

**APPENDIX B**

**HOW TO  
MANAGE AN  
“INHERITED  
PATIENT ON  
OPIOIDS”**



ARIZONA DEPARTMENT  
OF HEALTH SERVICES

## APPENDIX B: HOW TO MANAGE AN “INHERITED PATIENT ON OPIOIDS”

Establishing care of new patients on long-term opioid therapy can be difficult, but is an opportunity to optimize the treatment approach. The following is a guide to how to approach these situations, based upon the following underlying concepts:

- Safety is always more important than immediate pain relief.
- Care of the patient’s pain and distress is imperative; care does not necessarily include opioids.
- Assessment and management of substance use disorders is important.
- Opioid withdrawal can be very uncomfortable and distressing, but is rarely a medical emergency.
- Opioid withdrawal can be effectively managed with both pharmacologic and non-pharmacologic approaches.

### BEFORE THE VISIT

- Consider establishing a clinic policy that a patient’s first visit will serve as an assessment, which includes review of prior medical records and patient examination and does not involve prescribing of controlled substances.
- Contact new patients prior to their first visit to review clinic policies and what to expect at their first clinical visit, including the request to bring in all previous medical records and current medications.
- Verify that clinical providers and staff representatives have access to the Arizona Controlled Substances Prescription Monitoring Program.
  - CSPMP application: [arizona.pmpaware.net/login](http://arizona.pmpaware.net/login)
- Consider becoming a medication assisted treatment provider, to broaden the therapeutic options for patients at their primary facility.
  - See Buprenorphine Waiver Training: [samhsa.gov/medication-assisted-treatment/training-resources/buprenorphine-physician-training](http://samhsa.gov/medication-assisted-treatment/training-resources/buprenorphine-physician-training)

### DURING THE INITIAL VISIT

- Complete a comprehensive Biopsychosocial Assessment of the patient.
  - Elements of the biopsychosocial pain interview include a pain-related history, assessment of pertinent medical and psychiatric comorbidities including personal and family history of substance use disorder, functional status and functional goals, coping strategies, and psychosocial factors such as the patient’s beliefs and expectations about chronic pain and its treatment. This includes an evaluation of medical, psychiatric, and co-occurring substance use conditions, and the patient’s social support system.
- Review prior medical records and request consent to speak with prior prescriber.
- Check the AZ CSPMP record for the patient after verifying his or her identification.
- Obtain a baseline urine drug screen.
- Explain to the patient that more information may be needed before determining an optimal treatment regimen, and explain the risks and benefits of individual or combinations of drugs.
- Introduce current best practices for treating chronic pain, including emphasis on self-management, non-pharmacologic, and non-opioid pharmacotherapy, setting functional treatment goals and prioritizing safe and sustainable treatment plans.
- **Based on the information gathered above, determine patient’s level of risk.** Factors that constitute increased risk for adverse outcomes include: having no prior medical records, declining to provide consent to speak with prior providers, history of non-concordant urine drug testing or PDMP histories, history of or active substance use disorder, comorbid psychiatric and medical conditions, co-prescription of opioids and benzodiazepines and prescribed opioid dose of MED $\geq$ 90. A composite risk determination is made by integrating the above factors with the biopsychosocial assessment. Note that a medication regimen below MED of 90mg/day may still represent a high risk for adverse outcomes when other factors are present.

- **For a lower risk patient/medication regimen:** Consider initially continuing inherited regimen while building rapport, setting treatment goals and optimizing non-pharmacologic and non-opioid pharmacotherapy.
- **For a moderately high-risk patient/medication regimen:** Set clear boundaries, consider initiating medication changes to improve safety while applying principles from these guidelines. The long-term treatment plan may include an exit strategy from the use of long-term opioid therapy for chronic pain (See *Appendix E: How to approach an exit strategy from long-term opioid therapy*). It may not be appropriate to initiate opioid prescribing for patients who do not agree with a planned exit from long-term opioid therapy.
- **For a high-risk patient/medication regimen:** Avoid continuing the current treatment regimen, initiate safety planning (ensure not a danger to self or others) and provide other treatment options (refer to mental health, substance use disorder treatment, interdisciplinary pain teams, withdrawal support if indicated) and specifically provide non-opioid approaches to pain care.

Often patients at high risk have underlying untreated psychiatric and/or substance use disorders. It is critically important to offer appropriate treatment options for these patients: mental health treatment for psychiatric conditions and opioid agonist therapy when opioid use disorder is suspected or identified (see *Guideline #15*).

#### AFTER THE VISIT

- Do an initial follow-up and continue monitoring at a greater frequency (with shorter prescribing intervals), often every 1-2 weeks for the first several visits followed by every 2-4 weeks for the first 3-6 months.