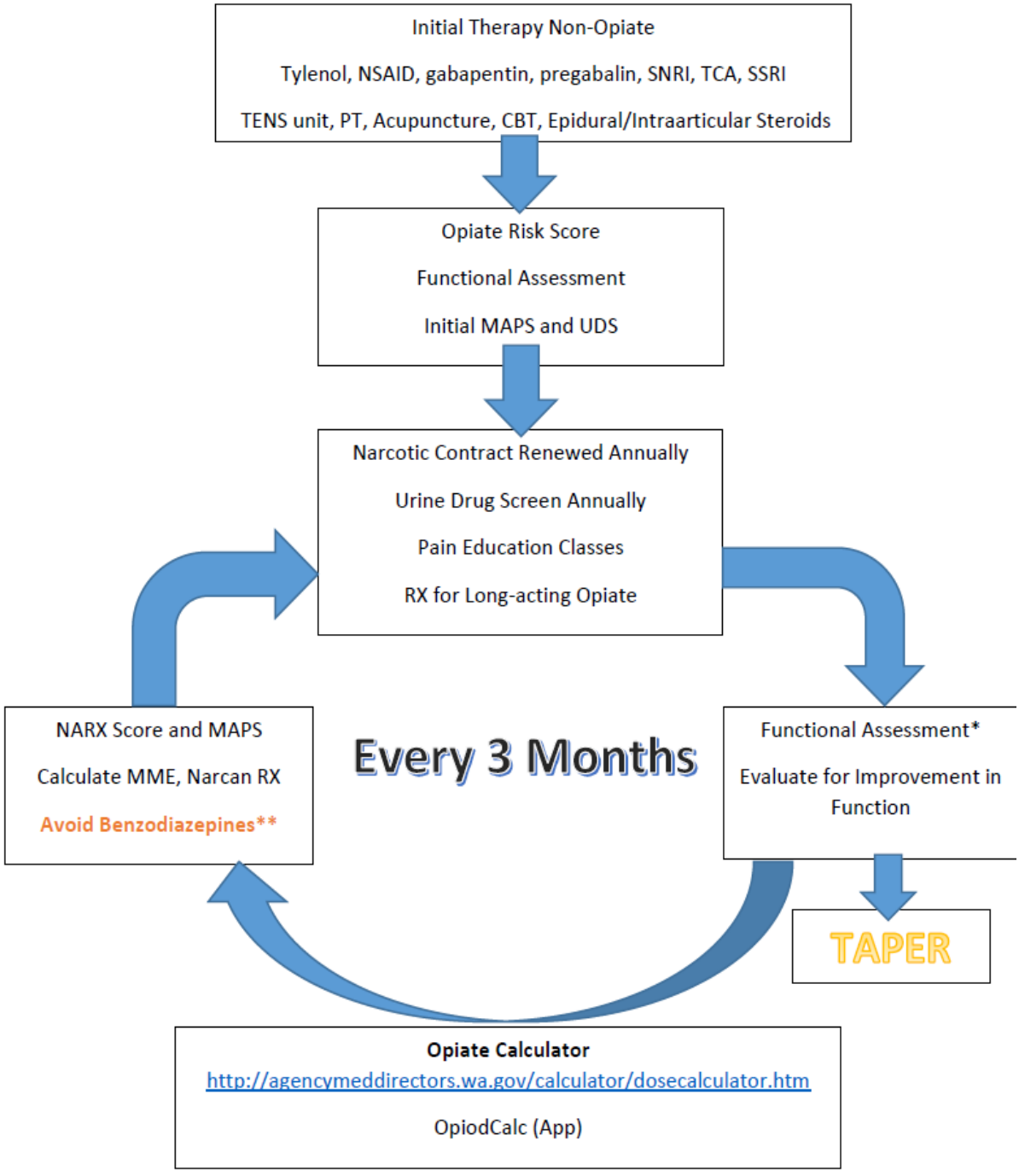
MUNSON HEALTHCARE
Family Practice Residency

Residency Based Approach to Opioid Epidemic

Non-Cancer Chronic Pain Practice Flowchart



*Pain, Enjoyment, General Activity Scale (PEG)

**Co-prescribing sedative sharply increase risk of overdose and death

1. Berna C, Kulich R, Rahtmell J. Tapering Long-Term Opioid Therapy in Chronic Noncancer Pain Evidence and Recommendations for Everyday Practice, May Clini Proc; 2015; 90 (6) 828-842.
2. CDC Dowell D, Robinson J, Tauben D Recommendations for Nonopioid Treatments in Management of Chronic Pain
3. UMHS Chronic Pain Management Guideline, Nov 2016
4. Krebs, E. et al. Development and Initial Validation of the PEG, a Three-item Scale Assessing Pain Intensity and Interference. Journal of Gen Int Med; 2009; 24 (6) 733- 738.

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Standardized Plan:

- Indication for Narcotic
- Opioid risk tool
- Functional Limitation Questionnaire
- Discussion with patient on risks vs benefits
- Last UDS date – minimum of annually
- Last MAPS – every prescription to q 3 months
- Last Controlled substance agreement – annually
- Morphine equivalents
- Assess concurrent BDZP use
- Naloxone script for MME > 50
- Plan/Goals of therapy: wean vs continue
- Next appointment – at least q 3 months

Tapering Guidelines:

1. Discuss Patient Benefits – lower risk of side effects and death
2. Set Expectations
    a. Minimal side effects with a 10% a week or month (CDC Guideline).
    b. Up to 20–50% depending on patient/clinical scenario
3. Maximize Non-Opioid Medications (TCAs/Pregabalin/Gaba/SSRI/SNRI)
4. Frequent visits: weekly to monthly depending on patient and wean (Care Management/Pharmacy).

GOAL: 30 MMEs vs 30% Original Dose vs desired dose achieved.

Patient/Action	Reason	Taper	Process
Slow Taper (no apparent addiction/able to tolerate outpatient taper)	Lack of benefit Opioid-induced toxicity/hyperalgesia Excessive dosing: > 90 MME	Gradual over 4 or more weeks	**Multiple agents:** Convert all medications to morphine, then taper. Maximize non-opioids; PT; Psychosocial support **Taper:** 10% of original dose every 7 days until 30% remains. Assess. Continue taper based on patient factors, until at **GOAL**.
Rapid Taper (unable/unwilling to engage in outpatient taper)	Non-compliance with evaluation or therapy plans Medication misuse Problem ("red flag") behaviors: Focus on opioids, early refills, multiple calls/visits, urine drug test results, illicit substance use, contract violations	Taper over few to several weeks.	**Multiple agents:** Convert all medications to morphine, then taper. Maximize non-opioids; PT; Psychosocial support **Taper:** 25% of original dose every 3–7 days (shorter interval for short half-life medications) until **OFF**.
Discontinue Immediately (dangerous opioid behavior)	Drug diversion/prescription forgery Danger to the patient Threats are made in the practice office Patient arrested	**STOP**	**No further prescribing** **Manage symptoms accordingly: Clonidine, Hydroxyzine, and/or Imodium.*
Buprenorphine Conversion with Taper	Pain & Addiction	Refer to chronic pain service/Suboxone provider *requires XDEA number & experience	

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