Updates in Managing Opioid Medications in the Primary Care Setting

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Objectives

- List key elements of the new CDC guidelines for managing patients with opioid therapy
- Develop compassionate, yet objective, evidence-based treatment plans for patients on chronic opioids
- Identify patients on chronic opioids who may be developing a disorder

Disclosures and Disclaimers

- No disclosures

- Some slides are wordy for your reference later

Pain is one of the most common reasons adults seek medical care

Acute pain (duration < 1 month) is a physiologic response to noxious stimuli that can become pathologic, is normally sudden onset, time limited, and often caused by injury, trauma, or medical treatments such as surgery

Chronic pain (duration of ≥ 3 months) can be the result of an underlying medical disease or condition, injury, medical treatment, inflammation, or an unknown cause.

Chronic pain is the leading cause of disability in the U.S.

- It is estimated that **~ 1 in 5 U.S. adults had chronic pain** in 2019
- **~ 1 in 14 adults experienced high-impact chronic pain**, defined as having pain most days or every day in the past three months that limited life or work activities.

Zelaya CE, Dahlhamer JM, Lucas JW, Connor EM. Chronic Pain Among U.S. Adults, 2019. NCHS Data Brief. 2020 Nov;(390):1-8. PMID: 33151145.

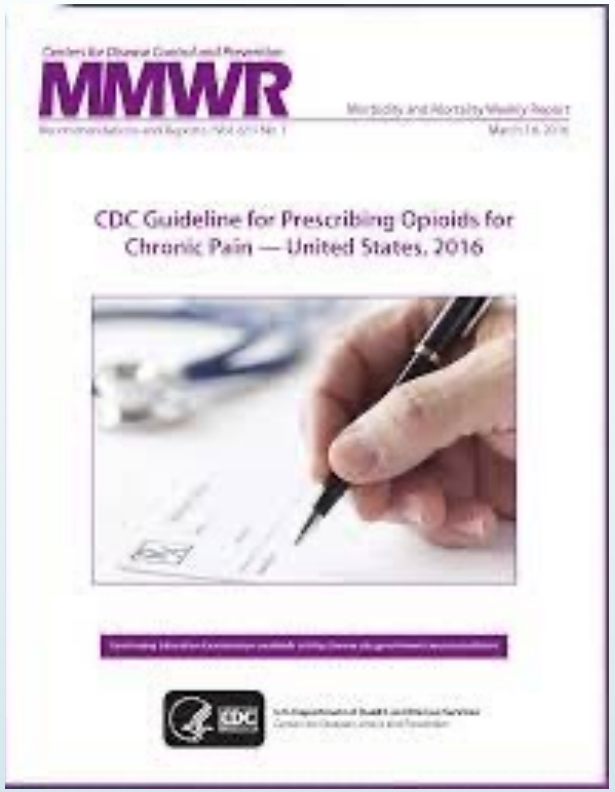
Pain is a complex phenomenon

- Pain is influenced by many factors
  - Biological
  - Psychological
  - Social factors
- There are many differences in pain treatment options and effectiveness
- Prevention, assessment and treatment of pain is a persistent challenge for clinicians and for health systems

Chou et al., Opioid Treatments for Chronic Pain. Comparative Effectiveness Review No 220. AHRQ Publication No 20-EHC011

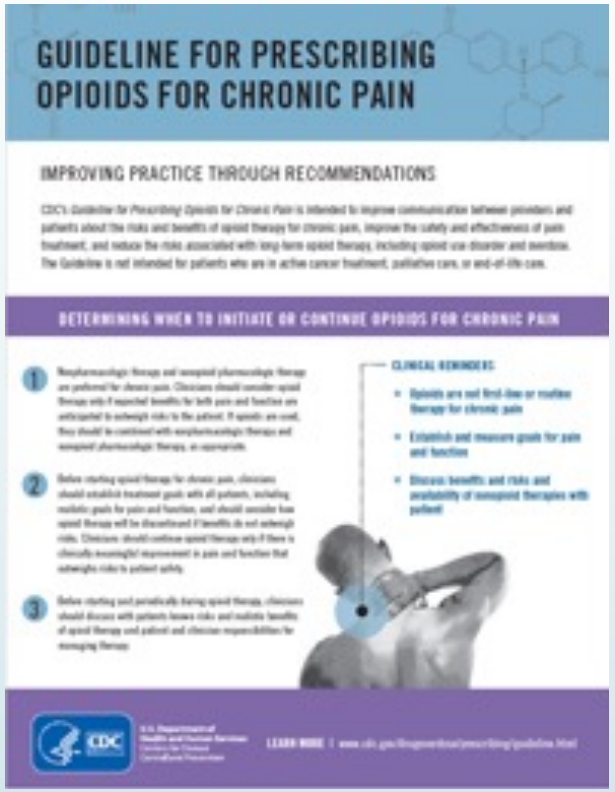
CDC Guidelines

- Released in 2016 in response to rising opioid overdose deaths
- Guideline to provide recommendations for prescribing opioid pain medication by primary care clinicians for chronic pain
- Meant to ensure that clinicians and patients consider **safer and more effective treatment, improve patient outcomes** such as reduced pain and improved function, **and reduce the number of patients who develop opioid use disorder, overdose or other adverse events**



2016 CDC Guidelines

- Recommendation for prescribing opioid pain medication
  - For patients 18 and older
  - In outpatient, primary care settings
  - In treating chronic pain
- Not intended for use in cancer treatment, palliative care, or end-of-life care
- Primary audience: primary care clinicians
  - Family Medicine
  - Internal Medicine
  - Physicians, Nurse Practitioners, Physician Assistants



2016 CDC Guidelines

Determining when to initiate or continue opioids for chronic pain

1. Opioids not first-line or routine therapy for chronic pain
2. Set goals for pain and function when starting
3. Discuss expected benefits and risks with patients

Opioid selection, dosage, duration, follow-up and discontinuation

4. Start with short-acting opioids
5. Prescribe lowest effective dose; reassess benefits and risks when increasing dose, especially to ≥50 MME; avoid or justify escalating dosages to ≥90 MME
6. Prescribe no more than needed for acute pain; 3 days often sufficient; >7 days rarely needed
7. If benefits of continuing opioids do not outweigh harms, optimize other therapies and work with patients to taper

Assessing risk and addressing harms of opioid use

8. Assess risks; consider offering naloxone
9. Check PDMP for other prescriptions, high total dosages
10. Check urine for other controlled substances
11. Avoid concurrent benzodiazepines and opioids whenever possible
12. Arrange medication-assisted treatment for opioid use disorder

Overall and high-risk opioid prescribing decreased at accelerated rates following 2016 CDC Guideline release

	Pre-Guideline (1/2012)	**Monthly decline prior to Guideline release** (1/2012-2/2016)	**Monthly decline following Guideline release** (4/2016-12/2017)
Opioid prescribing rate/100K population	6577	-23.48 (CI, -26.18 to -20.78)	-56.74 (CI, -65.96 to -47.53)
Patients with overlapping opioid + benzodiazepine Rx (%)	21.04%	-0.02% (CI, -0.04% to -0.01%)	-0.08% (CI, -0.08% to -0.07%)
High-dosage opioid Rx (≥90 MME/day)/100k population	683	-3.56 (95% CI, -3.79 to -3.32)	-8.00 (CI, -8.69 to -7.31)

From Bohnert ASB, Guy GP Jr, Losby JL. Opioid Prescribing in the United States Before and After the Centers for Disease Control and Prevention's 2016 Opioid Guideline. Ann Intern Med. 2018 Sep 18;169(6):367-375

Prescription Opioid Analgesics

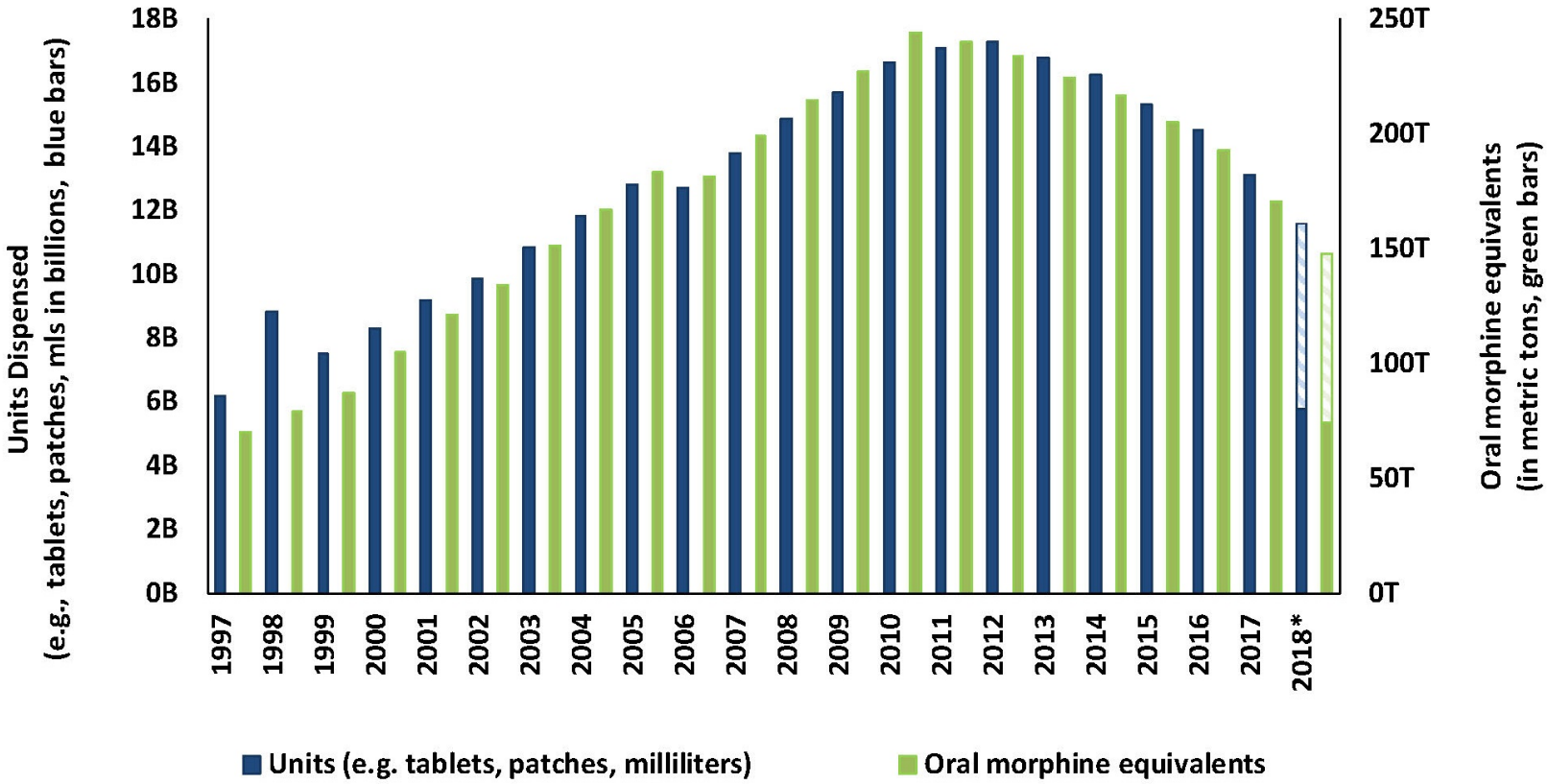


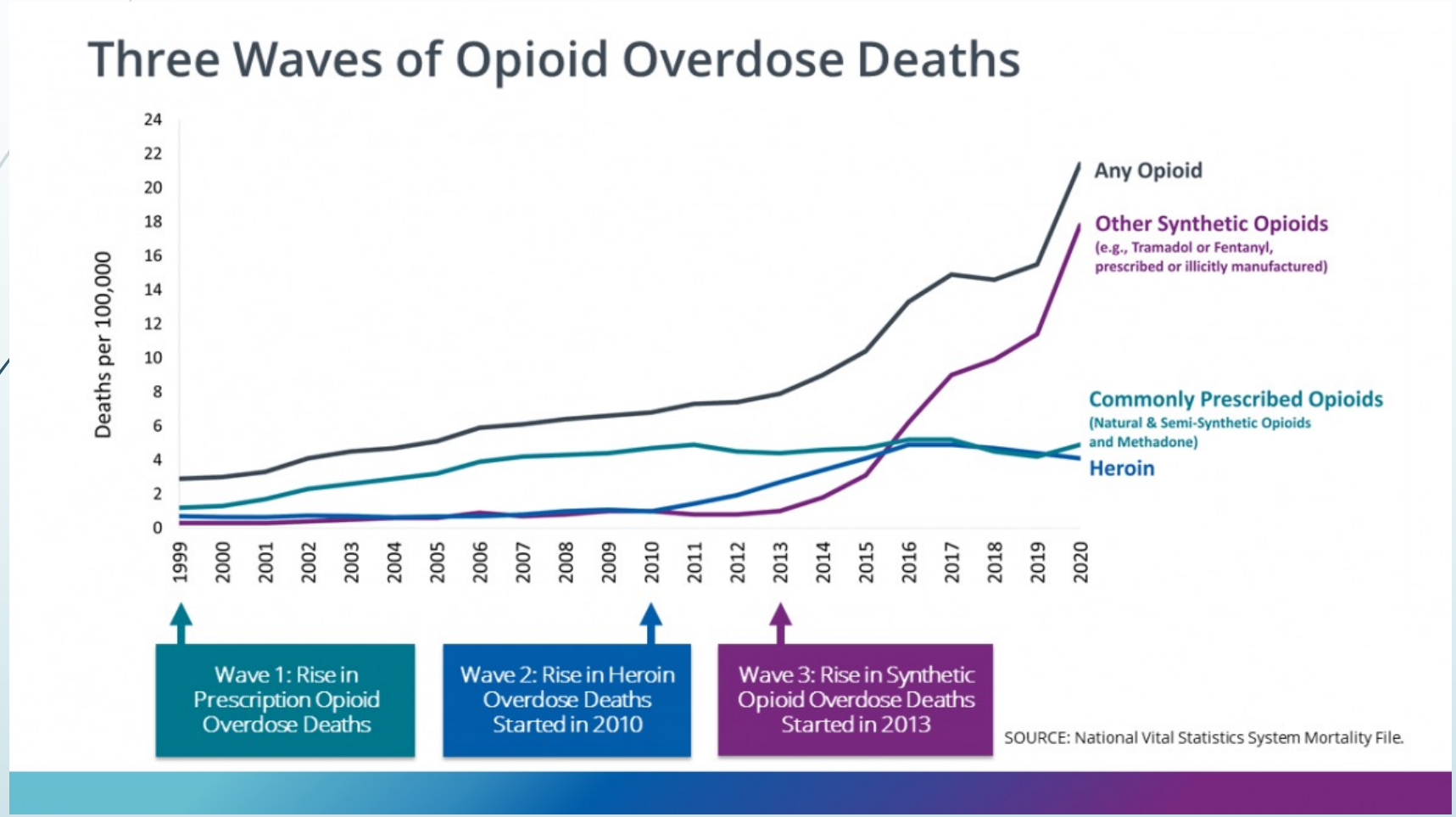
Figure 1: Estimated number of units (e.g., tablets, patches, milliliters) and calculated oral morphine equivalents (in metric tons) dispensed for opioid analgesic products from U.S. outpatient retail pharmacies, 1997 through projected year 2018*

Source: IQVIA, National Prescription Audit™. 1997-June 2018.

One billion MME is equivalent to 1 metric ton of oral morphine equivalents

*Projected year 2018 based on doubling the number of units and oral morphine equivalents dispensed during the first half of 2018 (Jan-June)

The Opioid Crisis Continues



Misapplications occurred

FDA identifies harm reported from sudden discontinuation of opioid pain medicines and requires label changes to guide prescribers on gradual, individualized tapering

FDA Drug Safety Communication

- Abrupt tapering or sudden discontinuation of opioids
  - Hundreds of documented suicides
  - Dismissal from physician practices
  - Inability to find medical care
  - Loss of function and quality of life
- Imposed hard limits or "cut off" of opioid dose
- Applied to populations outside of the 2016 Guideline's scope
  - Patients with cancer pain
  - Patients with post-surgical pain

"This is crucial, as misapplications of the 2016 guideline centered around a reductive focus on dose-based limits and tapering that was associated with patient harms," Darnall told *MedPage Today.*

HEALTH

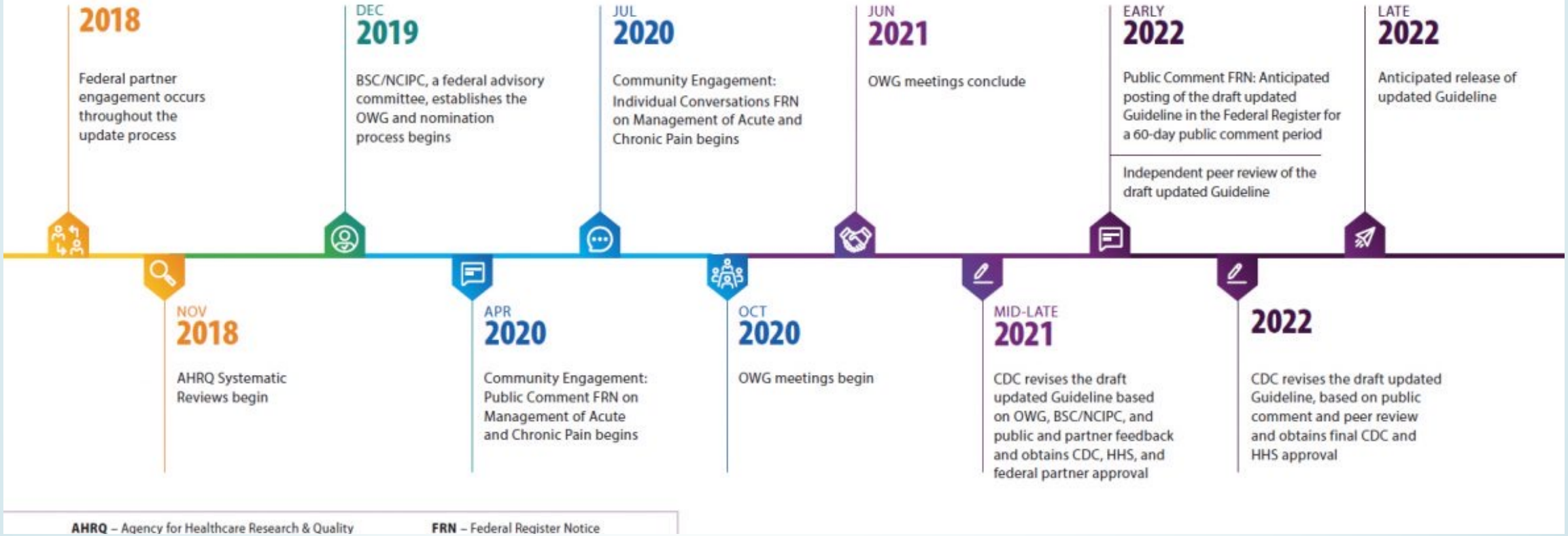
Her husband died by suicide. She sued his pain doctors — a rare challenge over an opioid dose reduction

Revisiting the guidelines

- Community engagement survey
  - Need for patients and clinicians to make shared decisions
  - Impact of misapplication of the 2016 CDC guideline
  - Inconsistent access to effective pain management solutions
  - Achieving reduces opioid use through diverse approaches
- Clinicians
  - Need for more evidence on treatment options for pain
  - Need for more assistance in determining whether to taper or discontinue long-term opioid therapy
- Public comment

PROCESS TIMELINE

Updating the CDC Guideline for Prescribing Opioids



AHRQ – Agency for Healthcare Research & Quality

FRN – Federal Register Notice

2022

CDC Clinical Practice Guideline for Prescribing Opioids for Pain

Five guiding principles should broadly inform implementation across recommendations:

1. Acute, subacute, and chronic **pain need to be appropriately and effectively treated** independent of whether opioids are part of a treatment regimen.

2. Recommendations are voluntary and are intended to support, not supplant, individualized, person-centered care. Flexibility to meet the care needs and the clinical circumstances of a specific patient are paramount.

3. A multimodal and multidisciplinary approach to pain management attending to the physical health, behavioral health, long-term services and supports, and expected health outcomes and well-being needs of each person is critical.

4. Special attention should be given to avoid misapplying this updated clinical practice guideline beyond its intended use or implementing policies purportedly derived from it that might lead to unintended consequences for patients.

5. Clinicians, practices, health systems, and payers should vigilantly attend to health inequities, provide culturally and linguistically appropriate communication, and ensure access to an appropriate, affordable, diversified, coordinated, and effective nonpharmacologic and pharmacologic pain management regimen for all persons.

2022 CDC Guidelines: Target patient population and providers

- The misapplication of the 2016 guideline to inadvertent patient groups was a significant concern
- Highlight intended patient populations, pain type and practice setting
  - Primary care clinicians and other clinicians providing care for outpatients aged ≥18 yo w
    - Acute pain (duration<1 month)
    - Subacute pain (duration 1-3 months)
    - Chronic pain (duration > 3months)
- Emphasis that the new guidelines are NOT applicable to pain treatment of sickle cell disease-related pain; cancer pain; palliative care; or end-of-life care

Evidence chart

Recommendation type

- **A**: applies to all persons, most patients should receive the recommended course of action.
- **B**: individual decision making needed; different choices will be appropriate for different patients. Clinicians help patients arrive at a decision consistent with patient values and preferences and specific clinical situations

Evidence type

- **1**: randomized clinical trials or overwhelming evidence from observational studies
- **2**: randomized clinical trials with important limitations, or exceptionally strong evidence from observational studies
- **3**: observational trials or clinical controlled trial with notable limitations
- **4**: clinical experience and observations or studies with limitations

Determining Whether or Not to Initiate Opioids for Pain

- Recommendation 1
- Nonopioid therapies are at least as effective as opioid for many common types of acute pain.
- Clinicians should maximize use of nonpharmacologic and nonopioid pharmacologic therapies as appropriate for the specific condition and patient and only consider opioid therapy for acute pain if benefits are anticipated to outweigh the risks to the patient.
- Before prescribing opioids for acute pain, clinicians should discuss with patients the realistic benefits and know risks of opioid therapy
- R:B, E:3

Determining Whether or Not to Initiate Opioids for Pain

- Recommendation 2
- Nonopioid therapies are preferred for subacute and chronic pain
- Clinicians should maximize use of nonpharmacologic and nonopioid pharmacologic therapies as appropriate for the specific condition and patient and only consider opioid therapy if expected benefits outweigh risks
- Before starting therapy, clinicians should discuss realistic expectations, benefits, risks and establish treatment goals for pan and function
- Should consider how opioid therapy will be discontinued if benefits do not outweigh the risks
- R:A, E:2

Selecting Opioids and Determining Opioid Dosages

- Recommendation 3
- When starting opioid therapy for acute, subacute, or chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release and long-acting (ER/LA) opioids

- R:A, E:4

Selecting Opioids and Determining Opioid Dosages

- Recommendation 4
- When opioids are initiated in an opioid naïve patient, clinicians should prescribe the lowest effective dose
- If opioids are continued for subacute or chronic pain, clinicians should use caution when prescribing opioids at any dose, and should carefully evaluate individual benefits and risks when considering increasing dosage
- And should avoid increasing above levels likely to yield diminishing returns

- R:A, E:2

Selecting Opioids and Determining Opioid Dosages

- Recommendation 5
- For patients already receiving opioid therapy, clinicians should carefully weigh benefits and risks and exercise care when changing opioid dosage.
- Clinicians should work closely with the patient to optimize nonopioid therapies
- If benefits do not outweigh risks, clinicians should work closely with the patient to gradually taper to lower dosages
- Unless there are indications of a life-threatening issue, opioid therapy should not be discontinued abruptly
- R:B, E:4

Deciding Duration of Initial Opioid Prescription and Conducting Follow-up

- Recommendation 6
- When opioids are needed for acute pain, clinicians should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids

- R:A, E:4

Deciding Duration of Initial Opioid Prescription and Conducting Follow-up

- Recommendation 7
- Clinicians should evaluate benefits and risks with patients within 1-4 weeks of starting opioid therapy for subacute or chronic pain or of dosage escalation
- Clinicians should regularly evaluate benefits and risks of continued opioid therapy

- R:A, E:4

Assessing Risk and Addressing Potential Harms of Opioid Use

- Recommendation 8
- Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk for opioid-related harms and discuss risk with patients
- Clinicians should work with patients to incorporate strategies to minimize risk into their management plan, including offering naloxone

- R:A, E:4

Assessing Risk and Addressing Potential Harms of Opioid Use

- Recommendation 9
- When prescribing initial opioid therapy for acute, subacute or chronic pain, and periodically during opioid therapy for chronic pain, clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data

- R:B, E:4

Assessing Risk and Addressing Potential Harms of Opioid Use

- Recommendation 10
- When prescribing opioids for subacute or chronic pain, clinicians should consider the benefits and risks of toxicology testing to assess for prescribed medication use as well as other prescribed and nonprescribed substances

- R:B, E:4

Assessing Risk and Addressing Potential Harms of Opioid Use

- Recommendation 11
- Clinicians should use particular caution when prescribing opioid pain medication and benzodiazepines concurrently and consider whether benefits outweigh the risks of concurrent prescribing of opioids and other CNS depressants

- R:B, E:3

Assessing Risk and Addressing Potential Harms of Opioid Use

- Recommendation 12
- Clinicians should offer or arrange treatment with evidence-based medications to treat patients with opioid use disorder
- Detoxification on its own, without medications for opioid use disorder, is NOT recommended for opioid use disorder
  - increased risk of resuming drug use
  - Increased risk of overdose and overdose death
- R:A, E:1

2022 CDC Guidelines: Initiating opioids

- Emphasis on the importance of treating acute, subacute and chronic pain
- Decision-making process of initiating opioid therapy
  - Duration of symptoms
  - Condition being treated
  - Alternative treatment options available
  - Special population considerations
- Using opioids for pain can be indicated
  - Severe traumatic injuries
  - Invasive surgeries with moderate to severe postoperative pain
  - Other severe acute pain when NSAIDs and other therapies are contraindicated or ineffective

2022 CDC Guidelines: Initiating opioids

- Start with lowest dosage to achieve expected effects in opioid naïve patients
- Usually single dose of 5-10 MME, with daily dose of 20-30 MME
  - Literature cited says there is not much benefit in pain or function after 50 MME/day
- First prescribe immediate-release (IR) opioids
  - Extended-release/long-acting opioids should be reserved for severe, continuous pain and for those already receiving higher doses of IR opioids for at least 1 week
- Follow-up visits- should be patient-centered, individualized approach
  - No longer need to limit acute pain prescription duration to 3-7 days
  - Patients should be evaluated a minimum of every 2 weeks for acute pain
  - Subacute or chronic pain follow-up interval around 4 weeks when titrating doses

2022 CDC Guidelines: Opioid duration and follow-up

- **Acute pain**
  - Nontraumatic, nonsurgical pain can often be managed without opioids
  - Opioids are sometimes needed for acute pain
    - Use shortest duration for pain severe enough to require opioids
  - Avoid prescribing opioids to patients "just in case" pain continues
  - Postoperative pain related to major surgery, use procedure-specific opioid specific recommendations
  - Reevaluate patients in a timely manner
    - at least every 2 weeks
  - In patients who are on chronic opioid therapy, only use additional opioids for the duration of pain severe enough to require additional opioid therapy
  - If opioids are prescribed continuously, around the clock, for more than a few days, the opioid should be tapered to minimize withdrawal symptoms

Summary of evidence for acute pain

- Dental pain, kidney stone pain → NSAIDS
- Musculoskeletal injuries→ topical NSAIDs, oral NSAIDs, acetaminophen
- Acute migraines→ triptans, NSAIDs, antiemetics, dihydroergotamine, CGRP antagonists
- Acute low back pain→ NSAIDs, topical therapies, skeletal muscle relaxants, heat therapy, acupressure, massage

2022 CDC Guidelines: Opioid duration and follow-up

- **Subacute pain**
  - Evaluate benefits and risks of opioids within 1-4 weeks after starting long-term opioid therapy or following dose escalation
  - Consider follow-up intervals within the lower range when using ER/LA opioids are started or increased, or when total daily opioid dose is ≥50 MME/day
  - Shorter follow-up duration should be used when starting methadone for pain. Suggested q 3 days
  - Regularly reassess all patients receiving long-term opioid therapy, at least every 3 months
  - When taking over a patient who is already receiving opioids, the clinician should establish clear treatment goals for continued opioid therapy

2022 CDC Guidelines: Opioid duration and follow-up

- **Follow-up**
  - Clinicians should assess patient perspectives and goals
  - Ensure treatment for depression, anxiety, or other psychological co-morbidities are optimized
  - Clinicians should ask patients about their preferences for continuing opioids
    - Does their use improve pain and function?
    - Do risks outweigh benefits?
    - Any adverse effects?
    - Does the patient want a dose reduction or discontinuation?

Summary of evidence for subacute/chronic pain

- Back pain, fibromyalgia, osteoarthritis
- Exercise and physical therapy help most subacute and chronic pain
- Counseling and mind-body activities are beneficial
- Neuropathic pain
  - Tricyclics (nortriptyline, amitriptyline)
  - SNRI (venlafaxine, duloxetine, milnacipran)
  - Selected anticonvulsants (pregabalin, gabapentin, enacarbil, oxcarbazepine)

Summary of evidence on pain management

- Several nonpharmacologic treatments and nonopioid medications are associated with improvements in pain and/or function
- Several noninvasive, nonpharmacological interventions improve chronic pain and function. Some of these are sustained following treatment
- Nonopioid drugs, including SNRI antidepressants, pregabalin/gabapentin, and NSAIDS, are associated with small to moderate improvements in chronic pain and function
- Opioid therapy is associated with similar or decreased effectiveness for pain and function vs NSAIDs across several acute pain conditions
  - Association between opioid use for acute pain and long-term opioid use
  - Evidence on long-term effectiveness of opioids remains very limited

New CDC Guidelines

What has changed?

- Removal of specific dosage cautions
- Removes cautions and limitations in statement 4 and 5
- Removes specific days duration of opioid therapy for acute pain in statement 6
- Statement 5 has repeated cautions with dose reduction
- Less absolute restriction with co-prescribing benzodiazepines
- Less restriction no PDMP frequency
- "Consider" drug testing

What has not changed?

- Still no clear guidance on when opioid medications are appropriate
- The evidence to support most of the CDC statements is still weak evidence
  - 7 of 12 statements have GRADE 4 "very weak" evidence
  - 4 of these 7 still have "A" recommendations

Case

Dr G is a family medicine physician seeing a new patient, Mr T, whose physician of many years, Dr A, recently retired. Mr T is 58 years old and takes 170 morphine milligram equivalents (MME) of oxycodone by mouth each day to treat chronic pancreatitis pain. Dr G is shocked by this large dose and asks Mr T about it. Mr T explains, "I've been at this dose for a while now. Dr A used to have folks from this drug's company who would visit his clinic, so he knew what he was doing."

Dr G sits and responds, "Well, that might be true, but I can't prescribe that amount. You've grown to tolerate this amount of this drug over time, but that's not good for you; it's not safe. I'm going to help you taper down, to gradually get used to lower doses. We'll make this change together over time."

Mr T looks terrified. "Look, I've run out of pills before. When that happened, I've never been so sick and miserable in my life. I didn't want to live." Becoming exasperated and starting to panic, Mr T insists, "I need to keep doing what's working for me now! Are you saying Dr A has been wrong all this time? You say, 'We'll make this change together over time.' What does that mean? How long will this take?"

Dr G suspects that the opioid therapy is primarily treating the physical dependence caused by the medication rather than the original pain. Based on recent guidelines, she also doesn't think chronic opioid therapy was likely a good strategy for Mr T. She wonders whether to say this explicitly to Mr T and what to do next.

Reider, TN. *Is Nonconsensual Tapering of High-Dose Opioid Therapy Justifiable? AMA J Ethics*. 2020;22(8):E651-657. doi: 10.1001/amajethics.2020.651

Opioids

Primary Care Models

What Do the CDC Guidelines Mean for Patients on Long-Term, High-Dose Opioids?

CDC opioid prescribing guidelines for legacy patients and long-term opioid therapy as part of chronic pain management.

Apr 29, 2019
Adrian Bartoli, MD, Medical Director, Interdisciplinary Pain Specialist
Courtney Kominek, PharmD, BCPS, CPE, Clinical Pharmacy Specialist in Pain Management

The latest data are sobering: death by drug overdose is now the leading cause of mortality among Americans under 50 years of age. Drug overdose deaths in 2016 exceeded 59,000, or the rough equivalent of a commercial airliner crashing every day and killing everyone on board.[1] This toll includes accidental overdose deaths and suicides from both illegal and prescribed opioid use; it may be exacerbated by patients' comorbid disease or combined drugs (benzodiazepines) and alcohol use at the time of death.

In part to address the opioid overdose epidemic and promote safer use of opioids, the Centers for Disease Control and Prevention (CDC) released the CDC Guideline for Prescribing Opioids for Chronic Pain in 2016.[2] The guideline is generally reasonable and conservative in its recommendations for how primary care providers (PCPs) should treat acute pain. Nevertheless, controversy has persisted over the appropriate treatment of patients with chronic pain (> 3 months) using high-dose opioids (> 90 mg morphine equivalents daily), which the CDC recommends be "carefully justified."

Editorials

Prescribing Opioids for Chronic Pain: Unintended Consequences of the 2016 CDC Guideline

Robert L. "Chuck" Rich Jr., MD, FAAFP, Bladen Medical Associates, Elizabethtown, North Carolina

See related Practice Guideline at https://www.aafp.org/afp/2016/0615/p1042.html.

In 2016, the Centers for Disease Control and Prevention (CDC) released a clinical practice guideline to help guide the use of opioid pain relievers assessment, optimizing assessments of risks vs. benefits, using the lowest effective dosage for pain relief and functional improvement, and monitoring patients with periodic drug screens, state prescription drug monitoring programs, and functional assessment tools.

The two recommendations subject to greatest misapplication are the 90-MME prescribing limit and avoidance of the combined use of opioids and benzodiazepines. Although escalation of opioid dosing to more than 90 MME per day should be

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CASE AND COMMENTARY

Is Nonconsensual Tapering of High-Dose Opioid Therapy Justifiable?

Travis N. Rieder, PhD

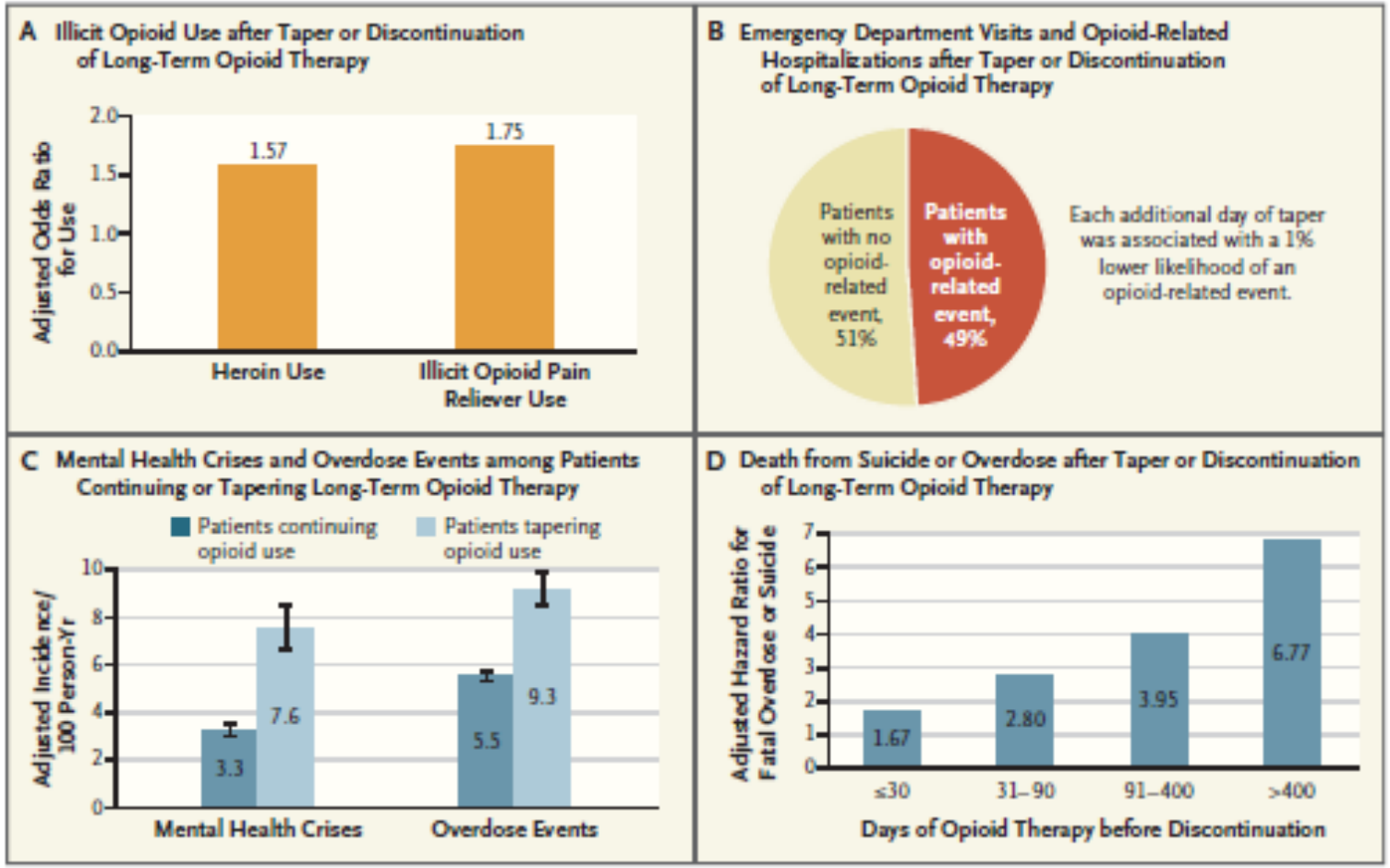
Abstract
This case considers a so-called legacy patient, one whose behaviors and symptoms express a legacy of past, aggressive opioid prescribing by a clinician. Some prescribers might feel pressured to taper doses of opioids for such patients, but this article argues that nonconsensual dose reductions for stable opioid therapy patients is impermissible because it both puts a patient at risk and wrongs an individual in a misdirected attempt to ameliorate a systemic wrong. Although perhaps surprising, this argument is supported by current evidence and recommendations for patient-centered pain care.

Patients on legacy opioid prescriptions

Many primary care practices face a common challenge of inheriting patients on legacy opioid prescriptions, often at high doses. Taking over the care for these patients is critical so that they 1) receive evidence-based opioid management, including opioid taper when appropriate, 2) have a primary care home, and 3) do not consider turning to use of illicit opioids. Caring for these patients can be challenging, and this document can help clinics develop strategies that support them in accepting these patients and offering them the evidence-based care that they need.

FDA identifies harm reported from sudden discontinuation of opioid pain medicines and requires label changes to guide prescribers on gradual, individualized tapering

FDA Drug Safety Communication



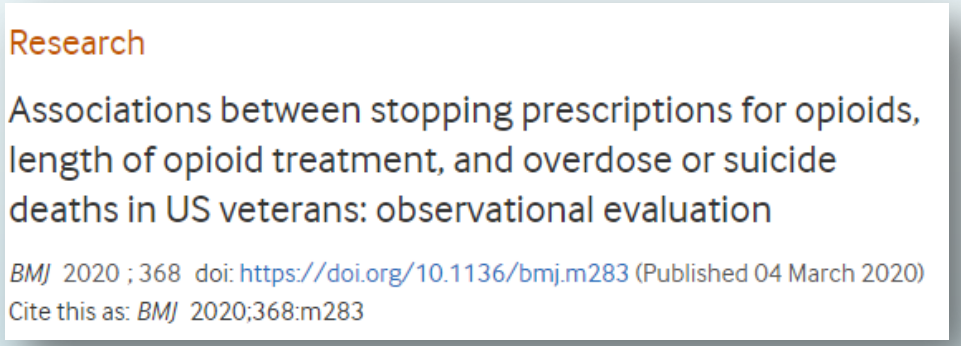
Risks Conferred by Tapering or Discontinuing Long-Term Opioid Therapy.

Among patients who have their long-term opioid therapy discontinued or tapered, there is an increased risk of illicit opioid use (Panel A), a high incidence of emergency department visits and opioid-related hospitalizations (Panel B), an increased incidence of mental health crises and overdose events (Panel C), and an increased risk of death from suicide or overdose (Panel D). I bars in Panel C indicate 95% confidence intervals. Data are from Coffin et al.,[2] Mark and Parish,[3] Agnoli et al.,[4] and Oliva et al.[5]

Coffin, et al. *Inherited Patients Taking Opioids for Chronic Pain-Considerations for Primary Care*. N Engl J Med 2022; 386:611-613. DOI: 10.1056/NEJMp2115244

Summary of evidence on pain management – "legacy patients"

- It can be very challenging for clinicians and patients to discontinue opioids after extended periods of continuous opioid use
- Tapering or discontinuing opioids in patients who have taken them long-term can be associated with significant risks, particularly if opioids are tapered rapidly or patients do not receive effective support



Research

Associations between stopping prescriptions for opioids, length of opioid treatment, and overdose or suicide deaths in US veterans: observational evaluation

BMJ 2020 ; 368 doi: https://doi.org/10.1136/bmj.m283 (Published 04 March 2020)
Cite this as: *BMJ* 2020;368:m283

2022 CDC Guideline

For patients already receiving higher opioid dosages, **clinicians should carefully weigh benefits and risks and exercise care when reducing or continuing opioid dosage.**

- If risks outweigh benefits of continued opioid therapy, clinicians should optimize other therapies and work closely with patients to gradually taper to lower dosages or, if warranted based on the individual clinical circumstances of the patient, to appropriately taper and discontinue opioids.
- Unless there are indications of a life-threatening issue, such as warning signs of impending overdose, e.g., confusion, sedation, or slurred speech, **opioid therapy should not be discontinued abruptly, and clinicians should not abruptly or rapidly reduce opioid dosages from higher dosages** (RB, E4)

Implementation considerations for taper

- Clinicians should consider tapering to a reduced dosage, or tapering and discontinuing opioid therapy, and discuss these approaches with patient prior to initiating changes, **when risks outweigh benefits** (potentially including avoiding risks of tapering) of continued opioid therapy
- Patient agreement and interest in tapering is likely to be a key component to successful tapers
- For patients agreeing to taper to lower opioid doses as well as for those who remain on higher doses, clinicians should establish goals with the patient for continued opioid therapy and maximize pain treatment with nonpharmacologic and nonopioid pharmacologic treatments as appropriate

Implementation considerations for taper

- Clinicians should collaborate with the patient on a tapering plan, including the patients in decisions as to how quickly to taper and when pauses may be warranted
- Clinicians should follow-up frequently with patients who are engaged in an opioid taper
- When opioids are reduced or discontinued, the taper should be slow enough to minimize symptoms and sings of opioid withdrawal
  - Anxiety, insomnia, abdominal pain, vomiting, diarrhea, diaphoresis, mydriasis, tremor, tachycardia, piloerection

Implementation considerations for taper

- Tapers can be completed over several months to years depending on the opioid dosage and should be individualized based on patient goals and concerns. Longer durations of previous opioid therapy might require longer tapers
- Tapers of 10% per month or slower are likely to be better tolerated than more rapid tapers, particularly when patients have been taking opioids for longer durations (e.g., for a year or longer)
- Significant opioid withdrawal symptoms can signal the need to further slow the taper rate
  - At times, tapers might have to be paused and restarted again when the patient is ready and might have to be slowed once patients reach low dosages

Implementation considerations for taper

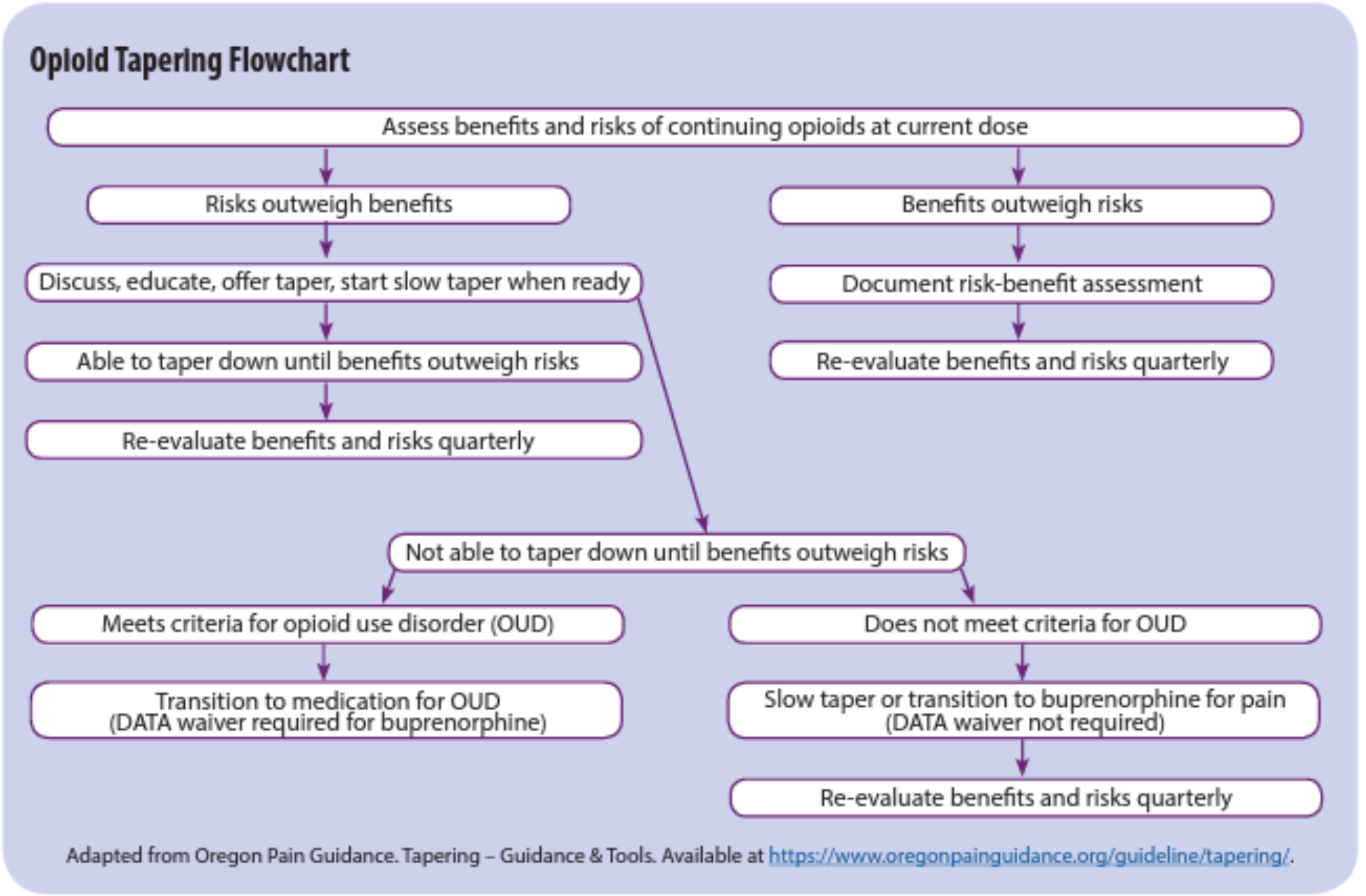
- Tapers should not be reversed without careful assessment of benefits and risks of increasing opioid dosage or without maximizing nonopioid treatments for pain and addressing behavioral distress
- Once the smallest available dose is reached, the interval between doses can be extended
- Goals of the taper may vary—some patients might achieve discontinuation; others might attain a reduced dosage. If the clinician has determined with the patient that the ultimate goal of tapering is discontinuing opioids, opioids may be stopped when taken less frequently than once per day.

Implementation considerations for taper

- Clinicians should access appropriate expertise if considering tapering opioids during pregnancy because of possible risk to the pregnant patient and to the fetus if the patient goes into withdrawal
- Clinicians should advise patients that there is an increased risk for overdose on abrupt return to a previously prescribed higher dose, caution that it takes as little as a week to lose tolerance, provide opioid overdose education, and offer naloxone.
- Clinicians should remain alert to signs of anxiety, depression, and opioid misuse or opioid use disorder (see Recommendations 8 and 12) that might be revealed by an opioid taper and provide treatment or arrange for management of these co-morbidities.

Implementation considerations for taper

- Clinicians should closely monitor patients who are unable to taper and who continue on high-dose or otherwise high-risk opioid regimens (e.g., opioids prescribed concurrently with benzodiazepines) and should work with patients to mitigate overdose risk
- Clinicians can use periodic and strategic motivational questions and statements to encourage movement toward appropriate therapeutic changes and functional goals
- Clinicians have a responsibility to provide or arrange for coordinated management of patients' pain and opioid-related problems, including opioid use disorder. **Clinicians should not abandon patients.**



https://www.hhs.gov/opioids/sites/default/files/2019-10/Dosage_Reduction_Discontinuation.pdf

Mr. Jones

- 62yo male with chronic pain secondary to previous trauma history. He was injured during a fall from a second story doing construction many years ago. He is on oxycodone 30mg QID for pain.
- Mr. Jones says the oxycodone is no longer working for his pain and he wants to get off the pills.
- He has been on oxycodone for many years and endorses needing higher and higher doses over the years.
- He is afraid of not having medication because he does have withdrawal symptoms when he doesn't take his oxycodone.

Next steps…

- Does Mr. Jones meet criteria for opioid use disorder?
- What is your diagnosis?
  - Based on what criteria?
- Does Mr. Jones qualify for office-based treatment for opioid use disorder based on this history?

Opioid Use Disorder

Severity

- Mild: 2-3 symptoms
- Moderate: 4-5 symptoms
- Severe: 6 mor more symptoms

*Tolerance and Withdrawal not considered to be met for those taking opioids solely under appropriate medical supervision

DSM-5 Criteria for Diagnosis of Opioid Use Disorder

Diagnostic Criteria*

These criteria not considered to be met for those individuals taking opioids solely under appropriate medical supervision.

Check all that apply

	Opioids are often taken in larger amounts or over a longer period of time than 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 to use opioids.
	Recurrent opioid use resulting in 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 use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.
	*Tolerance, as defined by either of the following: (a) a need for markedly increased amounts of opioids to achieve intoxication or desired effect (b) markedly diminished effect with continued use of the same amount of an opioid
	*Withdrawal, as manifested by either of the following: (a) the characteristic opioid withdrawal syndrome (b) the same (or a closely related) substance are taken to relieve or avoid withdrawal symptoms

More on Mr. Jones

- After more questioning, Mr. Jones does say that he has had to miss family events due to not having his medications
- He admits to taking oxycodone from friend when he ran out of pills and could not fill yet
- He says he has never had an overdose, but his wife is worried about him because he sometimes seems "drugged"

With more history…

- Does Mr. Jones meet criteria for opioid use disorder?
- What is your diagnosis?
  - Based on what criteria?
- Does Mr. Jones qualify for office-based treatment for opioid use disorder?

Mr. Jones

- Tolerance and Withdrawal: don't count
- Impaired control
  - Took medications from a friend because he ran out
- Social Impairment
  - Has had to miss family events
- Risky Use
  - Wife is concerned about oversedation

- Opioid Use Disorder: mild

Do you have a case?


ANY
Questions?