

Opioid Prescribing: Chronic Opioid Therapy

Updated: May 15, 2019

Background

These recommendations are directed to providers who become the primary provider for a patient who has been prescribed chronic opioid therapy by another provider.

Care should be individualized and thoughtful. Opioids should not be suddenly discontinued.¹

Chronic pain management should follow the 2019 Bree Collaborative [Collaborative Care for Chronic Pain Report and Recommendations](#) that outline a model centered within primary care. Chronic pain management should include a care team with a care management function, treatments based in evidence-informed care, and patient-centered supported self-management. These components are referenced throughout the guidelines below.

Patient Engagement

Start by engaging the patient in care, reviewing your credentials and background and that of your care team and discussing how you will review the patient's prior care and assess function, physical health, and behavioral health needs.²

- *Start the first session with “we won’t change very much today.”²*
- *Assure that your goal is to keep the patient safe.²*
- Do not discuss the process of reducing opioid prescriptions (tapering) until at least the third visit.²
- Assure the patient that you will not abandon them.³
- Talk about chronic pain treatment approaches outside of opioid prescriptions.⁴
- Pain intensity and function may improve after tapering chronic opioid therapy, however some report increases in pain.^{5,6}
- Ask if the patient's spouse, parents, children or others could be included.
- Make sure the patient knows who to contact on the care team with questions or concerns.
- Talk about the importance of and impact of self-management as outlined in the [Collaborative Care for Chronic Pain Report and Recommendations](#) (e.g., help patients identify goals for resuming life activities and addressing barriers to making progress toward goals, remove barriers to physical activity).

Assessment

- Complete history and directed physical exam as indicated including pain-related diagnoses and past experiences with pain interventions.
- Functional status with PEG.
- Urine drug screen. If results are aberrant, discuss this with the patient.
- Explain to patients the purpose of screening for depression, suicidality, alcohol misuse, anxiety, and drug use including the safety and security of the information.
- Screen for mental health and substance use conditions, using a validated instrument(s), including:
 - **Depression** (e.g. Patient Health Questionnaire-2, PHQ-3 and/or PHQ-9) and **anxiety** (e.g., Generalized Anxiety Disorder-2), follow guidelines within the 2017 Bree Collaborative [Behavioral Health Integration Report and Recommendations](#).
 - **Suicidality** (e.g. ninth question of the PHQ-9, first and second questions of the Columbia Suicide Severity Rating Scale (C-SSRS), the Ask Suicide-Screening Questions (ASQ) as well as current plans and any past attempts). If suicide risk is detected, follow guidelines within the 2018 Bree Collaborative [Suicide Care Report and Recommendations](#), or more recent if available.
 - **Alcohol misuse** (e.g., AUDIT-C) and **drug use** (e.g., single-item screener, ASSIST, DAST-10, single item cannabis and other drug use questions). If alcohol misuse or illicit drug use is detected, follow guidelines within 2015 Bree Collaborative [Addiction and Dependence Treatment Report and Recommendations](#), or more recent if available following the Screening, Brief Intervention, and Referral to Treatment (SBIRT) protocol.
 - **Post-traumatic stress disorder**
 - **Adverse childhood experiences**. More information [here](#).
- From Butler presentation²
 - *Document*
 - *Query Prescription Monitoring Program (PMP)*
 - *Treatment agreement (to include naloxone)*
 - *If patient is on >120 MED, mandatory consult is waived if the patient:*
 - *Has an established written agreement*
 - *Has been stable, non-escalating dose*
 - *Has been compliant with care plan*
 - *Has documented improved function on opioids*
 - *Assure they have naloxone*
 - *Review concomitant sedatives*
 - *Advise significant risk of concomitant sedatives*
 - *Involve them in plan to reduce opioid prescriptions*
 - *Often, given the choice, people prefer to taper opioids*
 - *Consider moving toward short acting opioids*
 - *Mandatory consult*
 - *Mandatory consult includes UW Tele-Pain*

Develop a Treatment Plan

Treatment plans should be developed in collaboration with the patient, and family or others if appropriate.

- We recommend that chronic pain be managed through collaborative care as described in the 2019 Bree Collaborative [Collaborative Care for Chronic Pain Report and Recommendations](#). These guidelines focus on goals of improved function, increased quality of life, and greater patient autonomy rather than a primary focus on pain relief.
- Treat opioid use disorder, if present, using evidence-based protocols including medication-assisted treatment (MAT). MAT combines the use of medications with behavioral therapy (e.g., counseling) for a whole-person approach, augmenting behavioral therapy alone and has been shown to be more effective than behavioral therapies, medically-supervised withdrawal, or abstinence alone.^{7,8,9} Follow guidelines within the 2017 Bree Collaborative [Opioid Use Disorder Treatment Report and Recommendations](#).
- From Butler presentation²
 - *Estimate risk of opioid misuse (high, moderate, low)*
 - *Calculate current MED*
 - *If above 120mg MED will need to document a plan:*
 - *Consult with pain specialist. May delay up to 3 months if*
 - *Has established written agreement*
 - *Has been on a stable non-escalating dose*
 - *Has been compliant with recommendations*
 - *Has documented improved function on opioids*
 - *Or, taper.*
 - *Frame this as an “opportunity to take another look at everything”*
 - *Involve behaviorists*
 - *“To help them through these changes”*
 - *Remember pain doesn’t cause depression, anxiety, or alcoholism*
 - *Opioids are effective at suppressing symptoms of anxiety, PTSD*
 - *Sleep dysfunction makes everything worse*
 - *Anger, shame, grief, existential crises*
 - *Review central sensitization syndrome*
 - *“New understanding since you were started on opioids”*
 - *Correlated with Adverse Childhood Experiences, PTSD*
 - *Correlated with high dose chronic opioids*
 - *Fibromyalgia, chronic daily headache, chronic pelvic pain, IBS, interstitial cystitis, chronic fatigue*
 - *Best managed with behavioral techniques*
- Review non-opioid pharmacological management of chronic pain including acetaminophen, topicals, intermittent steroid injections, possibility serotonin and norepinephrine reuptake inhibitors, and others as indicated.
- Review non-opioid, non-pharmacological management of pain. Identify, support and enhance what patients are already doing to manage chronic pain with life activity impacts. Discuss:
 - Pain amplifiers (e.g., sleep problems).

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- Integrative health practices (e.g., massage, acupuncture, spinal manipulation).
- Movement and body awareness strategies.
- Surgical and non-surgical interventions.
- Patient self-management as outlined in the [Collaborative Care for Chronic Pain Report and Recommendations](#) (e.g., help patients identify goals for resuming life activities and addressing barriers to making progress toward goals, remove barriers to physical activity).

Reducing Opioid Prescriptions

Determine together with the patient, and families or others if appropriate, whether to stay on opioids or to reduce opioid prescriptions at a rate consistent with their clinical and social situation. People may want to stop chronic opioid therapy due to a variety of reasons including lack of efficacy, impact on quality of life, and concerns about addiction.¹⁰

- Do not suddenly discontinue chronic opioid therapy as this can lead to acute opioid withdrawal.¹
- Address fears and how tapering plan will be individualized based on patient response.¹¹
- Remind patients that they have permission to take the time it takes and that the Washington opioid prescribing rules do not require a taper on a certain timeline.²
- If you and the patient decide to reduce opioid prescription amounts, reduction should be gradual and individualized. Many guidelines recommend 5-10% per month.¹² Tapering should be based on function with the PEG¹³ done at each visit.²
 - *“Taper opioid therapy gradually, especially in patients who experience intolerable withdrawal. Standard recommendations to decrease the dosage by 5% to 10% of the starting dosage every one to four weeks may still be too fast for some patients, especially those receiving high doses. Some patients may need to decrease the dosage by 5% or less every two to three months, with even smaller decrements toward the end of the taper.”*¹⁴
 - *“Gradually reduce 5% to 10% of the morphine-equivalent dose every 2 to 4 weeks with frequent follow-up.”*¹⁵
 - Ok to pause due to life events.³
- From Butler²
 - *Pledge you will not abandon patient*
 - *Taper long-acting opioids first (If patient is also on benzodiazepines, which to taper first?)*
 - *Discourage concurrent tapers*
 - *Offer pain self-management skills support*
 - *Anticipate pain “flare-ups”*

Opioid Prescribing: Chronic Opioid Therapy

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- ² Butler M. Presentation to Bree Collaborative Opioid Prescribing Workgroup. April 24th, 2019. Seattle, WA.
- ³ Matthias MS, Johnson NL, Shields CG, et al. "I'm Not Gonna Pull the Rug out From Under You": Patient-Provider Communication About Opioid Tapering. *J Pain*. 2017;18(11):1365–1373.
- ⁴ Ashton-James CE, Chemke-Dreyfus A, Costa D, Glare P. Time for change: an experimental investigation of chronic pain patients' emotional and attitudinal responses to simulated opioid-tapering advice. *Pain*. 2019 Mar 4.
- ⁵ McPherson S, Lederhos Smith C, Dobscha SK, Morasco BJ, Demidenko MI, Meath THA, Lovejoy TI. Changes in pain intensity after discontinuation of long-term opioid therapy for chronic noncancer pain. *Pain*. 2018 Oct;159(10):2097-2104.
- ⁶ Frank JW, Lovejoy TI, Becker WC, Morasco BJ, Koenig CJ, Hoffecker L, Dischinger HR, Dobscha SK, Krebs EE. Patient Outcomes in Dose Reduction or Discontinuation of Long-Term Opioid Therapy: A Systematic Review. *Ann Intern Med*. 2017 Aug 1;167(3):181-191.
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- ⁸ The Institute for Clinical and Economic Review. Management of Patients with Opioid Dependence: A Review of Clinical, Delivery System, and Policy Options. July 2014. Available: <https://icer-review.org/wpcontent/uploads/2016/01/CEPAC-Opioid-Dependence-Final-Report-For-Posting-July-211.pdf>
- ⁹ Mattick RP, Breen C, Kimber J, Davoli M. Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. *Cochrane Database Syst Rev*. 2014 Feb 6;(2):CD002207.
- ¹⁰ Goesling J, DeJonckheere M, Pierce J, Williams DA, Brummett CM, Hassett AL, Clauw DJ. Opioid cessation and chronic pain: perspectives of former opioid users. *Pain*. 2019 May;160(5):1131-1145.
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- ¹² Berna C, Kulich RJ, Rathmell JP. Tapering Long-term Opioid Therapy in Chronic Noncancer Pain: Evidence and Recommendations for Everyday Practice. *Mayo Clin Proc*. 2015 Jun;90(6):828-42.
- ¹³ Krebs EE, Lorenz KA, Bair MJ, et al. Development and initial validation of the PEG, a three-item scale assessing pain intensity and interference. *J Gen Intern Med*. 2009;24(6):733–738.
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