



**ACUTE AND CHRONIC PAIN MANAGEMENT:  
EDUCATING CLINICIANS ON THE IMPACT AND HISTORY OF THE OPIOID CRISIS**

**Wednesday, March 18th, 2020, 2:00 P.M. – 3:15 P.M. EST**

National Resource Center for Academic Detailing  
Division of Pharmacoepidemiology and Pharmacoeconomics [DoPE]  
Brigham and Women's Hospital | Harvard Medical School



**Guest Speaker:**

**Jim Shames, MD**, *Medical Director and Health Officer, Jackson County Founding Member, Oregon Pain Guidance*

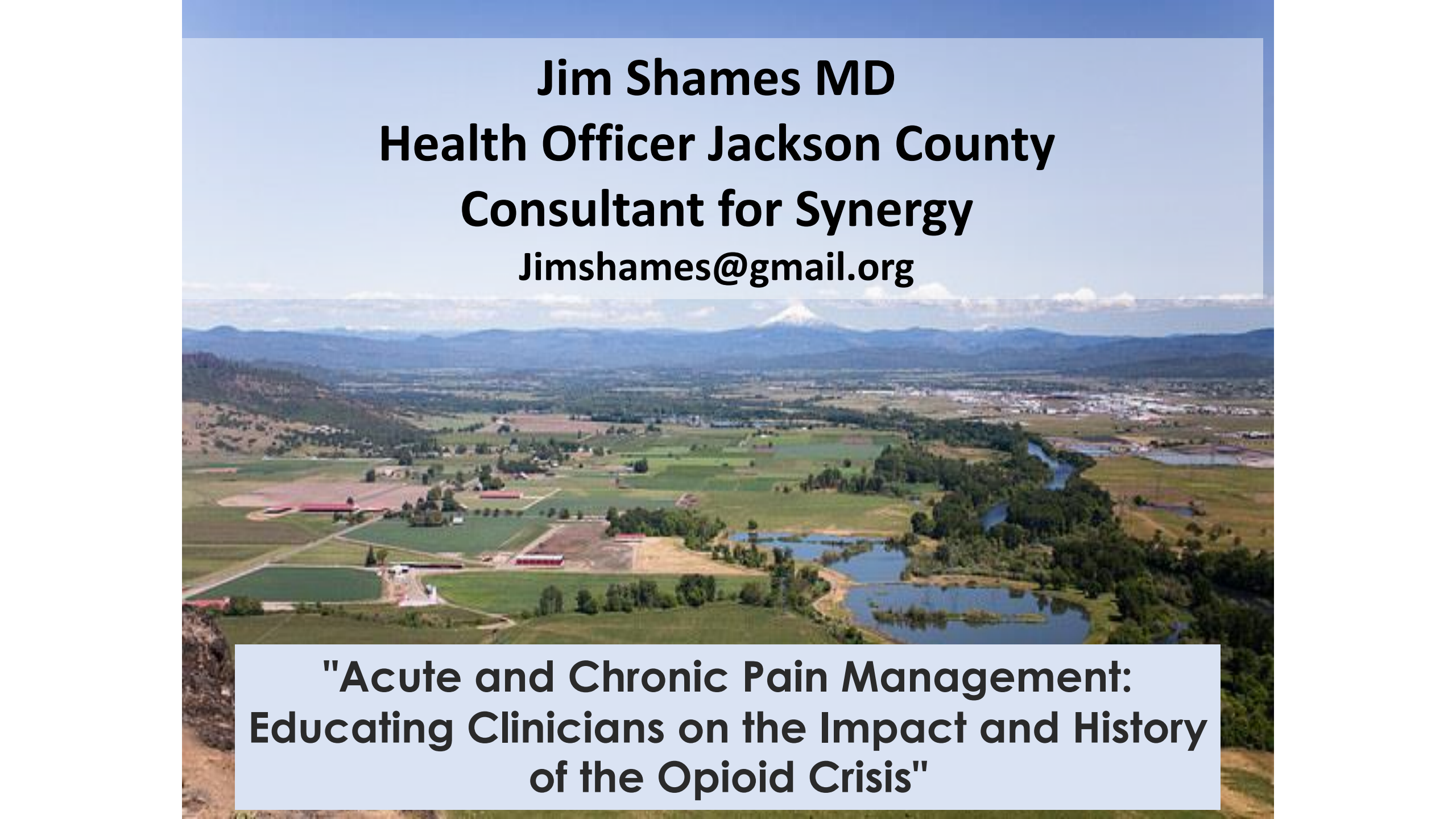
**Moderator:**

**Bevin Shagoury**, *Communications & Education Director, NaRCAD*



# Webinar Goals:

- ✓ Continued support from NaRCAD
- ✓ Explore the history of acute and chronic pain management
- ✓ Understand best practices for opioid tapering
- ✓ Q+A Session with Jim Shames



**Jim Shames MD**  
**Health Officer Jackson County**  
**Consultant for Synergy**  
**Jimshames@gmail.org**

**"Acute and Chronic Pain Management:  
Educating Clinicians on the Impact and History  
of the Opioid Crisis"**

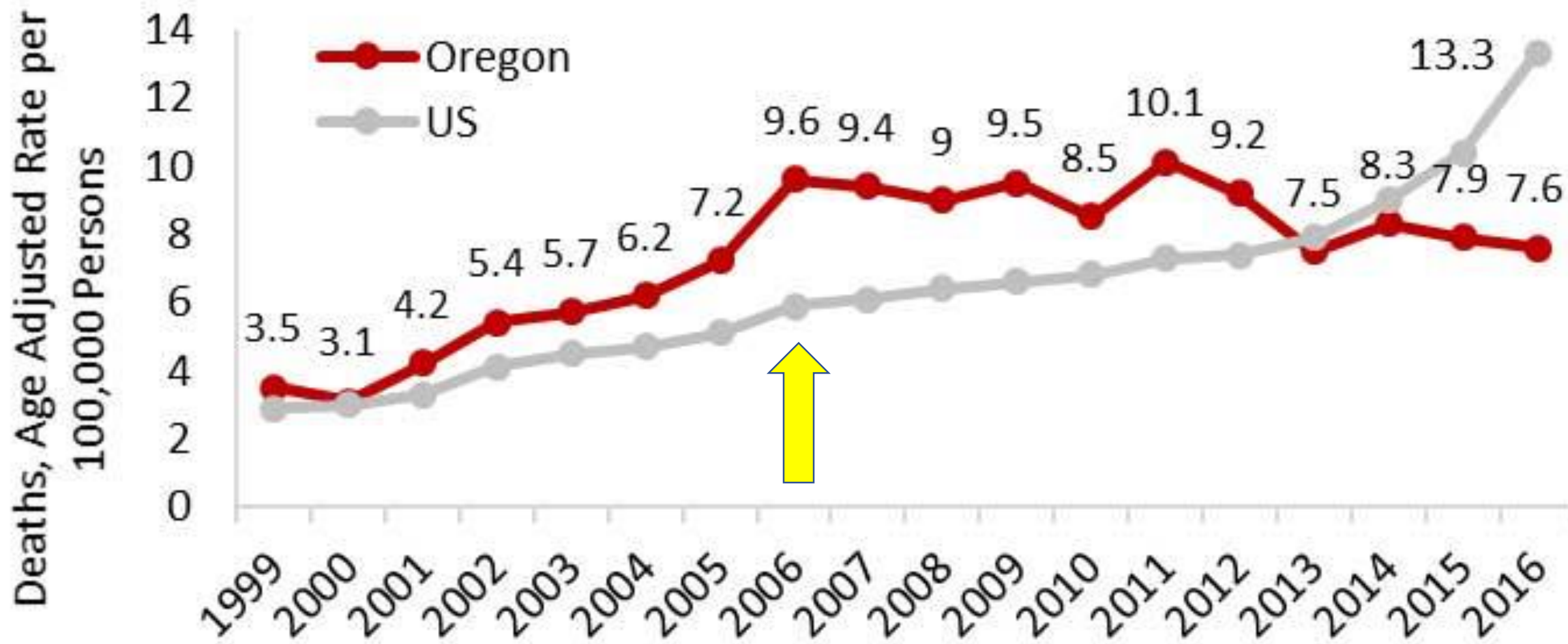
# My background

- Primary Care physician in a rural setting for 30 years
- Public Health Physician for Josephine then Jackson County
- Medical Director for a Medication Assisted Treatment program for 25 years
- Currently a consultant for Synergy concerning opioids.
- Member of the governor's task force on Opioids





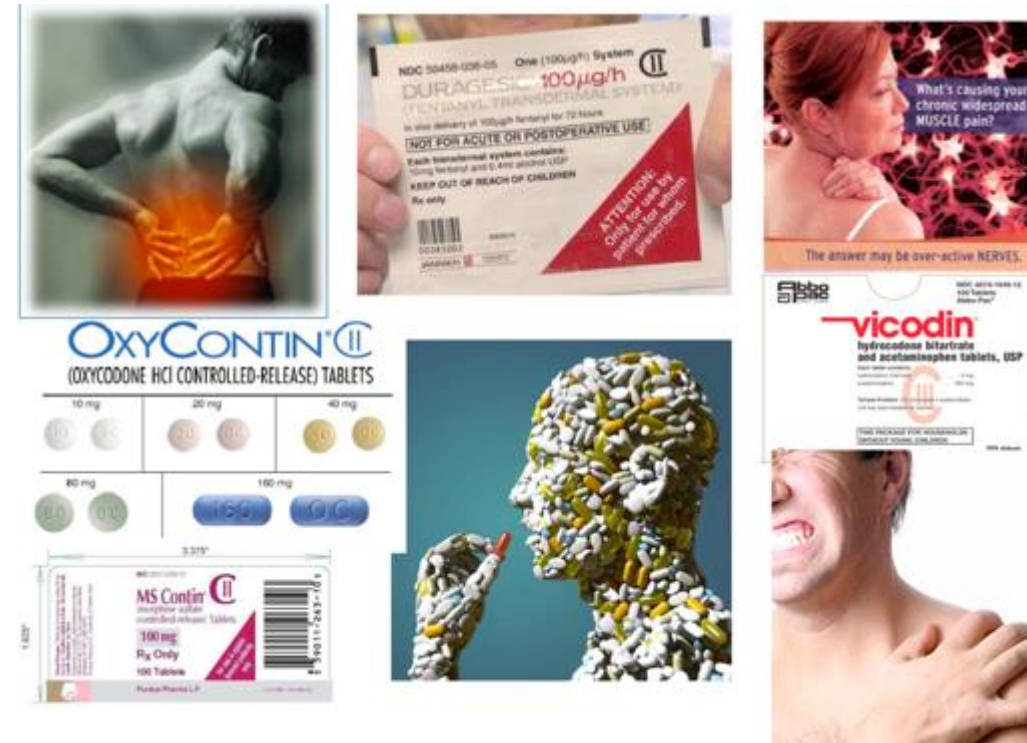
## Rate of Opioid Related Overdose Deaths in Oregon



Source: CDC WONDER

# What was the nature of the opioid problem in 2006?

- Initially:
  - Primarily an inappropriate over-prescribing problem
  - Providers didn't understand pain and pain treatment.
  - Providers (and patients) didn't appreciate the risks of opioids.





**Too many pills!**

**How did we get here?**



# The Recent Past

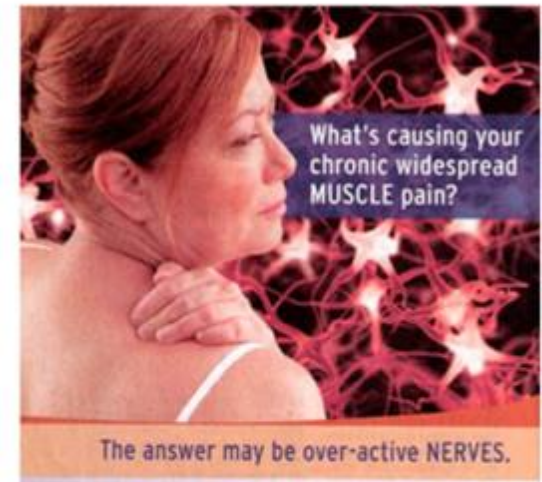


In 1991, 88% of Medical Board members believed that extended opioid prescribing for chronic non cancer pain was ***unlawful*** and ***unacceptable*** medical practice. <sup>1</sup>

1. Gilson AM, Joranson DE. Controlled substances and pain management: changes in knowledge and attitudes of state medical regulators. J Pain Symptom Manage 2001;21(3):227–37.







# OXYCONTIN® II

(OXYCODONE HCl CONTROLLED-RELEASE) TABLETS



# Pain Treatment



*"Ask your doctor if taking a pill to solve all your problems is right for you."*





- Created Oxycontin in 1996
- Became the best selling opioid in 2001
- The Sackler family is now one of the wealthiest in the world
- There are multiple billion dollar settlements related to misguiding patients and physicians around opioid safety.

# Influential Medical Leaders Promoting Opioid Use

**Russell Portenoy**



**Scott Fishman**



# Influential Licensing Agencies



## Inside:

License Applications  
Now Online: A  
Guide to the BME  
Website

2003 Legislative  
Review

Physical Therapy  
Referrals

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## NEW LAW CLARIFIES PATIENTS' RIGHTS TO ACCESS MEDICAL RECORDS

By Mike Sherman  
BME Complaint Resource Officer

Rarely does a day go by that the BME does not receive several telephone calls, from either patients or licensees, regarding a patient's right to copies of their medical records. It is clear from the type of questions received that there is misunderstanding in the medical community regarding patient rights and medical records.

To make matters more interesting, the 2003 Oregon Legislature passed House Bill (HB) 2305, making state patient-records laws comply with federal Health Insurance Portability and Accountability Act (HIPAA) regulations. This bill took effect upon passage and made some significant changes in state law regarding patient's access to medical records.

HB 2305 was meant to complement HIPAA, and needs to be read in conjunction with the federal regulations. I will attempt to summarize some of the more important changes the Oregon bill and HIPAA make. The BME is in the process of changing its administrative rule on the release of records to incorporate these changes.

The law gives patients the right to access their medical records personally, or to have them sent to an authorized person or organization. The law gives a very broad definition of information that the patient is entitled to obtain, and includes "information that relates to the past, present, or future physical or mental health of an individual" in any form. The law also includes billing information as information the patient is entitled to obtain.

Unlike the previous law, HB 2305 does not exempt the release of records of another health care provider which may be contained in the record. The new law allows the health care provider to require a written release from the requesting patient in a format very similar to the one specified by the old law (ORS 192.525, which has been repealed).

As in the old law, current law does allow

certain exemptions to the general requirement to release information. There is an exemption for release for information which would harm the health of the patient. Psychotherapy notes are exempt as is information compiled, in anticipation of, or for, litigation. If the medical record contains information obtained from someone other than a healthcare provider under a promise of confidentiality, then that information may be exempted if releasing the information would tend to identify the source.

HB 2305, like the previous law, allows charging a fee for reproducing records. However, the new law specifies the amount which may be charged. HB 2305 allows a fee of \$25 for the first ten pages of written material and 25 cents a page for orders of more than 10 pages. When X-rays or other non-written materials are ordered, the actual cost of reproducing the items may be charged. Inability to pay is not grounds to withhold medical records. Additionally, the law does not exempt the release of records when a patient's bill is not paid in full. Records should not be withheld for that reason.

In summary, HB 2305 and HIPAA:

- Give patients broad access to their medical records in the possession of the licensee who receives the request.
- Patients may request all or part of the record.
- Patients may request that the information be sent to them or to another person.
- Licensees may require a written release and require the patient to specify which part of the record they wish to obtain.
- A fee, which is specified in the statute, may be charged.

Please keep in mind that this article is a summary, and is not intended to substitute for a detailed reading of the current law. If questions arise concerning medical records, feel free to contact the Board's Complaint Resource Officer at (503) 229-5770. ■



## Joint Commission

on Accreditation of Healthcare Organizations

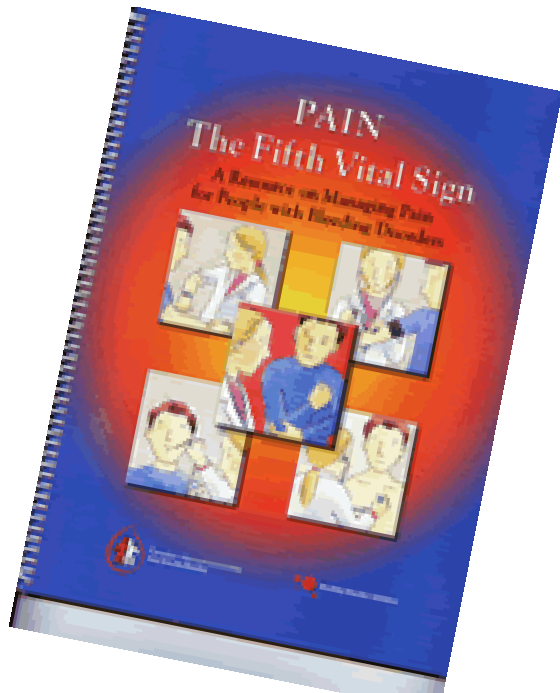
# Changes in Medical Practice



- Providers have less time with their patients
- They are more reliant on pharmaceuticals for their treatments
- The patient and physician expect a “pill” transaction.

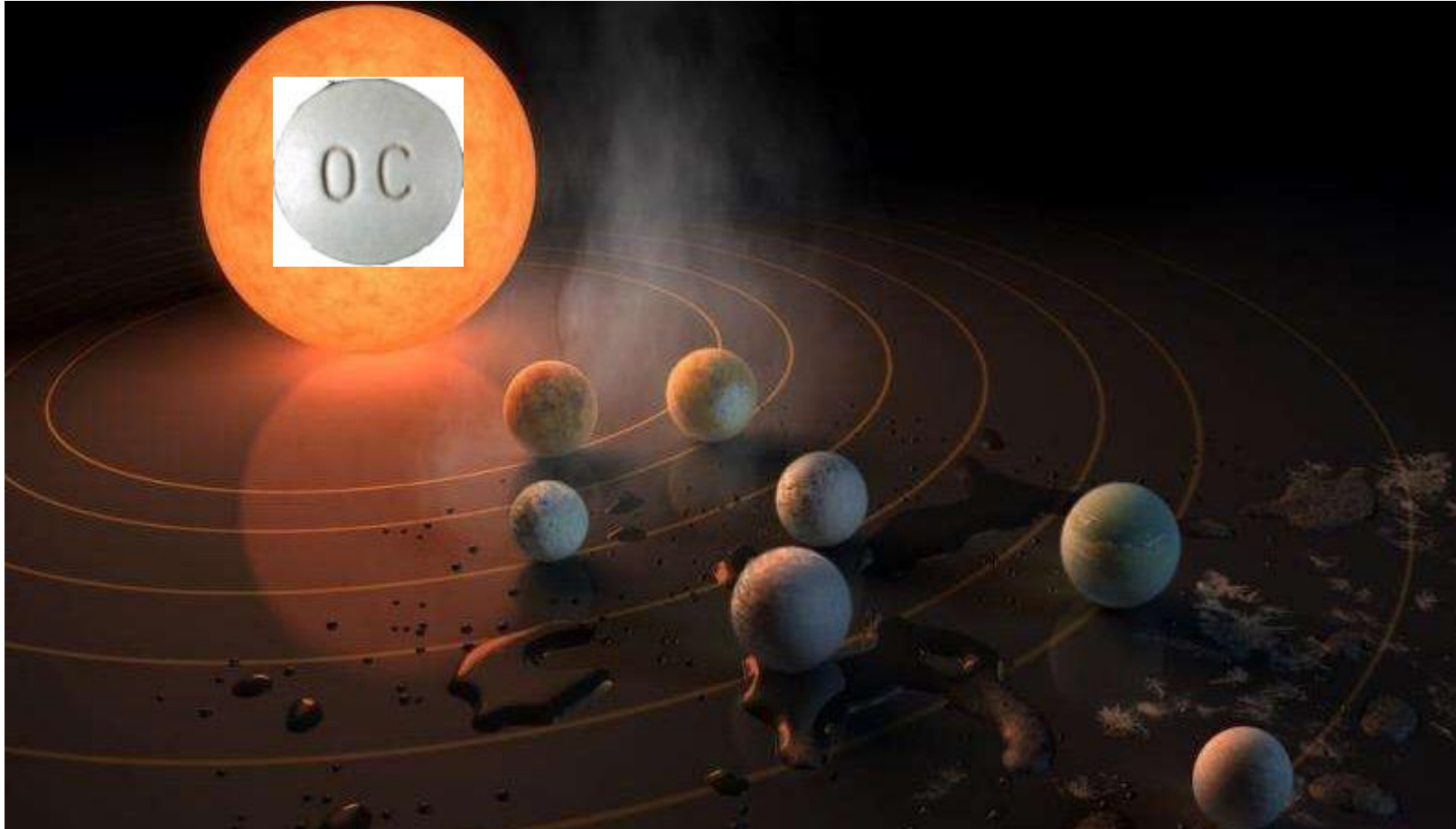


We were told that we needed to be more “compassionate” in the treatment of chronic pain.



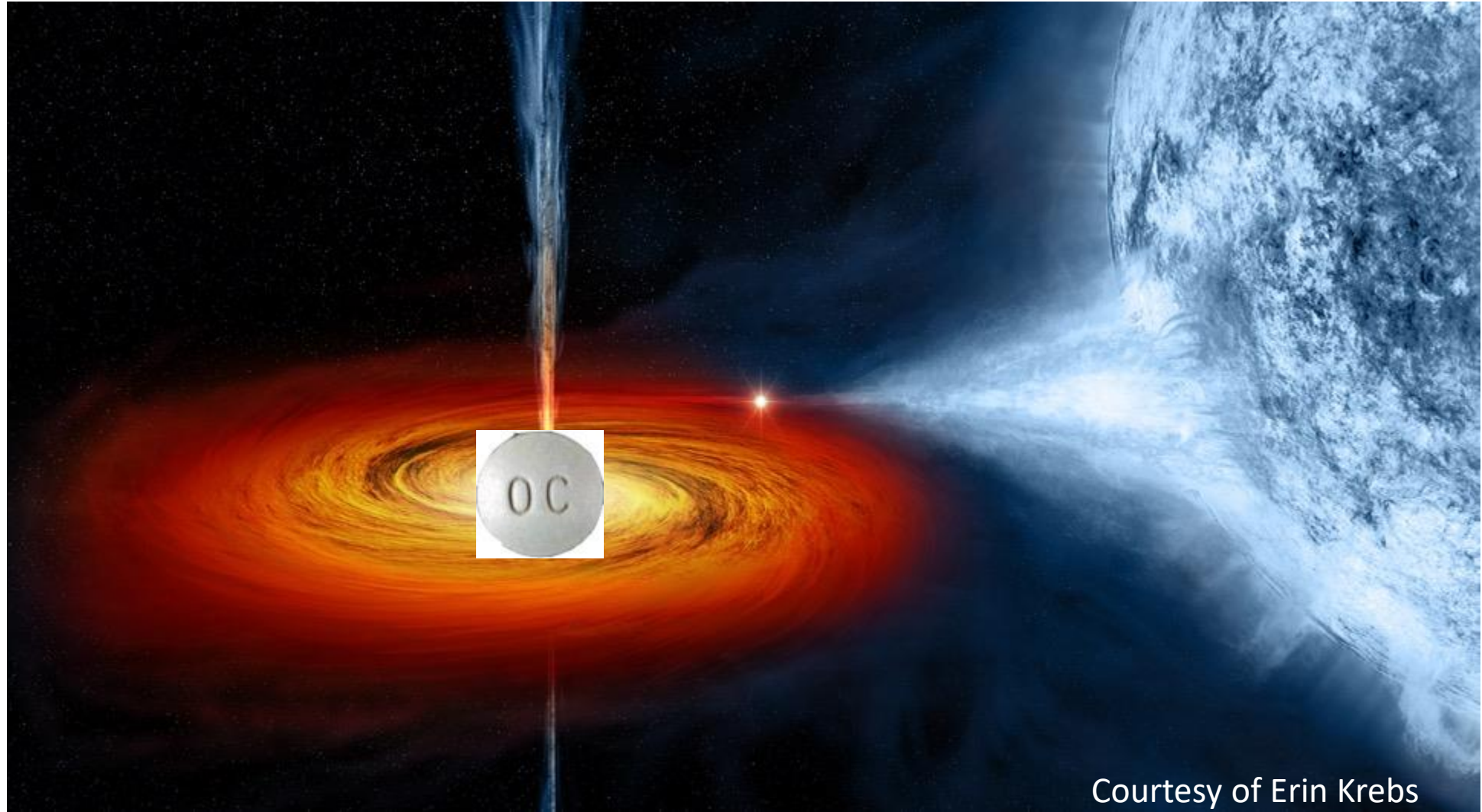


Opioids became the center of our pain management universe





It became a black hole, sucking all other treatment modalities out of existence



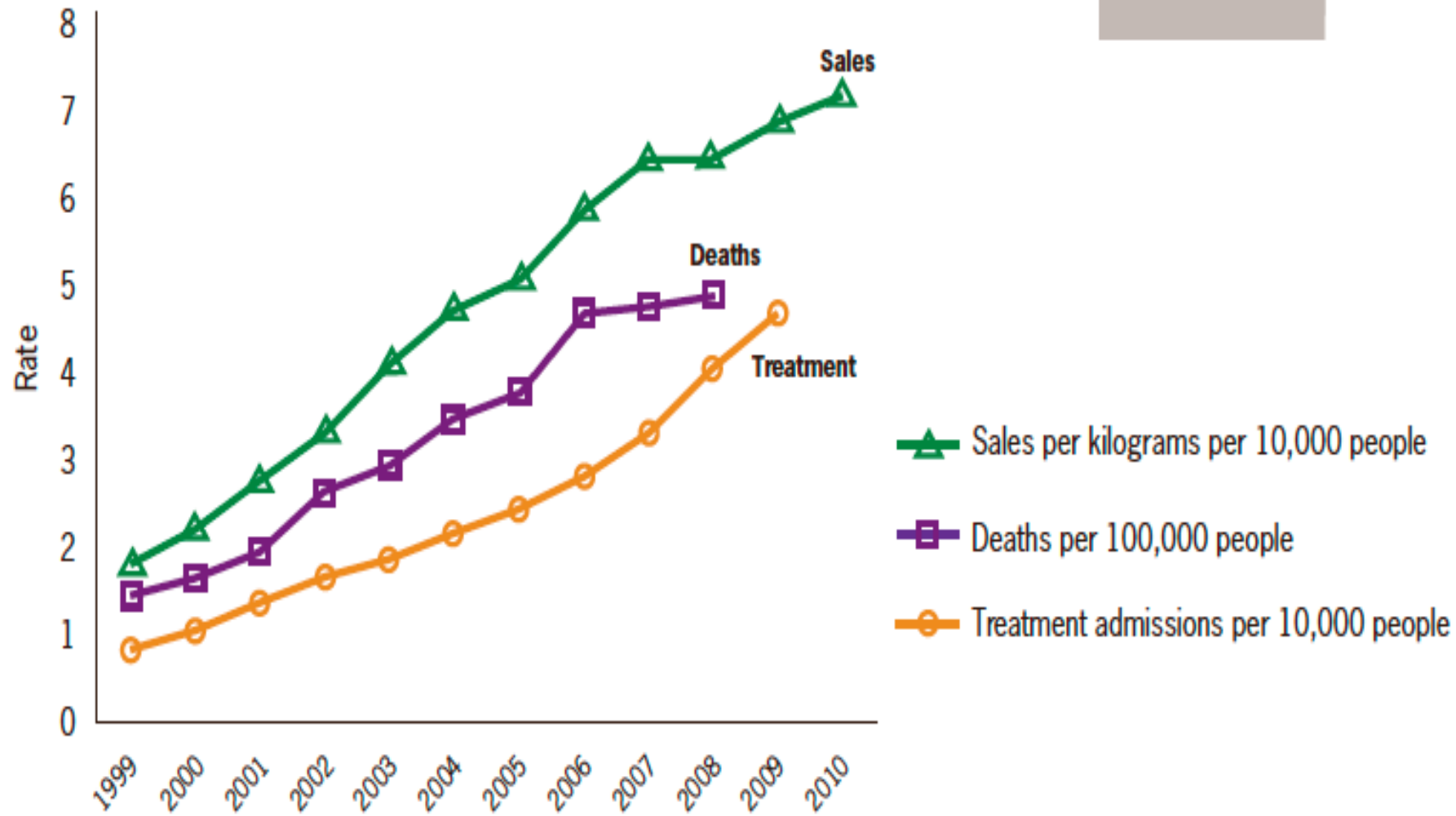
Courtesy of Erin Krebs



And it became a moral imperative to use opioids to relieve suffering

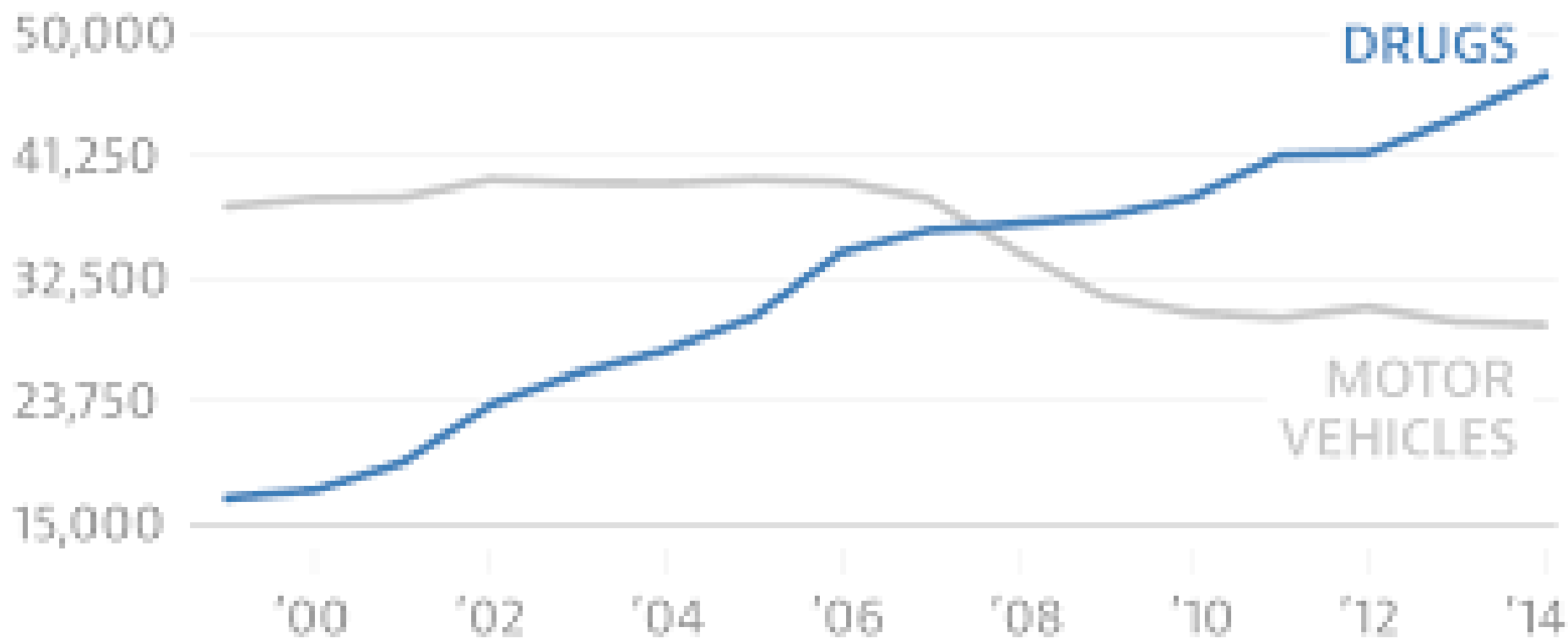


# Rates of prescription painkiller sales, deaths and substance abuse treatment admissions (1999-2010)



SOURCES: National Vital Statistics System, 1999-2008; Automation of Reports and Consolidated Orders System (ARCOS) of the Drug Enforcement Administration (DEA), 1999-2010; Treatment Episode Data Set, 1999-2009

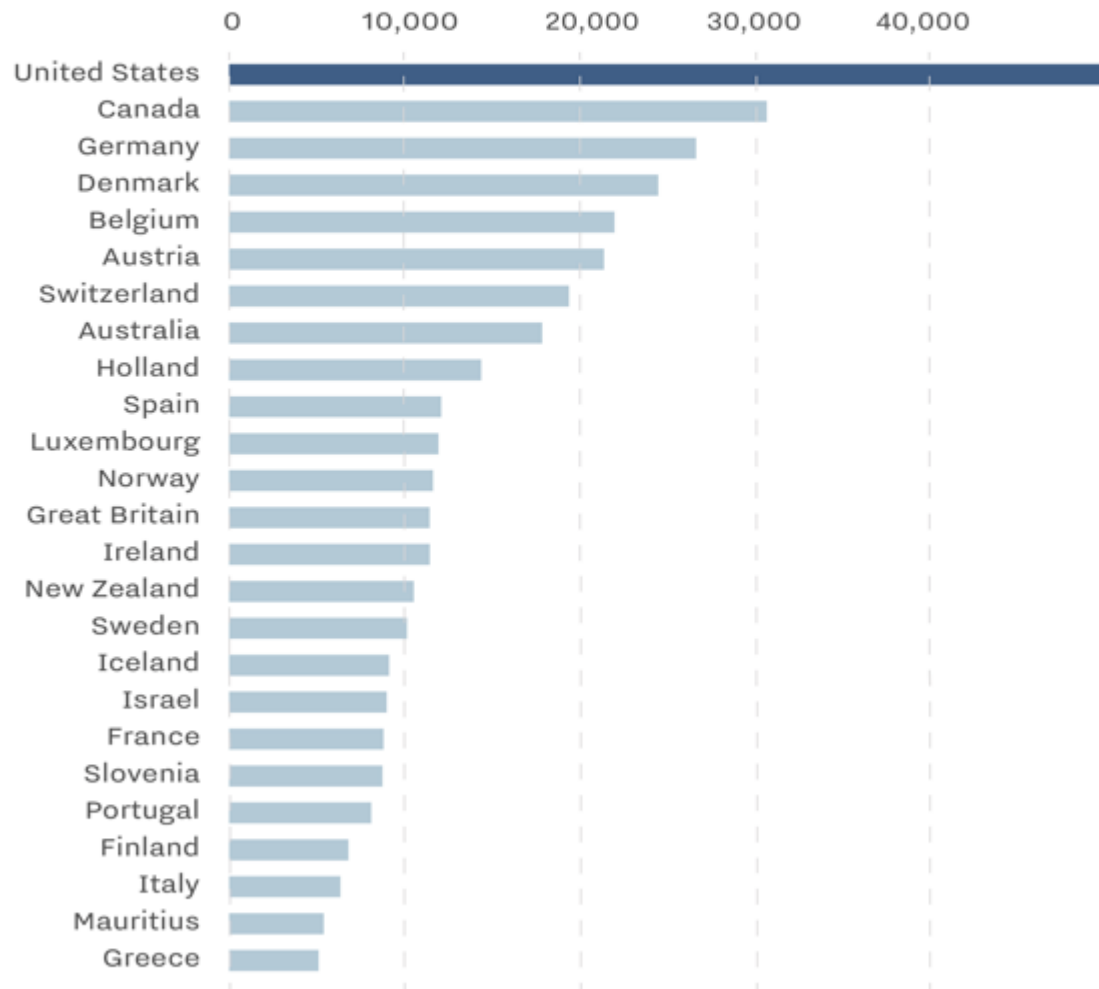
# Drug Overdose & Motor Vehicle Accident Deaths



Data: CDC

# Americans consume more opioids than any other country

*Standard daily opioid dose for every 1 million people*



Source: United Nations International Narcotics Control Board

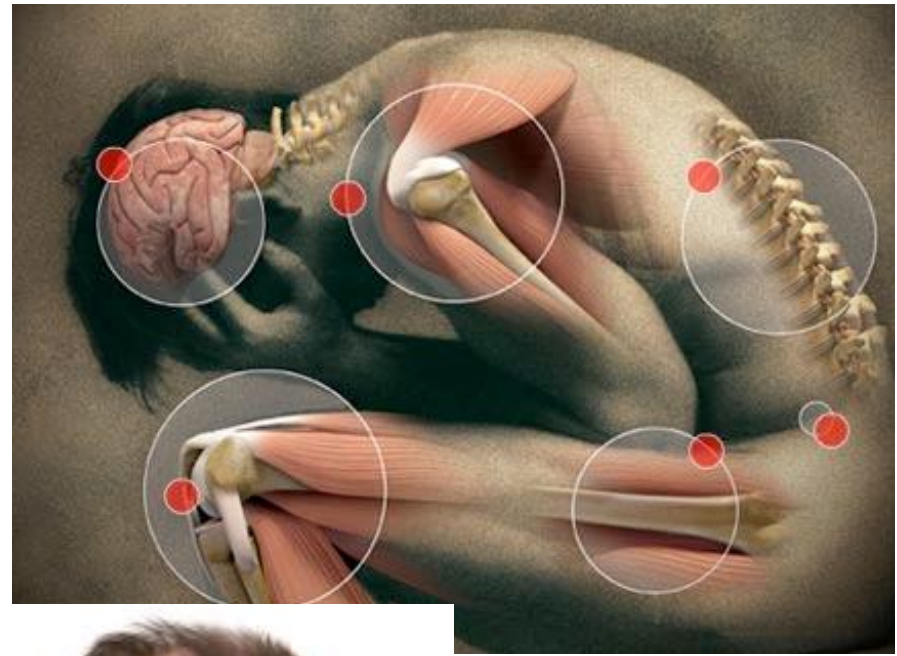
Credit: Sarah Frostenson

**Vox**

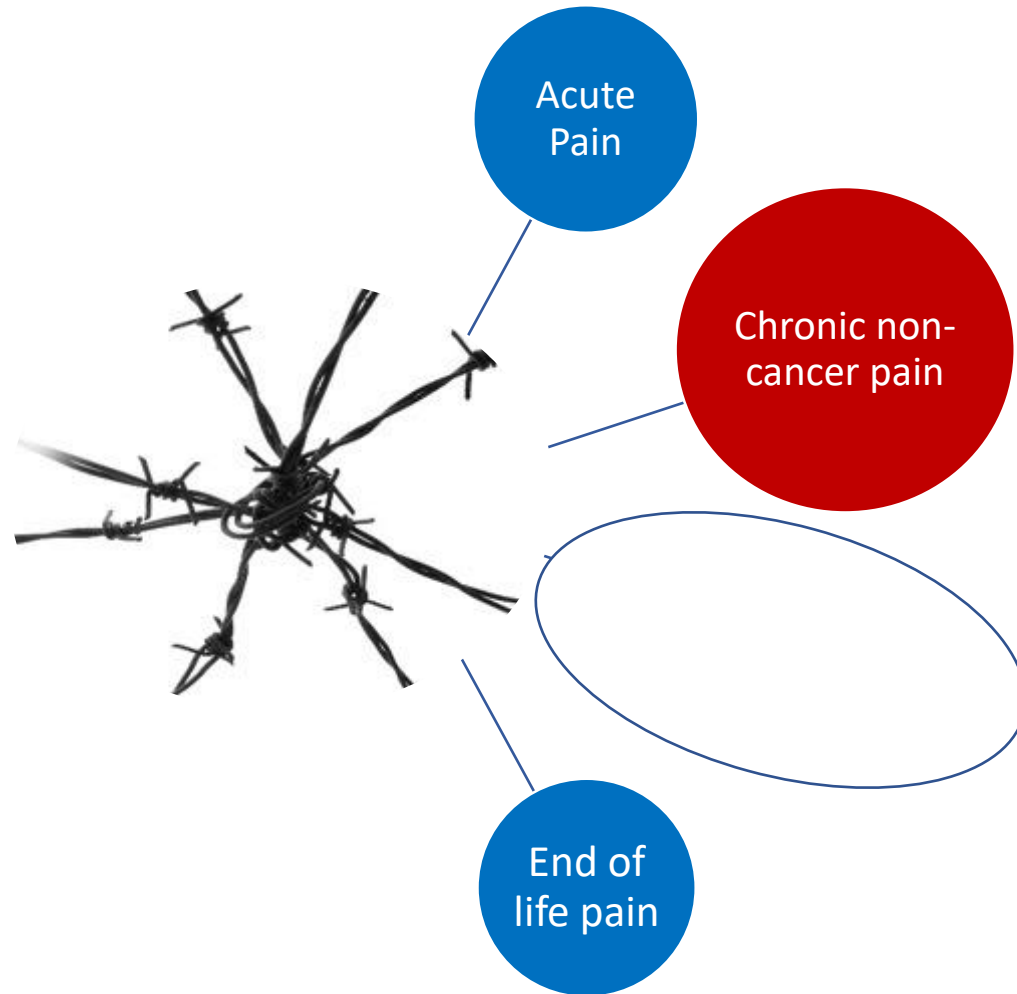




# Pain



# Pain Can Be Divided Into 3 Classes



# ACUTE PAIN



- Due to injury or surgery
- Tissue damage stimulates the pain receptors
- Nature usually will heal the problem
- Alleviating the pain is the short term goal, followed by return of function

# CHRONIC PAIN

- Poor correlation to pathology
- Greatly influenced by emotional overlay
- Management and functional improvement are the goals
- We cannot eliminate the pain



# CANCER and END OF LIFE PAIN

- Shares many features of acute pain
- Demands prompt, effective intervention
- The goal is to provide comfort

We do need to provide compassionate care to those with certain painful conditions

**We don't want to throw the baby out with the bathwater**

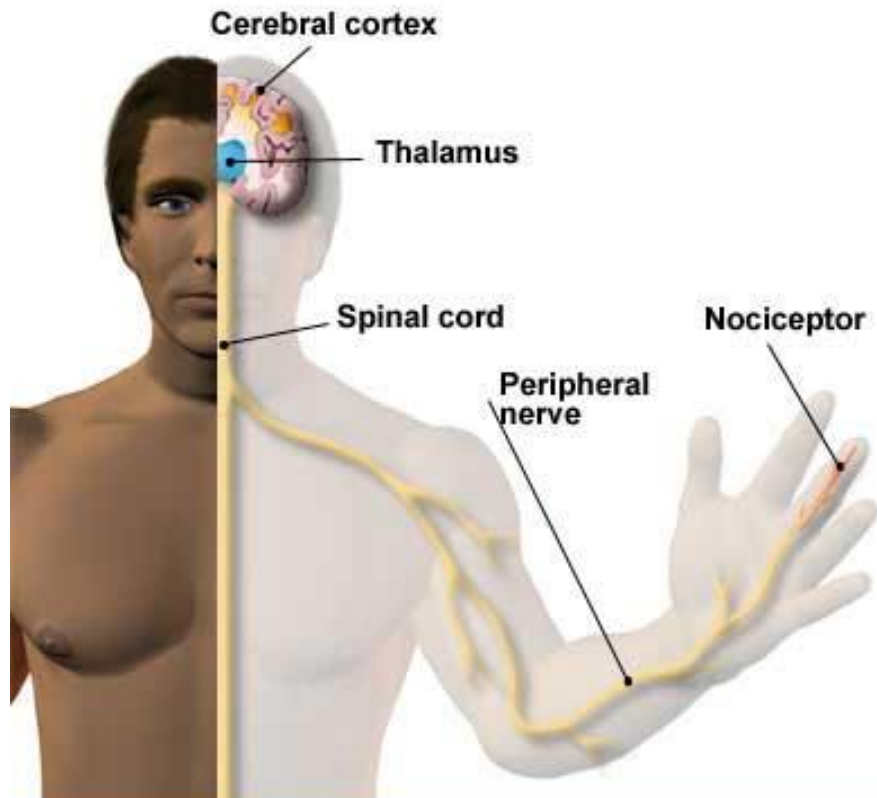


**Opioids have a role to play**

- In the treatment of acute and post surgical pain
- In cancer and other deteriorating painful conditions
- In some chronic conditions, when utilized at safe doses

# How we used to think about pain

**Nociceptive or injury related pain**



**neuropathic or “nerve pain”**

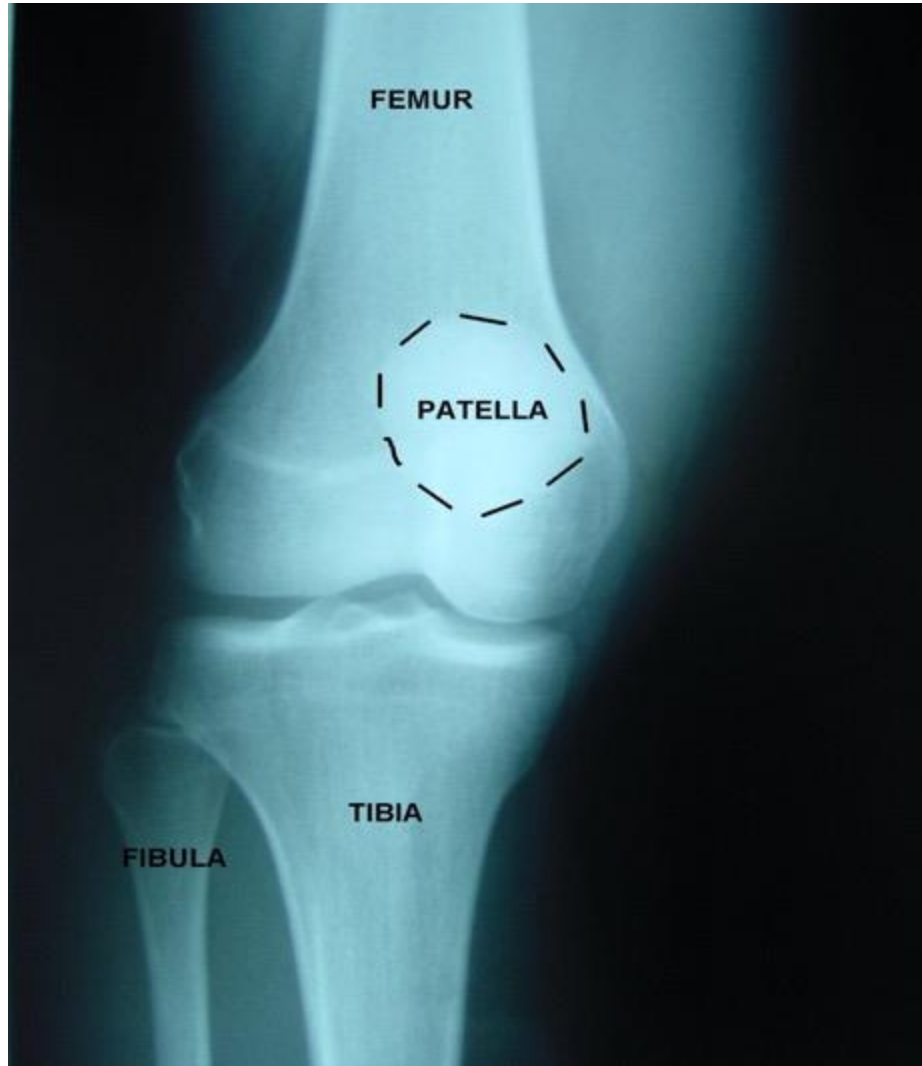


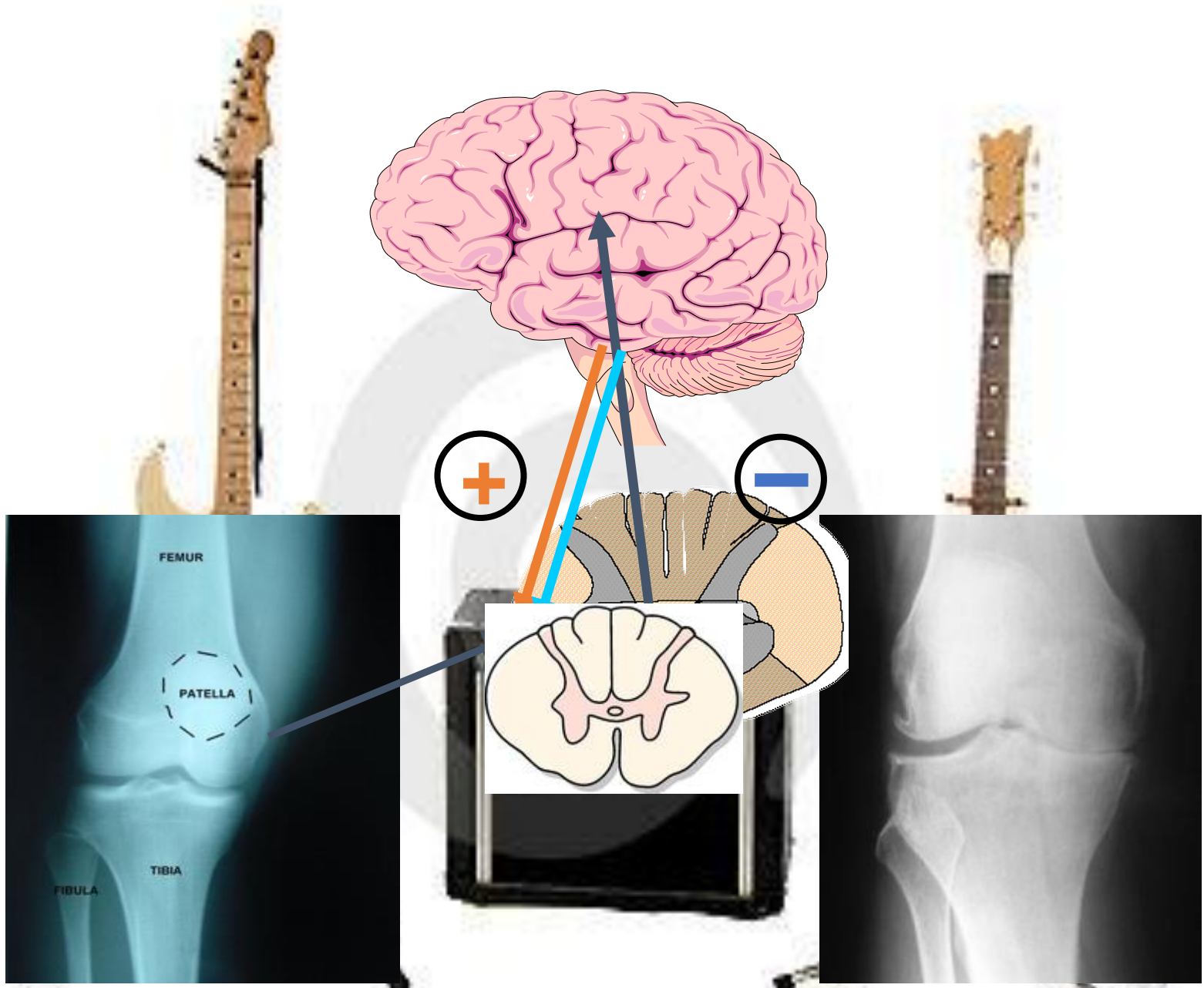
# 2020: More expansive view of pain

	<b>Nociceptive</b>	<b>Neuropathic</b>	<b>Centralized</b>
<b>Cause</b>	Inflammation or damage	Nerve damage or entrapment	CNS or systemic problem
<b>Clinical features</b>	Pain is well localized, consistent effect of activity on pain	Follows distribution of peripheral nerves (i.e. dermatome or stocking/glove), episodic, lancinating, numbness, tingling	Pain is widespread and accompanied by fatigue, sleep, memory and/or mood difficulties as well as history of previous pain elsewhere in body
<b>Screening tools</b>		PainDETECT	Body map or FM Survey
<b>Treatment</b>	NSAIDs, injections, surgery, ? opioids	Local treatments aimed at nerve (surgery, injections, topical) or CNS-acting drugs	CNS-acting drugs, non-pharmacological therapies
<b>Classic examples</b>	Osteoarthritis Autoimmune disorders Cancer pain	Diabetic painful neuropathy Post-herpetic neuralgia Sciatica, carpal tunnel syndrome	Fibromyalgia Functional GI disorders Temporomandibular disorder Tension headache Interstitial cystitis, bladder pain syndrome



Which person has pain?





# CHRONIC PAIN TREATMENT

## “COMPARATIVE EFFECTIVENESS”

Extrapolated averages of reduction in *Pain Intensity*

Opioids:	≤ 30%
Tricyclics/SNRIs:	30%
Anticonvulsants:	30%
Acupuncture:	≥ 10+%
Cannabis:	10-30%
<i>CBT/Mindfulness:</i>	<i>≥ 30-50%</i>
<i>Graded Exercise Therapy:</i>	<i>variable</i>
<i>Sleep restoration:</i>	<i>≥ 40%</i>
<i>Hypnosis, Manipulations, Yoga:</i>	<i>“+ effect”</i>

Turk, D. et al. Lancet 2011; Davies KA, et al. Rheum. 2008;  
Kroenke K. et al. Gen Hosp Psych. 2009; Morley S Pain 2011;  
Moore R, et al. Cochrane 2012; Elkins G, et al. Int J Clin Exp  
Hypnosis 2007.

# Expectation (75%) vs Reality (30%)

Patient Expectation

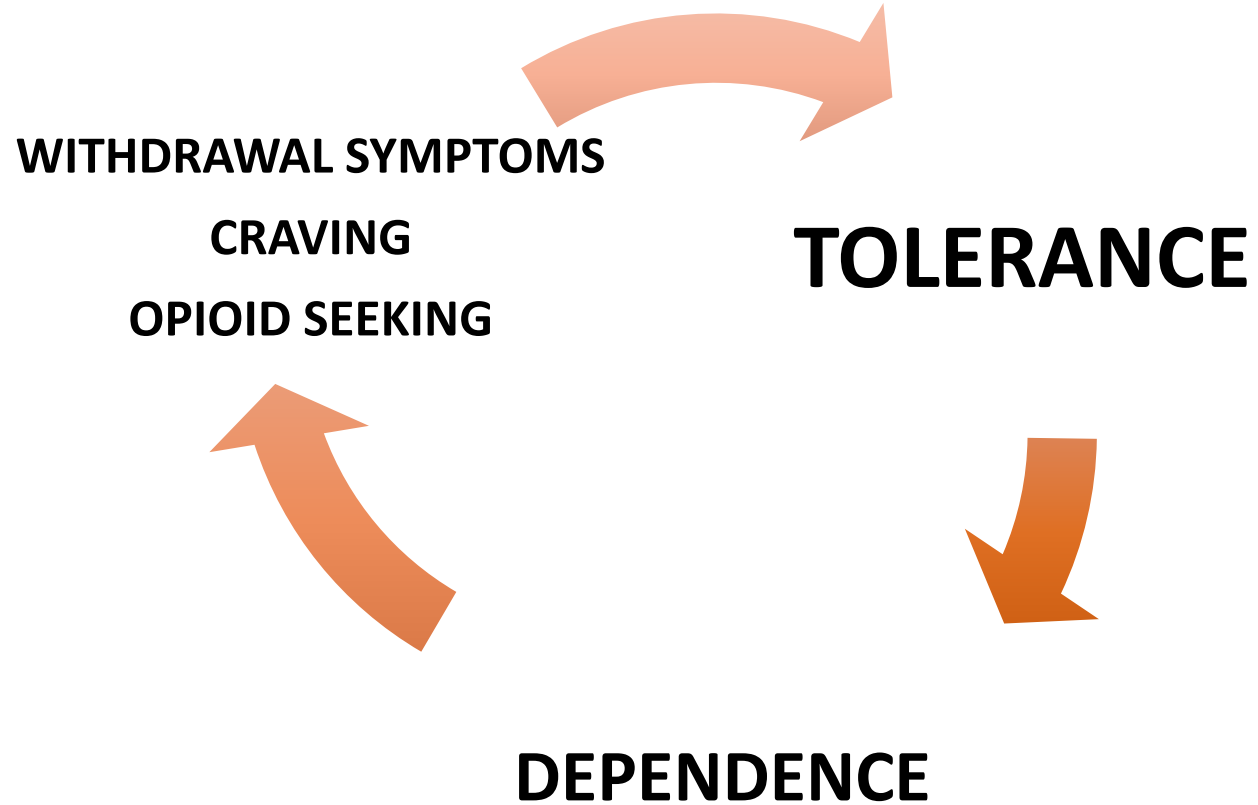


Medical Reality



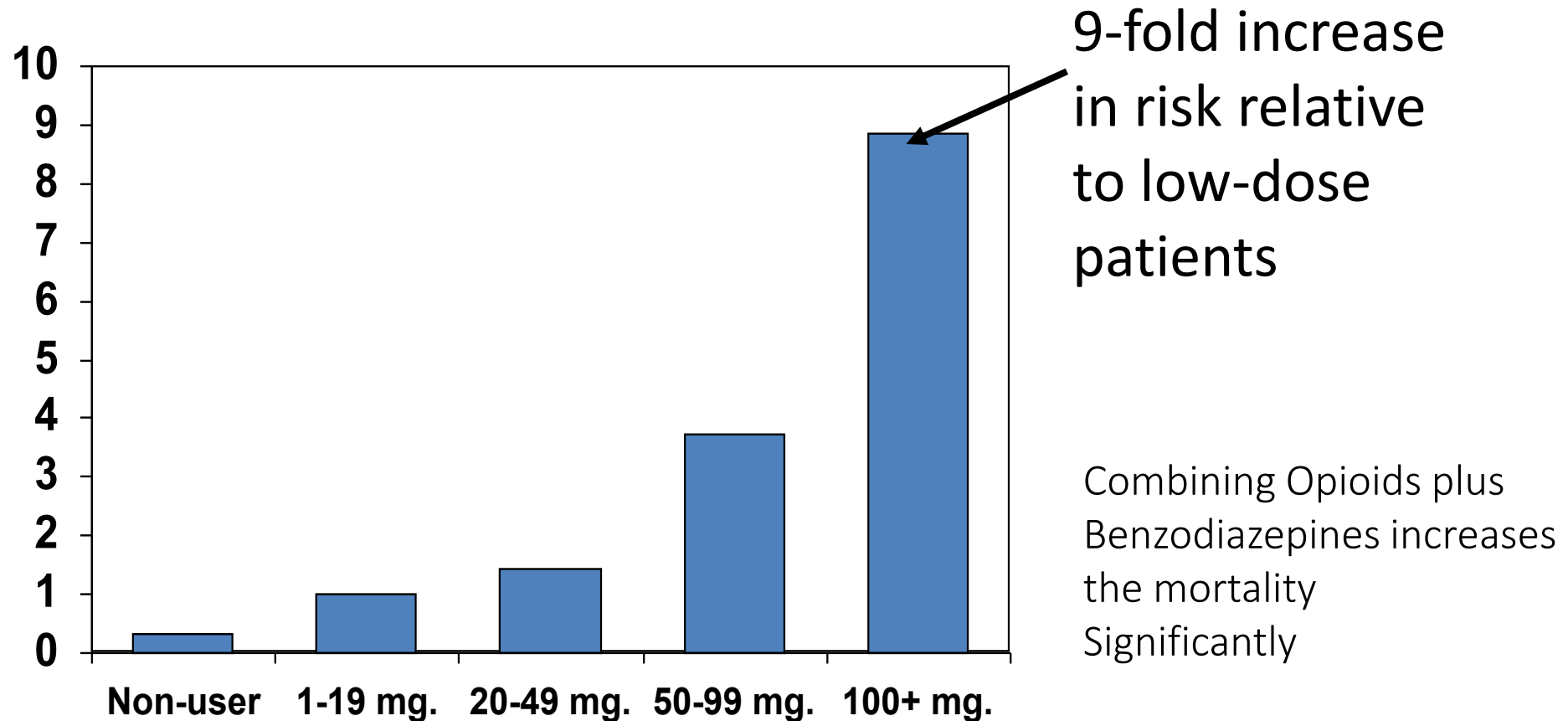


# Dose Escalation with Opioid Use



# As Dose Increases, So Does Mortality

Mortality risk compared to Morphine Equivalent Dose (MED)<sup>1</sup>



1. Dunn et al., Annals Int Med, 2010

2. [Pain Med.](https://doi.org/10.1111/pme.12907) 2015 Sep 1. doi: 10.1111/pme.12907. [Epub ahead of print] Cohort Study of the Impact of High-dose Opioid Analgesics on Overdose Mortality. Dasgupta N et al.

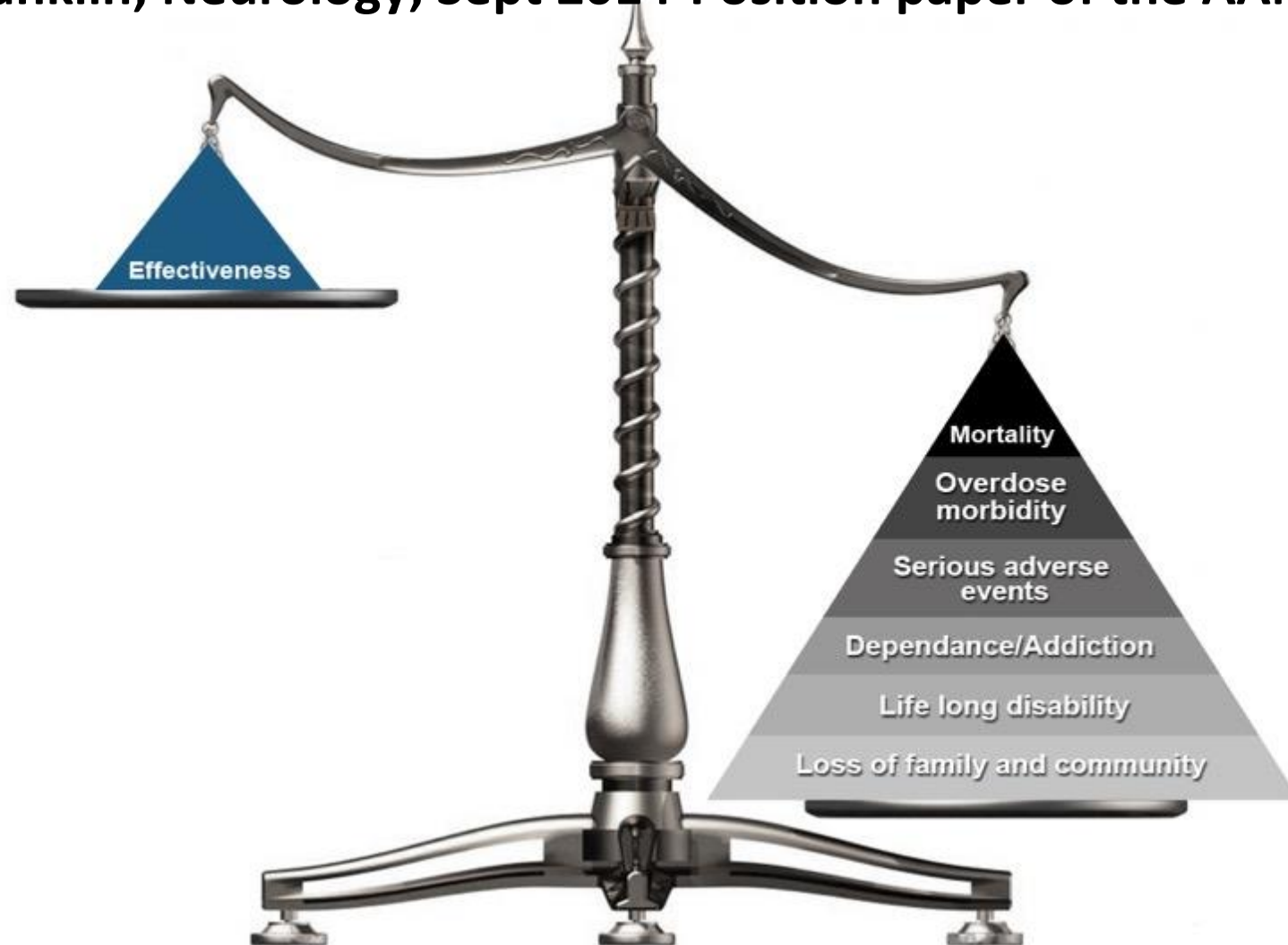
# SPACE Trial 2017

## Strategies for Prescribing Analgesics Comparative Effectiveness

- **opioid therapy vs. non-opioid therapy for chronic LBP and OA pain**
- One year VA trial in primary care, n=240
- All patients received individualized medication management using collaborative tele-care pain management model
- Opioid daily dose limited to 100 mg MED/day
- **At 12 months, no difference in function**
- **Pain worse in opioid group** (BPI severity 4.0 vs. 3.5, p=0.03)
- Clinically significant improvement: BPI int 59% vs. 61%; BPI severity
- 41% vs. 54% (p=0.007)
- **Opioids associated with more adverse symptoms**; no deaths or OUD

# Risk/Benefit of Opioids for Chronic Non-Cancer Pain

-Franklin; Neurology; Sept 2014-Position paper of the AAN-





# What are the hallmarks of pain management?

- Patient education
- Exercise
- Emotional support
- Team based care





PAIN  
IS INEVITABLE.

SUFFERING  
IS OPTIONAL.

*Buddha*

[www.meditationrelaxclub.com](http://www.meditationrelaxclub.com)

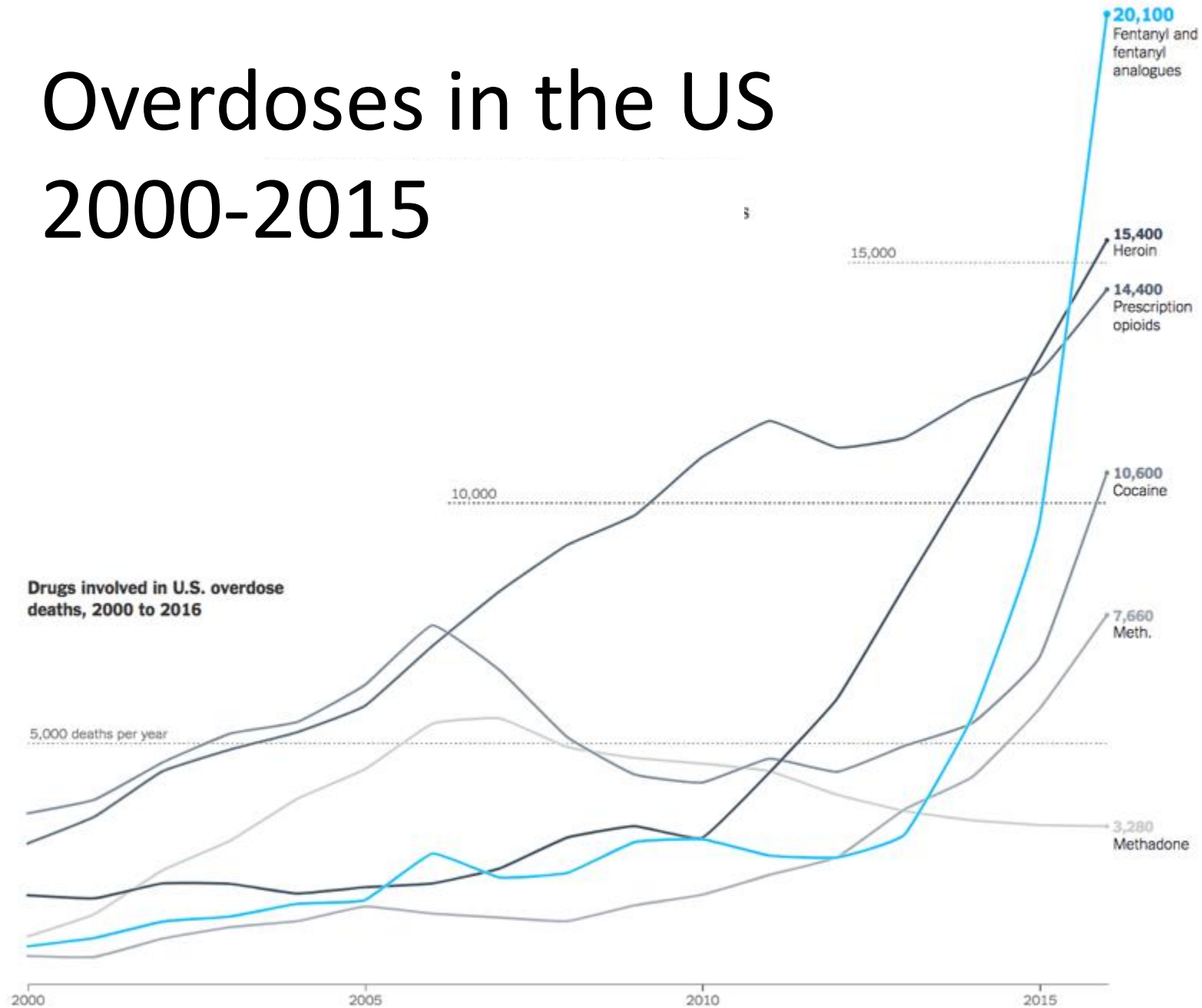


# How did the opioid problem evolve?

- Pills were diverted and misused
- Many with Opioid Use Disorder started by taking pills
- Many with OUD started switching to heroin
- Lots of kids getting involved with opioids through pills



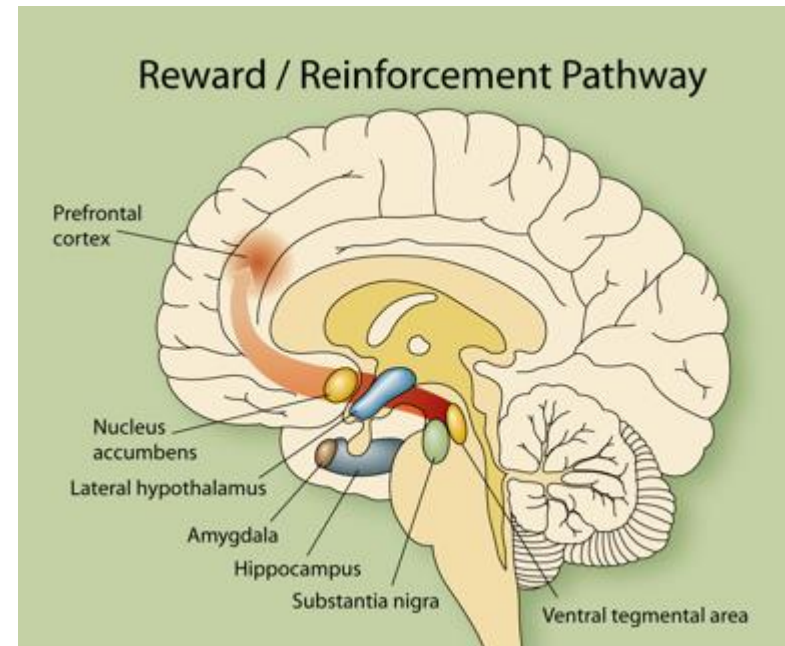
# Overdoses in the US 2000-2015





# Opioid Use Disorder

- Think of it as a chronic disease
- Taking the opioid in larger amounts and for longer than intended
- Wanting to cut down or quit but not being able to do it
- Spending a lot of time obtaining the opioid
- Craving or a strong desire to use opioids

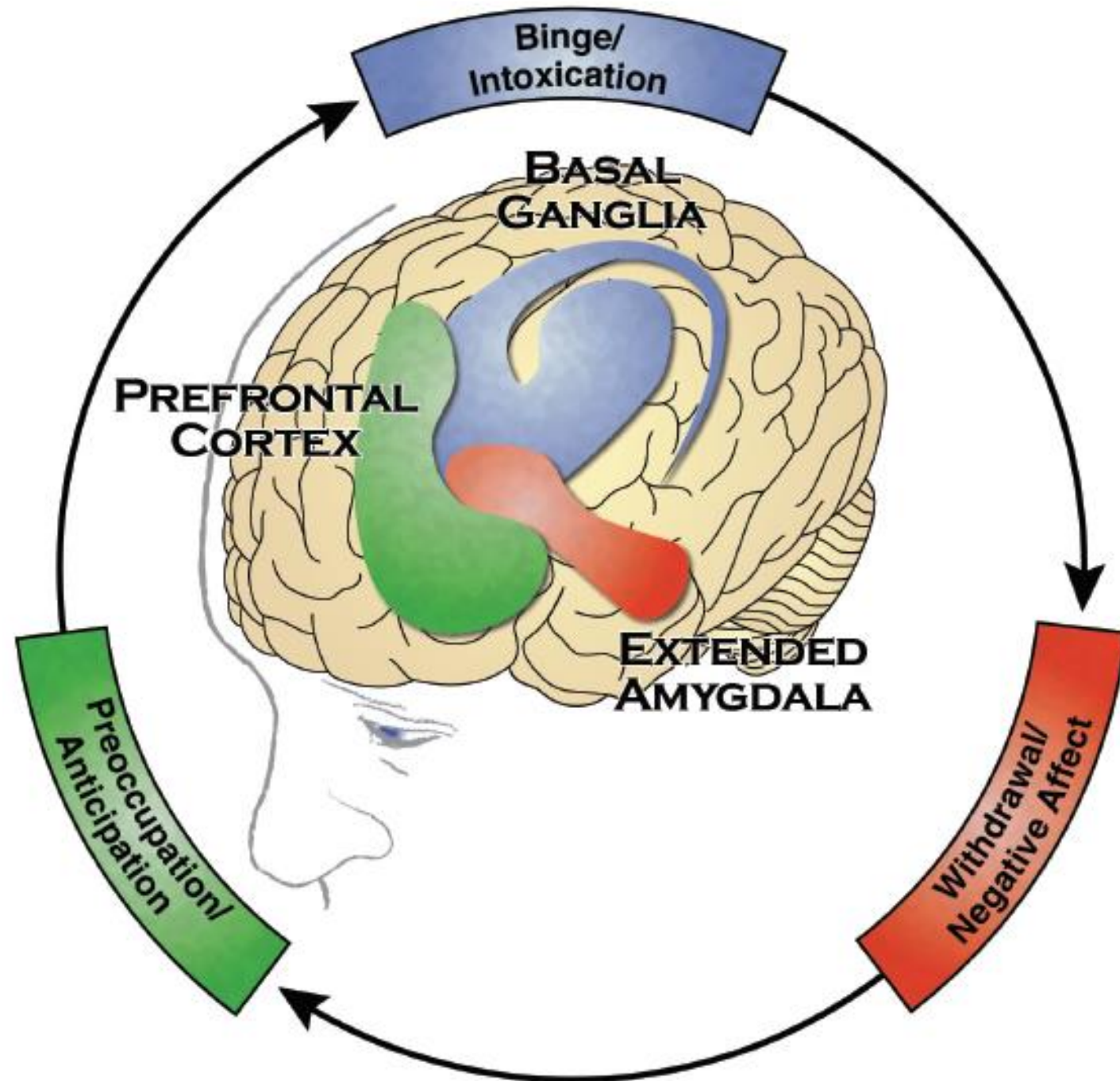


# The Opioid Use Disorder Cycle, The Primitive Brain in Charge

The addiction cycle is triggered by intoxication and pleasure (blue)

When intoxication wears off, the individual feels worse (red)

More substances are sought (green) to relieve distress, the cycle continues



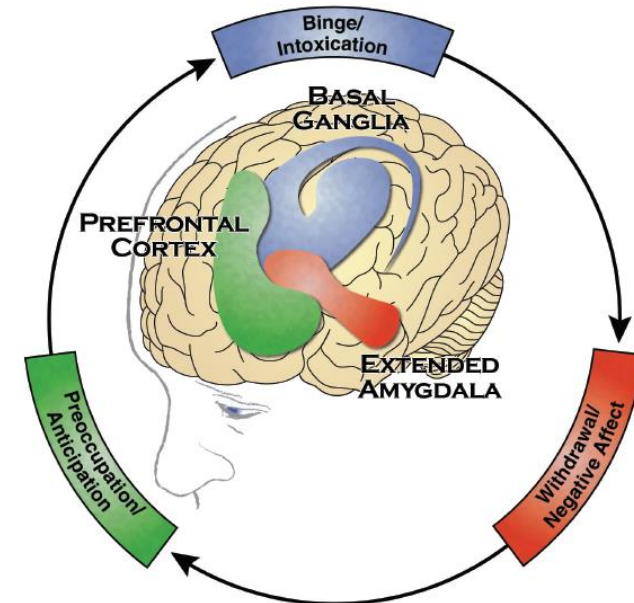
# Medication Assisted Treatment

- Methadone:
- Buprenorphine (Suboxone): A safe drug. Relieves cravings, offers pain relief, quite expensive, and is very hard to overdose on. Can be prescribed for addiction in a provider's office (unlike methadone).
- Naloxone injectable (Vivitrol):



# MAT is not substituting one drug from another

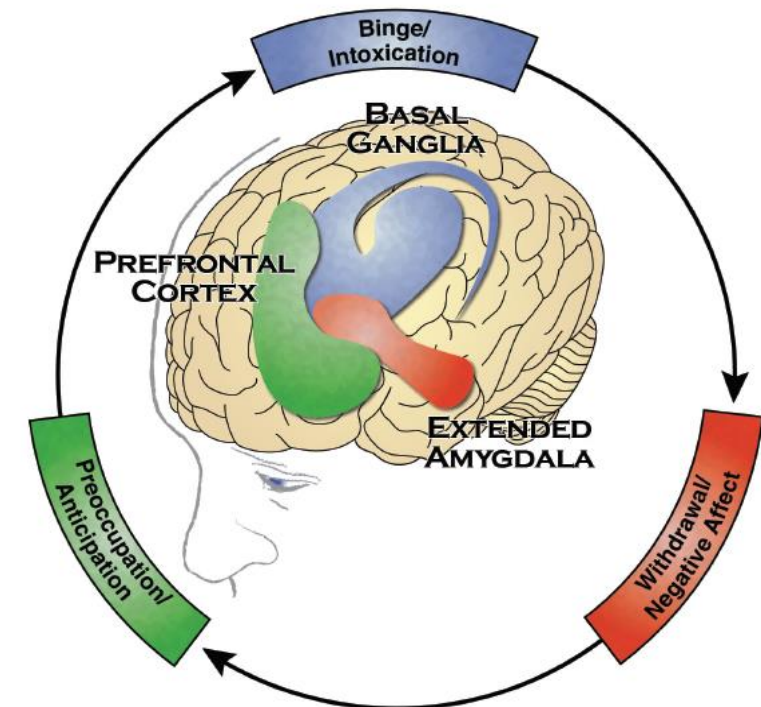
- The pattern of taking the same dose at the same time every day means there is no high or intoxication. The drug is not reinforcing.
- With MAT, addiction (obsessive craving) is replaced by physical dependence only. This is similar to the role of antidepressants or insulin.
- **When a drug's benefit outweighs its risks, continued use is healthy, not addictive.**



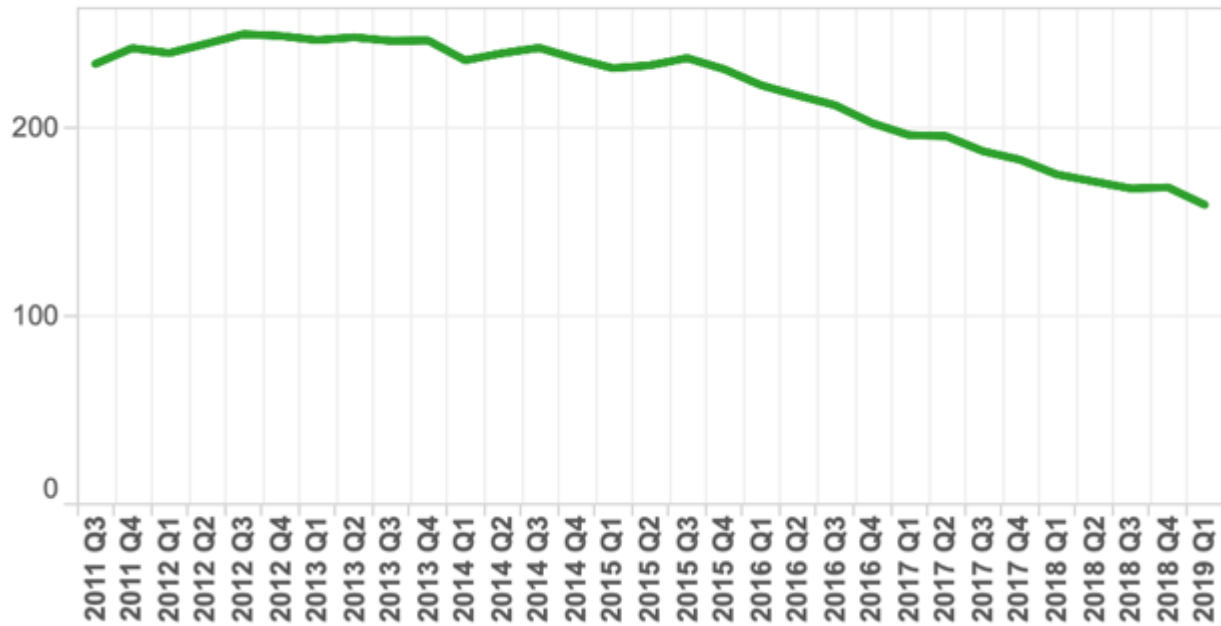


# Buprenorphine and pain management.

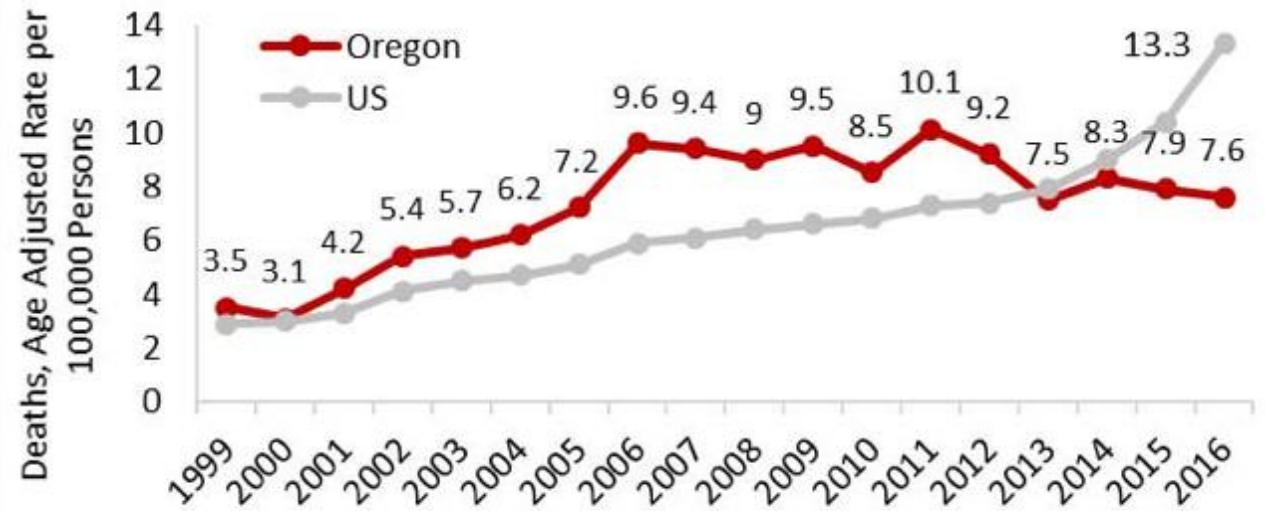
- Individuals on chronic opioids may have OUD.
- Some patients on opioids would be safer on buprenorphine
- We have to develop compassion and empathy for this segment of our patient population
- Prescribers should obtain their X waver and learn to utilize buprenorphine.
- We need to learn how to compassionately taper our LTOT patients.



## Oregon Controlled Substance Prescribing



## Rate of Opioid Related Overdose Deaths in Oregon



Source: CDC WONDER

# Why reduce a patient's opioid dose



- Way too many pills in circulation
  - Clearly much of what we are prescribing is being diverted
  - We need to turn down the spigot
- High dose opioids carry significant risks
- Opioids may not be providing much pain relief once dependence has occurred.

# Cons for reducing opioid dose



- Some folks are stable and safe on their current regime.
  - “If it ain’t broke don’t fix it”
- There is trauma associated with tapering, and some risk, especially if done rapidly

# The Problem: Our understanding in 2019

- Liberal opioid prescribing in the past has led to large numbers of individuals on LTOT for chronic pain
- We need to do something about this, but what?





# There is a consensus exemplified by CDC guidelines:

- It is generally unsafe and inappropriate for sustained opioid doses >50 MME (Morphine Mg. Equivalent)
- Morphine = 1mg  
Oxy = 1.5  
Methadone = 3-6

**GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN**

**IMPROVING PRACTICE THROUGH RECOMMENDATIONS**

CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

**DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN**

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.
2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

**CLINICAL REMINDERS**

- Opioids are not first-line or routine therapy for chronic pain.
- Establish and measure goals for pain and function.
- Discuss benefits and risks and availability of nonopioid therapies with patient.

U.S. Department of Health and Human Services  
12888 MDRC | [www.cdc.gov/drugoverdose/prescribingguidelines.html](http://www.cdc.gov/drugoverdose/prescribingguidelines.html)

# What does current science tell us about the effectiveness of COT?

- SPACE trial: JAMA 2018... "Treatment with opioids was not superior to treatment with nonopioid medications for improving pain-related function over 12 months."
- Structured Evidence-Based Systematic Review: Journal of Pain Medicine, December 2018.... "80% of CPPs had improved pain after taper."\*

- \*Hypothesis: **Objective:** To support or refute the hypothesis that opioid tapering in chronic pain patients (CPPs) improves pain or maintains the same pain level by taper completion but does not increase pain.
  - Review of 20 studies fulfilling criteria
  - Review of 2199 Chronic Pain Patients tapered off opioids
  - 100% supported the hypothesis.
  - 80% had improved pain after taper

# The Taper Dilemma: Decreasing high dose opioids is safe for most patients, but....

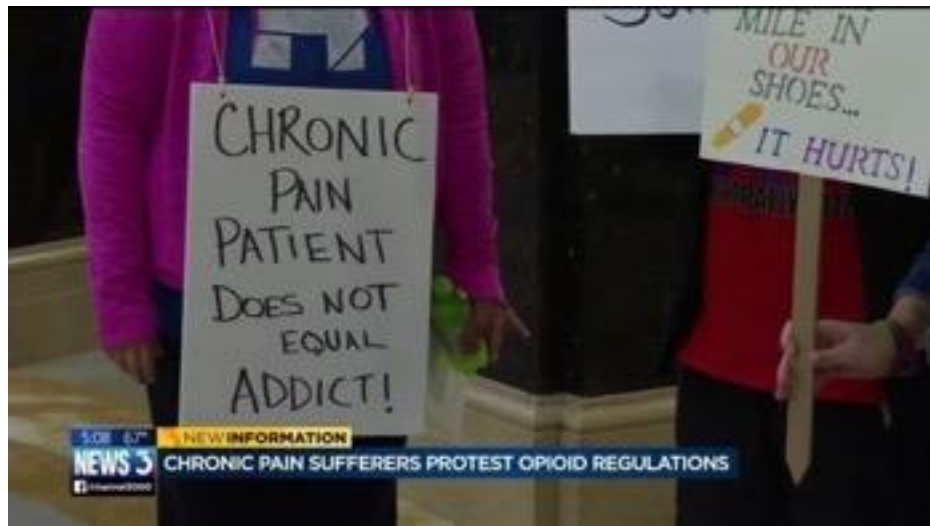
- Produces anxiety for patient and prescriber
- May create pain in short term if rapid.
- Can create stigma, animosity, and risk of suicide







# Pushback!



-Patients are scared  
-Doctors are scared  
-Some patients are harmed

# Adjustment to the CDC guidelines

- NEJM : Deborah Dowell, M.D., M.P.H., Tamara Haegerich, Ph.D., Roger Chou, M.D.
- No Shortcuts to Safer Opioid Prescribing
- Don't use inflexible tapering protocols
- Don't abruptly taper patients



The NEW ENGLAND  
JOURNAL of MEDICINE



Who is Working on this  
issue?



# Significant Tapering Articles:

## **Annals of Internal Medicine**

### **Rethinking Opioid Dose Tapering, Prescription Opioid Dependence, and Indications for Buprenorphine**

Roger Chou, MD; Jane Ballantyne, MD; and Anna Lembke, MD

### **HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics**

## IDEAS AND OPINIONS

#### Co-chairs

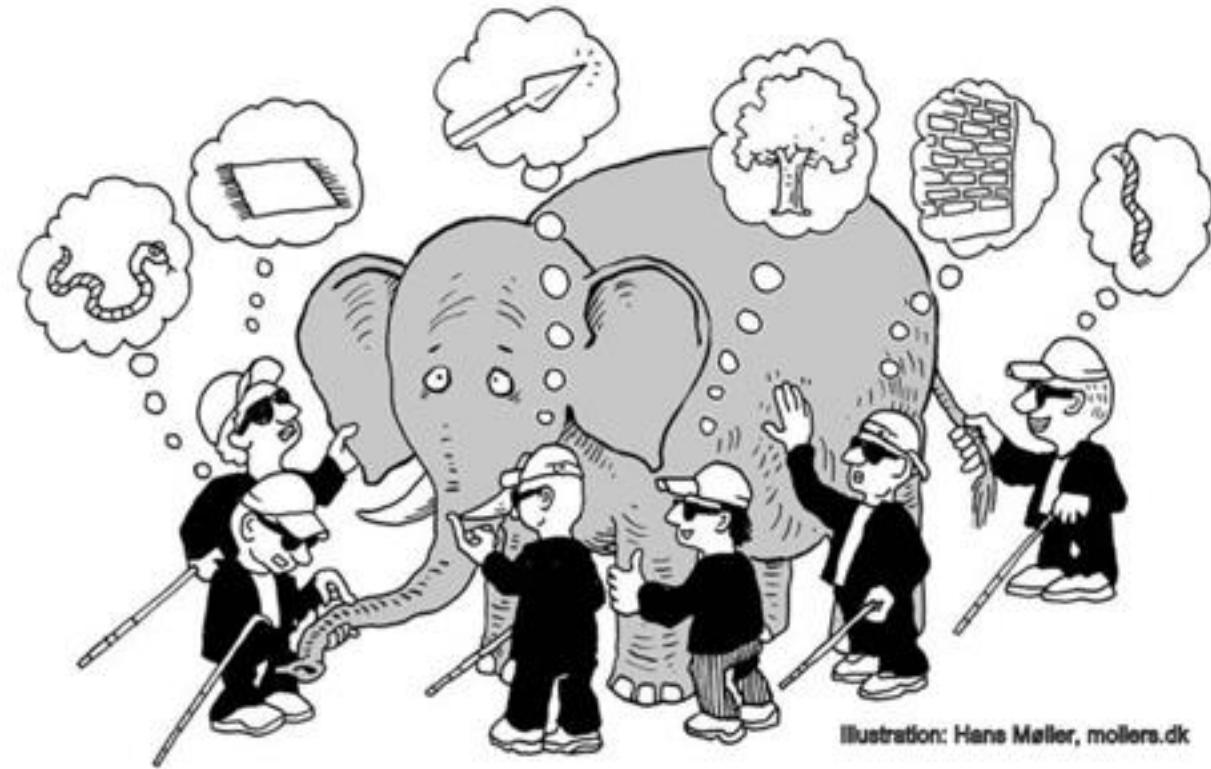
Deborah Dowell, MD, MPH  
CAPT, US Public Health Service  
*Centers for Disease Control and Prevention*

Christopher Jones, PharmD, DrPH  
CAPT, US Public Health Service  
*Centers for Disease Control and Prevention*

Wilson Compton, MD, MPE  
*National Institutes of Health*

# Oregon Opioid Tapering Taskforce

- Experts from many different disciplines
- To provide guidance to the OHA
- Create “best practice” for tapering



# OPG tapering guideline Workgroup

- Anna Lembke: Stanford
- Mark Stephens: Consultant
- Jim Shames: Jackson County
- Roger Chou: OHSU
- Paul Coelho: Salem Health
- Rubin Halpern: Providence Portland
- Jane Ballantyne: UW/Harvard
- David Tauben: UW
- Andrew Kolodny: Brandeis
- And others brought in to provide advice and consent



# BRAVO Overview

## B Broaching the Subject

- Involve the patient
- Take more time
- Get the support of your team
- Use motivational interviewing (reflection, validation, support)
- For inherited patients, maintain the current dose and document if considering a taper

## R Risk Benefit Assessment

Consider tapering for the following reasons:

<ul style="list-style-type: none"> <li>Patient request</li> <li>Pain and function not improved</li> <li>Adverse opioid effects</li> <li>Co-occurring conditions (including mental health)</li> </ul>	<ul style="list-style-type: none"> <li>Dose over 90 MED</li> <li>Concurrent sedatives</li> <li>Opioid use disorder</li> <li>Opioid overdose</li> </ul>
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## A Addiction and Dependence Happen

- Addiction = The 3 C's: *Control, Craving, continued use despite Consequences*
- Dependence = Tolerance, withdrawal, without the 3 C's
- Anyone can become addicted or dependent
- Reassure patients there is effective treatment for both
- Consider buprenorphine

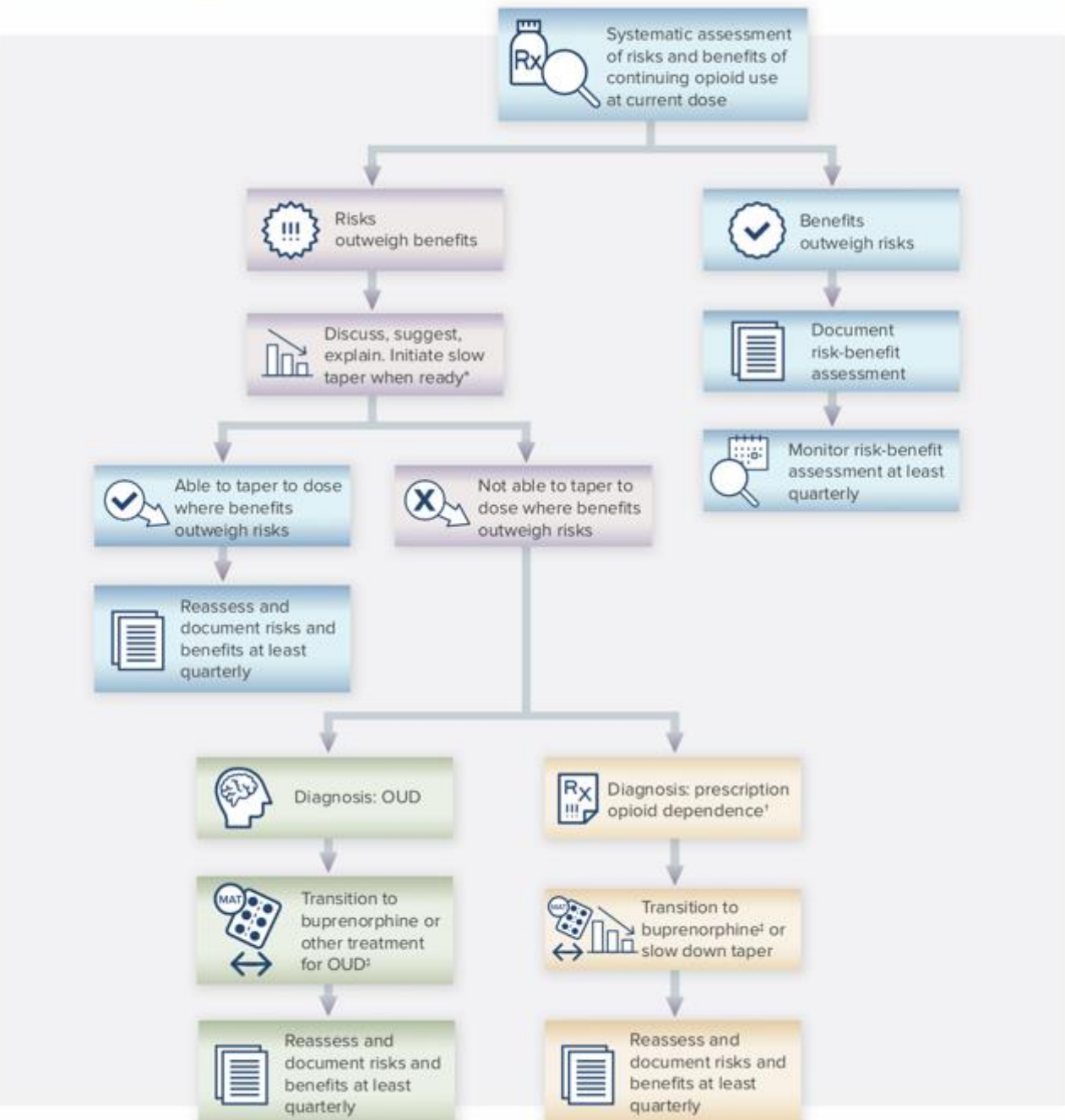
## V Velocity and Validation

- Go slowly (*Tapering Examples*)
- Maintain the same schedule (BID, TID)
- Let the patient drive "*Which opioid would you like to taper first?*"
- Take breaks, but never go backwards
- Warn patients that pain gets worse before it gets better
- Validate that opioid tapering is hard

## O Other Strategies for Coping with Pain

- Help patients understand how pain works
- Encourage regular, restful sleep
- Promote healthy activities
- Maintain a positive mood
- Foster social connections
- Make good nutritional choices
- Consider non-opioid pain medications

# Clinical Pathway for LONG-TERM OPIOID THERAPY MANAGEMENT



## Tapering Example

### CONSIDER THE FOLLOWING PATIENT:

- 48 year old male on oxycodone for 16 years since a motor vehicle crash
- Dose: oxycodone 30 mg four times daily = 120 mg of oxycodone = 180 mg MED
- Pain: Still rates his pain as a 10, wants to increase to 40 mg four times daily
- Function: Hasn't worked since crash. Divorced 9 years ago. Lives alone. On bed or couch 20 hours daily
- Co-morbid conditions: sleep apnea, diabetes 2, hypertension, depression, osteoarthritis of knees

After a long discussion he admits that the oxycodone doesn't help him much, but he's afraid of how bad his pain will be on less of it or without it. He reluctantly agrees to the taper when you explain that his dose is unsafe and you don't feel comfortable continuing to prescribe it.

How to taper? *Make sure other ongoing strategies are in place before you begin.* He goes to a pain education class, watches several videos and meets with the behaviorist in clinic. The behaviorist encourages him to join a pain group where he will have a chance to learn and share experiences with other patients in a similar situation.

Week	Dose 1	Dose 2	Dose 3	Dose 4	Total daily dose	MED
0	30 mg	30 mg	30 mg	30 mg	120 mg	180 mg
1-2	30 mg	25 mg	30 mg	30 mg	115 mg	172.5 mg
3-4	30 mg	25 mg	25 mg	30 mg	110 mg	165 mg
5-6	30 mg	25 mg	25 mg	25 mg	105 mg	157.5 mg
7-8	25 mg	25 mg	25 mg	25 mg	100 mg	150 mg

At the end of 8 weeks you have decreased the oxycodone by about 16%. He's had mild withdrawal symptoms, but nothing intolerable

Week	Dose 1	Dose 2	Dose 3	Dose 4	Total daily dose	MED
9-10	25 mg	20 mg	25 mg	25 mg	95 mg	142.5 mg
11-12	25 mg	20 mg	20 mg	25 mg	90 mg	135 mg
13-14	25 mg	20 mg	20 mg	20 mg	85 mg	127.5 mg
15-16	20 mg	20 mg	20 mg	20 mg	80 mg	120 mg

At the end of 16 weeks you have decreased the oxycodone by about 33%. Withdrawal symptoms mild. He has noticed that his pain isn't any worse. Even so, he tells you he is afraid to keep going, but agrees that everything you told him has been correct.

Week	Dose 1	Dose 2	Dose 3	Dose 4	Total daily dose	MED
17-18	20 mg	20 mg	15mg	20 mg	75 mg	112.5 mg
19-20	20 mg	15 mg	15 MG	20 MG	70 MG	105 MG
21-22	20 mg	15 mg	15 mg	15 mg	65 MG	97.5 90
23-24	15 mg	15 mg	15 mg	15 mg	60 MG	90 MG

At 24 weeks he is on 50% of his starting opioid dosing. He admits that his pain is no worse. He also tells you his mind feels less foggy and he's been using some of the relaxation techniques when he does feel pain. He began physical therapy a few

## Tapering Example

Week	Dose 1	Dose 2	Dose 3	Dose 4	Total daily dose	MED
25-26	15 mg	15 mg	10 mg	15 mg	55 mg	82.5
27-28	15 mg	10 mg	10 mg	15 mg	50 mg	75 mg
29-30	15 mg	10 mg	10 mg	10 mg	45 mg	67.5 mg
31-32	10 mg	10 mg	10 mg	10 mg	40 mg	60 mg

At 32 weeks he is on 30% of his starting opioid dosing. Pain is not worse, in fact he thinks it might be a little better. He's now walking up to an hour daily. He says, I think I want to go to 10 mg 3 times daily and then cut down from there.

Week	Dose 1	Dose 2	Dose 3	Total daily dose	MED
33	10 mg	10 mg	10 mg	30 mg	45 mg
34	Same dose as week 33: he has a little more withdrawal and asks to stay on 10 mg TID for another 2 weeks				
35-36	10 mg	10 mg	10 mg	30 mg	45 mg
37	10 mg	5 mg	10 mg	25 mg	37.5 mg
38	Same dose as week 37: he wants to cut the morning dose before evening dose because he is worried he won't sleep well				
39-40	5 mg	5 mg	10 mg	20 mg	30 mg
40	5 mg	5 mg	5 mg	15 mg	22.5 mg

At 40 weeks he is on 12.5% of his starting opioid dosing. He cut down a little faster in last 2 weeks. He is excited by the prospect of getting off completely but still feels like he needs to keep tapering and can't just stop at this dose

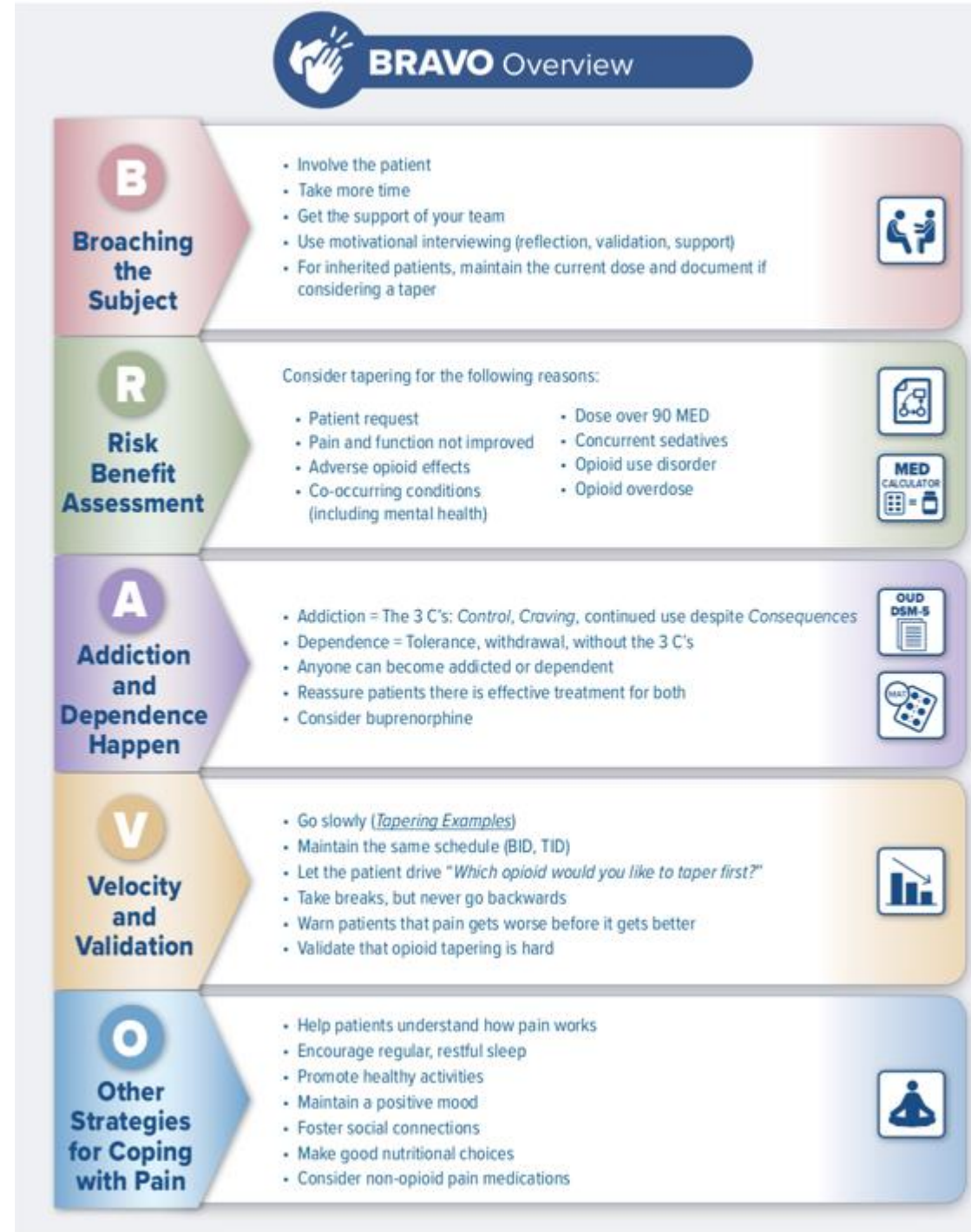
Week	Dose 1	Dose 2	Dose 3	Total daily dose	MED
41-42	5 mg	2.5 mg	5 mg	12.5 mg	18.25 mg
43-44	5 mg	5 mg		10 mg	15 mg
45-46	2.5 mg	5 mg		7.5 mg	11.25 mg
47	X	5 mg		5 mg	7.5mg
48	0			0 mg	0 mg

It took 48 weeks – almost a year, but he successfully came off of a high dose opioid he had been on for 16 years. He admits that his pain is minimal. He is more active than he has been in years, has lost 18 lbs. and he is contemplating going back to work.



# BRAVO

- A simple way of conveying the essentials for successful tapering
- Patient centered
- Safety centered
- Provides useful tools to providers
- Is based on current science





## Broaching the Subject

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Start with empathy and compassion for your patient's situation. Your patient is likely to be anxious about any change in their pain medications. It is normal for you to be anxious or uncomfortable as well. Simply naming this anxiety in your patient and in yourself can be very helpful. If the patient is not in imminent danger, take the time to build a trusting and supportive relationship before making any changes to the pain medication. Reassure your patient that you will not abandon them and will continue to work with them to improve their function and quality of life. Explain that you will go slowly if necessary and that patients can experience improved quality of life after lowering pain medications.

**Involve the patient** – Ask the patient about their perceptions of risks, benefits, and adverse effects of continued opioid therapy. Clear up any misconceptions they may have. Give them your assessment of the risks, benefits, and alternatives to opioids. Involve them in decisions, such as which medication or dose to change first and how quickly the changes will occur. Tapering will be more successful with the patient's input and collaboration.

**Take more time** – Schedule a longer appointment when you discuss possible tapering. Use the extra time to listen to your patient's story about their pain and their concerns about any changes to their treatment. Patients often report that providers don't take the time to hear their story. Make sure your patient feels you fully understand their perspective. This promotes empathy and builds a therapeutic alliance.

**Get the support of your team** – Making changes to pain medications is best managed by the entire healthcare team. It is ideal if all team members are aware of the treatment plan and communicate their empathy and support for the patient on a regular basis. If the conversation with the patient gets stressful, have a team member standing by to join you to diffuse the situation. During the tapering process, arrange for a team member to check in with the patient every week or more often via phone, text, clinic visit, etc.

**Use motivational interviewing (reflection, validation, support)** – Be sensitive to the patient's reactions to your conversation with them. Remember, you don't have to agree with the patient to show that you understand and validate their feelings. Here are some example phrases.

**Reflection:** *"You seem upset by what I have said. Can you talk about how you are feeling right now?"*

**Validation:** *"I absolutely believe your pain is real." "I know it is very challenging for you to make changes to your medication." "It's perfectly normal for you to be anxious, fearful, and angry."*

**Support:** *"I know you can do this, and I am going to stick by you on this journey." "I am sorry to see you suffering. I care about you and I want your health to improve." "I see that you are suffering right now. By working together I am confident you can do this and that over time your quality of life will improve"*

**For inherited patients, maintain the current dose and document if considering a taper** – If safety allows, do not make any medication changes at the first visit. Explain that you are making a careful assessment of the risks and benefits of continued opioid therapy. Reassure your patient that you will involve them before making any changes. Assure them of your concern for their health and safety. In your documentation, make it clear that you are maintaining the current dose of opioids in the broader context of assessing risks and benefits and developing a relationship of trust.

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**If the patient is not in imminent danger, take the time to build a trusting and supportive relationship before making any changes to the pain medications.**

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## Risk Benefit Assessment

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The prescriber needs to do a careful assessment of the risks and benefits of continued long-term opioid therapy. If your patient is doing well, engaging in activities, taking medication as prescribed, and has no other concerning risk factors, there may be no need to taper them off their current dose. But remember, the patient's subjective report is just one data point. Be sure to check other data points, such as collateral information from family, the Prescription Drug Monitoring Program, and urine drug screening. Document your assessment and monitor patients at least quarterly for any change in status. Remember patients can develop problems at any point in their opioid therapy. Review [Broaching the Subject](#) for advice on how to discuss tapering with your patient. For specific language on how to talk to your patients about opioid risks, see [Weighing the Risks and Benefits of Chronic Opioid Therapy](#)

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**Carefully assess the risks and benefits of continued long-term opioid therapy. If the patient is doing well with no other concerning risk factors, continuing opioids may be appropriate. If the risks outweigh the benefits, tapering is recommended.**

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Consider tapering for the following reasons:

**Patient request** – If your patient requests reducing or eliminating opioids, you should initiate tapering. If pain is still a problem, offer alternatives. See [Other Strategies for Coping with Pain](#).

**Pain and function not improved** – If your ongoing evaluation of the patient demonstrates that their pain and function are not meaningfully improved, then tapering is recommended.

**Adverse opioid effects** – Consider tapering if your patient is suffering adverse opioid side effects such as constipation, lethargy, sexual dysfunction, confusion, depression, increased risk for falls, immune suppression, or respiratory depression. Tolerance, dependence, and withdrawal can be adverse effects, and may themselves be indication for a taper.

**Co-occurring conditions (including mental health)** – Consider tapering if your patient has co-occurring health conditions such as lung disease, sleep apnea, liver disease, kidney disease, cardiac arrhythmias, obesity, or dementia. If your patient suffers from depression, anxiety, PTSD, or childhood trauma, they are at higher risk for developing opioid misuse or an opioid use disorder. Integrating mental health treatment alongside chronic pain treatment increases the odds of a successful and therapeutic opioid taper.

**Dose over 90 MED (Morphine Equivalent Dose)** – Morphine Equivalent Dosing (MED) is a patient's cumulative intake of all opioids over 24 hours measured in morphine milligram equivalents. Adverse outcomes are dose and duration dependent. Some patients at higher doses may be fully adherent and functioning well with no other risk factors. However, the risks of overdose, addiction, and other serious side effects increase above 90 MED. At least quarterly, reassess the benefits versus the risks of continued opioid therapy at doses over 90 MED. [MED Calculator](#)

**Concurrent sedatives** – Consider tapering if your patient is prescribed benzodiazepines, carisoprodol, or other sedatives, or regularly drinking alcohol. You may want to taper the sedative before or instead of the opioid. Involve patients in the discussion of which to taper first. Check your state Prescription Drug Monitoring Program.

**Opioid Use Disorder** – Tapering is recommended if the patient meets criteria for a diagnosis of Opioid Use Disorder (OUD) (see [Addiction and Dependence Happen](#)). Also consider tapering opioids in patients at higher risk for developing an OUD, such patients on high doses, those with a personal or family history of addiction, a history of childhood trauma, co-occurring mental illness, or other psycho-social stressors that predict a poor response to opioids. [DSM-5 OUD Criteria](#)

**Opioid Overdose** – If your patient has had an overdose or other serious medical event (e.g., hospitalization, injury) due to opioids, immediate action is needed. It is likely that tapering will be necessary in conjunction with treatment of other conditions.



## Addiction and Dependence Happen

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**Addiction** – Addiction to opioids is called opioid use disorder (OUD). There are 11 diagnostic criteria for OUD in the [DSM-5](#). A shorthand way to remember the DSM-5 criteria is by the 3 C's: Loss of *Control*, *Craving*, and continued use despite *Consequences*. Careful screening for addiction should be a part of any opioid treatment regimen. Buprenorphine, other pharmacotherapy, and/or psychosocial interventions for addiction should be used in the treatment of OUD.

**Dependence** – Some patients develop severe physiologic dependence on prescription opioids and do not tolerate tapering even when tapering is medically indicated. When the risks of continuing prescription opioids outweigh the benefits (i.e. the patient needs to taper) and severe dependence limits the patient's ability to taper, yet the patient does not meet DSM-5 criteria for opioid use disorder, then the patient has medically debilitating Prescription Opioid Dependence (POD). These patients often exhibit an exaggerated pain response, dysphoria, negative affect, reward deficiency, and social isolation with even mild dose reduction. Patients with medically debilitating POD may need to be tapered much more slowly than the average patient. In some cases, these patients may need years to get to a lower dose or off opioids.

**Anyone can become addicted or dependent** – Addiction and dependence are medical conditions that can occur with exposure to opioids, especially long-term exposure at high doses. Opioids have powerful effects, and anyone can become addicted to and/or dependent on them. Explore the possibility of these diagnoses with your patient in an objective, compassionate, and stigma-free manner.

**Reassure the patient there are effective treatments for OUD** – Let your patient know before you begin the tapering process that the taper sometimes unmasks an OUD. If an OUD is detected, this is nothing shameful, but rather an indication that another type of treatment is necessary. Detecting an OUD doesn't mean you're giving up on treating the patient's pain. It means you need to treat the OUD in addition to treating the pain.

**Consider buprenorphine for addiction and dependence** – Become [X-waivered](#) so you can utilize buprenorphine in the treatment of OUD. Just as you have developed competency and know your community's resources for managing diabetes say, you should develop those same skills to handle OUD. Those needing a higher level of care should be referred to appropriate community services. Buprenorphine may also be a useful tool in patients with prescription opioid dependence who are unable to taper when medically indicated.

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**Opioids have powerful effects, and anyone can become addicted to and/or dependent on them. Explore the possibility of these diagnoses with your patient in an objective, compassionate, and stigma-free manner.**

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## Velocity and Validation

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The biggest mistake providers make when tapering opioids is going too quickly. Tapering can be accomplished safely and humanely utilizing a few simple principles.

**Go slowly, especially as dosages decrease** – A taper protocol slow enough to minimize opioid withdrawal symptoms is best in most situations (ref 1). Tapers should be individualized and done in partnership with your patient. Most tapers involve dosage reduction of 5-20% per month. Slower tapers are better tolerated than faster tapers, especially in patients who have been on opioids for years.

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**Tapers should be individualized and done in partnership with your patient. The biggest mistake providers make when tapering opioids is going too quickly. Go slowly enough to minimize withdrawals symptoms.**

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**Maintain the same schedule (BID, TID)** – It may be helpful to keep the same dosing cadence (e.g., twice daily, three times daily), especially in the beginning of the taper. The brain is habituated to having the medication at set times. If the patient is on a regimen of taking doses two times or three times a day, keep that schedule during the taper for as long as possible.

**Let the patient drive, within reason** – “Which opioid would you like to taper first?” – Tapering is a frightening experience for many patients. People tolerate stress best when they feel empowered. If your patient is concurrently taking a prescription benzodiazepine, increasing their risk of accidental overdose, offer to taper the benzodiazepines first and then reconsider the risks and benefits of the opioid. Don't try to taper both at once. Most patients can't tolerate this, and by changing too many variables at the same time, it's difficult to track patient response. Bottom line: After you've decided a taper is necessary, collaborate with your patient on how to do it.

**Take breaks, but never go backwards** – Breaks in the taper are appropriate. Patients can maintain a given dose for some period before continuing. For example, if the patient has an important event scheduled and does not want to risk being in low-grade withdrawal, including subtle psychological symptoms of withdrawal such as anxiety, irritability, and dysphoria, it is reasonable to defer the next decrement in dose. It is imperative never to go backward during the taper (i.e., increase the dose). Going back up on the dose risks losing the hard work already invested. Nonaddictive medications can help relieve symptoms of withdrawal.

**Warn patients that pain might get worse before it gets better** – Tell patients that their body pain will likely get worse each time the opioid dose is decreased, but that with time and with the body adjusting to the new lower dose (approximately four weeks), the pain level will return to baseline. The increased pain patients experience after the dosage decrease does not indicate progression of their underlying pain condition. Rather, the pain represents time-limited, opioid withdrawal-mediated pain. Patients with chronic pain who successfully taper down or off long-term opioid therapy often report improved pain.

**Validate that opioid tapering is hard and that you will work with the patient however long it takes** – Validate that opioid tapering can be scary and painful. Don't try to minimize the difficulty, which can lead to patients feeling invalidated. Remind your patient that people just like them have been successful, resulting in an improved quality of life. Validate the challenges you as a provider face in helping patients taper, and avoid dismissing patients from care by having compassion for them and yourself. You can do this!



## Other Strategies for Coping with Pain



## Other Strategies for Coping with Pain

Patients with long term chronic pain often gradually lose capabilities in many areas of their life. They tend to avoid activities that might cause discomfort. They may withdraw socially which can cause or add to depression and anxiety. They may not take care of themselves and have poor nutrition. All these things can amplify the pain they experience. The good news is that patients can also recover their capabilities if they work on improving these areas of their life. As these areas improve, patients are likely to see a reduction in the pain they experience and a general improvement in their well-being and function.



**Help patients understand how pain works** – This video explains that people often believe that pain is only a bottom-up process, where the brain receives sensory inputs from the body from tissue damage, triggering pain. But there's also a top-down process whereby the brain itself can change the pain experience. For example, stress, depression, anxiety, lack of sleep, and poor nutrition can all make pain worse independent of tissue damage. Improving mood, sleep, and nutrition can make pain better, again independent of tissue damage. Life-style improvements help reduce pain. Patients learn what can cause pain, what can reduce pain, and what they can do to improve their life despite having pain. Encourage your patient to watch this video to learn how pain works.

**The good news is that when patients make healthy lifestyle changes, they usually have reduced pain and their well-being and function is improved.**



**Encourage regular, restful sleep** – Most patients with chronic pain sleep poorly. Lack of sleep causes irritability, memory issues, trouble concentrating, and poor balance. It can amplify depression and anxiety, weaken the immune system, lower sex drive, and cause high blood pressure. Getting good, restful sleep on a regular basis can have a very positive effect on pain. Check if your patient has problems sleeping. If they do, have them watch this video. Work with them to improve their sleep.



**Promote healthy activities** – Patients with chronic pain may avoid activity for fear of re-injuring themselves. Their brains can be overly protective, equating hurt with harm. Gradually their bodies lose fitness and even simple tasks can become exhausting. It is important that patients re-engage in physical activities as tolerated. They need to pace themselves to avoid flare-ups caused by overdoing things. Encourage your patient to watch this video on being active.



**Maintain a positive mood** – Mood, stress, and pain are closely linked. Chronic pain can cause depression, anxiety, and anger. Stress can trigger the body's stress response system, increasing heart rate and blood pressure and causing muscles to tense up. When patients work on improving mood, many other aspects of their life improve as well. Patients can learn to be more positive and reduce stress. Several techniques can help, such as practicing mindfulness or meditation, reframing negative thoughts, and engaging in social activities. Encourage your patient to watch this video on improving mood.



**Foster social connections** – Patients with persistent pain often withdraw socially. Social isolation can cause them to focus more on their pain which in turn can intensify depression, anxiety, and anger. When patients start reconnecting with old friends and make new social connections, their sense of self-worth improves. New social connections which involve new activities are especially helpful. If your patient has withdrawn socially, have them watch this video. Then explore with them how they can expand their social life.



**Make good nutritional choices** – Nutrition is often overlooked as part of a treatment plan. A healthy gut microbiome is critical to our general health. Poor nutrition can cause inflammation and visceral pain. Good nutrition can help alleviate constipation and other side effects of medication. Discuss with your patient their eating habits and the importance of a healthy gut microbiome. Encourage them to watch this [video](#) on healthy nutrition.



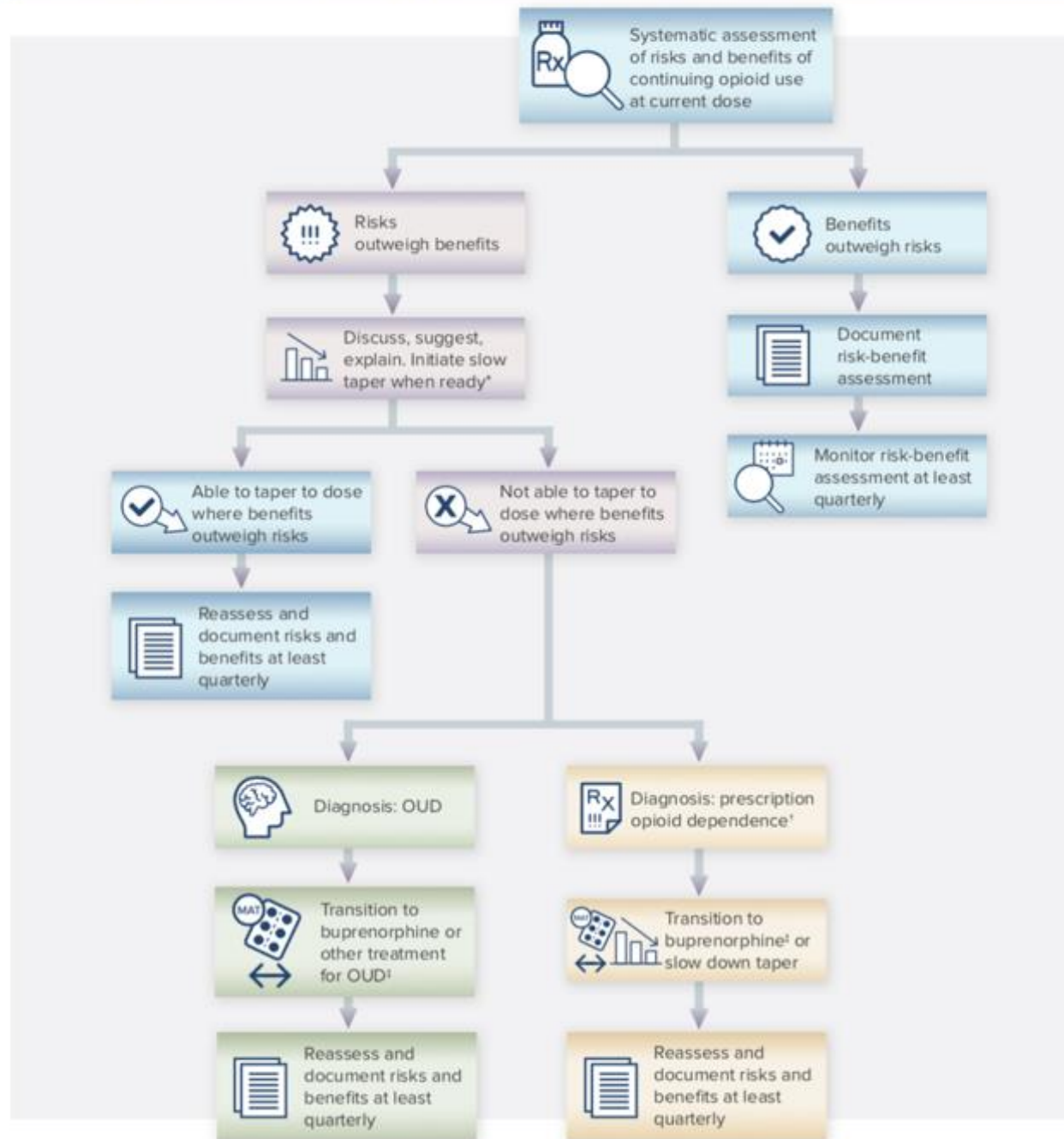
**Consider non-opioid pain medications** – Although no medication is without risk, medications like ibuprofen and acetaminophen have been shown to help with pain. In general, these medications are safer than opioids and should be considered as possible alternatives. Encourage your patient to watch this video on non-opioid pain medications.



**Plan for flareups** – For people with chronic pain, flareups are common. They can come on suddenly and cause intense pain lasting for hours or days. Patients are very concerned that something new is wrong with them. This can cause depression, anxiety, and anger. All these emotions just amplify the pain. Patients may even go to the emergency department. With education, patients can learn to become detectives and investigate possible causes or triggers. They can learn what steps they can take to anticipate and moderate their flareups. If your patient has problems with flareups, have them watch this video.



# Clinical Pathway for LONG-TERM OPIOID THERAPY MANAGEMENT







Systematic assessment  
of risks and benefits of  
continuing opioid use  
at current dose



Risks  
outweigh benefits



Benefits  
outweigh risks

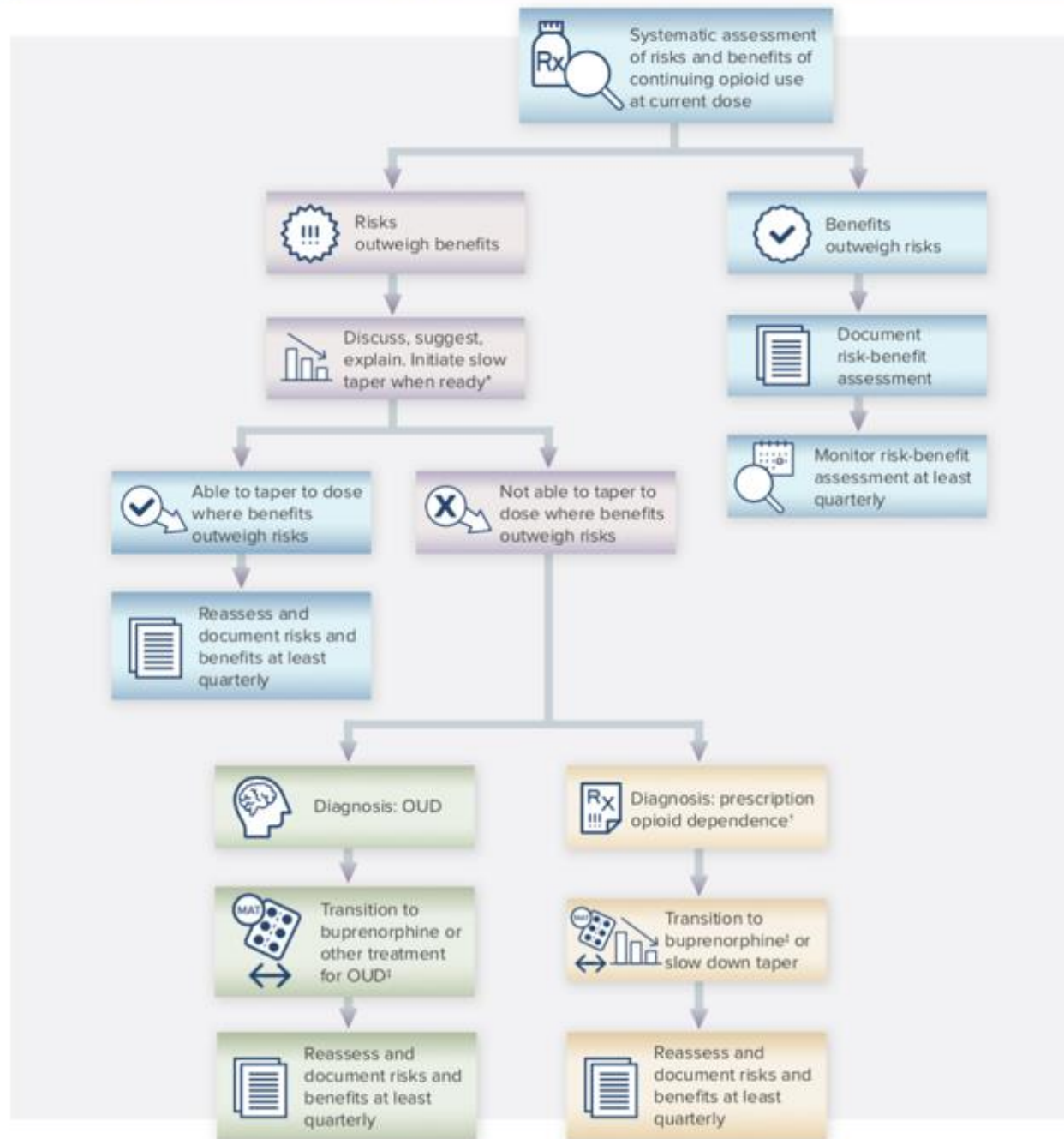



Discuss, suggest,  
explain. Initiate slow  
taper when ready\*




Document  
risk-benefit  
assessment

# Clinical Pathway for LONG-TERM OPIOID THERAPY MANAGEMENT






Able to taper to dose where benefits outweigh risks

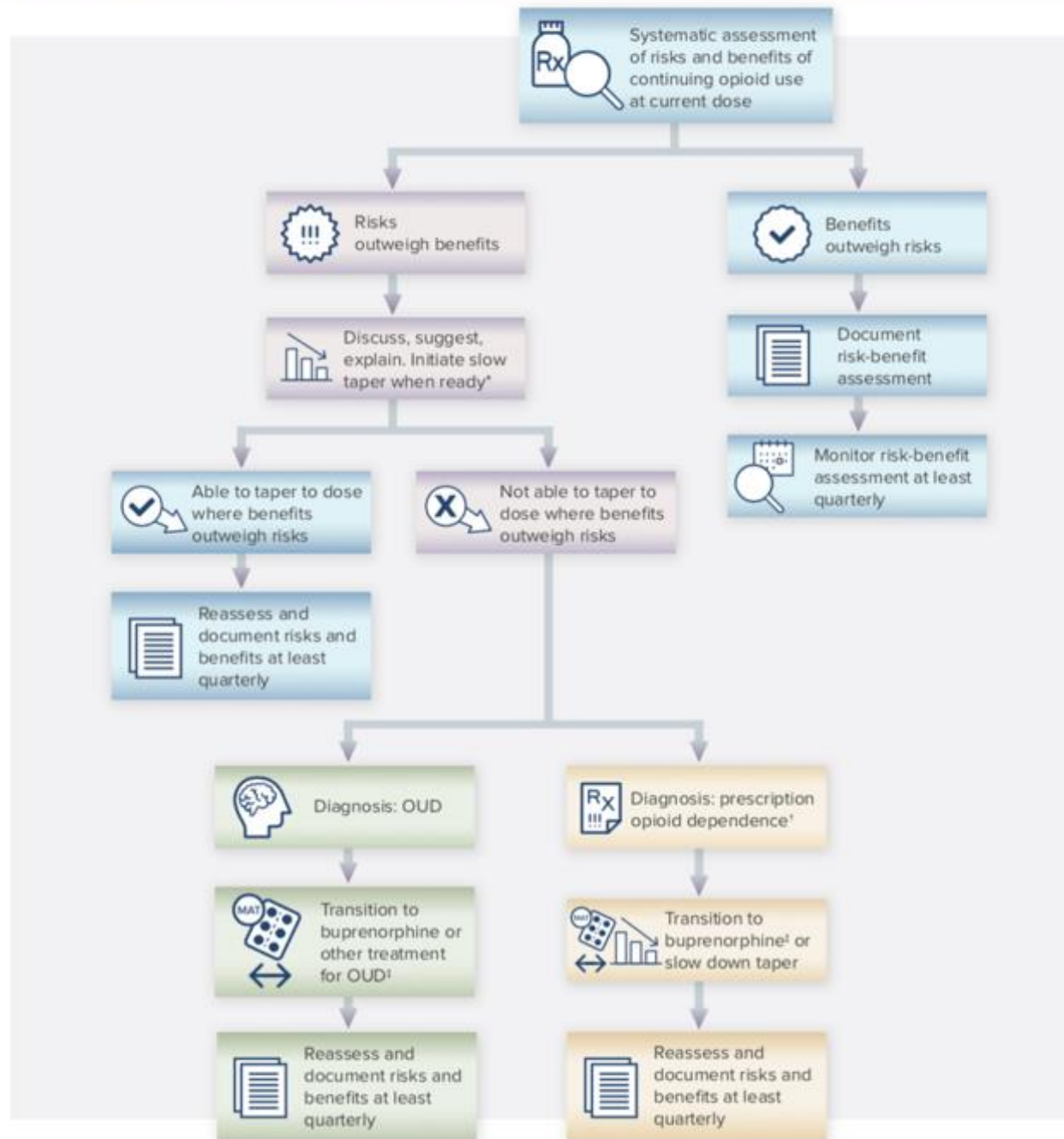


Reassess and document risks and benefits at least quarterly



Not able to taper to dose where benefits outweigh risks

# Clinical Pathway for LONG-TERM OPIOID THERAPY MANAGEMENT







Diagnosis: OUD



Transition to  
buprenorphine or  
other treatment  
for OUD<sup>†</sup>



Reassess and  
document risks and  
benefits at least  
quarterly



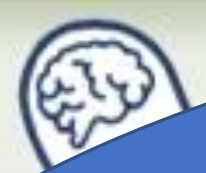
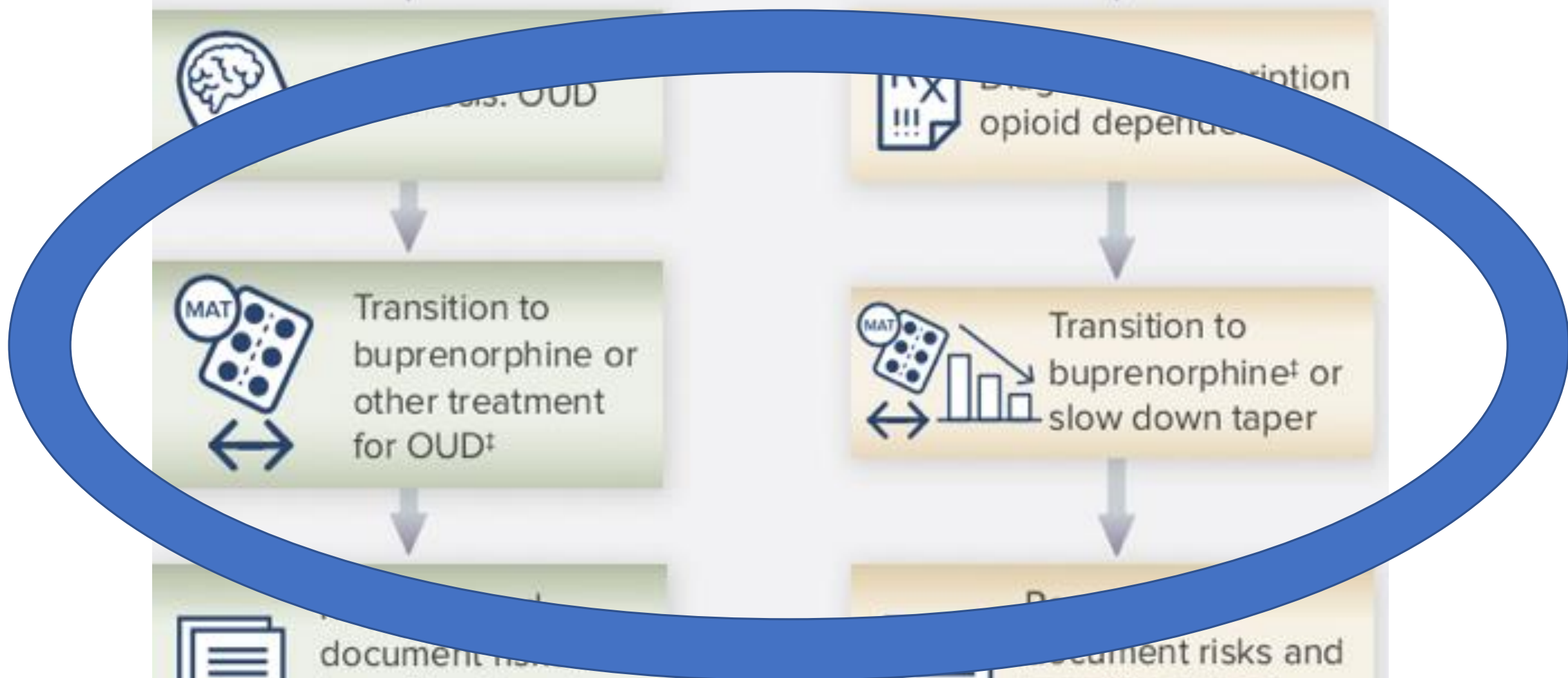
Diagnosis: prescription  
opioid dependence<sup>†</sup>



Transition to  
buprenorphine<sup>‡</sup> or  
slow down taper



Reassess and  
document risks and  
benefits at least  
quarterly



...s. OUD



Transition to buprenorphine or other treatment for OUD†



document risks and benefits at least quarterly



...scription  
opioid dependence



Transition to buprenorphine† or slow down taper



document risks and benefits at least quarterly



*"I'm afraid you've had a paradigm shift."*



# The Paradigm Shift





Please type your questions into the Zoom Q + A box.

We'll try to get to all of your questions!

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