specialty referral considerations for patients with OUD seeing MAT primary care providers. (submitted by David Labby)

17. Difficult Conversations video from OPG. (submitted by Laura Heesacker) https://www.oregonpainguidance.org/resources/difficult-conversations/

18. Opioid Safety and Risks (submitted by Jonathan Robbins - attached)

19. Summary of beliefs and perspective. (submitted by Laura Heesacker – below, source documents for summary-The Journal of Pain. (2017) "I'm Not Gonna Pull the Rug out From Under You": Patient-Provider Communication About Opioid Tapering and JAMA Intern Medicine. (2018) Patient-Centered Prescription Opioid Tapering in Community Outpatients with Chronic Pain.)

***BOLD items submitted since July 2019 meeting**

20. **JAMA Psychiatry. (2014) The changing face of heroin use in the United States: a retrospective analysis of the past 50 years. https://www.ncbi.nlm.nih.gov/pubmed/24871348 (submitted by Paul Coehlo)**

21. **JAMA Internal Medicine. (2019) Association of Opioid Overdose With Opioid Prescriptions to Family Members. https://www.ncbi.nlm.nih.gov/pubmed/31233088 (submitted by Paul Coehlo)**

22. **Washington. DIRE tool. http://www.agencymeddirectors.wa.gov/Files/AssessmentTools/11-DIRE_score.pdf**

23. **Oregon Pain Guidance Opioid Tapering Guidance and Tools: https://www.oregonpainguidance.org/guideline/tapering/ (submitted by OHA)**

24. **Oregon Pain Management Commission education module for providers: Changing the Conversation about Pain (submitted by OHA)**

25. **Oregon Morphine Equivalent Dose Calculator (submitted by OHA)**

26. **Oregon ECHO Network for addictions medicine, persistent pain (submitted by OHA)**

27. **AMA Opioid Task Force issues new recommendations (submitted by Safina Koerishi)**

28. **Whole Health Talking Points (submitted by Meenakshi Dogra)**

29. **Asante Physician Partners – Medication Assisted Treatment for Opioid Use Disorder Guideline(submitted by Safina Koerishi)**

30. **OHSU FM MAT Program Treatment Agreement (submitted by Safina Koerishi)**

31. **Blackburn SUDS Models of Care: All SUDS, All require Auth/MOTS (submitted by Safina Koerishi)**

32. **Boston Medical. (2016) Obat Policy And Procedure Manual (submitted by Safina Koerishi)**

33. **Central City Concern. (2019) Buprenorphine Outpatient Protocol (submitted by Safina Koerishi)**

34. **Clackamas Health Centers. (2019) Buprenorphine – Patient Agreement (submitted by Safina Koerishi)**

35. **Central City Concern. (2017) Opioid Prescribing and Persistent Pain Policy (submitted by Safina Koerishi)**

36. **Multnomah County. (2018) Guideline for Treatment of Chronic Non-Cancer Pain and Safe Opioid Therapy Prescribing (submitted by Safina Koerishi)**

37. **Central City Concern. OBOT Treatment Matrix (submitted by Safina Koerishi)**

38. **OHSU. MAT Treatment Program Agreement (submitted by Safina Koerishi)**

39. **Rogue Community Health. Naloxone Pharmacy prescribing/education workflow (submitted by Safina Koerishi)**

40. **VA/DoD. Personal Health Inventory (submitted by Meenakshi Dogra)**

41. **Specialty referral considerations for patients with OUD seeing MAT primary care providers. (submitted by David Labby)**

Summary beliefs and perspectives on opioid tapering from people on chronic opioid prescriptions

1. Don't believe they are at risk of overdose
2. Don't believe in non-opioid Rx options
3. Highly fearful of their pain and the pain of withdrawal
4. Need to understand individualized reasons for tapering
5. Need to have some input in the tapering agenda (e.g. rate, etc.)
6. Need to believe they won't be abandoned throughout the tapering process
7. Have a strong belief in a trusted healthcare provider, family and friends

Working Draft: Oregon Opioid Tapering Guidelines

Draft: August 19, 2019

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 misuse, 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. Over-prescribing of opioid medications not only has an adverse impact on the patients themselves, but on household members and the larger community through potential diversion and misuse.

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. [Note: The Opioid Initiative is NOT intended to address opioid prescribing in the context of managing cancer pain or for palliative or end-of-life situations.]

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[1] based on the *CDC Guideline for Prescribing Opioids for Chronic Pain*.[2] 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 prioritize both patient safety and the need for compassionate care.

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.

It is important to note that not all patients on opioids need to be tapered, such as those that experience minimal side effects and remain on a stable dose while experiencing good pain control and quality of life. Overall, providers should avoid inappropriate treatment of pain. As noted by the Washington Medical Commission, this includes "non-treatment, under-treatment, over-treatment, and the continued use of ineffective treatments" (2018).

Principles

- The overarching goals for opioid tapering are to improve patient safety, to maintain or improve functional status, and to improve quality of life through provision of 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 a team-based, 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 dose or to discontinue opioid therapy using an individualized approach.

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)

Opioid Dependence: NIDA describes the development of dependence when the neurons adapt to the repeated drug exposure and only function normally in the presence of the drug. When the drug is withdrawn, several physiologic reactions occur (https://www.drugabuse.gov/publications/teaching-packets/neurobiology-drug-addiction/section-iii-action-heroin-morphine/8-definition-dependence).

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

1. 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;
2. 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:

1. Characteristic opioid withdrawal syndrome;
2. 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.

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-centered Care: The Institute of Medicine defines patient-centered care as "providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions."

Trauma Informed Care: Trauma is common in society, and trauma informed care recognizes the widespread impact of trauma. Although there is no universal definition, trauma informed care requires an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma. Trauma informed care emphasizes physical, psychological, and emotional safety for both patients and providers, and helps survivors rebuild a sense of control and empowerment (https://traumainformedoregon.org/wp-content/.../What-is-Trauma-Informed-Care.pdf www.traumainformedcareproject.org).

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**(*After reviewing other changes, 8/27 discussion will begin here)*

I. Assessing the patient

A comprehensive evaluation, including an assessment of pain, function and adverse consequences, is recommended for every patient to determine if they are appropriate for either tapering or continuation of their long-term opioid therapy. As with chronic pain management, a multidisciplinary, team-based approach to assessment is recommended when available. The comprehensive assessment can occur in one visit or sequential visits and should be determined by the urgency and complexity of the patient's needs. Finally, ongoing reassessment and evaluation of progress are critical to ensure the efficacy of the chosen approach.

The patient assessment should use a combination of tools to assess and document the efficacy of current chronic opioid therapy including the "5 A's": activities, adverse effects, aberrancy, affect and analgesia. In addition, the assessment should include a complete biopsychosocial assessment, physical exam, and an assessment of risks versus benefits. Appendix X includes a description of the "5 A's" plus a list of essential comprehensive assessment components.

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 or reduce 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) (*Query: should we say "patient meets criteria for substance use disorder"?)
- 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

* May be applicable to partial opioid agonists in addition to full agonists when used for the treatment of chronic pain.

- The patient's mental health condition (e.g., post-traumatic stress disorder [PTSD], depression, anxiety) develops or worsens with opioid therapy

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

Shared decision making between the provider and patient is fundamental to achieving the goals of opioid tapering and improving patient safety. 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. Key principles that underlie and support shared decision making include: establishing trust; allowing pauses in tapering; allowing patients to direct the focus of tapering; and understanding and incorporating patient values and belief systems.

While shared decision making is important for a successful taper, providers must also determine whether there is an imminent threat to patient safety that may necessitate tapering opioids to safer levels. If the provider determines that an imminent threat to patient safety exists, providers should convey their concern to the patient, ensure the patient understands the risks; and consider referral to a specialist (where available).

Examples of exceptional cases where there are significant risks to patient safety that might limit the appropriateness of shared decision making include: evidence that opioids are being diverted to other users; history of overdose; poly-pharmacy involvement; known active illicit drug use; signs of sedation or intoxication during office visit; bowel obstruction or other emergent and significant side effects. Providers should rely on objective data assessing patient safety, including checking the Prescription Drug Monitoring Program; urine drug screen; drug reconciliation; and patient history. Providers should consider risk-mitigating strategies in consultation with the patient.

Tapering plan

While there are general approaches to tapering, each plan should be individualized based on the patient's history and objective assessment.

Moreover, providers should be aware that: 1) this is a rapidly evolving field; 2) on a population basis, 10% taper per month can be a helpful guide; 3) every taper plan should be individualized; and 4) examples provided are current as of the date of publication of the guideline.

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.

- 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)
- Team-based care should be utilized when available to facilitate tapering, and referral to behavioral health or other specialists should be considered as needed
- 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 prescribing information on 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

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

Adapted from Argoff, 2009 & Tauben, 2015

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 and patient response. 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 and consider the following:

- 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 may need to take precedent instead of slowing the taper rate; in this situation, prioritize appropriate medications to address withdrawal symptoms as well as multidisciplinary approaches

- Providers should not use benzodiazepines or other high-risk medications to treat withdrawal.
- **Consider reference/link to resource on withdrawal management here**

VII. When to refer

To facilitate a taper plan, providers may consider referring patients to other providers with expertise in specific areas. In a team-based model of care, a provider may refer to another member of the team (when the need is outside the provider scope of practice), such as a pharmacists or social worker to facilitate the taper plan.

When the need is outside the clinic's scope of practice i.e., patients with significant mental illness, challenging tapers, or critical social needs, a provider may want to consider referring to an outside entity/provider. Such specialist referral could include referrals to: addiction medicine, behavioral health, peer support, support groups, and/or pain specialists.

VIII. Long-term support and follow-up

For tapers to be successful over the long run, long-term support should include the following:

- Continual assessment of pain (e.g. PEG) and function;
- Ongoing assessment of withdrawal symptoms;
- Ongoing assessment and education on opioid use disorder/substance use disorder and discussing patient interest level in addiction treatment, if relevant;
- Discussion with the patient regarding their functional goals;
- Mental health assessments;
- Alternative therapy consideration and discussion;
- Social supports that patient has or needs over the long run to be successful meeting their goals.

IX. Patient and Provider Resources

Opioid tapering offers the opportunity for providers to learn more about the patient and their values and to help them understand and manage their pain.

*Potential areas for provider education (*refer also to discussion on resources submitted by Task Force members)*

- *Resources for patient centered approaches*
- *Opioid risks*
- *Pain Science*
    - *Central pain syndrome*
    - *Hyperalgesia*
    - *Oregon Pain Management Commission education modules*
- *Addiction medicine*

    - *Addictive risk of high dose opioids*
- *Community resources (e.g. OPG, Project ECHO, OPAL-K, Synergy)*
- *Education tools for patients*
    - *Pain education models for patients*
- *Training for X Waiver*
- Trauma-informed care

Potential resources for patient education

CDC Helpful Materials for Patients – Resources for chronic and acute pain. PDF downloads from the CDC on multiple topics around opioids and pain. Based on the CDC Rx Awareness Campaign. https://www.cdc.gov/drugoverdose/patients/materials.html

VA Veteran / Patient Education – Links to VA and other Gov resources (FDA, SAMHSA, etc.) on opioids, pain and its treatment. Updated regularly and available in multiple languages. https://www.va.gov/PAINMANAGEMENT/Opioid_Safety/Patient_Education.asp

NIH National Institute on Drug Abuse – Prescription Opioids Drug Facts for Adults – Revised June 2019. Provides a range of patient facing information and is available as a downloadable PDF. Also available in Spanish. https://www.drugabuse.gov/publications/drugfacts/prescription-opioids

From NIH - NIDA for Teens: https://www.drugabuse.gov/publications/opioid-facts-teens/letter-to-teens

American Society of Regional Anesthesia and Pain Medicine website: Safe opioid storage, tapering, and disposal. This web page includes patient facing information that includes tapering recommendations from various organizations (CDC, VA, Mayo Clinic), what your physician may do during the taper, and a few tips to minimize withdrawal symptoms. https://www.asra.com/page/2725/safe-opioid-storage-tapering-and-disposal

American Chronic Pain Association – Pain Management Tools. "Living with a chronic condition requires changing the way you think about your health care and your life. The ACPA describes this as moving from patient to person." The information on this website helps pts begin to regain control of your life and become an active participate in their treatment team. ACPA also provides a resource list for peer to peer programs by state. https://www.theacpa.org/pain-management-tools/

Swedish Medical Center - STOMP Pain Management Guide: The Swedish STOMP (Structuring Your Own Management of Pain) program is intended to be a resource for individuals facing the limitations of the medical system in dealing with complex chronic pain needs. https://www.swedish.org/services/pain-services/pain-management-guide

X. Organizational supports

From existing Oregon Opioid guidelines

Health care systems/clinic responsibilities

- Endorse the Oregon guidelines for opioid prescribing, including guidelines for tapering and for chronic and acute pain.
- Adopt these guidelines and implement them as the standard of care across practice settings.
- Monitor the results of guidelines implementation, reviewing overall opioid prescribing by health system and practice setting.
- Perform quality review of guideline implementation; identify best-practices for clinical settings and implement across the health system.

XI. Community-level interventions

Outside the medical practice setting, patients live in community environments that can be supportive or can hinder their success at tapering. In addition, inappropriate prescribing, storage and/or disposal of opioids can impose risks to the community, such as increasing rates of opioid misuse, opioid use disorder, and overdose. Community-level interventions aimed at improving community safety and ensuring patient support for opioid tapers include: safe handling, storage, and disposal of unused medications; community education, and beyond. See Appendix X for examples of important community-level resources.

XII. 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-douglasthrockmorton-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*

Appendix *X*. Patient Assessment:

It is important to perform an initial patient assessment using a combination of tools. Critical components of a global assessment should include, but may not be limited to:

Assess and document efficacy of current chronic opioid therapy using the 5 A's

- ***Activities***: this includes activities of daily living and functional activities
- ***Adverse effects***: this represents side effects from medications including but not limited to: sedation, respiratory depression, constipation
- ***Aberrance***: this must be assessed and documented in a consistent manner
- ***Affect***: this assesses the impact of opioid therapy on mood and sleep
- ***Analgesia***: this refers to effectiveness of pain control

Complete a biopsychosocial assessment (including clinical interview and patient self-report)

- Patient-centered interview and exploration of goals, questions, concerns, beliefs, expectations, and fears related to opioid therapy and tapers
- History of pain and duration of symptoms, including: onset, location(s), radiation, previous episodes, and intensity
- Patient perception of symptoms; example tools to document patient reported symptoms 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), and the effect on pain
- Patient general medical history, including but not limited to: physical comorbidities (e.g., sleep apnea, diabetes); chronic pain related treatments and outcomes (surgery and procedures; pharmacology; non-pharmacological treatments (e.g., physical therapy)
- Patient substance use/mental health history, including but not limited to: mood disorders, suicidality/prior suicide attempts; history of self-injurious behavior; history of medications for psychiatric conditions and outcomes; trauma history; psychosis; ADHD; substance use history, including tobacco, and associated prescription medication use; cannabis use disorder (using standardized screening measures e.g. the CUDIT-R); history of overdose
- Lifestyle/behavioral history, including but not limited to: exercise, nutrition, leisure time, time in nature, sleep hygiene practices
- Social history, including: social support, family factors e.g., family solicitousness (unintentional reinforcement of illness behaviors) versus positive support (reinforcement of wellness behaviors); employment or disability status; living conditions; social-economic status and finances; legal issues
- Family history, including but not limited to: history of chronic pain conditions, psychological/psychiatric history, history of substance use disorders, or history of suicide

Physical exam

- A thorough physical exam should be completed, with particular attention to areas of chronic pain, in addition to neurologic and psychiatric system examination
- Can include diagnostic studies as appropriate
- Consider consultation as needed

Risk Assessment

The following tools can help assess the risk of opioid use among patients:

- Urine drug screen
- Prescription Drug Monitoring Program
- Self-reported Measures, including:
    - Opioid Risk Tool (ORT)
    - Screener & Opioid Assessment for Patients with Pain- Revised (SOAPP-R)

Appendix *X*. Community-based interventions

The following resources are important to enhance patient supports for tapering and/or to limit community-level risks related to opioid prescribing and use. Some overlap with patient resources. Organization TBD

Empower consumers to make safe choices

- Oregon *Heal Safety* education campaign for patients: https://healsafely.org/
- Oregon pain education toolkit for patients (includes clinician guide): https://www.oregonpainguidance.org/resources/patient-education-toolkit/
- *Changing the conversation about pain*: Oregon Pain Management Commission pain education module for health care providers: https://www.oregon.gov/oha/HPA/dsi-pmc/Pages/module.aspx
- Oregon chronic pain self-management programs: https://www.oregon.gov/oha/PH/PreventionWellness/SelfManagement/Pages/index.aspx
- How to manage your pain safely and effectively (CDC): https://www.cdc.gov/drugoverdose/patients/index.html

Ensure coverage for non-opioid pain treatment

- Oregon Health Plan Guideline Note 56: Non-interventional treatments for conditions of the back and spine
- Oregon Health Leadership Council Evidence Based Best Practices Work Group developing recommended opioid practices for insurers and health plans

Partnerships with public safety and emergency responders

- OHA EMS and Trauma Systems training on lifesaving treatment protocols: naloxone
- Oregon specialty courts for nonviolent individuals with substance use or mental health issues underlying their criminal behavior

Safe Drug storage, and disposal for unused medications

- OHA Safe Disposal of Medications in Oregon

Naloxone availability

- Board of Pharmacy: Oregon pharmacists prescribing of naloxone
- OHA Public Health naloxone rescue for overdose website
- Naloxone toolkit for Oregon pharmacists
- Map of Oregon pharmacies distributing naloxone

- OSU College of Pharmacy naloxone training for pharmacists
- Oregon's Good Samaritan law protects you from being arrested or prosecuted for drug-related charges or parole/probation violations based on information provided to emergency responders.

Peer recovery supports

- Oregon peer delivered services for behavioral health conditions
- Oregon directory of peer support specialist programs
- House Bill 4143 funds peer support mentors for people experiencing overdose on hospital campuses

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[1]. 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.

[2]. 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.

DIRE Score: Patient Selection for Chronic Opioid Analgesia

For each factor, rate the patient's score from 1-3 based on the explanations in the right-hand column

SCORE	FACTOR	EXPLANATION
	DIAGNOSIS	1 = Benign chronic condition with minimal objective findings or no definite medical diagnosis. Examples: fibromyalgia, migraine headaches, non-specific back pain. 2 = Slowly progressive condition concordant with moderate pain, or fixed condition with moderate objective findings. Examples: failed back surgery syndrome, back pain with moderate degenerative changes, neuropathic pain. 3 = Advanced condition concordant with severe pain with objective findings. Examples: severe ischemic vascular disease, advanced neuropathy, severe spinal stenosis.
	INTRACTABILITY	1 = Few therapies have been tried and the patient takes a passive role in his/her pain management process. 2 = Most customary treatments have been tried but the patient is not fully engaged in the pain management process, or barriers prevent (insurance, transportation, medical illness). 3 = Patient fully engaged in a spectrum of appropriate treatments but with inadequate response.
	RISK	(**R** = Total of **P+C+R+S** below)
	Psychological	1 = Serious personality dysfunction or mental illness interfering with care. Example: personality disorder, severe affective disorder, significant personality issues. 2 = Personality or mental health interferes moderately. Example: depression or anxiety disorder. 3 = Good communication with clinic. No significant personality dysfunction or mental illness.
	Chemical Health	1 = Active or very recent use of illicit drugs, excessive alcohol, or prescription drug abuse. 2 = Chemical coper (uses medications to cope with stress) or history of chemical dependence (CD) in remission. 3 = No CD history. Not drug-focused or chemically reliant.
	Reliability	1 = History of numerous problems: medication misuse, missed appointments, rarely follows through. 2 = Occasional difficulties with compliance, but generally reliable. 3 = Highly reliable patient with meds, appointments & treatment.
	Social Support	1 = Life in chaos. Little family support and few close relationships. Loss of most normal life roles. 2 = Reduction in some relationships and life roles. 3 = Supportive family/close relationships. Involved in work or school and no social isolation.
	EFFICACY SCORE	1 = Poor function or minimal pain relief despite moderate to high doses. 2 = Moderate benefit with function improved in a number of ways (or insufficient info – hasn't tried opioid yet or very low doses or too short of a trial). 3 = Good improvement in pain and function and quality of life with stable doses over time.

_____ **Total score = D + I + R + E**

Score 7-13: Not a suitable candidate for long-term opioid analgesia

Score 14-21: May be a good candidate for long-term opioid analgesia

NOTES

A DIRE Score of ≤13 indicates that the patient may not be suited to long-term opioid pain management.

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