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Oregon Opioid Tapering Guidelines

Recommendations for individualized care to reduce harm from **opioid use**

Oregon Health Authority
PUBLIC HEALTH DIVISION

Contents

Oregon opioid tapering guidelines overview

Background

From 1999 to 2006, Oregon experienced a sharp increase in prescription opioid overdose and death. Oregon attributes this mostly to an increase in opioid prescriptions to treat pain. The rate of prescription opioid overdose deaths has been declining since 2006. However, the rate is still three times higher than in 1999. Over-prescribing of opioid medications adversely affects patients, their families, household members, and the larger community through potential diversion and misuse.

Existing Oregon opioid prescribing guidelines

The Oregon Health Authority has gathered experts from across the state to develop clinical guidelines for opioid prescribing to improve patient safety, spread best practices, and address the need for compassionate care.

In 2016, Oregon's Opioid Prescribing Guidelines Task Force approved adoption of Oregon-specific opioid prescribing guidelines. Oregon based these guidelines on the CDC Guideline for Prescribing Opioids for Chronic Pain. Through similar collaborations, Oregon developed guidelines to address opioid prescribing for:

- Acute pain
- Dental settings, and
- Addressing opioid use in pregnant women

In September 2019, the U.S. Department of Health and Human Services released the HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics. These Oregon Opioid Tapering Guidelines complement the new HHS Guide as well as Oregon's previous prescribing guidelines.

Opioid Tapering Guidelines Framework

The Oregon Opioid Tapering Guidelines Task Force developed these opioid tapering guidelines between March and October 2019. The goal of the tapering guidelines is to reduce harms to patients associated with opioid use and promote patient-centered care.

The guidelines set out:

- General principles and best practices for opioid tapering
- Potential indications for and approaches to tapering
- Reasons for referral, and
- Important long-term supports.

WARNING:
There is no one approach to tapering. These recommendations are meant to provide guidance. In addition, they inform how a clinician and patient can work together when considering opioid tapering. Tapering requires individualized assessment and treatment.

Not all patients on opioids need tapering. For example, a patient on a stable opioid dose with minimal side effects who is experiencing good pain control, function, and quality of life may not require tapering. In addition, these guidelines do not apply to patients receiving treatment for cancer, palliative care, or hospice care.

These guidelines stress the need to provide patient-centered and trauma-informed care, as well as collaborative pain management. In addition, these guidelines stress that it is important to avoid inappropriate treatment of chronic pain. As stated in Washington Administrative Code (WAC), this includes "nontreatment, undertreatment, overtreatment, and the continued use of ineffective treatments" (WAC 246-919-850).

Principles

Principles that underlie these guidelines:

- 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 and payers 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.

Terms

Clinicians and patients should understand these terms when they use these guidelines:

Tapering: Prescribing clinician and patient work together to reduce opioid dose or to stop opioid therapy for the patient. The focus is on individualized care specific to the patient.

Patient-centered care: Patient-centered care is a collaborative relationship between clinician and patient. It is respectful of and responsive to patient preferences, needs and values. It ensures patient values guide clinical decisions.

Trauma-informed care: Trauma-informed care recognizes the widespread and potentially negative health impacts 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 clinicians. It also helps survivors rebuild a sense of control and empowerment. Trauma is common in society and among persons with substance use disorder. Find more information at Trauma Informed Oregon.

Opioid tolerance: The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) defines tolerance by either:

» Need for markedly increased amounts of opioids to achieve desired effect whether therapeutic or recreational, or

» Markedly reduced effect with continued use of the same amount of opioid. (1)

Physiologic opioid dependence: Dependence on opioids can occur when a person's 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: DSM-5 defines opioid withdrawal syndrome by criteria A and B. Patients must have:

A. Either of the below:

   a. Cessation of, or reduction in, opioid use that has been heavy and prolonged (i.e., several weeks or longer), or

   b. Administration of an opioid antagonist after a period of opioid use, as well as:

B. Three or more of the following, developing within minutes to several days after criterion A:

   a. Dysphoric mood

   b. Nausea or vomiting

   c. Muscle aches

   d. Lacrimation or rhinorrhea

   e. Pupillary dilation

   f. Piloerection or sweating

   g. Diarrhea

   h. Yawning

   i. Fever, or

   j. Insomnia.

In addition, according to DSM-5, signs or symptoms in criterion B must cause clinically significant distress or impairment (i.e., in social, occupational or other important areas of functioning). Also, the symptoms may not be attributable to another condition or mental disorder. (1)

Opioid withdrawal: DSM-5 defines opioid withdrawal by either:

1. Characteristic opioid withdrawal syndrome (see above), or
2. Opioids (or a closely related substance) taken to relieve or avoid withdrawal symptoms. (1)

Opioid use disorder (OUD): A problematic pattern of opioid use that leads to clinically significant impairment or distress. To confirm a diagnosis of OUD, according to DSM-5, at least two of the below should be observed within a 12-month period:

- ☐ The patient takes opioids 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.
- ☐ Great time is spent in activities 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 results in a failure to fulfill major duties at work, school or home.
- ☐ Continued opioid use despite 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 dangerous.
- ☐ Continued opioid use despite knowledge that it likely causes or makes worse a persistent or recurrent physical or psychological problem.
- ☐ *The patient exhibits tolerance.
- ☐ *The patient exhibits withdrawal.

According to DSM-5, clinicians should not consider OUD criteria marked by an asterisk above (*) met for persons taking opioids solely under proper medical supervision.

Severity of OUD is specified as:

- Mild (2-3 criteria)
- Moderate (4-5 criteria), or
- Severe (6 or more criteria).

Note: DSM-5 no longer lists opioid dependence as a separate category from opioid use disorder.

Substance use disorder (SUD): DSM-5 states the diagnosis of SUD is based on a pattern of behaviors that relates to use of a specific substance (i.e., alcohol use disorder, cannabis-related disorder, opioid use disorder, etc.). A critical feature of a substance use disorder includes a cluster of cognitive, behavioral and physiological symptoms that indicates the person continues to use the substance despite significant substance-related problems. Criteria for each substance use disorder are grouped according to:

- Impaired control
- Social impairment
- Risky use, and
- Pharmacological criteria.

Guidelines

I. Assessing the patient

A comprehensive evaluation is recommended for every patient to determine if they are appropriate for either tapering or continuation of 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 or sequential visits. The urgency and complexity of the patient's needs should determine the number of visits. Ongoing reassessment and evaluation of progress are critical to ensure the efficacy of the chosen approach.

A comprehensive assessment should include:

- A complete biopsychosocial assessment
- A physical exam, and
- An assessment of risks versus benefits of opioid therapy.

This comprehensive assessment should also include an evaluation of ***pain, function*** and ***adverse consequences*** related to opioid therapy. One framework to help complete this evaluation is the "5 As" which include:

1. **A**ctivities
2. **A**dverse effects
3. **A**berrancy
4. **A**ffect
5. **A**nalgesia.

Appendix A includes a description of the "5 As" framework plus a list of essential comprehensive assessment components.

II. When to consider opioid tapering

As shown below, various circumstances should prompt consideration for opioid tapering.* The patient and prescribing clinician should determine if and how to proceed with opioid tapering based on shared decision making. The decision should be made on an individualized basis and balance the risks and benefits of opioid therapy.

WARNING:

The list below gives examples of circumstances and risk factors that should prompt consideration for opioid tapering. Whether to proceed with tapering must be an individualized decision based on:

- **The patient's unique context**
- **An assessment of risks versus benefits**
- **The latest emerging science, and**
- **The goal for patient safety and health.**

Consider tapering when opioids are no longer indicated or there is imminent danger of harm:

- The underlying condition that prompted an opioid prescription (e.g., injury, surgical pain) has resolved and opioids are no longer indicated.
- The patient:
  - » Experiences no reduction in pain
  - » Experiences no improvement in function, or
  - » Asks to stop or reduce opioid therapy.
- The patient experiences unmanageable adverse effects associated with opioid therapy (e.g., drowsiness, constipation, cognitive impairment, worsening pain despite increasing doses).
- The patient develops suicidality or worsening mood associated with opioid therapy.
- The patient experienced a previous or recent overdose event that involves opioids.
- The patient does not adhere to their treatment plan or exhibits unsafe behaviors (e.g., early refills, lost or stolen prescription, buying or borrowing opioids, failure to obtain or aberrant urine drug test).

* Tapering may apply to partial opioid agonists (in addition to full opioid agonists) when used for treatment of chronic pain.

The presence of other risk factors may also warrant consideration of opioid tapering:

- The patient is on a high daily opioid dose and the individual risks outweigh the benefits. **Note:** There is no opioid dose threshold (i.e., milligram morphine equivalent or MME) that applies to all patients. Individual doses should not serve as a mandate for dose reduction.
  - » The 2016 CDC Guideline for Prescribing Opioids for Chronic Pain states, "Clinicians should explain in a nonjudgmental manner to patients already taking high opioid dosages (≥90 MME/day) that there is now an established body of scientific evidence showing that overdose risk is increased at higher opioid dosages. Clinicians should empathically review benefits and risks of continued high-dosage opioid therapy and should offer to work with the patient to taper opioids to safer dosages." (2)
- The patient has medical risk factors (e.g., lung disease, sleep apnea, liver disease, renal disease, fall risk, medical frailty) that can increase the risk of adverse outcomes such as overdose.
- The patient takes other medications that increase the risk of drug-drug interactions or the risk of overdose. Examples are benzodiazepines or other sedating medications (e.g., diphenhydramine [Benadryl®], gabapentin [Neurontin®]). Prescribers should be mindful of a patient's hepatic and renal function that may affect drug metabolism.
- The patient's history shows an increased risk for substance use disorder (SUD). Examples may include a past diagnosis of SUD, SUD-related behaviors, or family history of SUD. If the patient meets diagnostic criteria for SUD or OUD, arrange for the proper evidence-based treatment.

III. Approaches to opioid tapering

Shared decision making

Shared decision making between the prescribing clinician and patient is fundamental when considering opioid tapering. The prescribing clinician and patient should approach the taper as an alliance with the goal to improve safety and quality of life. Key principles that underlie and support shared decision making include:

- Establishing trust
- Allowing pauses in tapering
- Ensuring the patient directs the focus of tapering, and
- Understanding and incorporating patient values and belief systems.

Shared decision making is critical. However, prescribing clinicians must also determine whether an imminent threat to patient safety may call for tapering opioids to safer levels. If the prescribing clinician determines that an imminent threat exists, the clinician should:

- Tell the patient their concern
- Ensure the patient understands the risks, and
- Consider referral to a specialist as needed and available.

Examples of exceptional cases where significant risks to patient safety might limit 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, and
- Bowel obstruction or other emergent and significant side effects.

The prescribing clinician should rely on objective data to assess patient safety. This includes:

- Checking the Oregon Prescription Drug Monitoring Program
- Urine drug screens
- Medication reconciliation
- Patient history, and
- Physical examination.

The prescribing clinician also should consider risk-mitigating strategies in consultation with the patient, including prescribing naloxone.

Setting expectations and goals through patient and clinician collaboration

Discussions about tapering can be difficult for both patients and clinicians. This is especially true when patients are anxious or fear withdrawal symptoms or worsening pain, and when clinicians have limited experience with opioid tapering. For a taper to be successful, it is important for a clinician and patient to:

- Acknowledge and validate these experiences
- Develop a shared understanding of what constitutes success, and
- Seek additional resources when needed.

Key practices to foster patient and clinician collaboration include:

- Explore patient concerns in a non-judgmental way.
- Address common beliefs and learn about the patient's perspectives.
- Educate the patient about:
  - » How opioids work
  - » Opioid risks, and
  - » Best practices for safekeeping, storage and disposal.
- Use motivational interviewing techniques to find out patient goals.
- Set patient-centered and realistic expectations for the treatment plan together, informed by a thorough assessment of the patient's risks and benefits related to opioid therapy.
- Reassure the patient that they will receive continuity of care throughout tapering. Avoid dismissing patients from care and patient abandonment.*
- Tell patients about what to expect during the taper and the potential for withdrawal.
- Commit to monitoring and addressing withdrawal symptoms.

Tapering plan

When harms of continuing opioid therapy outweigh the benefits, prescribing clinicians should approach the taper plan as an alliance with the patient to ensure its success. There are general approaches to tapering. However, patients and clinicians should be aware this is a rapidly evolving field.

It is essential that each taper plan is individualized and based on the patient's history, goals, and an objective assessment. Generally, a 5 to 20 percent taper per month can be a helpful guide.† Patients on higher doses of opioids may tolerate a more rapid taper. Those on a lower dose or who have been on opioids for a long time may need a slower taper. The most common cause of failed tapers is trying to taper too rapidly.

* According to Black's Law Dictionary 10th edition (2015), 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.

† U.S. Department of Veterans Affairs. Opioid Taper Decision Tool. (2016) https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Pain_Opioid_Taper_Tool_IB_10_939_P96820.pdf

Risks of rapid opioid tapers*

Prescribing clinicians should carefully consider the rate of opioid tapers and tailor to meet individual needs. The risks of rapid opioid tapering may include:

- **Acute opioid withdrawal symptoms**
- **Worsening pain**
- **Psychological stress or suicidal thoughts**
- **Seeking other sources of opioids, including possible illicit opioids**
- **Unsuccessful fulfillment of taper goals**

Prescribing clinicians should do the following during opioid tapering:

- Work with the patient to determine whether the goal is dose reduction or to stop opioids completely.
- Develop tapering plans that minimize symptoms of opioid withdrawal
- Maximize pain treatment with nonpharmacologic therapies and nonopioid medications.
- Use interdisciplinary, team-based care when available to facilitate tapering. Also, consider a referral to behavioral health or other specialists as needed.
- Establish a written taper plan that is easy to understand. The plan should be flexible. Routinely re-evaluate the plan.
- Establish the rate of taper based on individual patient factors and safety considerations. There is no available evidence to recommend a specific taper rate or length.
- Consider more rapid tapering based on safety concerns. This may include a patient:
  - » With a history of recent overdose
  - » Evidence of diversion, or
  - » Actively using illicit drugs.

  It is important to co-prescribe naloxone in these circumstances.
- Coordinate taper plans with any other clinicians who have prescribed a controlled substance (e.g., opioids, benzodiazepines) for the patient. Ensure all are aware and supportive of the plan.

* Adapted from: U.S. Department of Health and Human Services. HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics. https://www.hhs.gov/opioids/sites/default/files/2019-10/8-Page%20version__HHS%20Guidance%20for%20Dosage%20Reduction%20or%20Discontinuation%20of%20Opioids.pdf

Various health organizations have published example taper plans.*† However, prescribing clinicians should always approach those plans with flexibility. Clinicians and organizations should use up-to-date resources on opioid tapering and stay abreast of emerging evidence.

Multidisciplinary supports and chronic pain management

Clinicians should align with the biopsychosocial model of pain management and offer patients multidisciplinary supports for the treatment of chronic pain throughout opioid tapering. Recommendations to ensure these supports are in place include:

- Approach chronic pain and opioid use disorders as chronic conditions using a trauma-informed approach.
- Optimize team-based care. This includes integrated behavioral health services as well as complementary and integrative medicine.
- Include treatment approaches that focus on behavioral activation and behavioral therapy.
- Engage mental health providers to help with treatment of co-occurring conditions when needed, such as depression, anxiety and post-traumatic stress disorder.
- Offer patients services available in the community to support well-being. This includes peer-delivered services.
- Recognize that long-term, stable recovery depends on one's biopsychosocial and spiritual environment.

Clinicians should consider multi-modal therapies for the treatment of chronic pain. This includes cognitive, behavioral, physical, spiritual and integrative health approaches. Examples include but are not limited to: patient education regarding current pain science, mindfulness, cognitive behavioral therapy, biofeedback, yoga, acupuncture, chiropractic care, occupational therapy, physical therapy, interventional therapies, and tribal-based or other cultural practices. Clinicians should consider the underlying diagnosis, patient preferences and existing evidence to determine appropriate therapies for individual patients.

* Oregon Health & Science University. Adult Safe Opioid Prescribing Guideline for Chronic, Non-End-Of-Life Pain and Practice Resources for Clinical Implementation. (2017) https://www.ohsu.edu/sites/default/files/2018-12/Safe-Opioid-Prescribing-Guideline_FINAL_12-6-18.pdf

† U.S. Department of Veterans Affairs. Opioid Taper Decision Tool. (2016) https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Pain_Opioid_Taper_Tool_IB_10_939_P96820.pdf

Patient monitoring and reassessment

The tapering plan should include frequent follow-up and assessment of progress. This may vary (i.e., daily, weekly or monthly) based on the rate of the taper and patient response. During follow-up, clinicians should:

- Regularly assess patient function including pain intensity, sleep, physical activity, personal goals, and stress levels.
- Adjust the rate and duration of the taper based on the patient's response. Prescribing clinicians may slow or pause the rate while monitoring and managing withdrawal symptoms.
- The clinician should monitor for signs of anxiety, depression, and opioid use disorder that might be unmasked or precipitated by an opioid taper. Clinicians should arrange for prompt management of these co-morbidities.
- Assess for the need to shift to safer medications based on the ongoing risk and benefit reassessment.

A decision to return to a previous (higher) dosage during opioid tapering should be based on reassessment of the patient and shared decision making. Any upward dosage change should be made cautiously and in a step-wise fashion. Strongly consider a naloxone prescription in these situations. Also, clinicians should advise the patient of an increase in risk for overdose when there is a return to a higher-level dosage. This is due to a potential loss of opioid tolerance.

IV. Managing withdrawal and complicated tapers

Managing withdrawal

Withdrawal can cause significant distress. It can also undermine the success of opioid tapering. Clinicians should regularly assess the patient for withdrawal symptoms during an opioid taper and consider that:

- Withdrawal symptoms may be an indication that the taper is going too quickly. The presence of withdrawal symptoms is an opportunity to pause, rethink and slow down.
- A person may need a faster taper (e.g., when there is evidence of diversion, use of an illicit substance, or a recent overdose). In these cases, active management of withdrawal symptoms may need to take precedent rather than to slow the taper rate. In this scenario, clinicians should use appropriate medications to address withdrawal symptoms and incorporate multidisciplinary approaches.
- Benzodiazepines and other high-risk medications are not appropriate to treat withdrawal.

Handling complicated tapers

Some patients experience minimal or manageable symptoms during opioid tapering. However, others have more difficulty even despite attempts to slow the taper rate. For these patients, it is important to assess for opioid use disorder using DSM-5 criteria. If criteria are met, arrange for evidence-based OUD treatment.

As highlighted in the HHS guide*, these persons may benefit from transitioning to buprenorphine, a partial opioid agonist. Clinicians may prescribe buprenorphine either as maintenance therapy or for eventual, continued tapering. Buprenorphine may be used to treat pain as well as OUD.†‡ Also, there is evidence that it can be helpful to lessen withdrawal symptoms.§ Furthermore, buprenorphine has less risk for respiratory depression than full opioid agonists. Prescribing clinicians must be aware of the following when considering the use of buprenorphine:

- This is an evolving research area. Clinicians should stay up to date related to the newest evidence on buprenorphine, opioid dependence and opioid tapering.
- Take caution when transitioning patients from full opioid agonists to buprenorphine. For more information, review the HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics. Also, consult additional expertise as needed.
- Use of buprenorphine for opioid use disorder requires the prescribing clinician get a practitioner or "X" waiver. Visit https://www.samhsa.gov/medication-assisted-treatment/training-materials-resources/apply-for-practitioner-waiver for more information. In contrast, buprenorphine can be prescribed as a treatment for chronic pain without a practitioner waiver.
- See the example flowchart in Appendix B (Clinical Pathway for Long Term Opioid Therapy Management). This flowchart highlights an approach to care for a person who experiences a difficult time with tapering.
- Complete prescribing information and medication guides for buprenorphine containing products is here: https://www.btodrems.com/SitePages/MedicationGuides.aspx.

Managing opioid use disorder

Prescribing clinicians should evaluate patients for opioid use disorder (OUD) or other substance use disorders before initiating a taper. If a patient meets criteria for OUD, offer or arrange

* U.S. Department of Health and Human Services. HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics. https://www.hhs.gov/opioids/sites/default/files/2019-10/8-Page%20version__HHS%20Guidance%20for%20Dosage%20Reduction%20or%20Discontinuation%20of%20Opioids.pdf

† Treatment of Chronic Pain With Various Buprenorphine Formulations: A Systematic Review of Clinical Studies. (2018) https://www.ncbi.nlm.nih.gov/pubmed/29239947

‡ Sublingual buprenorphine as an analgesic in chronic pain: a systematic review. (2014) https://www.ncbi.nlm.nih.gov/pubmed/24995716

§ Gowing et. al. Bupernorphine for managing opioid withdrawal. Cochrane Database of Systematic Reviews. (2017)

for them to receive appropriate evidence-based treatments. An OUD treatment example is buprenorphine or methadone maintenance therapy in combination with behavioral therapies. Be aware that methadone is only available for treatment of OUD through an Opioid Treatment Program (OTP). Also, only an X-waivered clinician can prescribe buprenorphine. Care for any patient that experiences OUD with compassion. Be aware of and address any stigma a patient may face with this diagnosis.

Addressing unique populations

These taper guidelines do not address important considerations for all populations. First, these guidelines do not apply to patients receiving cancer treatment, palliative care or hospice care.

In addition, tapering may be more complex for certain unique groups including, but not limited, to pregnant women, children, patients with another SUD and/or dual diagnoses of mental illness and SUD. Patients in these populations may require consultation or referral to a clinician with specific expertise these areas.

When to refer

To facilitate a taper plan, prescribing clinicians may consider referring patients to other clinicians with expertise in specific areas. In a team-based model of care, a prescribing clinician may engage another team member (when the need is outside clinician's scope of practice) to facilitate the taper plan. Examples are a pharmacist or integrated behavioral health provider.

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 prescribing clinician may want to consider referral to an outside entity or clinician. Such specialist referrals might include:

- Addiction medicine
- Behavioral health
- Peer support
- Support groups, and
- Pain specialists.

Clinicians can also receive guidance by phone consultation services (e.g. the Oregon Psychiatric Access Line [OPAL] call center). Links to OPAL and other clinician resources are in guideline section VIII.

V. Long-term support and follow up

Even after completion of a safe and effective taper, clinicians and patients should maintain a longitudinal care plan. Long-term support beyond the tapering period for persons with chronic pain should include:

- Continual assessment of pain, function and functional goals (i.e., using the pain, enjoyment, general activity [PEG] scale).
- Mental health assessments.
- Assessment of need for additional therapy or social supports.
- Ongoing assessment and education on opioid use disorder or substance use disorder. Also, 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:

- Endorse the Oregon Opioid Tapering Guidelines.
- Dedicate executive leadership and resources towards opioid tapering.
- Provide expert consultation to help with implementation of these guidelines as the standard of care across practice settings.
- Develop team-based care for comprehensive pain management. This includes providers of:
  - » Behavioral health
  - » Integrative health
  - » Peer delivered services and beyond.

  Also, ensure referral resources as needed.
- Sponsor clinician and practice training in:
  - » Interdisciplinary chronic pain management
  - » Patient-centered and trauma informed care, and
  - » Buprenorphine prescribing and obtaining an X-waiver.
- Adopt electronic medical record changes that support best practices and clear documentation for opioid tapering.
- Adopt schedule changes to allow for high quality and patient-centered care. An example is extended clinic visits for opioid tapering.
- Develop an evidence-based treatment program for opioid use disorder including enough X-waivered clinicians who can prescribe buprenorphine.
- Ensure appropriate referral processes and resources related to opioid tapering.
- Perform quality review of guideline implementation and monitor the results.

VII. Community-level interventions

Outside the medical setting, patients live in community environments that can be supportive or can hinder their success with 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.

VIII. Patient, clinician and community resources

The goal of these guidelines is to:

- Promote patient-centered care, and
- Reduce harms associated with opioid use.

These guidelines intend to help in this effort, but they are not exhaustive. Listed below are supplemental resources to aid in implementation of the tapering guidelines. Additional resources are available on the Oregon Heath Authority (OHA) opioid website.

Patient resources

- Oregon Pain Guidance (OPG). Tapering - Guidance & Tools.
- Centers for Disease Control and Prevention (CDC). CDC Helpful Materials for Patients – Resources for chronic and acute pain.
- Veteran's Administration (VA). VA Veteran / Patient Education Opioids – Links to VA and other government resources (FDA, Substance Abuse and Mental Health Services Administration [SAMHSA], etc.) on opioids, pain and its treatment. Updated regularly and available in multiple languages.
- American Society of Regional Anesthesia and Pain Medicine (ASRA) – 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."
- Substance Abuse Mental Health Services Administration (SAMHSA). Opioid Overdose Prevention TOOLKIT: Safety Advice for Patients & Family Members

- Swedish, STOMP (Structuring Your Own Management of Pain). STOMP Pain Management Guide.
- National Center for Complementary and Integrative Health (NIH).

Clinician and practice resources

- Oregon Pain Management Commission. Changing the Conversation about Pain: Pain Care is Everyone's Job. Education module for providers.
- Oregon Pain Guidance (OPG). Provider resources on tapering.
- Stanford Center for Continuing Medical Education for "How to Taper Patients Off of Chronic Opioid Therapy" (the BRAVO Tapering Protocol). Free continuing medical education (CME).
- Oregon State University College of Pharmacy. Naloxone training for pharmacists – Accredited naloxone education.
- Oregon Health Authority (OHA). Naloxone rescue for opioid overdose – Includes toolkit for Oregon pharmacists and FAQs.
- Substance Abuse Mental Health Services Administration (SAMHSA). Opioid Treatment Program Directory – List of opioid treatment programs (OTP) by state with contact information.
- Centers for Disease Control and Prevention (CDC). Opioid Overdose: Information for Providers – Multiple resources include:
  - » Guideline overview
  - » Training materials, Prescription Drug Monitoring Program (PDMP) overview, FAQs.
- Oregon Behavioral Health Services – Information specific to Oregon for behavioral health.
- Veteran's Administration (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.
- Oregon Health & Science University Comprehensive Pain Center: consultation services.
- Oregon Psychiatric Access Line (OPAL): consultation and call center.

- University of California, San Francisco, Clinician Consultation Center (free and confidential clinician-to-clinician consultation that focuses on substance use evaluation and management for primary care clinicians. Sponsored by the Health Resources and Services Administration [HRSA]).
- University of Washington Pain Medicine- TelePain (free, weekly service for community providers to increase knowledge and confidence in chronic pain management).
- U.S. Department of Health and Human Services. HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics.
- Northwest Portland Area Indian Health Board- Opioid resources and clinical resources for tribal communities.

Community resources

- Heal Safely – Heal Safely is a campaign to empower people to heal safely after injury or surgery.
- Trauma Informed Oregon has resources for providers, organizations, individuals and families.
- Oregon Health Authority (OHA). Safe Disposal of Medications in Oregon – Information on safe disposal and drug take back; includes collection boxes across Oregon.
- Oregon Health Authority (OHA). Oregon peer delivered services for behavioral health conditions – Information on peer support specialists and peer wellness specialists. Includes substance use disorder peer delivered services curriculum.

Endnotes

1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA. American Psychiatric Association; 2013.
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Appendix A

Patient assessment

It is important to perform an initial and thorough patient assessment using a combination of tools. Critical components of a global assessment should include:

Assess and document efficacy of current chronic opioid therapy using the 5As:

- **Activities:** includes activities of daily living and functional activities
- **Adverse effects:** represents side effects from medications. For example:
  - » Sedation
  - » Respiratory depression, and
  - » Constipation
- **Aberrance:** must be assessed and documented in a consistent manner
- **Affect:** assesses the impact of opioid therapy on mood and sleep
- **Analgesia:** refers to effectiveness of pain control

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

- Patient-centered interview. Exploration related to opioid therapy and taper goals, questions, concerns, beliefs, expectations and fears.
- History of pain and duration of symptoms. This includes:
  - » Onset
  - » Locations
  - » Radiation
  - » Previous episodes, and
  - » Intensity
- Patient perception of symptoms; example tools to document patient reported symptoms include:

  - » Pain, Enjoyment of Life and General Activity (PEG) tool
  - » Defense and Veterans Pain Rating Scale (DVPRS) scale
  - » Brief Pain Inventory (BPI)
  - » Pain Numeric Rating Scale, and
  - » Pain Catastrophizing Scale
- Coexisting conditions, treatments (e.g., use of benzodiazepines or other sedating medications), and the effect on pain.
- Patient general medical history. This includes:
  - » 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 and mental health history. This includes:
  - » Mood disorders
  - » Suicidality and prior suicide attempts
  - » History of self-injurious behavior
  - » History of medications for psychiatric conditions and outcomes
  - » Trauma history
  - » Psychosis
  - » Attention deficit hyperactivity disorder (ADHD)
  - » Substance use history, including tobacco, and associated prescription medication use
  - » Presence of a specific substance use disorder (using standardized screening measures e.g. the cannabis use disorder identification test- revised [CUDIT-R]), and
  - » History of overdose
- Lifestyle and behavioral history. This includes:
  - » Exercise
  - » Nutrition
  - » Leisure time

- » Time in nature, and
- » Sleep hygiene practices

- Social history. This includes:
  - » 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
  - » Economic status and finances, and
  - » Legal issues
- Family history. This includes:
  - » History of chronic pain conditions
  - » Psychological and psychiatric history
  - » History of substance use disorders, or
  - » History of suicide

Conduct a physical exam

- Complete a thorough physical exam. Pay particular attention to:
  - » Areas of chronic pain
  - » Neurologic examination, and
  - » Psychiatric examination.
- Include diagnostic studies as appropriate.

Conduct a risk assessment

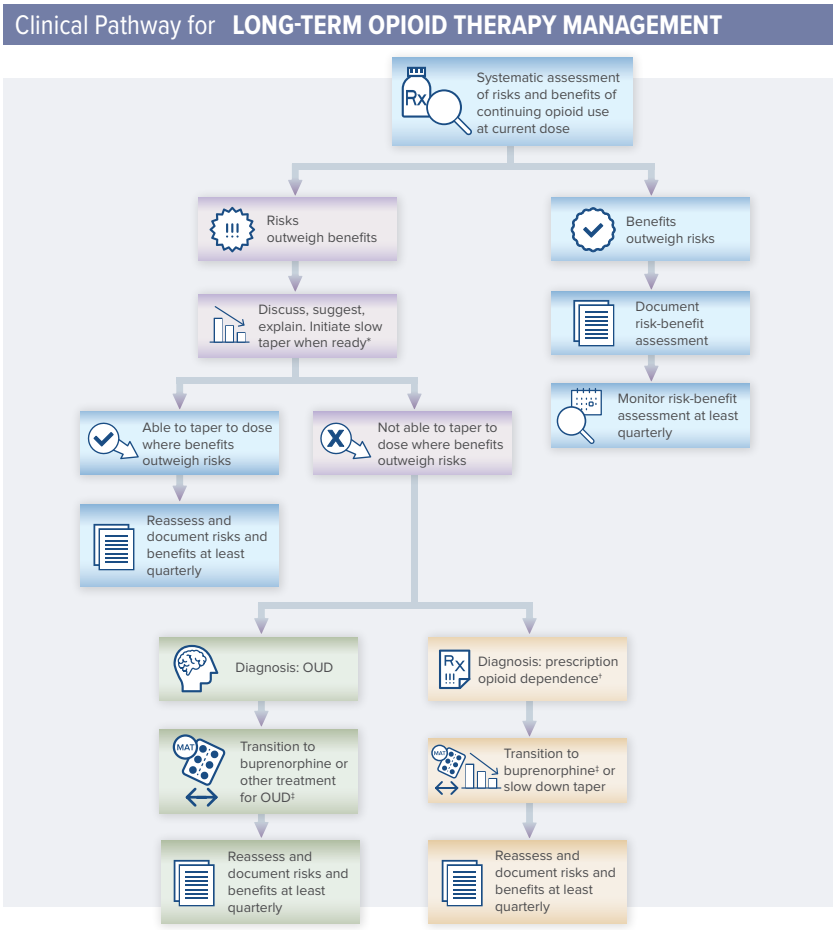
The following tools can help assess the risk of opioid use among patients:

- Urine drug screen
- Prescription Drug Monitoring Program
- Self-reported measures. These include:
  - » Opioid Risk Tool (ORT)
  - » Screener and Opioid Assessment for Patients with Pain- Revised (SOAPP®-R)

Appendix B

Clinical pathway for long-term opioid therapy management

As referenced in the HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics, the Clinical Pathway for Long-Term Opioid Therapy Management flow chart is a tool for clinicians, health systems and organizations. It is the responsibility of clinicians and organizations to use up-to-date materials. Flow chart can be found on the Oregon Pain Guidance website. https://www.oregonpainguidance.org/wp-content/uploads/2019/10/Clinical_Pathway_for_Long_Term_Opioid_Therapy_Management_Oct_2019.pdf?x91687.



Patients with improved function, adequate pain relief, and low risk for opioid-related harms may continue their current dose (right side of diagram), but with regular risk–benefit assessments. Patients in whom risks outweigh benefits (left side of diagram) should initiate a dose taper. Those who are unable to taper successfully may meet criteria for OUD or prescription opioid dependence. Those with OUD should receive evidence-based treatment, and those with prescription opioid dependence should receive additional taper support (e.g., BRAVO) or be transitioned to buprenorphine. DSM-5 = Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition; OUD = opioid use disorder.

* Recommendations for successful tapers using the BRAVO framework: Broach the subject with empathy (acknowledge anxiety and be clear that tapering is not punitive), Risk–benefit assessment (address effects on pain and function, risk for overdose and addiction, and other adverse events), Addiction assessment (normalize addiction and initiate appropriate management if OUD emerges), Velocity and Validate (do not taper too quickly, slow down if needed, and validate the pain of withdrawal), Other strategies for coping with pain (implement nonopioid alternatives for pain treatment).

† Characterized by persistent difficulty with tapering and meeting ≤1 DSM-5 criterion, excluding withdrawal and tolerance. Other features include negative affect, reward deficiency, and social isolation.

‡ Maintenance therapy with an opioid agonist, partial agonist, or antagonist is considered standard of treatment for OUD because of improved outcomes compared with tapering and withdrawal. Clinicians must undergo training and obtain a waiver from the Drug Enforcement Administration to prescribe sublingual and buccal formulations of the partial opioid agonist buprenorphine (with or without naloxone) for treatment of OUD. Use of these buprenorphine formulations for chronic pain or prescription opioid dependence without OUD is currently off-label.

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