and developing new approaches that will permit the delivery of safe and equitable care across the health care continuum during both normal and extraordinary times. We cannot afford to wait until the pandemic ends.

An audio interview with Dr. Fleisher is available at NEJM.org

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Inherited Patients Taking Opioids for Chronic Pain — Considerations for Primary Care

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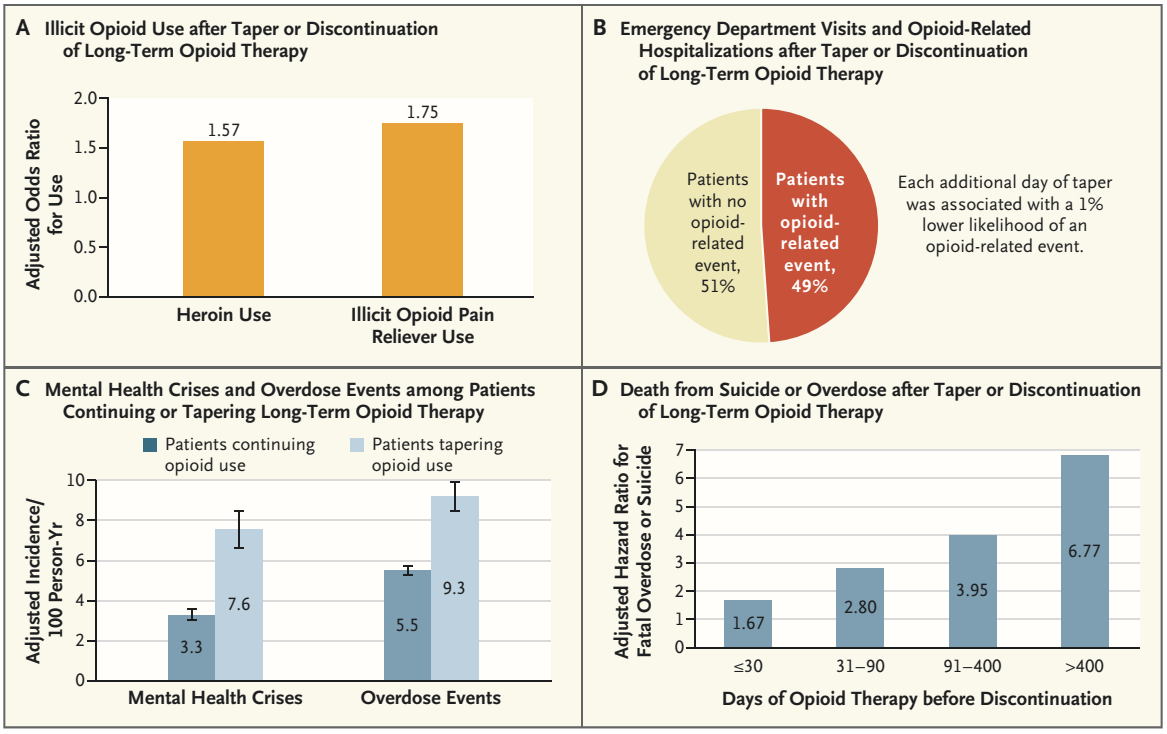
On May 19, 2021, a total of 28 Lags Medical Center pain-management clinics in California abruptly closed, leaving approximately 20,000 patients without pain management.[1] The patients who were on long-term opioid therapy received 30 days' worth of medications and instructions to contact their primary care clinicians or locate new ones. Many patients quickly found that their primary care clinicians were unwilling to prescribe opioids. Patients without a current clinician learned that almost none would prescribe opioids to new patients, and some would not prescribe opioids at all. Referrals to pain-management specialists would take as long as 6 months. Many of these patients have been going from emergency department to emergency department trying to obtain medications to avert opioid withdrawal. This crisis is ongoing and represents a blight on U.S. health care.

U.S. medical practice and policy with regard to opioids radically changed in the 1990s and again in the 2010s, swinging between extremes. First, a vast liberalization of opioid prescribing, in response to inadequate pain relief in end-of-life care, was shepherded by pharmaceutical companies, supported by many physician groups, and bolstered by welfare reform, the emergence of managed care organizations seeking low-cost ways to address pain, and the economic abandonment of swaths of the country.

After the Centers for Disease Control and Prevention (CDC) recognized the opioid overdose crisis in 2007, countervailing interventions began to emerge. Pain clinics that had dispensed enormous quantities of opioids were shuttered by the Drug Enforcement Administration. States developed controlled substance monitoring programs (CSMPs), which were often run by law-enforcement agencies rather than health care agencies. Pharmacists began to question or refuse to fill opioid prescriptions. Health plans instituted new rules regarding opioids or demands for confidential patient data and refused to cover some prescriptions. Clinic systems began requiring patient–provider agreements for opioid prescriptions, urine drug screening with consequences for unexpected results, and documentation that clinicians had checked the CSMP before prescribing opioids. Medical boards and other regulators began investigating opioid overdose deaths and bringing cases against clinicians. The opioid-prescribing guidelines issued by the CDC in 2016 (for which one of us was a core expert) led to steeper reductions in prescribing. Today, it is hard to find a clinician who will prescribe opioids for chronic pain — and nearly impossible if you are a patient receiving long-term



Risks Conferred by Tapering or Discontinuing Long-Term Opioid Therapy.

Among patients who have their long-term opioid therapy discontinued or tapered, there is an increased risk of illicit opioid use (Panel A), a high incidence of emergency department visits and opioid-related hospitalizations (Panel B), an increased incidence of mental health crises and overdose events (Panel C), and an increased risk of death from suicide or overdose (Panel D). I bars in Panel C indicate 95% confidence intervals. Data are from Coffin et al.,[2] Mark and Parish,[3] Agnoli et al.,[4] and Oliva et al.[5]

opioid therapy and seeking a new clinician.

Opioids, especially high-dose opioids, are rarely indicated for chronic pain that is not associated with end-of-life conditions. Avoiding opioids as first-line treatment is a wise change in policy. However, patients who have been prescribed opioids for years for such conditions must be treated differently because exposure to long-term opioid therapy causes profound physiological and neurologic changes. Reflexive and one-size-fits-all approaches to tapering or discontinuing opioids prescribed for chronic pain should be avoided.

The Food and Drug Administration and the CDC have made it clear that these patients, often referred to as "legacy patients," require individualized care. Tapering and discontinuing opioid therapy for chronic pain have been associated with multiple negative outcomes in both publicly and commercially insured populations (see figure). Outcomes include increased illicit opioid use,[2] increased use of emergency medical services and opioid-related hospitalizations,[3] increased rates of mental health crises and overdose events,[4] and increased mortality from overdose and suicide.[5] Outcomes tend to be worse the longer patients have been receiving opioids before tapering[5] and the more abrupt the taper.[3,4] Even more troubling, outcomes are worse among patients who are the most likely to have their doses tapered: those with mental health or substance use disorders.[3] It must be clearly understood that withdrawing opioid therapy is not the same as not having prescribed opioids in the first place.

This problem is thrown into stark relief when pain-management clinics close abruptly, but this issue also affects patients whose clinicians relocate or retire. One of us recently admitted to the inpatient service a man in a sickle-cell pain crisis; it was his first hospitalization in several years. He had been adhering to hydroxyurea therapy but had recently changed clinicians and, after undergoing a urine drug screen that was positive for cocaine, was abruptly cut off from the oral hydromorphone that he had been taking at a dose of 4 mg four times a day for more than a decade. Within a week, the patient was hospitalized for a poten-

Steps in Caring for Patients with Chronic Pain Who Have Received Long-Term Opioid Therapy from a Previous Clinician.

1. **Review the case with the former clinician if possible.** Try to develop a treatment plan that slowly adjusts to your style of management while avoiding a radical divergence from the previous plan of care.
2. **Consider providing a therapeutic bridge for the patient until a plan of care is determined, given the risks associated with stopping opioid therapy.** Abruptly tapering or stopping opioid therapy can be dangerous for multiple reasons. Opioids may be crucial for the patient's condition (e.g., sickle-cell disease), and the patient may be at risk for other harms when opioids are tapered or discontinued (see figure).
3. **Develop a patient-centered care plan.** If a taper is needed, empower the patient to make decisions, including which medications to taper first and how fast. Successful tapers may take years.
4. **Assess the patient for opioid use disorder and start discussing medication options right away.** Patients may find it challenging to accept an opioid use disorder diagnosis; give them time.
5. **Document opioid stewardship and the rationale for the treatment plan.** Investigations into opioid prescribing are often based on insufficient documentation.

tially life-threatening pain crisis, clearly precipitated by opioid withdrawal. This result was virtually guaranteed by the hasty discontinuation of the hydromorphone and, to us, represents a dangerous and shameful misinterpretation of opioid-prescribing guidelines.

Some patients with chronic pain may also have an opioid use disorder (OUD), which can be identified with the use of criteria from the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (DSM-5), or any of several validated screening tools. In such cases, stigma can be devastating, and clinicians should address OUD without judgment, as they would any other disease. Medications for treating OUD reduce mortality and should be strongly encouraged. Methadone may be difficult to obtain in some areas, and extended-release naltrexone may not be optimal for patients in need of ongoing analgesia. Buprenorphine, however, may provide potent pain relief while also, thanks to a ceiling effect that limits respiratory depression, safely treating OUD. Buprenorphine can be prescribed by any clinician; when used to treat OUD, it does require a Drug Addiction Treatment Act of 2000 (DATA 2000) waiver, which can now be obtained at no cost and with no additional training simply by submitting a "notification of intent" electronic form to the Substance Abuse and Mental Health Services Administration. Buprenorphine may now also be provided by means of telehealth services, which further alleviates barriers to care.

We are at a precipice, with "legacy patients" being abandoned and patients who appropriately rely on opioid medications — such as those with sickle-cell disease — being subject to life-threatening misapplication of opioid stewardship efforts. Physicians fear losing their medical licenses, being disciplined by their clinics or health care systems, or having to battle every 30 days with health insurers to pay for needed medications. Pain-management specialists are expected not just to consult but also to absorb the patient care and associated risks, even though primary care providers possess the skills to care for most patients and are able to develop stronger, longitudinal relationships. Crises sparked by the sudden closing of pain-management clinics, like the one we are experiencing in California, are all too common.

A personalized, patient-centered approach to opioid management can prevent iatrogenic harm and death — but it will take time and require the perseverance to develop trusting relationships between patients and clinicians (see box). We believe the medical establishment must step forward to resist applying a one-size-fits-all approach to inherited patients, fight back against overzealous regulators, and stop abandoning patients. Patients who have received long-term opioid therapy cannot be treated the same as those who have not.

The opinions expressed are those of the authors and may not reflect those of their respective institutions.

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