Chronic Opioid Therapy
Shared Decision-Making Tool

General Approach to Tapering

This document is meant to facilitate discussions between primary care providers and their patients about opioid therapy for the treatment of chronic pain. These clinical guidelines can help identify patients at risk for substance use disorder (SUD) and opioid use disorder (OUD) and outline potential interventions. Prior to the appointment, patients are encouraged to complete the following:

+ Pain, Enjoyment, General (PEG) Activity Screening Tool (Link)
+ The Current Opioid Misuse Measure (COMM) Survey (Link)

Opioid Risk/Benefit Discussion Tool (Check all that apply)

Risk Category		Risk Level	Recommendation
Opioid dosage	☐	Opioid dosage >90 MME/day or extended-release formulation (fentanyl patch, Oxycontin, MS-Contin)	Strongly recommend tapering opioid to a safer level.
	☐	Opioid dosage 50-90 MME	Evaluate efficacy; recommend tapering opioid to a lower level.
	☐	Opioid dosage < 50 MME/day	Evaluate efficacy; consider tapering/ discontinuing opioid.
Medication and substance use	☐	Benzodiazepine, barbiturate, sedative	Discontinue sedative and/or opioid. (If taking benzodiazepines, remember to taper to prevent withdrawal; tapers often require 12-18 months). If unable to do either, consider transitioning to buprenorphine.
	☐	SUD or injection drug use	Taper opioid and treat SUD; increase monitoring. In patients with alcohol use disorder, strongly consider tapering opioid. Patients with OUD should be transitioned to medication-assisted treatment (buprenorphine, methadone, or naltrexone).
	☐	Gabapentinoid (gabapentin or pregabalin) and/or carisoprodol	Evaluate for sedation and respiratory depression. Consider discontinuation of either opioid or gabapentinoid.

	☐	Occasional alcohol, marijuana, or drug use (not meeting definition of SUD)	Provide counseling on alcohol and concomitant substance use; increase monitoring. If risky use continues, consider tapering or discontinuing opioids.
	☐	Tobacco use	Provide tobacco-cessation interventions and counseling on how nicotine affects opioids/ pain. (Nicotine decreases the effectiveness of opioids.)
	☐	No medication or substance use issues	Encourage continued healthy substance-use practices.
Medical comorbidities	☐	Organ failure or disease (lung, kidney, liver)	In patients with lung disease, a further evaluation of respiratory status is strongly recommended. Strongly recommend tapering opioids to a safer level; consider transitioning to buprenorphine (in patients with pulmonary or renal disease).
	☐	Age < 40 years or age > 65 years	For patients < 40 years, provide counseling on the increased risk of dependence and OUD. For those > 65 years, provide counseling on the increased risk of falls/morbidity and mortality.
	☐	Sleep apnea (confirmed or suspected)	Treat sleep apnea or offer diagnostic testing.
	☐	Obesity	Encourage weight loss and discuss how opioids may contribute to weight gain.
	☐	Healthy without additional contributory health comorbidities	Encourage continued health maintenance and routine screening.
Psychiatric comorbidities	☐	Mental health or mood condition (depression, anxiety, bipolar disease, PTSD)	Discuss the effect of opioids on depression and anxiety. Provide suicide screening and safety planning. Consider tapering opioids.
	☐	History of SUD (excluding tobacco)	Provide treatment for SUD. Use extreme caution when prescribing controlled substances. Taper opioids.
	☐	History of childhood/sexual trauma (ACES)	Increase psychiatric services and monitoring. Discuss the effect of opioids on depression and anxiety; consider tapering opioids.
	☐	Personality disorder (antisocial or borderline)	Increase psychiatric services and monitoring.
	☐	Family history of SUD	Increase monitoring and provide counseling with the involvement of a patient support network.
	☐	No psychiatric comorbidities	
Medication history and aberrancy	☐	Opioid started within last year with dose escalations, multiple prescribers for the same condition, a suspicious pattern on the PDMP, or drug screen aberrancies.	Screen for OUD, increase monitoring, and consider tapering or discontinuing opioids.

	☐	Opioid usage stable over 1-2 years; opioid prescriptions from one prescriber, with the exception of medications for surgery or appropriate acute painful conditions; no drug screen aberrancies.	Evaluate whether the opioid is still providing the desired analgesic and functional effects. Use shared decision-making if opioid tapering would be of benefit.
	☐	Patient stable on opioid dosage for >2 years; no dose increases; no concerning PDMP patterns; no concerning PDMP patterns; no drug screen aberrancies.	Evaluate whether the opioid is still having the desired effect. Initiate shared decision-making if opioid tapering would be of benefit.
Number of HIGH risk factors (7)		_____ x 4	_____ +
Number of MODERATE risk factors (10)		_____ x 2	_____ –
Number of PROTECTIVE factors (5)		_____ x 1	_____ =
Total Score			

Risk Rating and Recommended Interventions

Risk Level	Points	Interventions (Use in conjunction with recommendations outlined in the table above.)
Extreme risk	12+	Strongly consider referral to a pain management specialist to oversee opioid regimen and create a concrete plan to decrease risk (opioid tapering, medication modifications, SUD treatment, etc). Consider transitioning to buprenorphine when appropriate. Confirm naloxone prescription has been filled and provide mandatory overdose counseling. Schedule monthly visits or phone checkins if possible; at minimum, schedule quarterly visits and increase monitoring (including but not limited to urine drug screenings, pill counts, and social support). Obtain additional "high risk" consent for treatment.
Very high risk	9-11	Strongly consider referral to a pain management specialist to oversee opioid regimen and create a concrete plan to decrease risk (opioid tapering, medication modifications, SUD treatment, etc). Consider transitioning to buprenorphine when appropriate. Confirm naloxone prescription has been filled and provide mandatory overdose counseling. Schedule monthly visits or phone checkins if possible; at minimum, schedule quarterly visits and increase monitoring (including but not limited to urine drug screenings, pill counts, and social support). Obtain additional "high risk" consent for treatment.

High risk	4-8	Consider referral to a pain management specialist to oversee opioid regimen and create a concrete plan to decrease risk (opioid tapering, medication modifications, SUD treatment, etc). Consider transitioning to buprenorphine when appropriate. Confirm naloxone prescription has been filled and provide mandatory overdose counseling. Schedule quarterly visits or phone checkins and increase monitoring (urine drug screening twice per year, pill counts, social support, physician visits). Obtain additional "high risk" consent for treatment.
Moderate risk	2-3	Consider transitioning to buprenorphine. Provide naloxone prescription and overdose counseling. Provide continued monitoring (urine drug screening, pill counts, social support).
Low risk	0-1	Provide naloxone prescription and overdose counseling. Discuss the risks and benefits of possible opioid tapering or discontinuation. Provide continued monitoring (urine drug screening, pill counts, social support).

Disclaimer: *The risk-scoring and discussion tool above is based on expert opinion, established opioid/prescribing guidelines, and studies regarding the risk of opioid overdose and SUD. It is meant to help guide shared decision-making between physicians and patients. Although this document recommends certain interventions, it is not a substitute for the advice of a physician or other knowledgeable health care professional. Individual patients may require different treatments from those specified here and in the MSRH guidelines. This tool is not entirely inclusive or exclusive of all methods of reasonable care that can obtain/produce the same results. Although the tool considers variations in clinical settings, resources, and common patient characteristics, it cannot address the unique needs of each case or the combination of resources available to a particular community or health care provider. Deviations from these recommendations may be justified by individual circumstances.*

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