# 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.

## Approaches to caring for new patients already on long-term opioid therapy

- Obtain past medical records related to their chronic pain care and ask why they terminated care with their last clinician.
- When a patient already on long-term opioid therapy comes to you for care, assess the following as soon as possible, but always within 3 months.
    - History and physical to confirm diagnosis and appropriate use of opioids based on diagnosis
    - Potential benefits of non-opioid therapies
    - Risk level
    - Potential for substance/opioid misuse, abuse, or disorder (e.g., ORT, SOAPP, COMM, DAST, TAPS, or DSM-5)
    - Conduct urine drug test
    - Other prescriptions filled (prescription drug monitoring program database)
    - Morphine equivalent dose
    - Progress meeting functional goals (e.g., Pain, Enjoyment, General activity scale)
    - Co-prescribing of sedatives
    - Anxiety and depression
    - Informed consent for long-term opioid therapy with a patient agreement
- Prescribe naloxone if assessment reveals elevated risk or if MED ≥50.
- Before prescribing opioids, discuss risks of opioid use with the patient.
- If you identify a patient who has **opioid use disorder**, discuss treatment with buprenorphine or a referral to an opioid treatment program for methadone. Also provide a referral to behavioral health services, if available.

### Tapering

- If the patient is at an **opioid dose of ≥90 MED**, but their dose, pain, function, and compliance are stable, a pain consultation and tapering are not required for the first 3 months of prescribing.



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- Evaluate when tapering or other adjustments in the treatment plan can or should be done.
- If appropriate, begin a tapering protocol tailored to the patient by the end of the 3rd month of care. Slow opioid **tapers** (e.g., 10% per month or slower) as well as pauses in the taper with a defined resume time allow gradual accommodation to lower opioid dosages and are best practices. If a patient is enthusiastic about tapering, they can increase the taper rate (e.g., 10% every 2 weeks). Avoid increasing doses once tapering begins by identifying non-opioid strategies for pain flares. The only exception is a new acute pain problem.
- Be aware that unrecognized depression, anxiety, and PTSD may be uncovered during a taper.
- If not tapering and the patient has an MED of 90 to 119 MED/day, consider a **pain specialist consultation**. After 3 months, a pain specialist consultation is required at a dose of ≥ 120 MED/day unless the patient is following a tapering schedule, treatment is for short-term acute pain, pain and function are stable with a non-escalating dose of opioids, or reasonable attempts to obtain consultation have failed.
- If **co-prescribing** opioids and sedatives for a patient, begin tapering when appropriate and within 3 months. Engage the patient in the process by deciding which to taper and at what rate. The tapering plan can change over time (e.g., which medicine is currently being tapered can alternate over time; tapering rate can change).
- If the patient chooses not to follow a tapering regimen and the clinician believes that **maintaining the current opioid dose is a significant health risk**, inform them that they will not continue to receive long-term opioid therapy. However, it is important to continue offering primary care to this patient.
- If the patient chooses not to follow a tapering regimen and the clinician believe that it is not a significant health risk to maintain the current opioid dose, the clinician can use clinical judgement and continue opioids. In this case, the clinician should broach the tapering conversation at every visit and document in the chart about the conversations.

## How to have the tapering conversation

Engaging in a conversation about tapering opioids can be challenging. It can be helpful to keep the following principles in mind when engaging in these conversations with patients.[1]

1. Keep the primary focus on outcomes patients care about.
2. When discussing risk, focus on the drugs not the patient.
3. Redirect clinical encounters to focus on what patients can do to improve their quality of life.

Here are few suggestions with sample language you can consider when developing your own "scripts" for these conversations. For more suggestions, see the Planned, Patient-Centered Visits resources on the Six Building Blocks website (www.improvingopioidcare.org).

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| *"We used to think these medications were safe, we now know that they are not. I am primarily concerned about your safety. Let's talk more about this in the next visit. In the meantime I want you to read this about the risks of opioids."* |
| *"From what you've told me, the medicine isn't as effective as you'd like. Let's think about trying something different."* |
| *"For most people, the benefits wear off as the body gets used to the medications. Then they're stuck on a medicine that isn't really doing much for them. They often assume they'll be worse off without it, but it turns out that's not true. Let's talk about what you can do to live a better life."* |
| *"You're telling me that your pain is really terrible, and I hear you. It seems to me that what we're doing just isn't working. I know they helped you at first, but I think the effect of the medications has worn off. Are you interested to hear how opioids might actually be making your pain worse?"* |
| *"We used to think the dose didn't matter as long as we went up slowly, but now we know higher doses can lead to higher risks of serious injuries and accidental death. And, higher doses don't seem to reduce pain over the long-run."* |
| *"Our clinic is making changes for all our patients so that medication prescribing is safer than it has been in the past."* |

[1] *Krebs, Erin E, Safer Management of Opioids for Chronic Pain: Principles and Language Suggestions for Talking with Patients.*