

Oregon Health Authority
Oregon Opioid Taper Guidelines Task Force
AGENDA



Oregon Opioid Taper Guidelines Task Force

September 23, 2019

1:00-4:00

Portland State Office Building

800 NE Oregon, Room 1A

Conference Line: 1-888-278-0296

Public Meeting ID: 843163

Goals

- Review and continue discussion of guidelines

Agenda

- **Welcome, goals, agenda review, introductions** - Dana Hargunani, Chief Medical Officer, Oregon Health Authority; Diana Bianco, Principal, Artemis Consulting
- **Updates** – Dana
- **Working draft guideline review**
 - Section by section review
 - Is the input of the Task Force accurately captured?
 - Is anything major missing?
- **Public comment** (approx. 3:45)
 - Final meeting: October 25th, 9:00-12:00
- **Next steps and summary**
 - Final meeting: October 25th, 9:00-12:00

Oregon Health Authority

Oregon Opioid Taper Guidelines Task Force

MEETING NOTES



Oregon Opioid Taper Guidelines Task Force

Meeting Summary- August 27, 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, reported on a meeting she had with chronic pain stakeholders and advocates who shared concerns about some of the content of the draft guidelines. They raised the following issues: the guidelines shouldn't indicate or imply that everyone should be tapered; the importance of good pain management should be highlighted along with tapering; we should be thoughtful about how we address mental health issues in the guidelines; and we should be mindful of how the guidelines may impact stigma. Dana noted that we would consider these issues as we review the draft guidelines.

Roger Chou, Task Force member, provided an overview of an article he co-authored that was just published in the Annals of Internal Medicine entitled, “Rethinking Opioid Dose Tapering, Prescription Opioid Dependence, and Indications for Buprenorphine.”

Task Force communication

Several Task Force members had asked for talking points about the background and purpose of the Task Force and OHA drafted a document that was distributed to members for consideration. Members of the group expressed that the Task Force is focused on collaborative pain management and some wondered if we should eliminate the word “taper” from the name of the Task Force. We decided not to change the name of the Task Force, given that we are focused on tapering and we are many months into the process. Members noted the importance of reframing the work and underscoring that not everyone needs to be tapered. The guidelines are focused on patient safety and are meant to ensure that tapering is done in a person-centered and safe manner. This frame should be clearly reflected in the guidelines.

Resource list interval updates

OHA shared the updated resource list. This set of resources submitted by Task Force members is not meant to be included in the guidelines (that's a separate list), but is meant to inform our work. We discussed the DIRE tool and learned it wasn't validated (only looked at in one study in 2006). We also talked about the opiate conversion chart from Kaiser Permanente; some members thought we shouldn't include it in these guidelines because that would represent a switch from what Oregon has used in previous opioid guidelines.

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Working draft guideline review

Introduction, Background, Principles

The Task Force wants an introductory paragraph based on the highlighted language on page 13 that emphasizes the importance of patient-centered care and that states that not all patients need to be tapered. Additionally, the Task Force would like the principles re-ordered to reflect the importance of individualized care and patient-centered pain management. We discussed, but did not decide whether we should change the title of the guidelines and not use the word “taper.”

Definitions

The Task Force reviewed the updates to the definitions section. We changed the term “opioid dependence” to “physiologic opioid dependence.” The Task Force also suggested updating the trauma-informed care definition to underscore that trauma and SUD are interconnected. Task Force members also suggested removing the words “providing care” from the definition of patient-centered care.

Determining when to taper

The Task Force recommended suggested changing the language from “opioid tapering should be considered” to “opioid tapering may be considered.” The Task Force discussed how to balance content, length and audience in this section. We don’t want the section to be determinative of when people should be tapered, but want providers to consider certain factors. At the same time, the document should provide sufficient guidance. We also considered listing the “most concerning” factors at the top. After some discussion, Eve Klein volunteered to revise this section for the Task Force to review at our September meeting.

Specific changes to this section that were agreed upon by the Task Force include:

- Change the language pertaining to polypharmacy to “patients taking medications that include but not limited to: those that produce risk of drug-drug interactions or increase risk of overdose, such as but not limiting to sedating medications.” The group also suggested adding language so that providers are mindful of both renal and hepatic function, which impacts the drug-drug interaction and risk profile.
- For the language pertaining to mental health, the group suggested revised language as follows: “the patient develops suicidality or worsening mood.”

Patient Engagement and Education

The Task Force reviewed the patient education and provider education sections. We will combine these sections as well as the engagement section. We will continue to include framing language that focuses on patient care throughout the taper process. OHA will review the content in these sections, crosswalk with current OHA Opioid website resources, and propose a new combined section at the September meeting.

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Tapering Plan

The Task Force agreed to update the tapering plan sections with framing that emphasizes patient safety and patient centeredness. The Task Force also discussed whether to include a reference to a taper rate, noting that the focus should be on individualization. We agreed that a starting point for reference may be useful. We decided to include 2.5-10% as a potential rate of taper per month, while noting that individualization is paramount. Task Force members noted that some individuals at higher doses may tolerate faster tapers, while slower tapering may be necessary at the end of a taper.

Handling Complicated Tapers

Section content reviewed by the Task Force with no recommended edits. We will move this section above the “managing opioid use disorder” section.

Managing Opioid Use Disorder

The Task Force reviewed this section and requested adding information about how to apply for an X waiver.

Addressing Special Populations

The Task Force didn't have edits for this section.

Multidisciplinary Support

The Task Force recommended adding acupuncture to this section.

Patient Follow up and Monitoring

The Task Force recommended that this section immediately follow the “taper plan” and “managing withdrawal” sections.

Managing Withdrawal

The Task Force did not have edits to this section, but suggested it be moved before “patient follow up” section.

When to Refer

The Task Force did not have edits to this section.

Long-term Support

The Task Force wanted to highlight that this section is relevant after completion of a safe and effective taper.

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Patient and Provider Resources

Task Force members agreed to combine the patient and provider resources sections. OHA staff will review patient and provider resources on the OHA opioid page, align content with the working draft, and bring back to the Task Force for review.

Organizational Support

The Task Force affirmed the importance of this section. Dr. Koreshi will provide ideas for content and we will discuss at the September meeting.

Community-level Interventions

The Task Force reviewed this section and agreed that the community-based interventions should be combined with the information listed in the “patient and provider resources” section.

Public comment

Two individuals provided in-person public comment. In addition, we received three written public comments prior to the meeting and shared those with Task Force members. We also received written public comment after the deadline for this meeting. These comments will be collated and shared with Task Force members prior to the next meeting.

Next steps and summary

The final two Task Force meetings are:

- September 23, 1:00-4:00
- October 25, 9:00-12:00

Oregon Opioid Tapering Guidelines

Working Draft: September 16, 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 overdose and death, attributed largely to increased opioid prescribing to treat chronic pain. While the rate of prescription opioid overdose deaths has been declining since 2006, the rate is still three times higher than in 1999. Over-prescribing of opioid medications not only adversely impacts patients, but their families, household members and the larger community through potential diversion and misuse.

Existing Oregon opioid prescribing guidelines

In order to improve patient safety, disseminate best practices, and address the need for compassionate care, the Oregon Health Authority convened experts from across the state to develop clinical guidelines for opioid prescribing. In 2016, Oregon's Opioid Prescribing Guidelines Task Force approved adoption of Oregon-specific opioid prescribing guidelines¹ based on the [CDC Guideline for Prescribing Opioids for Chronic Pain](#).² Through similar collaborations, Oregon developed guidelines to address opioid prescribing for acute pain; in dental settings; and to assist clinicians in addressing opioid use in pregnant women ([refs](#)). The Oregon Opioid Tapering Guidelines are intended to complement these previously established guidelines.

Opioid tapering guideline overview

The goal of these guidelines is to reduce harms to patients associated with opioid use and promote patient-centered care. It is important to note that ***not all patients on opioids need to be tapered***. For example, a patient on a stable opioid dose with minimal side effects who is experiencing good pain control and quality of life may not require tapering.

The Oregon Opioid Tapering Guidelines lay out general principles and best practices 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 patient-centered and trauma-informed care, as well as collaborative pain management. In addition, these guidelines emphasize the importance of avoiding inappropriate treatment of chronic 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

Principles that underlie these guidelines include:

- Pain management, with or without opioids, should be patient-centered, trauma-informed and based on current pain science.
- 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 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 individualized, clear, flexible, and include 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.

Patient-centered Care: Patient-centered care consists of a collaborative therapeutic relationship between provider and patient that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide clinical decisions.

Trauma Informed Care: Trauma is common in society as well as among individuals with substance use disorder. Trauma informed care recognizes the widespread and potentially negative health impact of trauma. 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.

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)

Physiologic Opioid Dependence: Dependence on opioids can occur when patient physiology adapts to repeated drug exposure and only functions normally in the presence of the opioid. When the drug is withdrawn, several physiologic reactions occur that can produce both physical and psychological symptoms.

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

- A. Either of the following: cessation of (or reduction in) opioid use that has been heavy and prolonged (several weeks or longer), or administration of an opioid antagonist after a period of opioid use, in addition to:
- 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:

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. Many patients who experience OUD have a history of adverse childhood experiences, or traumatic stress during their lifetimes.

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 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.

Guideline Recommendations

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 such as the “**5 As**”: 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 As” plus a list of essential comprehensive assessment components.

II. Determining when to taper opioids

As illustrated below, a variety of circumstances should prompt consideration for opioid tapering. However, the decision whether to proceed with opioid tapering should be determined on an individualized basis through shared decision making between the patient and provider in consideration of the balance between risks and benefits of opioid therapy. Circumstances when

opioid tapering¹ should be considered include:

- The underlying condition for which opioids were prescribed (e.g., injury, surgical pain) has resolved and opioids are no longer indicated.
- 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).

Tapering should also be considered when factors exist that may increase the risk of an adverse event, such as:

- The patient is on a daily opioid dose of 50-90 MED or 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 has experienced a previous overdose event involving opioids.
- The patient's history indicates an increased risk for substance use disorder (SUD) (e.g., past diagnosis of SUD, SUD-related behaviors, family history of SUD).
- The patient develops suicidality or worsening mood associated with opioid therapy.
- 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).
- The patient is taking other medications that increase the risk of drug-drug interactions or the risk of overdose, such as benzodiazepines or other sedating medications (e.g., Benadryl, Gabapentin). Prescribers should be mindful of an individual patient's hepatic and renal function that may impact drug metabolism.

III. Approaches to opioid tapering

Shared decision making

Shared decision making between the provider and patient is fundamental when considering opioid tapering. Clinicians must approach the decision to taper as an alliance with the patient focused on the goal of improving 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 critical, providers also must determine whether there is an imminent threat to patient safety that may necessitate tapering opioids to safer levels. If the

¹ May be applicable to partial opioid agonists in addition to full agonists when used for the treatment of chronic pain.

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 as needed and 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; 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 screens; drug reconciliation; and patient history. Providers should consider risk-mitigating strategies in consultation with the patient.

Patient and provider engagement and education

Discussions about tapering can be difficult for both patients and providers. This is especially true when patients are anxious or fearful of withdrawal symptoms or worsening pain, or when providers have had limited experience with opioid tapering. For a taper to be successful, it is important to acknowledge and validate these experiences, to seek additional resources when needed, and to develop a shared understanding of what constitutes success. Best practices for provider and patient engagement include:

- Explore patient concerns in a non-judgmental fashion.
- Address common beliefs and learn about the patient's perspectives.
- Utilize motivational interviewing techniques to determine patient goals.
- Set patient-centered and realistic expectations for the treatment plan together, informed by a thorough assessment of the patient's individual risks and benefits related to opioid therapy.
- Reassure the patient that they will receive continuity of care throughout the tapering process.
- Inform patients about what to expect during the taper and the potential for opioid withdrawal. Reassure patients that withdrawal symptoms will be monitored for and addressed.
- Educate patients on safekeeping of opioids and other controlled substances.

Tapering plan

Shared decision making between the provider and patient is fundamental to achieving the goals of improved patient safety and quality of life. When the harms of continued opioid therapy outweigh the benefits, the taper plan should be approached as an alliance between the provider and patient to ensure its success. While there are general approaches to tapering, providers should be aware that this is a rapidly evolving field.

It is essential that each taper plan is individualized based on the patient's history and objective assessment. On a population basis, a range of 2.5% to 10% taper per month can be a helpful guide. However, patients on higher doses of opioids may tolerate a more rapid taper, while those on a lower dose may need a slower taper. The most common cause of failed tapers is attempting to taper too rapidly.

The following principles should be applied during opioid tapering:

- The patient and provider should determine whether the goal is a dose reduction or complete discontinuation of opioids.
- Tapering plans 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.
- A written taper plan should be established that is clearly understood. The plan should 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.
- Situations when more rapid tapering is indicated based on safety concerns may include but are not limited to: patients with a history of recent overdose, evidence of diversion, or those who are actively using illicit drugs i.e., heroin.
- It is important to coordinate taper plans with any other providers who have prescribed a controlled substance (e.g., opioids, benzodiazepines) to the patient to ensure that all are aware and supportive of the plan.

Example taper plans have been created by various health organizations but should always be approached with flexibility to meet individual patient needs and circumstances. Links to example taper plans have been provided as part of these guidelines (see Appendix X), although it is the responsibility of the provider to ensure they are up to date and tailored to each individual patient's needs.

Multidisciplinary supports

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:

- Approach chronic pain and opioid use disorders as chronic conditions using a trauma-informed approach.
- Optimize the use of team-based care.
- 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 referral to 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 conditions and beliefs, catastrophizing (pain coping characterized by excessively negative thoughts and statements about the future)
Behavioral approaches	Mindfulness, meditation, yoga, relaxation, biofeedback
Physical	Acupuncture, 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

Patient 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. (ref 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.

IV. Managing withdrawal and complicated tapers

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 (e.g., 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 incorporate multidisciplinary approaches.
- Providers should not use benzodiazepines or other high-risk medications to treat withdrawal.

Handling complicated tapers

While some patients experience minimal or manageable symptoms during opioid tapering, other patients experience more difficulty. This may indicate that the taper needs to be slowed down.

Providers might want to consider prescribing **buprenorphine** (off-label) as part of tapering, which may be a safer or more effective method compared to full opioid agonists, based on the risk/benefit calculation.

- This is an emerging area and likely requires that the provider obtain a practitioner or “X” waiver (as required for treatment of OUD) due to the complex regulatory landscape. Visit <https://www.samhsa.gov/medication-assisted-treatment/training-materials-resources/apply-for-practitioner-waiver> for more information.
- Complete prescribing information for buprenorphine containing products can be found here: <https://www.btodrems.com/SitePages/MedicationGuides.aspx>
- There may be billing/reimbursement differences across payors with regards to the specific diagnosis codes used in association with buprenorphine.

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.

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. Patients in these populations may require consultation or referral to a clinician with specific expertise in medication tapering.

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 pharmacist 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 referrals might include addiction medicine, behavioral health, peer support, support groups, and/or pain specialists.

V. Long-term support and follow up

After completion of a safe and effective taper, a longitudinal care plan should be developed. Long-term support beyond the tapering period for individuals with chronic pain should include the following:

- Continual assessment of pain, function and functional goals (i.e., using the PEG scale).
- Mental health assessments.
- Assessment of need for additional therapy or social supports.
- Ongoing assessment and education on opioid use disorder/substance use disorder and discussing patient interest level in addiction treatment, if relevant.

VI. Organizational supports

Health systems and payers share responsibility for ensuring the success of opioid tapering. These organizational responsibilities include but are not limited to:

- Actively endorse the Oregon Opioid Tapering Guidelines.
- Provide expert consultation to assist with guideline implementation as the standard of care across practice settings.
- Assist in the development of team-based care, including providers of behavioral health, integrative health, peer delivered services and beyond, and ensure referral resources as needed.
- Sponsor provider/practice training in patient-centered and trauma informed care.
- Adopt electronic medical record changes that support best practices and clear documentation for opioid tapering.

- Perform quality review of guideline implementation and monitor results.
- Support schedule changes, such as extended clinic visits for opioid tapering, to allow for high quality and patient-centered care.

VII. 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; increased availability of naloxone; community education, and beyond. See Appendix X for examples of important community-level resources.

VIII. Patient, Provider and Community Resources

The overall goal of these guidelines is to reduce harms to patients associated with opioid use and promote patient-centered care. While the Guidelines are intended to assist in this effort, they are not intended to be exhaustive. Listed below are additional resources to aid in the implementation of the tapering guidelines. Additional resources can also be found on the OHA Opioid website: <https://healthoregon.org/opioids>.

Patient resources

- [CDC Helpful Materials for Patients](#) – Resources for chronic and acute pain.
- [VA Veteran / Patient Education](#) – Links to VA and other government resources (FDA, SAMHSA, etc.) on opioids, pain and its treatment. Updated regularly and available in multiple languages.
- [American Society of Regional Anesthesia and Pain Medicine website](#) – 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.”
- [SAMHSA Opioid Overdose Prevention TOOLKIT: Safety Advice for Patients & Family Members](#)
- [STOMP Pain Management Guide](#): – The Swedish Medical Center, STOMP (Structuring Your Own Management of Pain)

Provider/Practice resources

- [SAMHSA Opioid Treatment Program Directory](#) – List of opioid treatment programs (OTP) by state, including contact information.
- [CDC Opioid Overdose: Information for Providers](#) – Multiple resources include: guideline

overview, training materials, PDMP overview, FAQs.

- [Oregon Addictions and Mental Health Services](#) – Information specific to Oregon for Addictions and Mental Health.
- **Stratified Tool for Opioid Mitigation: STORM (unable to find website)**
- [PEG-3: Pain Screening Tool and PEG Demonstration Video](#) – Pain, Enjoyment, General Activity screening tool and a provider and patient demonstration video of the tool in use.
- [Changing the Conversation about Pain](#) – Oregon Pain Management Commission education module for providers.
- [VA Provider Education](#) – Tools for providers in the following areas: pain and opioid safety, opioid use disorder, benzodiazepines, and opioid overdose and naloxone distribution tools.

Community resources

- [Heal Safely Campaign](#) – Heal Safely is a campaign to empower people to heal safely after injury or surgery.
- [OHA Safe Disposal of Medications in Oregon](#) – Information on safe disposal and drug take back; includes collection boxes across Oregon.
- [Naloxone toolkit for Oregon pharmacists](#) – Information on naloxone rescue for opioid overdose, including FAQ section.
- [OSU College of Pharmacy naloxone training for pharmacists](#) – Accredited naloxone education.
- [Oregon peer delivered services for behavioral health conditions](#) – Information on peer support specialists and peer wellness specialists, including substance use disorder peer delivered services curriculum.

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 As

- **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)

OOTG: Combined Education and Resource List

Resource Topic	Audience	Info available on web	Existing OHA	Working Draft 9.17.19
Heal Safely Campaign	Community	Yes	Yes	X
Naloxone toolkit for Oregon pharmacists	Community	Yes	No	X
OHA Safe Disposal of Medications in Oregon	Community	Yes	No	X
Oregon peer delivered services for behavioral health conditions	Community	Yes	No	X
OSU College of Pharmacy naloxone training for pharmacists	Community	Yes	No	X
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.”	Patient	Yes	Yes	X
American Society of Regional Anesthesia and Pain Medicine website: Safe opioid storage, tapering, and disposal.	Patient	Yes	Yes	X
CDC Helpful Materials for Patients – Resources for chronic and acute pain.	Patient	Yes	Yes	X
Oregon pain education toolkit for patients: OPG (includes clinician guide)	Patient	Yes	Yes*	X
SAMHSA Opioid Overdose Prevention TOOLKIT: Safety Advice for Patients & Family Members	Patient	Yes	Yes	X
Swedish Medical Center - STOMP Pain Management Guide: The Swedish STOMP (Structuring Your Own Management of Pain)	Patient	Yes	Yes	X
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.	Patient	Yes	Yes	X
CDC Opioid Overdose: Information for Providers	Provider	Yes	No	X
Oregon Addictions and Mental Health Services	Provider	Yes	Yes	X
Oregon Pain Management Commission education module for providers: Changing the Conversation about Pain (submitted by OHA)	Provider	Yes	Yes	X
PEG-3: Pain Screening Tool and PEG Demonstration Video: https://www.oregonpainguidance.org/resources/difficult-conversations/	Provider	Yes	No	X
SAMHSA Opioid Treatment Program Directory	Provider	Yes	Yes	X
Stratified Tool for Opioid Mitigation: STORM	Provider	?	No	X
VA Provider Education	Provider	Yes	No	X
Oregon directory of peer support specialist programs		Yes	No	duplicative
Addiction Medicine				
Board of Pharmacy: Oregon pharmacists prescribing of naloxone		Yes	No	
Central Pain Syndrome				
Chronic disease self-management programs		Yes	Yes	
Community Resources (e.g. OPG, Project ECHO, OPAL-K, Synergy)				
From NIH - NIDA for Teens:		Yes	Yes	
How to manage your pain safely and effectively (CDC website)		Yes	Yes	
Hyperalgesia				

Legend:

Green – on both working draft and OHA web page Grey – Aug working draft Ivory – OHA website

OOTG: Combined Education and Resource List

Resource Topic	Audience	Info available on web	Existing OHA	Working Draft 9.17.19
Map of Oregon pharmacies distributing naloxone		Yes	No	
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.		Yes	Yes	
OHA EMS and Trauma Systems training on lifesaving treatment protocols: naloxone		Yes	No	
OHA Public Health naloxone rescue for overdose website		Yes	No	
Opioid risks				
Oregon Health Leadership Council Evidence Based Best Practices Work Group developing recommended opioid practices for insurers and health plans		Yes	No	
Oregon Health Plan Guideline Note 56: Non-interventional treatments for conditions of the back and spine		Yes	Yes	
Oregon specialty courts for nonviolent individuals with substance use or mental health issues underlying their criminal behavior		Yes	No	
Oregon's Good Samaritan law		Yes	No	
Pain Science				
PainWise website (Benton, Lincoln and Linn counties)		Yes	Yes	
Resources for patient centered approaches				
Southern Oregon Treatment and recovery resources		Yes	Yes	
Substance use helpline		Yes	Yes	
Trauma Informed Care				
Understanding pain and what to do about it (video from the Department of Defense and Veterans Health Administration)		Yes	Yes	

Legend:

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