

Opioid Prescribing: Chronic Opioid Therapy

Updated: June 25, 2019

Background

This supplement was developed by the Dr. Robert Bree Collaborative (Bree Collaborative) and the Washington Agency Medical Directors' Group (AMDG) in collaboration with an advisory group of the state's academic pain leaders, pain experts, providers in general care and specialty areas, and patients. The supplement updates the evidence and aligns best practice recommendations with those from the 2015 AMDG Interagency Guideline on Prescribing Opioids for Pain. The recommendations in this supplement are based on the current best available clinical and scientific evidence from the literature and a consensus of expert opinion and are intended for use in addition to, rather than a replacement of, the guidelines for addressing patients on chronic opioid therapy in the 2015 AMDG guidelines. The overall intent is to improve health outcomes and reduce morbidity and mortality related to the opioid epidemic.

This supplement is designed to help primary care and other providers managing patients with chronic pain. Providing appropriate opioid therapy and pain management for these patients should be individualized and focus on goals of clinically meaningful improvement in function, as well as improved quality of life, and greater patient functional independence rather than on pain relief. In addition, patient safety and avoidance of serious adverse outcomes is a priority.

Primary care providers should follow the 2019 Bree [Collaborative Care for Chronic Pain Report and Recommendations](#) that outline a chronic pain management model within primary care. The model includes a team with care coordination function, multi-modal treatments based in evidence-informed care, and patient-centered supported self-management tools. These components are referenced in the 2015 AMDG Guideline, in the 2016 CDC opioid guideline, and throughout the guideline below.

Patient Engagement and Support

Build a trusting relationship. Start by engaging the patient in care, discussing their goals (e.g., “*what are your expectations,*” “*what do you hope to accomplish*”), preferences, and needs, including concerns or fears around pain.

- Review your credentials and background and that of your care team and discuss how you will review the patient’s prior care and assess function, physical health, and behavioral health needs.¹
- *Start the first session with “we won’t change very much today.”² Do not discuss the possibility of changing prescriptions until at least the second visit.²*
- *Assure that your goal is to keep the patient safe² while also maximizing function and ability to live a full life.*
- Assure the patient that you will not abandon them.²
- *Assess the patient’s knowledge about their medications including how they work, side effects, and risks and their diagnoses.*
- *Discuss differences between addiction, dependence, tolerance, and misuse and the patient’s feelings about those. Ask about fears or concerns around pain.*
- Talk about chronic pain treatment approaches outside of chronic opioid therapy.³
- Ask if the patient’s spouse, parents, children or others could be included in any treatment plan.
- 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).

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Assessment

- Complete a history and directed physical exam as indicated including pain-related diagnoses and past experiences with pain interventions.
- Assess functional status with PEG pain intensity and interference scale.
- **Provide patient with current MED.**
- Query the Prescription Monitoring Program and update the patient's current medication list.²
- Document the current treatment agreement.²
- Conduct a urine drug screen. If results are aberrant, discuss this with the patient.
- Explain to patients the purpose of screening for depression, anxiety, suicidality, and alcohol 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](#).
 - **Estimate risk of opioid misuse. Talk about addiction.**
- If patient is on >120mg MED, mandatory consult is waived if the patient:²
 - Has an established written treatment agreement
 - Has been stable on a non-escalating dose
 - Has been compliant with care plan
 - Has documented improved function on opioids
- Assure that the patient has naloxone and counsel on how to use naloxone.²
- Review concomitant sedatives (e.g., benzodiazepines, z drugs, muscle relaxants, EtOH)²
 - Advise of significant risk of concomitant sedatives
 - Involve them in plan to reduce sedatives
 - Often, given the choice, people prefer to taper opioids
- Assess other risk factors for overdose (e.g., sleep apnea, patient age). Calculate risk high/medium/low.

Develop a Treatment Plan

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

- 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 supported by a care team.
 - If possible, involve behaviorists.²
 - *“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, questioning whether life has meaning or purpose*
- Review central sensitization syndrome²
 - *“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, 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).
 - Cognitive-behavioral therapy
 - Integrative health practices (e.g., massage, acupuncture, spinal manipulation).
 - Reactivation methods, eg via psychologically informed physical therapy, activity coaching,)
 - Movement and body awareness strategies.
- Determine together with the patient and their families whether to stay on opioids, reduce opioid prescriptions at a rate consistent with their clinical and social situation or transition to medication-assisted treatment (MAT). 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.⁴

Treatment Pathways

Pathway #1: Maintain & Monitor

Start with the foundation in 2015 AMDG Interagency Guideline on Prescribing Opioids for Pain, Part IV (Prescribing Opioids for Chronic Non-cancer Pain)

- Document the current treatment agreement.²
- If patient is on >120mg MED, mandatory consult is waived if the patient:²
 - Has an established written treatment agreement
 - Has been stable on a non-escalating dose
 - Has been compliant with care plan
 - Has documented improved function on opioids
- Consider moving toward short acting opioids²
- Assure that the patient has naloxone²

Pathway #2: Taper (Wean)

Start with the foundation in 2015 AMDG Interagency Guideline on Prescribing Opioids for Pain, Part V (Reducing or Discontinuing Chronic Opioid Analgesic Therapy)

In addition to the principles outlined in the 2015 AMDG opioid guideline, the following should also be followed:

- Discuss how pain intensity and function may improve after tapering chronic opioid therapy, however some report increases in pain.^{5,6} **Opioids may also be worsening pain.**
- Set realistic expectations.
- Address fears and how tapering plan will be individualized based on patient response.⁷ Discuss the patient's feelings about reducing opioid prescriptions, normalize feelings and express empathy.
- Do not suddenly discontinue chronic opioid therapy as this can lead to acute opioid withdrawal.¹ If you and the patient decide to reduce opioid prescription amounts, reduction should be gradual and individualized. Follow the [2015 Agency Medical Directors Guideline on Prescribing Opioids for Pain](#) section on tapering, part IV. See **Appendix C**.
 - Manage Opioid Abstinence Syndrome as outlined in the [2015 Agency Medical Directors Guideline](#) including restlessness, sweating, tremors; nausea; diarrhea; muscle pain, neuropathic pain or myoclonus; insomnia; and others.
 - *"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."*⁸
 - *"Gradually reduce 5% to 10% of the morphine-equivalent dose every 2 to 4 weeks with frequent follow-up."*⁹

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- *Be sure the patient knows who to contact on the care team with questions or concerns.*
- 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
- *Pausing due to life events is ok.*³
- *Discuss what to do in the event of a pain flare-up.*²
- **Continue to assess depression, suicidality, alcohol misuse, anxiety, and drug use and follow care pathway outlined above, if positive.**

Pathway #3: Transition to MAT

Start with the foundation in 2015 AMDG Interagency Guideline on Prescribing Opioids for Pain, Part VI (Recognition and Treatment of Opioid Use Disorder)

- Use evidence-based therapy including medication-assisted treatment (MAT) if opioid use disorder is present. Follow the 2017 Bree Collaborative [Opioid Use Disorder Treatment Report and Recommendations](#) and the [2015 Agency Medical Directors Guideline on Prescribing Opioids for Pain](#) Part VI Recognition and Treatment of Opioid Use Disorder.

Recommendations for Health Systems

- Provider support

Evidence

Many guidelines recommend 5-10% per month.¹⁰ Tapering should be based on function with the PEG¹¹ done at each visit.²

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.^{12,13,14}

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Appendix C: [2015 Agency Medical Directors Guideline](#)

Reasons to Discontinue COAT and Considerations Prior to Taper

- *Help the patient understand that chronic pain is a complex disease, and opioids alone cannot adequately address all of the patient's pain-related needs. Exploring the patient's resistance to discontinuing opioids will guide taper strategy. Motivational interviewing skills may be useful when having this conversation.*
- *Consider tapering patients in an outpatient setting if they are not on high dose opioids or do not have comorbid substance use disorder or an active mental health disorder, as this can be done safely and they are at low risk for failing to complete the taper.*
- *Seek consultation from a pain management specialist or Structured Intensive Multidisciplinary Pain Program (SIMP; described in Non-opioid Options) for patients who have failed taper in an outpatient setting or who are at greater risk for failure due to high dose opioids, concurrent benzodiazepine use, comorbid substance use disorder or any active mental health disorder. If SIMP is not available, engage patients in activities that emulate the biopsychosocial approach of such a program. Rarely, inpatient management of withdrawal may be necessary.*
- *Refer patients with aberrant behaviors (Table 9) for evaluation and treatment.*

How to Discontinue Opioids

- *Consider sequential tapers for patients who are on chronic benzodiazepines and opioids. Coordinate care with other prescribers (e.g. psychiatrist) as necessary. In general, taper off opioids first, then the benzodiazepines.*
- *Do not use ultra-rapid detoxification or antagonist-induced withdrawal under heavy sedation or anesthesia (e.g. naloxone or naltrexone with propofol, methohexital, ketamine or midazolam).*
- *Establish the rate of taper based on safety considerations: a. Immediate discontinuation if there is diversion or non-medical use, b. Rapid taper (over a 2 to 3 week period) if the patient has had a severe adverse outcome such as overdose or substance use disorder, or c. Slow taper for patients with no acute safety concerns. Start with a taper of $\leq 10\%$ of the original dose per week and assess the patient's functional and pain status at each visit.*
- *Adjust the rate, intensity, and duration of the taper according to the patient's response (e.g. emergence of opioid withdrawal symptoms (Table 10)).*
- *Watch for signs of unmasked mental health disorders (e.g. depression, PTSD, panic disorder) during taper, especially in patients on prolonged or high dose opioids. Consult with specialists to facilitate a safe and effective taper. Use validated tools to assess conditions (Appendix B: Validated Tools for Screening and Assessment).*
- *Consider the following factors when making a decision to continue, pause or discontinue the taper plan: a. Assess the patient behaviors that may be suggestive of a substance use disorder b. Address increased pain with use of non-opioid options. c. Evaluate patient for mental health disorders. d. If the dose was tapered due to safety risk, once the dose has been lowered to an acceptable level of risk with no addiction behavior(s) present,*

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consider maintaining at the established lower dose if there is CMIF, reduced pain and no serious adverse outcomes.

- *Do not reverse the taper; it must be unidirectional. The rate may be slowed or paused while monitoring for and managing withdrawal symptoms.*
- *Increase the taper rate when opioid doses reach a low level (e.g. <15 mg/day MED), since formulations of opioids may not be available to allow smaller decreases.*
- *Use non-benzodiazepine adjunctive agents to treat opioid abstinence syndrome (withdrawal) if needed. Unlike benzodiazepine withdrawal, opioid withdrawal symptoms are rarely medically serious, although they may be extremely unpleasant. Symptoms of mild opioid withdrawal may persist for six months after opioids have been discontinued (Table 10).*
- *Refer to a crisis intervention system if a patient expresses serious suicidal ideation with plan or intent, or transfer to an emergency room where the patient can be closely monitored.*
- *Do not start or resume opioids or benzodiazepines once they have been discontinued, as they may trigger drug cravings and a return to use.*
- *Consider inpatient withdrawal management if the taper is poorly tolerated.*

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