Virginia Department of Health Professions
Board of Medicine

Welcome to the Ad Hoc Committee on Opioid Continuing Education

The Virginia Board of Medicine will hold an electronic meeting of the **Ad Hoc Committee on Opioid Continuing Education** on **December 1, 2020 at 12:00 Noon**. This meeting will be supported by Cisco WebEx Meetings application.

For the best WebEx experience, you may wish to download the Cisco WebEx Meeting application on your mobile device, tablet or laptop in advance of the meeting. Please note that WebEx will make an audio recording of the meeting for posting.

This electronic meeting is deemed warranted under Amendment 28 to HB29 based on that requiring in-person attendance by the Advisory Board members is impracticable or unsafe to assemble in a single location.

Comment will be received during the meeting from those persons who have submitted an email to **william.harp@dhp.virginia.gov** no later than 8:00 a.m. on November 30, 2020 indicating that they wish to offer comment. Comment may be offered by these individuals when their names are announced by the chairman.

Whether you are a member of the Ad Hoc Committee or a member of the public, you can join the meeting in the following ways.

- **JOIN by WEBEX**

https://covaconf.webex.com/covaconf/j.php?MTID=m79a945a3695247f21497137c3c62c0d5
Meeting number (access code): 178 607 9149

- **JOIN BY PHONE**

+1-517-466-2023 US Toll
+1-866-692-4530 US Toll Free
Meeting number (access code): 178 607 9149

TECHNICAL DIFFICULTIES: Should you experience technical difficulties, you may call the following number: (804) 339-0627 for assistance. Any interruption in the telephonic or video broadcast of the meeting shall result in the suspension of action at the meeting until repairs are made and public access is restored.

The Board of Medicine and the Freedom of Information Act Council are interested in your evaluation of the electronic experience of this meeting. You can provide comment via the following form **HERE**.

VIRTUAL - Ad Hoc Committee on Opioid Continuing Education

Virginia Board of Medicine
December 1, 2020
12:00 p.m.

VIRTUAL MEETING OF THE
Ad Hoc Committee on Opioid
Continuing Education

Tuesday, December 1, 2020 @ 12:00 p.m.

Page

Call to Order of the Ad Hoc Committee — Lori Conklin, MD, President, Chair

---DRAFT UNAPPROVED---

VIRGINIA BOARD OF MEDICINE
MINUTES
Ad Hoc Committee on Controlled Substances Continuing Education

Friday, November 27, 2018 Department of Health Professions Henrico, Virginia

CALL TO ORDER: The meeting of the Ad Hoc Committee convened at 1:59 p.m.

MEMBERS PRESENT: Kevin O'Connor, MD, Chair
Robin Hills, NP
Ralph Orr
David Taminger, MD

MEMBERS ABSENT: Lori Conklin, MD

STAFF PRESENT: William L. Harp, MD, Executive Director
Tamika Hines, Discipline Reinstatement & CCA Case Manager
Barbara Allison-Bryan, MD, DHP, Deputy Director

OTHERS PRESENT: Jerry Canaan, HDJ

SUMMARY OF MEETING:

Dr. O'Connor called the meeting to order. The roll was called and a quorum declared. The Emergency Evacuation Instructions were given.

Dr. Taminger moved to approve the minutes of October 28, 2016. The motion was seconded and carried.

Dr. Taminger moved to adopt the agenda as presented. The motion was seconded and carried.

The members discussed Code Section 54.1-2912.1 which authorizes the Board of Medicine to require 2 hours of continuing education on opioids each biennium. The topics included in the law are those related to pain management, the responsible prescribing of controlled substances, and the diagnosis and management of addiction. The Board is to notify its licensees subject to the 2-hour requirement prior to January 1 of each odd-numbered year. The Ad Hoc Committee met on November 27, 2018 and developed a recommendation for the next biennium for the Board's consideration.

The Committee thought the Board should offer a "package" of continuing education that would satisfy the 2-hour requirement. It also endorsed the principle that licensees should be able to select activities they deemed valuable to their day-to-day practice.

The "package" would include:

- Reading the Board of Medicine Regulations Governing Prescribing Opioids and Buprenorphine
- Reading the Board's FAQ's on Opioids and Buprenorphine
- Viewing the PMP video on NarxCare (Generic Navigation-6 minutes & 51 seconds)
- Taking the Stanford University course on "How to Taper Patients Off of Chronic Opioid Therapy" which provides 1.25 hours of Category I AMA PRA credit

MOTION: The members unanimously agreed to recommend both a 2-hour "package" on the Board's website and the option for licensees to pick their 2 hours of opioid continuing education activities.

With no further business to discuss, the meeting was adjourned at 2:57 p.m.

_____
Kevin O'Connor, MD
Chair

_____
William L. Harp, M.D.
Executive Director

_____
Tamika Hines
Recording Secretary

Code of Virginia
Title 54.1. Professions and Occupations
Chapter 29. Medicine and Other Healing Arts

This section has more than one version with varying effective dates. Scroll down to see all versions.

§ 54.1-2912.1. (Effective until July 1, 2022) Continued competency and office-based anesthesia requirements.

A. The Board shall prescribe by regulation such requirements as may be necessary to ensure continued practitioner competence, which may include continuing education, testing, or any other requirement.

B. In promulgating such regulations, the Board shall consider (i) the need to promote ethical practice, (ii) an appropriate standard of care, (iii) patient safety, (iv) application of new medical technology, (v) appropriate communication with patients, and (vi) knowledge of the changing health care system.

C. The Board shall require prescribers identified by the Director of the Department of Health Professions pursuant to subdivision C 10 of § 54.1-2523 to complete two hours of continuing education in each biennium on topics related to pain management, the responsible prescribing of covered substances as defined in § 54.1-2519, and the diagnosis and management of addiction. Prescribers required to complete continuing education pursuant to this subsection shall be notified of such requirement no later than January 1 of each odd-numbered year.

D. The Board may approve persons who provide or accredit such programs in order to accomplish the purposes of this section.

E. Pursuant to § 54.1-2400 and its authority to establish the qualifications for registration, certification, or licensure that are necessary to ensure competence and integrity to engage in the regulated practice, the Board shall promulgate regulations governing the practice of medicine related to the administration of anesthesia in physicians' offices.

1997, c. 227; 2002, c. 324; 2016, c. 447.

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1997, c. 227; 2002, c. 324.

The chapters of the acts of assembly referenced in the historical citation at the end of this section may not constitute a comprehensive list of such chapters and may exclude chapters whose provisions have expired.

11/19/2020

TRENDS NOTED IN COMMUNICATIONS WITH THE BOARD

Both the Discipline Section and Administrative Section, through its Call Center, have knowledge of inquiries and comments from prescribers and patients.

The most obvious trend is that there are far fewer calls than there used to be. This may be attributable to the "package" of Continuing Education on opioids recommended to all prescribers for 2019-2020. The "package" included reading the regulations, reading the FAQ's, viewing the NarxCare video, and completing the Stanford University course on "How to Taper Patients Off of Chronic Opioid Therapy." Recommending these activities was in response to calls to the Board from patients who were upset that their prescriber was reducing their dose, referring them to a pain management specialist, and in some instances, terminating care. From a number of these conversations, Board staff inferred that not all prescribers had read the regulations, and if they had, were not complying with them. Reducing the dose of opioid in patients with bona fide pain issues can lead to a poor outcome, so that is why the Stanford course was recommended.

Comments from the Discipline Section

From prescribers:
- UDS and frequency of seeing patients for *non-opioid* prescribing, e.g., stimulants?
- COVID-19 related, e.g., do I need to see patients for in-office visit?

From patients:
- Still some questions re: prescriber saying I have to try something new when what I've been taking is working
- Requiring me to come for an in-office visit during COVID-19
- Some still mad about prescriber requiring UDS

Comments from the Call Center
-Calls about opioids are few in number

TRENDS NOTED BY THE PRESCRIPTION MONITORING PROGRAM

MME's continue to decline.

Multiple provider episodes are trending downward as well.

Long-acting opioids are still being prescribed to opioid-naïve patients. PMP data indicates that 5% of patients that are being prescribed long-acting preparations are opioid-naïve. This prescribing puts patients at greater risk of respiratory depression and inadvertent overdose than immediate-release preparations.

According to the Office of the Chief Medical Examiner, the rate of opioid overdose deaths has remained stable.

LICENSEES REQUIRED TO OBTAIN 2 HOURS OF OPIOID CE

The law requiring 2 hours of opioid CE was passed by the General Assembly in 2016. It authorized the Director of DHP to identify those licensees who should obtain opioid CE for renewal of their license. At the October 2016 meeting of the Ad Hoc, it was decided to recommend that all licensees of the Board of Medicine with prescriptive authority be required to obtain the 2 hours of CE. This decision was based on the fact that the requirement was a new initiative, and it was thought that each and every prescriber shared the responsibility of helping address the statewide opioid crisis. The data showed that opioid overdose deaths and crime associated with opioid addiction were not slowing down, further emphasizing the urgency of an "all hands on deck" approach. And prescribers were seen as playing a pivotal role in helping slow down the crisis.

When the requirements were sent to all prescribers, some physicians in specialties which seldom or never write prescriptions for opioids asked why they must obtain the opioid CE. The response given was that the crisis was serious, and all prescribers needed to help deal with it. Even if a practitioner never wrote opioids, he/she would most likely be seeing patients that were on opioids. And it is a good idea for all practitioners to know about the proper prescribing of opioids and be able to identify abuse and addiction.

In 2018, the Ad Hoc recognized that not all prescribers had read the regulations, and that all practitioners were not skilled in the tapering of opioids. So again, the Ad Hoc recommended that all prescribers licensed by the Board be required to obtain the 2 hours of CE.

In 2020, the opioid crisis continues. Staff believes that the required CE has had a positive impact on prescriber decision-making and prescribing behavior. Staff also believes that all prescribers have become accustomed to obtaining the 2 hours each biennium. And there is an abundance of good, free courses on the Internet. Therefore, staff endorses the continued requirement of all prescribers licensed by the Board of Medicine to obtain the 2 hours during the upcoming biennium whether they have a DEA registration or not.

This item is for Committee discussion and determination.

Dear Colleague:

In 2016, the General Assembly passed law that authorizes the Board of Medicine to require 2 hours of continuing education on controlled substances each biennium. The Board is to notify licensees prior to January 1st of each odd-numbered year that they are required to obtain the 2 hours in the next biennium.

For the first biennium, 2017-2018, all Board of Medicine licensees with prescriptive authority were required to obtain any 2 hours of continuing education related to pain management, the responsible prescribing of controlled substances, and the diagnosis and management of addiction.

Some physicians asked the Board to develop a 2-hour course for their convenience. What the Board did in early 2017, in concert with the Medical Society of Virginia, was to post on the Board's website a list of free, online courses developed by professional societies, universities, and government agencies.

Since the opioid regulations became effective in March 2017, the Board has recognized 2 significant issues. The first is that not all practitioners with prescriptive authority have read the regulations and understand them. The second is that some practitioners, having made the decision to reduce a patient's opioid, do not always taper in an effective way. So in response to these 2 issues, the Board endorses a 2-hour "package" of continuing education for its prescribing licensees. These 2 hours qualify as Type 1 continuing education for the purpose of renewal.

The 2 hours can be met by:

- Reading the Board of Medicine Regulations Governing Prescribing Opioids and Buprenorphine https://www.dhp.virginia.gov/medicine/leg/Medicine_Opioid_Regs_08082018.doc
- Reading the Board's Frequently Asked Questions on Opioids and Buprenorphine https://www.dhp.virginia.gov/medicine/docs/FAQPrescribingBuprenorphine.pdf
- Viewing the Prescription Monitoring Program 7-minute video on NarxCare https://app.brainshark.com/appriss/NarxCareNavigation?nodesktopflash=1
- Taking the Stanford University course on "How to Taper Patients Off of Chronic Opioid Therapy" (1.25 hours CAT I) https://stanford.cloud-cme.com/default.aspx?P=8&EID=20909

This "package" will be on the Board of Medicine website at https://www.dhp.virginia.gov/medicine/ under Controlled Substances CE Requirements.

Or if you so choose, you may obtain any other 2 hours as long as they relate to pain management, the responsible prescribing of controlled substances, and the diagnosis and management of addiction.

I hope this is helpful to you for 2019-2020.

With kindest regards,

William L. Harp, MD
Executive Director
Virginia Board of Medicine

DESIGNATION OF CE RESOURCES FOR LICENSEES

In 2016, the Board simply required its licensees to obtain 2 hours of Type 1 (CAT I) CE of their choosing. Some prescribers said that they could not find any such CE, and others said that the requirement was a financial burden. So in coordination with the Medical Society of Virginia, the Board did develop a list of good, free resources on the Internet that could satisfy the requirement.

In 2018, the Board approved the "package" of CE recommended by the Ad Hoc, and also approved that any other 2 hours of opioid CE would satisfy the requirement.

In the following pages, you will find several good opioid CE resources that are easily accessible on the Internet at no cost.

The last resource listed, UpToDate's article on "Prescription of Opioids for Acute Pain in Opioid-Naïve Patients," is only available by subscription. However, those prescribers that already have a subscription or work in an institution that has a subscription, can access the article at no cost.

This list of resources is for discussion by the Ad Hoc and subject to additions and deletions.

Commonwealth of Virginia

Harp, William <william.harp@dhp.virginia.gov>

FW: Enhance Your Pain Management Strategies: Free CME from NEJM Knowledge+

1 message

Hardesty, Ilana T <hardesty@bu.edu> Fri, Nov 6, 2020 at 8:09 AM
To: "william.harp@dhp.virginia.gov" <william.harp@dhp.virginia.gov>

Dear Dr. Harp,

Thank you for your e-mail! We would be very pleased to have the Virginia Board of Medicine include our programming as an option for clinicians to meet their opioid prescribing education requirements.

The program referenced here was developed by NEJM Knowledge+.

In addition, we urge you to review our 2-hour *SCOPE of Pain* program at www.scopeofpain.org. SCOPE of Pain is BUSM's award-winning opioid education program, and currently serves to meet education requirements in several states, including New York.

Please do not hesitate to contact me if you have any questions or need any additional information.

All best,

Ilana Hardesty

Ilana Hardesty

Senior Operations Manager, SCOPE of Pain

Barry M. Manuel Continuing Medical Education Office

Boston University School of Medicine

72 East Concord Street, B208

Boston, MA 02118

P 617-358-5038 | F 617-358-5042

www.bucme.org

www.scopeofpain.org

From: Harp, William <william.harp@dhp.virginia.gov>
Sent: Wednesday, November 4, 2020 9:41 AM
To: cme <cme@bu.edu>
Subject: Re: Enhance Your Pain Management Strategies: Free CME from NEJM Knowledge+

Dear Boston University CME/Dr. Daniel Alford:

Thanks for the email about your revised course, and I have a question.

Each biennium, licensees of the Virginia Board of Medicine that have prescriptive authority are required to obtain 2 hours of CAT I CME on issues related to the prescribing of opioids. The licensees need to be notified prior to January 1 of the odd years, hence 2021.

My question is: Could the Virginia Board of Medicine promote your course as an option for opioid CME to approximately 50,000+ licensees, including MD's, DO's, DPM's, PA's and NP's?

I will only do this if you say OK; I don't want to uninvitedly overwhelm your system.

Thanks for your consideration, and kindest regards.

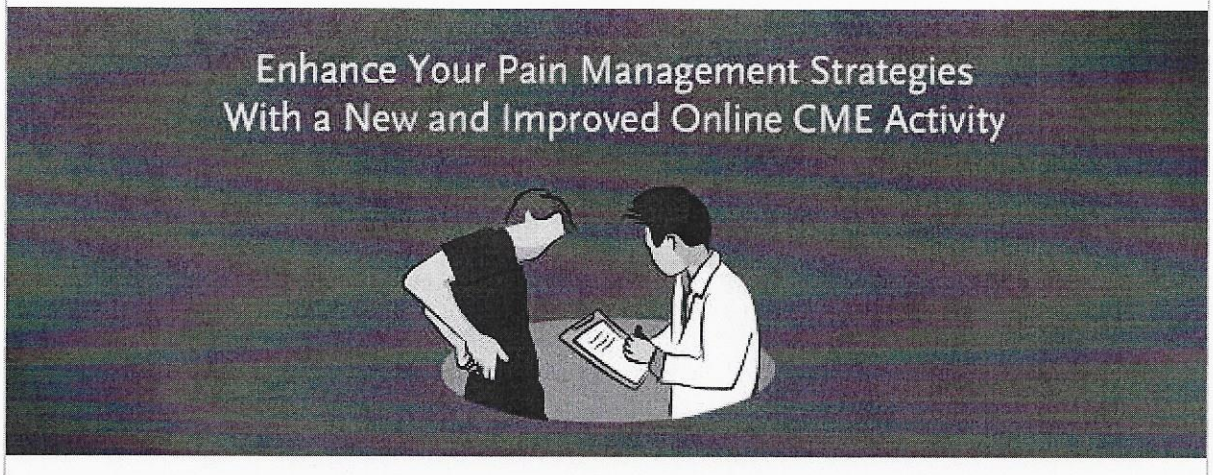
William L. Harp, MD

Executive Director

Virginia Board of Medicine

On Wed, Nov 4, 2020 at 9:25 AM BU›CMECNE <cme@bu.edu> wrote:

Email not displaying correctly?
View it in your browser.



New and Improved Pain Management and Opioids from NEJM Knowledge+

NEJM Knowledge+ Pain Management and Opioids CME course has been used by more than 25,000 clinicians in the past year and has received overwhelming positive reviews. Now, the course has been enhanced to include infographics and multimedia learning resources on the topics that clinicians told us they find most challenging, including:

- Talking to patients about their opioid use
- Strategies for tapering opioid therapy
- The basics of urine drug testing

This online CME activity continues to be offered free of charge and we invite you to register now.

Developed with ***SCOPE of Pain*** Course Director, MD, Daniel Alford, this program offers up to ***10 AMA PRA Category 1 Credits™*** and the is curated into 8 topic areas for streamlined learning.

1. Musculoskeletal pain
2. Common nonmusculoskeletal pain
3. Basics of opioid prescribing I
4. Basics of opioid prescribing II
5. Complex situations in opioid prescribing
6. Opioid pharmacology
7. Acute pain
8. Opioid use disorder

Pain Management & Opioids
Register for FREE

NEJM Knowledge+ Pain Management and Opioids course will help you manage the pressures of providing superior patient care while meeting mandated state requirements. Take advantage of the latest content and resources with this free CME module today to help you confidently assess and manage your patients' pain.

In partnership with Boston University School of Medicine's Safer/Competent Opioid Prescribing Education ***(SCOPE of Pain)*** program.

Disclosure of Support

This activity is supported by an independent educational grant from the Opioid Analgesic REMS Program Companies. Please see https://ce.opioidanalgesicrems.com/RpcCEUI/rems/pdf/resources/List_of_RPC_Companies.pdf for a listing of REMS Program Companies. This activity is intended to be fully compliant with the Opioid Analgesic REMS education requirements issued by the US Food and Drug Administration.

SCOPE of Pain
Safer/Competent Opioid Prescribing Education

BU School of Medicine

Friend on Facebook Follow on Twitter

-Page 13-

Our mailing address is:

72 East Concord Street

Boston, MA 02118

US

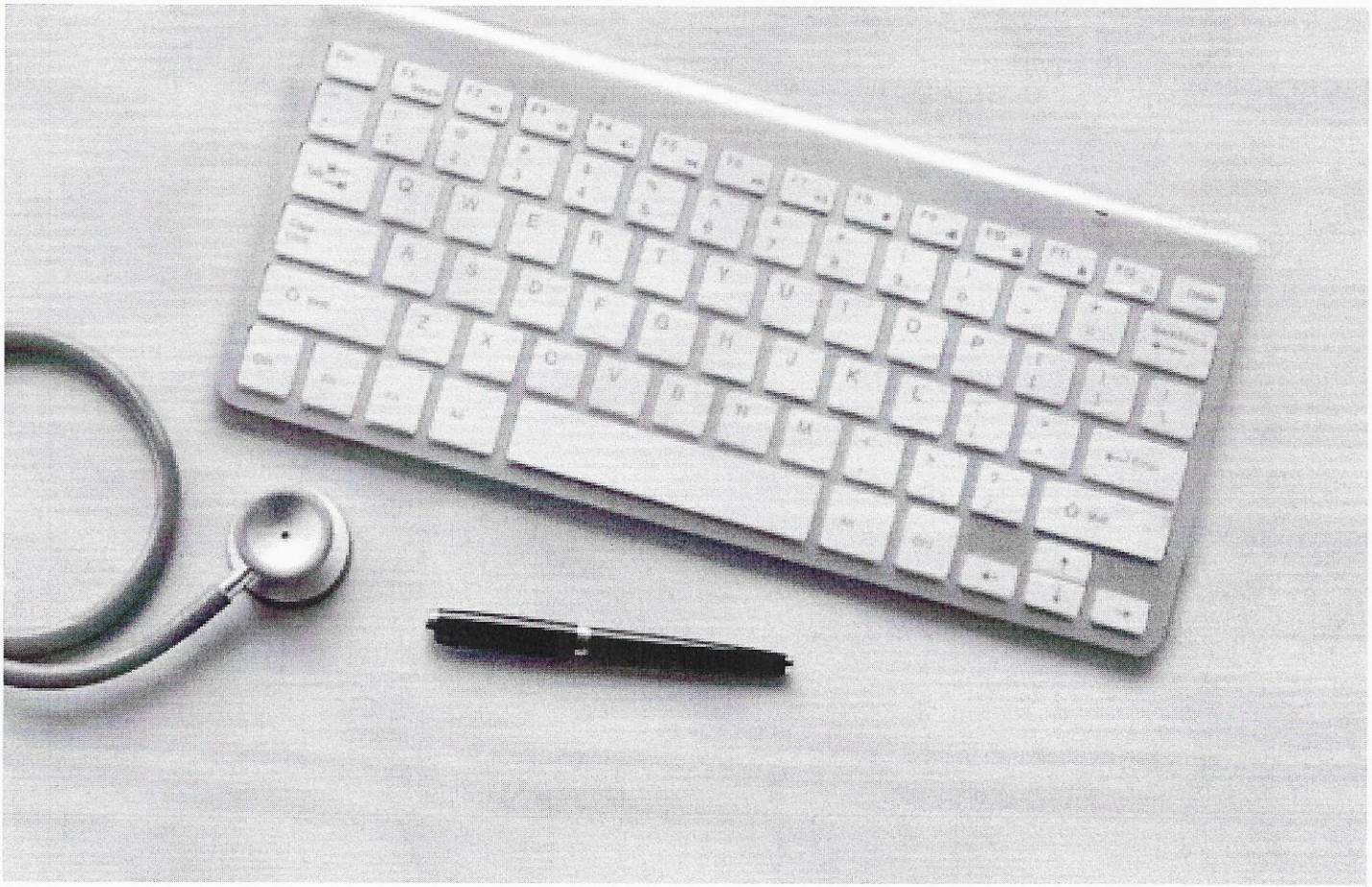
Click here to unsubscribe

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

Opioid Overdose

Interactive Training Series for Healthcare Providers

Applying CDC's Guideline for Prescribing Opioids



ɔ improve coordination of care across healthcare settings and promote safer opioid prescribing and dispensing. Course #WB4359

In 2017, almost 57 million American patients had at least one prescription for opioids filled or refilled. The average number of opioid prescriptions per patient was 3.4, and the average days of supply per prescription was 18 days.[1] Taking opioids for longer periods of time or in higher doses increases the risk of addiction, overdose, and death. The *CDC Guideline for Prescribing Opioids for Chronic Pain* provides recommendations for safer and more effective prescribing of opioids for chronic pain in patients 18 and older in outpatient settings outside of active cancer treatment, palliative care, and end-of-life care.

This interactive online training series aims to help healthcare providers apply CDC's recommendations in clinical settings through patient scenarios, videos, knowledge checks, tips, and resources. Providers can gain a better understanding of the recommendations, the risks and benefits of prescription opioids, nonopioid treatment options, patient communication, and risk mitigation.

Each stand-alone module is self-paced. Physicians, nurses, and other health professionals can receive free continuing education for each training by registering on CDC Training and Continuing Education (TCE) Online, searching for the corresponding course number, and completing the evaluation.

Addressing the Opioid Epidemic: Recommendations from CDC
Get an overview of the CDC Guideline for Prescribing Opioids for Chronic Pain. This module explains the rationale for the Guideline's creation, highlights key recommendations, and describes the benefits of implementing the Guideline.
Course #WB2857

Treating Chronic Pain Without Opioids
Review various options and tools for managing chronic pain. Skills include identifying appropriate nonopioid medications and nonpharmacologic treatments and facilitating a patient-centered approach.
Course #WB2859

Communicating With Patients
Learn communication strategies they can use when treating chronic pain, including motivational interviewing.
Course #WB2858

Reducing the Risks of Opioids
Learn best risk mitigation strategies and when to employ them when prescribing an opioid.
Course #WB2864

Assessing and Addressing Opioid Use Disorder
Learn methods for assessing and addressing an opioid use disorder when it is suspected.
Course #WB2863

Dosing and Titration of Opioids: How Much, How Long, and How and When to Stop
Learn methods for properly dosing and titrating opioids in order to reduce risk of opioid use disorder and overdose.
Course #WB2861

Determining Whether to Initiate Opioids for Chronic Pain
Learn mechanisms for deciding if opioids should be prescribed, and next steps for treatment – whether opioid or non-opioid treatments are selected.
Course #WB2860

Implementing CDC's Opioid Prescribing Guideline into Clinical Practice
Learn quality improvement strategies and tools to help incorporate Guideline recommendations into clinical workflow.
Course #WB2862

Opioid Use and Pregnancy
Learn about unique considerations that come with opioid use during pregnancy, and best practices for providing care for both the mother and baby.
Course #WB2858

Motivational Interviewing
Focus on the use of motivational interviewing during the management and treatment of chronic pain, which can enhance patients' motivation to change behaviors relative to chronic pain conditions. The content includes principles, steps, and best practices.
Course #WB2957

Collaborative Patient-Provider Relationship in Opioid Clinical Decision Making
Learn ways to strengthen the patient-provider relationship and coordinate care with other specialist to support shared-decision making in the use of opioids for chronic pain.
Course #WB4033

A Nurse's Call to Action for Safer Opioid Prescribing Practices
Explore how nurses can support the implementation of the CDC Guideline through risk mitigation strategies, quality improvement practices, patient communication techniques, and care coordination.
Course #WB4192

Using the Prescription Drug Monitoring Program to Promote Patient Safety in Opioid Prescribing and Dispensing
Explore how healthcare providers (e.g., physicians, pharmacists, nurse practitioners, physician assistants), state health departments, and prescription drug monitoring program managers can use prescription drug monitoring programs to improve coordination of care across healthcare settings and to promote safer opioid prescribing and dispensing.
Course #WB4359

More Information

- MMWR: CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016
- JAMA Special Communication: CDC Guideline for Prescribing Opioids for Chronic Pain
- Earn additional Free Continuing Education credit with our COCA Webinar Series: *Guideline for Prescribing Opioids for Chronic Pain*

Related Pages

Information for Providers
Information for Patients
Training for Providers
Shareable Graphics
Guideline Resources: Clinical Tools & Materials for Patients
Resources from HHS

References

1. Centers for Disease Control and Prevention. 2018 Annual Surveillance Report of Drug-Related Risks and Outcomes — United States. Surveillance Special Report 2 . Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. Published August 31, 2018.

Page last reviewed: October 26, 2020
Content source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control

Commonwealth of Virginia

Harp, William <william.harp@dhp.virginia.gov>

Re: CME Course

1 message

Anna Lembke <alembke@stanford.edu> Mon, Nov 9, 2020 at 12:51 PM
To: "Harp, William" <william.harp@dhp.virginia.gov>
Cc: Anna Lembke <alembke@stanford.edu>

Dear Dr. Harp,

I would be honored for you to include our teaching tool in Virginia's opioid CME.

Please see attached an infographic we developed for academic detailing on how to taper long-term opioid therapy in patients with chronic pain. You might make that available to your learners as well as a companion article.

Best,

Anna

From: "Harp, William" <william.harp@dhp.virginia.gov>
Date: Monday, November 9, 2020 at 5:53 AM
To: Anna Lembke <alembke@stanford.edu>
Subject: CME Course

Good morning, Dr. Lembke:

I hope your year has been a good one, despite all the challenges with COVID-19.

The Virginia Board of Medicine is getting ready to have its biennial meeting about opioid CME, so we can send notice to all licensees with prescriptive authority by January 1 for the 2021-2022 biennium. You graciously allowed us to include your course on tapering opioids in late 2018, and if your course is still available for credit, the Board would like to be able to include it again.

I can assure you that the Board appreciates your contribution to the opioid crisis; I, as a psychiatrist, certainly do.

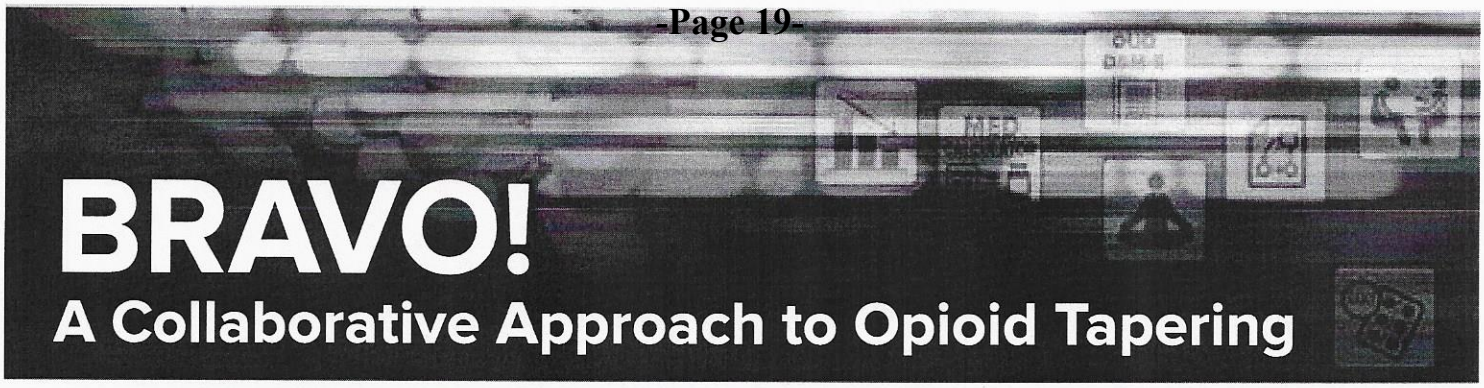
With kindest regards,

William L. Harp, MD

Executive Director

Virginia Board of Medicine

BRAVO FINAL 3.13.20 copy.pdf
278K



BRAVO!

A Collaborative Approach to Opioid Tapering

Introduction

This booklet provides primary care providers with guidelines and tools to support them as they work with patients on long term opioid therapy. It is also intended to provide materials for academic detailing on tapering.

It incorporates guidance and content from these key sources:

- U.S. Department of Health and Human Services Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics October 2019
- Oregon Health Authority – Opioid Tapering Guidelines - Recommendations for individualized care to reduce harm from opioid use
- BRAVO – A protocol developed by Dr. Anna Lembke (credits below)
- Risk Benefit Analysis flowchart – Developed by the Oregon Pain Guidance Clinical Advisory Group and incorporated into the HHS guidelines on tapering
- Veterans Health Administration Opioid Taper Decision Tool (withdrawal medications)

We are also grateful for the academic detailing framework provided by the National Resource Center for Academic Detailing (NaRCAD).

Contents

Authors

- Anna Lembke, MD - Associate Professor of Psychiatry and Behavioral Sciences, and by courtesy Pain Medicine, at the Stanford University School of Medicine
- Dr. Jim Shames, MD - Medical Director/Health Officer for Jackson County, Oregon
- Laura Heesacker, LCSW - Behavioral Health Specialist, Jackson Care Connect/Care Oregon
- Ruben Halperin, MD – Medical Director, Quality Improvement, Providence Health, Oregon
- Mark Stephens, BS – Oregon Pain Guidance Healthcare Consultant

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:

- Patient request
- Pain and function not improved
- Adverse opioid effects
- Co-occurring conditions (including mental health)
- Dose over 90 MED
- Concurrent sedatives
- Opioid use disorder
- Opioid overdose

A — Addiction and Dependence Happen

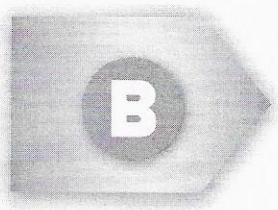
- Addiction = The 3 C's: *Control*, *Craving*, continued use despite *Consequences*
- Dependence = Tolerance, withdrawal, without the 3 C's
- Anyone can become addicted or dependent
- Reassure patients there is effective treatment for both
- Consider buprenorphine

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



Broaching the Subject

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.

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.

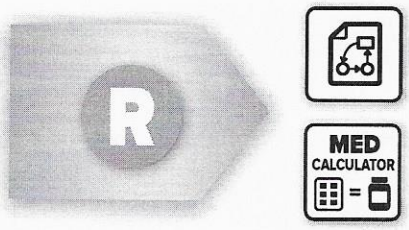
Take more time – Schedule a longer appointment when you discuss possible tapering. Use the extra time to listen to your patient's story about their pain and their concerns about any changes to their treatment. Patients often report that providers don't take the time to hear their story. Make sure your 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.



Risk Benefit Assessment

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

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.

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.

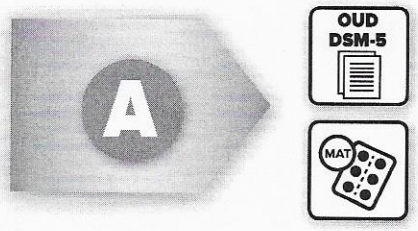
Co-occurring conditions (including mental health) – Consider tapering if your patient has co-occurring health conditions such as lung disease, sleep apnea, liver disease, kidney disease, cardiac arrhythmias, obesity, or dementia. If your patient suffers from depression, anxiety, PTSD, or childhood trauma, 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

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.

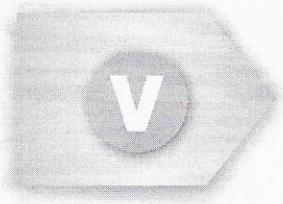
Dependence – Some patients develop severe physiologic dependence on prescription opioids and do not tolerate tapering even when tapering is medically indicated. When the risks of continuing prescription opioids outweigh the benefits (i.e. the patient needs to taper) and severe dependence limits the patients 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.

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.

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 of 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.



Velocity and Validation

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.

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.

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

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.

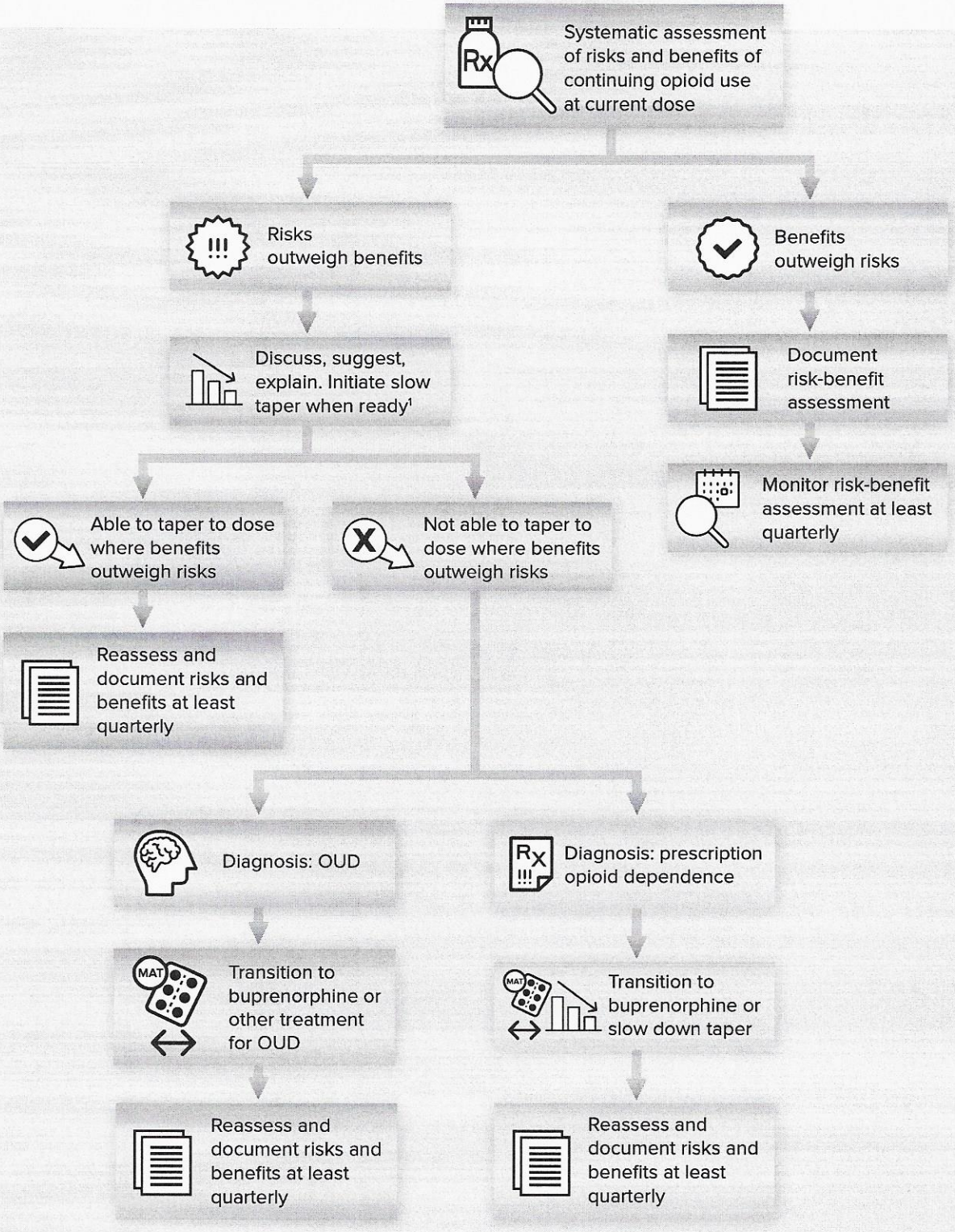
Other Strategies for Coping with Pain

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.

Risk Benefit Assessment Flowchart



- Start your assessment with a systematic review of the risks and benefits of continued opioid.
- If patients have improved function, adequate pain relief, and low risk for opioid-related harms, continue their current dose, but with regular risk–benefit assessments.
- If the risks outweigh the benefits, explain the need for tapering (see *Broaching the Subject*) and initiate a slow taper. If tapering is successful over time, document progress and continue to assess risks quarterly.
- If patient is unable to taper to a dose where benefits outweigh the risks, check for a diagnosis of prescription opioid dependence (POD) or opioid user disorder (OUD) (see *Addiction and Dependence Happen*).
- For POD, consider transitioning to buprenorphine as a harm reduction strategy, or slow down the taper. Reassess at least quarterly.
- For OUD, transition to buprenorphine or other treatment for OUD. Reassess at least quarterly.

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 weeks back and is now walking 15 – 20 minutes daily

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.

Medications to Treat Opioid Withdrawal Symptoms

Sometimes medications can be used to help mitigate the symptoms of opioid withdrawal. These medications should be used sparingly and with caution. Ideally if the taper is slow enough, patients are experiencing minimal and tolerable opioid withdrawal and don't need adjunctive medication. Be wary of using addictive medications, like benzodiazepines and/or cannabis to help patients get off of opioids. This can lead to patients becoming dependent on and addicted to another set of medications.

INDICATION	TREATMENT OPTIONS
Autonomic symptoms (sweating, tachycardia, myoclonus)	**FIRST LINE** • **Clonidine** 0.1 to 0.2 mg oral every 6 to 8 hours; hold dose if blood pressure <90/60 mmHg (0.1 to 0.2 mg 2 to 4 times daily is commonly used in the outpatient setting) – Recommend test dose (0.1 mg oral) with blood pressure check 1 hour post dose; obtain daily blood pressure checks; increasing dose requires additional blood pressure checks – Re-evaluate in 3 to 7 days; taper to stop; average duration 15 days **ALTERNATIVES** • **Baclofen** 5 mg 3 times daily may increase to 40 mg total daily dose – Re-evaluate in 3 to 7 days; average duration 15 days – May continue after acute withdrawal to help decrease cravings – Should be tapered when it is discontinued • **Gabapentin** start at 100 to 300 mg and titrate to 1800 to 2100 mg divided in2 to 3 daily doses* – Can help reduce withdrawal symptoms and help with pain, anxiety, and sleep • **Tizanidine** 4 mg three times daily, can increase to 8 mg three times daily
Anxiety, dysphoria, lacrimation, rhinorrhea	• Hydroxyzine 25 to 50 mg three times a day as needed • Diphenhydramine 25 mg every 6 hours as needed**
Myalgias	• **NSAIDs** (e.g., naproxen 375 to 500 mg twice daily or ibuprofen 400 to 600 mg four times daily)*** • **Acetaminophen** 650 mg every 6 hours as needed • **Topical medications** like menthol/methylsalicylate cream, lidocaine cream/ointment
Sleep disturbance	• **Trazodone** 25 to 300 mg orally at bedtime
Nausea	• **Prochlorperazine** 5 to 10 mg every 4 hours as needed • **Promethazine** 25 mg orally or rectally every 6 hours as needed • **Ondansetron** 4 mg every 6 hours as needed
Abdominal cramping	• **Dicyclomine** 20 mg every 6 to 8 hours as needed
Diarrhea	• **Loperamide** 4 mg orally initially, then 2 mg with each loose stool, not to exceed 16 mg daily • **Bismuth subsalicylate** 524 mg every 0.5 to 1 hour orally, not to exceed 4192 mg/day

*Adjust dose if renal impairment; **avoid in patients > 65 years old; ***caution in patients with risk GI bleed, renal compromise, cardiac disease

DSM-5 OUD Criteria*

A problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period.

CHECK ALL THAT APPLY:	
☐	1. Opioids are often taken in larger amounts or over a longer period of time than was intended.
☐	2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
☐	3. A great deal of time is spent in activities to obtain the opioid, use the opioid, or recover from its effects.
☐	4. Craving, or a strong desire or urge to use opioids.
☐	5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
☐	6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused by or exacerbated by the effects of opioids.
☐	7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.
☐	8. Recurrent opioid use in situations in which it is physically hazardous.
☐	9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that's likely to have been caused or exacerbated by the substance.
☐	10. Tolerance, as defined by either of the following: a. A need for markedly increased amounts of opioids to achieve intoxication or desired effect b. A markedly diminished effect with continued use of the same amount of an opioid **Note:** This criterion is not met for individuals taking opioids solely under appropriate medical supervision.
☐	11. Withdrawal, as manifested by either of the following: a. The characteristic opioid withdrawal syndrome a. The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms **Note:** This criterion is not met for individuals taking opioids solely under appropriate medical supervision.
	Total number of symptoms: _____
☐ **Mild** = 2–3 symptoms	☐ **Moderate** = 4–5 symptoms ☐ **Severe** = 6 or more symptoms

*Criteria from American Psychiatric Association (2013) Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Washington, DC, American Psychiatric Association page 541.

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- Veterans Health Administration PBM Academic Detailing Service. Pain Management Opioid Taper Decision Tool_A VA Clinician's Guide.

Resources

VIDEOS

- Understanding Pain and Healthy Life-Style Changes – Eight videos on understanding pain, nutrition, activity, sleep, mood, social, flareups, and non-opioid medications.
- Broaching the Subject of Collaborative Opioid Management – Practical tips for raising the subject of opioid addiction or dependence with patients.
- High Risk Low Benefit – (6:03 min): Provider uses good listening skills, motivational interviewing, and overall effective communication strategies in the face of a poorly motivated patient.
- Motivational Interviewing for Change – Provider skillfully navigates a conversation about changes to opioid prescriptions using PEG, a three-item Scale Assessing Pain Intensity and Interference.

ONLINE TRAINING

- BRAVO! How to Taper Patients Off Opioids – Free one hour course from Stanford
- Changing the Conversation about Pain – Free one hour CME course from the Oregon Pain Management Commission.
- Free X-Waiver Online Training – From Providers Clinical Support System

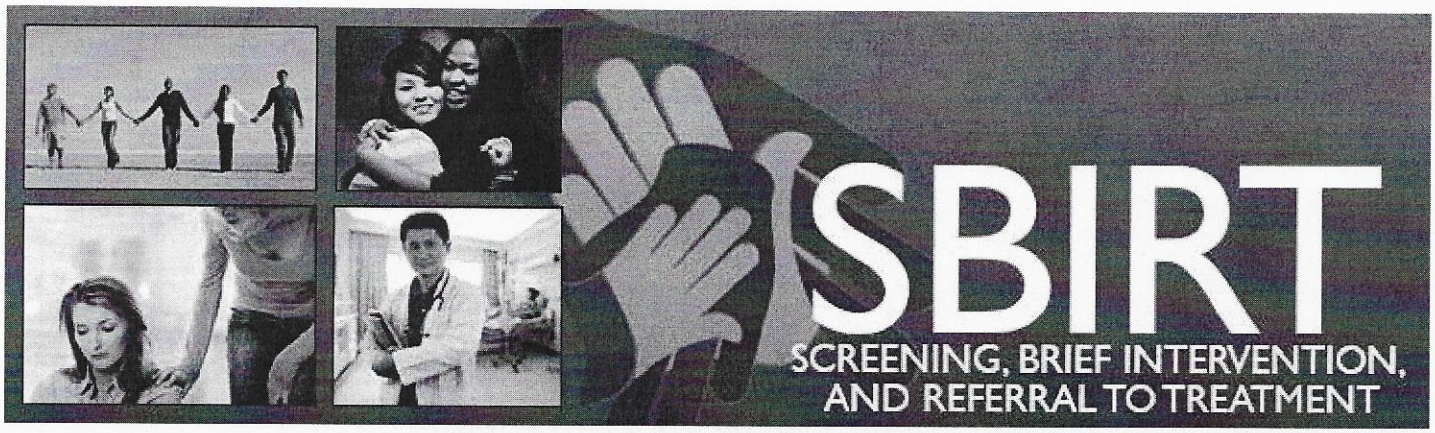
WEBSITE RESOURCES

- Oregon Pain Guidance – This website has guidelines and tools for healthcare professionals helping patients with chronic pain, including those on long term opioid therapy.
- This booklet online – OPIOID TAPERING: A Collaborative Management Approach

MORPHINE EQUIVALENT DOSE (MED) CALCULATOR

- https://www.oregonpainguidance.org/opioidmedcalculator/

Search SAMHSA.gov Sear



Screening, Brief Intervention, and Referral to Treatment (SBIRT)

SBIRT is an approach to the delivery of early intervention and treatment to people with substance use disorders and those at risk of developing these disorders.

About SBIRT

» Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment.

» Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.

» Referral to treatment provides those identified as needing more extensive treatment with access to specialty care.

Learn more about SBIRT

Resources

Resources are available online or by calling SAMHSA's toll-free helpline at 1-800-662-HELP (4357).

Learn more about SBIRT resources

Coding for Reimbursement

Reimbursement for screening and brief intervention is available through commercial insurance Current Procedural Technology (CPT), Medicare G codes, and Medicaid Healthcare Common Procedure Coding System (HCPCS).

View available reimbursement codes

SBIRT Grantees

Since 2003, SAMHSA has funded 17 Medical Residency Cooperative Agreements, 15 State Cooperative Agreements, and 12 Targeted Capacity Expansion Campus Screening and Brief Intervention (SBI) Grants.

» Colleges & Universities SBIRT Programs

» Medical Residency Training Programs

» Medical Professional Training Programs

» State Cooperative Agreements

» Grantee Websites

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