CIAO Time Presents:

Opioid Tapering

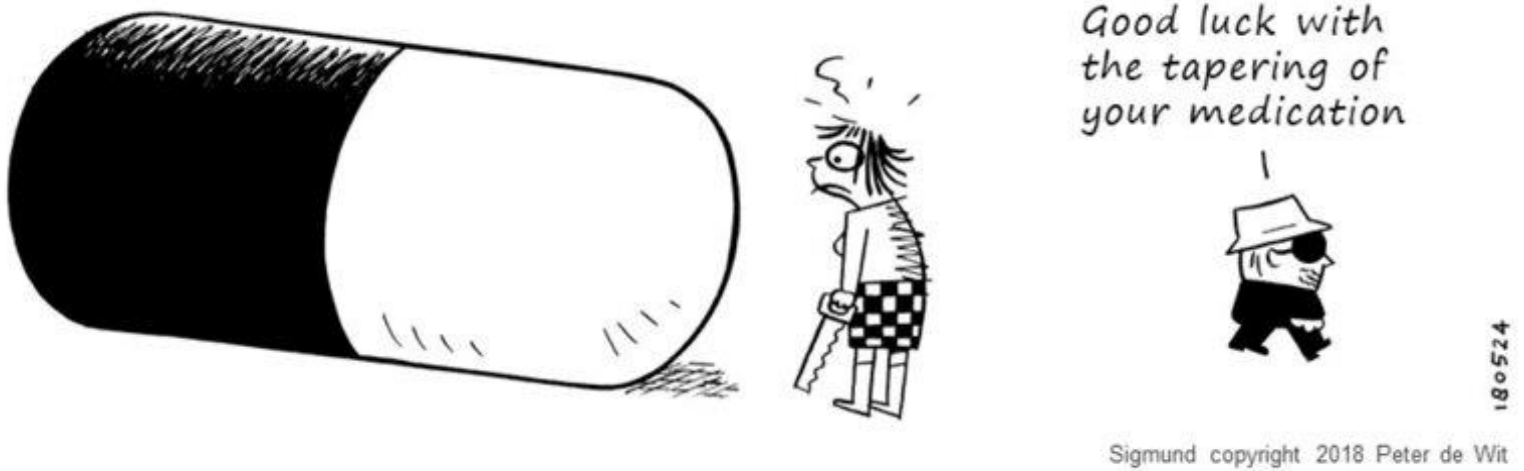
The Center for Innovation in Academic Detailing on Opioids

San Francisco Department of Public Health

Agenda

1. Introduction to CIAO
2. Case Study on Opioid Tapering
3. Academic Detailing Demonstration

* *Please send questions to Nicola Gerbino in the* ***Chat Box***



Our Team

Phillip Coffin
MD, MIA, FACP, FIDSA
Program Medical Director
he/him/his

Rebecca Martinez
MS, RN FNP-C
Clinician trainer
she/her/hers

Brian Wylie
OTD, MPH
Program Manager
he/him/his

Nicola Gerbino
Program Assistant
she/her/hers

The Center for Innovation in Academic Detailing on Opioids

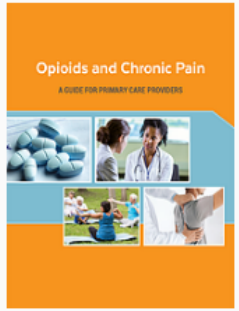
Our vision: We aim to decrease opioid-related morbidity and mortality by promoting balanced approaches to opioid management.

Our mission: We collaborate with healthcare providers to improve opioid and chronic pain-related care through innovative training and technical assistance services.

CENTER FOR INNOVATION IN ACADEMIC DETAILING ON OPIOIDS

HOME ABOUT SERVICES RESOURCES CONTACT US SEARCH...

Our materials



Opioids and Chronic Pain: A guide for primary care providers (book)

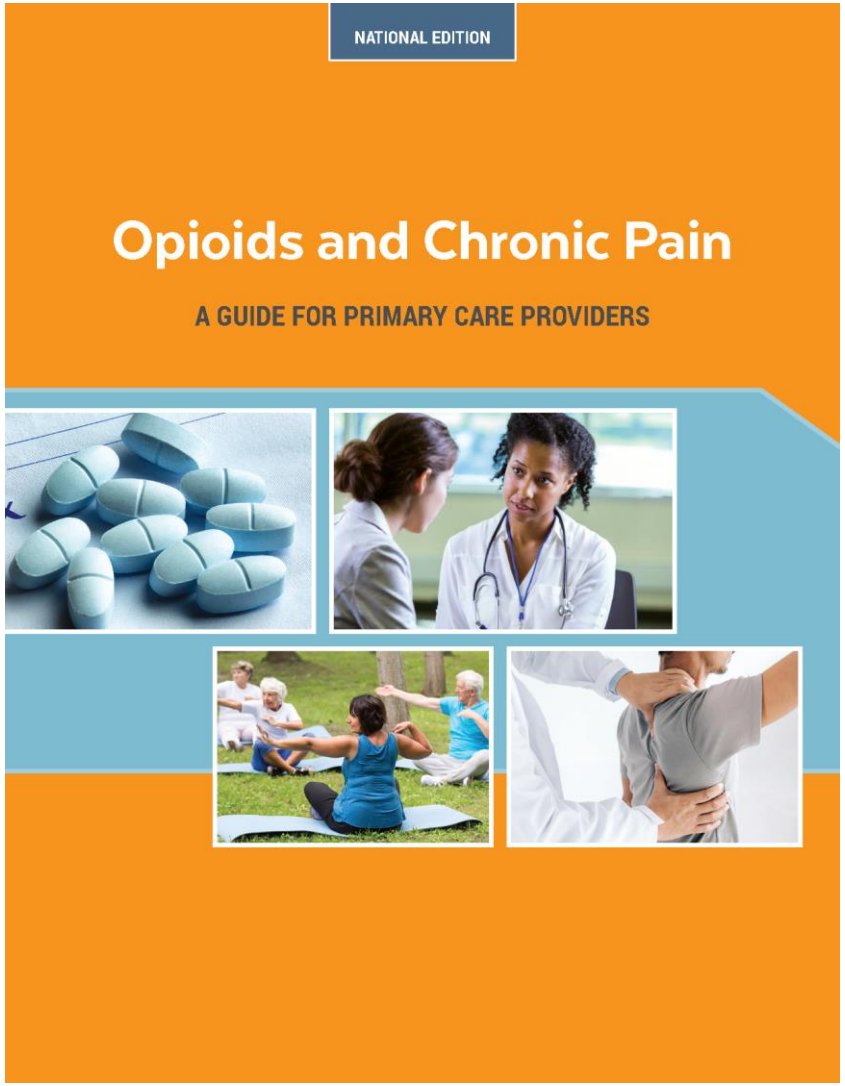
California edition
National Edition

CIAO's Academic Detailing and Technical Assistance Services (PDF)

Managing Chronic Non-Cancer Pain (poster)

California edition
National Edition

California Pharmacists and Furnishing Naloxone: What you need to know (PDF)



View more of our academic detailing materials at **www.ciaosf.org/our-materials**

Case Study:

To taper or not to taper?

A nurse practitioner has a first visit with a **45-year-old male** who has been on long-term opioid therapy for chronic lower back pain for **30 years** since falling off a building at work. Previously received care from a pain management doctor whose license was suspended.

Prescription:

- Morphine sulfate extended release 60mg twice a day #60
- Hydrocodone-acetaminophen 10-300mg every 6 hrs as needed #90.

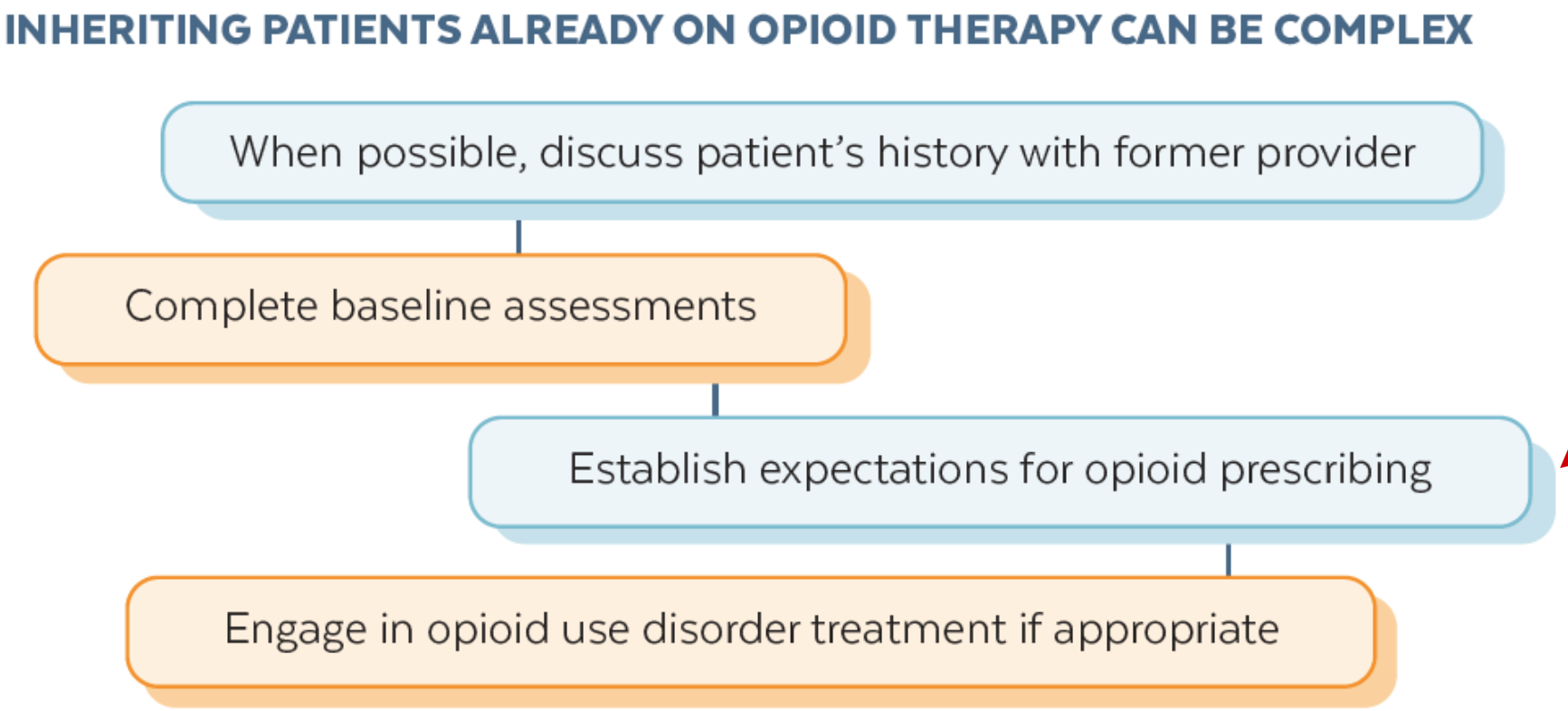
At the first visit, ***urine drug screening*** is performed as part of the clinic's protocol for patients on prescription opioids:

- *expected results*: (+) morphine
- *unexpected results*: (+) methamphetamine

  (-) hydrocodone

First Poll

Managing patients on opioids



Avoid sudden changes to opioid prescription. Take time to understand the patient's history and speak to other providers before tapering opioids.

Opioids and Chronic Pain Guidebook (page 8)

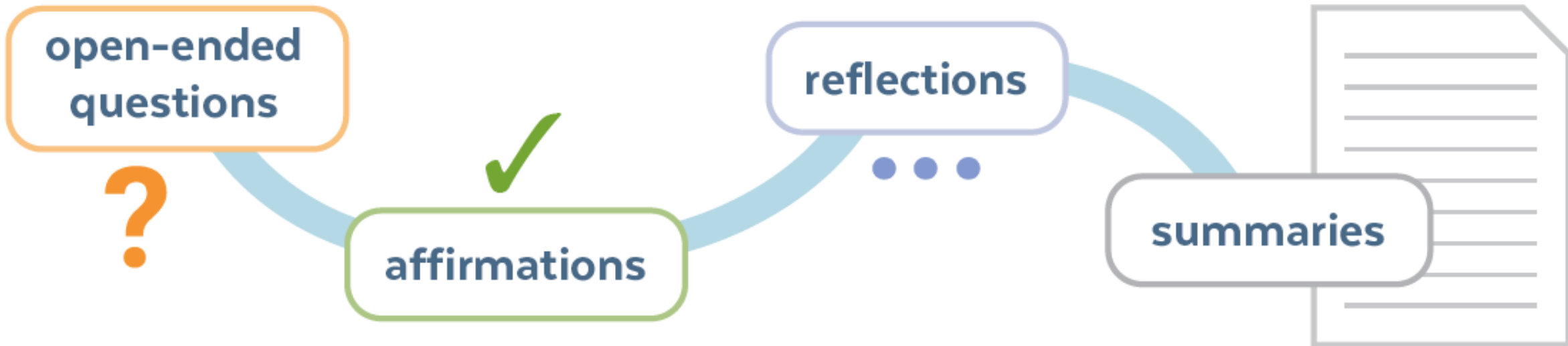
PATIENT ENGAGEMENT

- **Recognize patient** (e.g. psychosocial stressors), **provider** (e.g. time pressure, burnout), **and environmental factors** (e.g. regulatory changes) that lead to challenging conversations.
- Stigma can have a negative impact on the patient-provider relationship and a patient's mental health.[5] Use patient-first language.

Instead of these terms:	Use these:
addict	person with a substance use disorder
dirty urine	unexpected results
abuse	problematic use

Opioids and Chronic Pain Guidebook (page 8)

- Use motivational interviewing techniques



For more information, go to: **motivationalinterviewing.org**

Opioids and Chronic Pain Guidebook (page 8)

Case Study

Next steps:

- Don't make any changes today.
- Get to know the patient, explore his understanding of pain and opioid risks.
- Screen for opioid use disorder.
- Start thinking about a taper.

OPIOID STEWARDSHIP:

- Check Controlled Substance Monitoring Program
- Request prior medical records
- Calculate morphine equivalence = 150 MEQ
- Prescribe naloxone

Second Poll

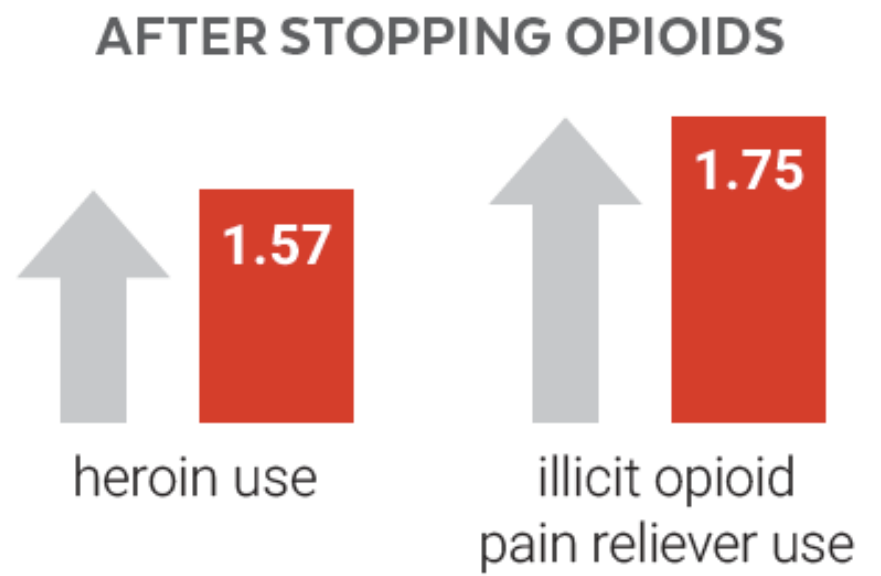
Preparing to reduce opioid dose

Opioids and Chronic Pain Guidebook (page 9)

Tapering opioids may improve pain, based on a systematic review of 20 studies demonstrating improved or similar pain after a successful taper.[6]

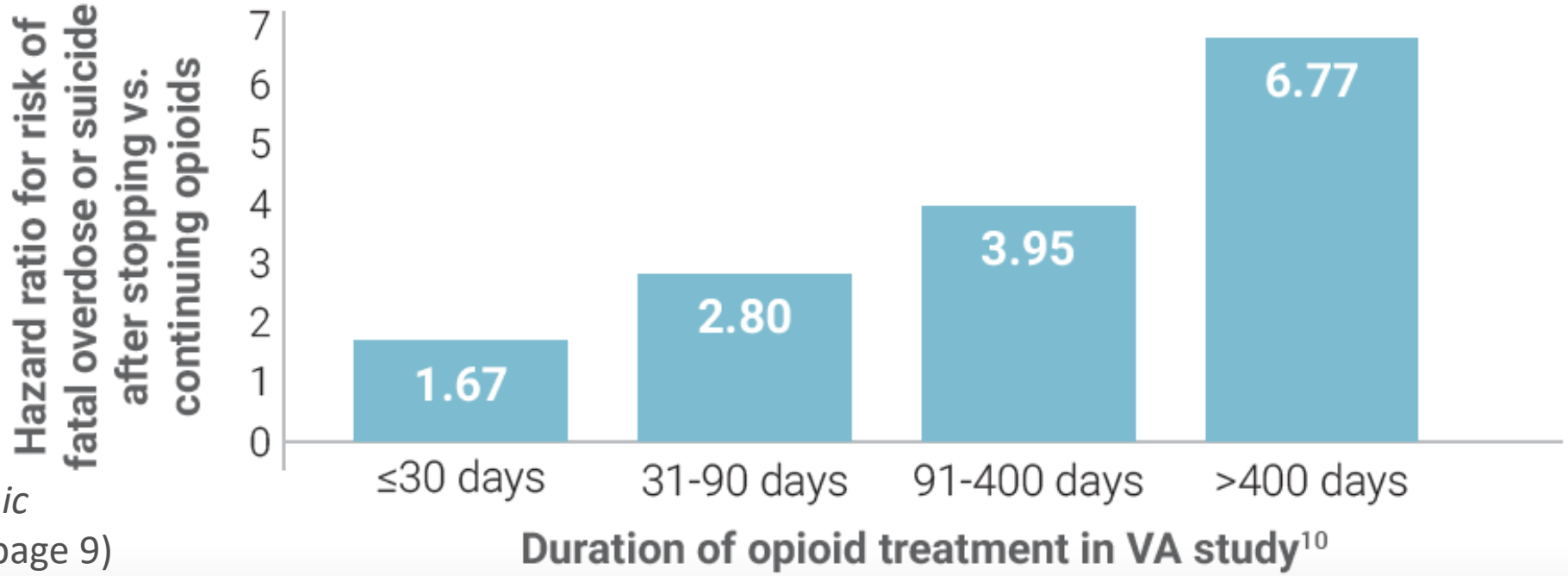
HOWEVER, THERE ARE RISKS TO REDUCING OPIOID THERAPY:

- **Complex persistent dependence:** Patients living with chronic pain may experience neuroplastic effects from long-term opioid use, which may cause increased pain, decreased function, and psychological distress.[7]
- **Increased illicit substance use:** Stopping prescribed opioids increased the chance of more frequent heroin and illicit opioid pain reliever use.[8]



- **Opioid-related adverse events:**
  Approximately half of Medicaid patients in Vermont had an opioid-related ED visit or hospitalization following discontinuation of high-dose opioids. Speed of taper and substance use disorder diagnosis were the strongest predictors.[9]

- **Mortality:** In a study of 1,394,102 patients in the VA, patients were at greater risk of fatal overdose or suicide after stopping opioid treatment, with increasing risk the longer patients had been treated before stopping.[10] Other studies have shown similar findings.[11]



Opioids and Chronic Pain Guidebook (page 9)

FDA and CDC recommend opioid prescribing be individualized for each patient to modulate the risks of changing dose. Go to: **bit.ly/CDC_opioidguide** and **bit.ly/FDA_opioidguide**

FDA identifies harm reported from sudden discontinuation of opioid pain medicines and requires label changes to guide prescribers on gradual, individualized tapering

FDA Drug Safety Communication

CDC Advises Against Misapplication of the *Guideline for Prescribing Opioids for Chronic Pain*

Some policies, practices attributed to the Guideline are inconsistent with its recommendations

Media Statement

Case Study

What should this provider consider in tapering this patient?

Third Poll

Shared decision-making for opioid therapy

Opioids and Chronic Pain Guidebook (page 10)

Avoid making a decision without an individualized conversation with the patient.

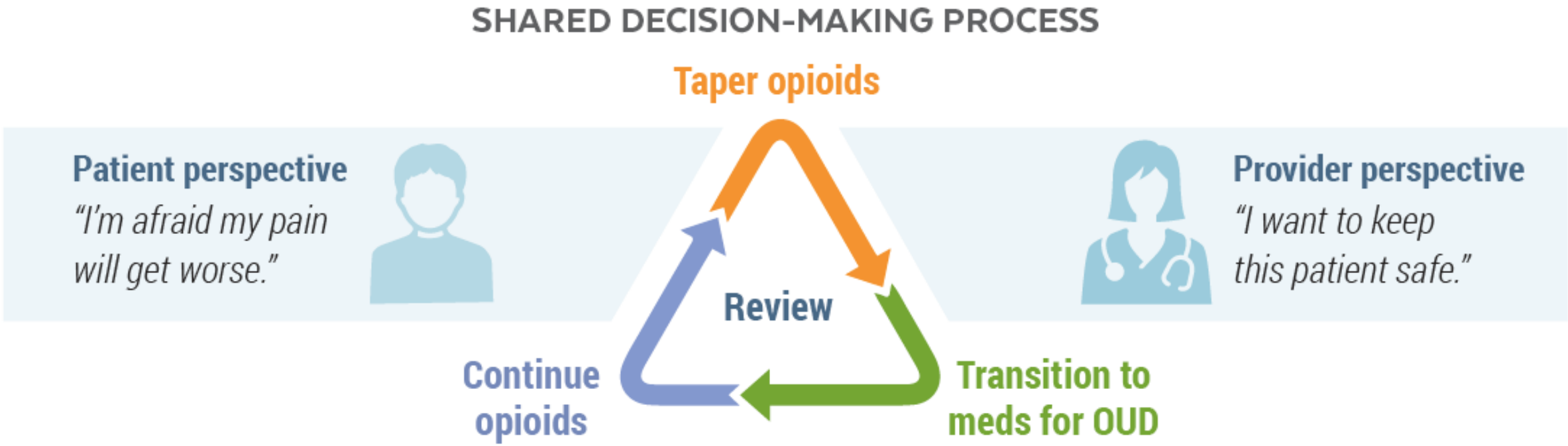
1 Ask the patient to describe perceived risks and benefits.

Patients may identify scenarios with limited benefit or increasing risk such as:

- On opioids after pain condition addressed
- No evidence of pain/function improvement
- Very high dose of opioids
- Other risky medications (e.g. benzodiazepines)
- Adverse effects (constipation, overdose, etc.)
- Worsening comorbidities
- Active opioid use disorder

2 Develop a plan with the patient.

Opioids and Chronic Pain Guidebook (page 10)



Communication techniques:

- Validate patient's pain and experience
- Recognize power dynamics
- Empower patient to participate in treatment planning
- Don't judge
- Be flexible
- Prepare for emotion

Opioids and Chronic Pain Guidebook (page 10)

3 Before implementing change, review and develop a plan for:

- Social issues (e.g. housing, finances, intimate partner violence)
- Alternative pain management strategy (other medication and non-medication strategies)
- Mental health services
- Social support
- Withdrawal medications
- Changes in tolerance and overdose risk

Sometimes patient safety can be impacted by changes to opioid dose (e.g. in settings of homelessness, intimate partner violence, diversion), and must be addressed prior to making changes

Recent data on opioid tapering

Sturgeon et al, 2020	Davis et al, 2020	Sullivan et al, 2020
When a <u>patient-centered approach</u> was taken to tapering (e.g. patient can choose to pause and which opioid to taper first), *no adverse events (e.g. overdose, suicide) or returns to illicit opioids were observed.* **Higher baseline opioid dose observed among patients with failed taper and predicted transition to buprenorphine.**	<u>Evidence-based consensus approach to tapering:</u> • Screen for trauma and OUD prior to tapering (B) • Refer patient for behavioral health evaluation (A) • Refer the patient for treatment if any risk for OUD (A) **Reasonable to prescribe an opioid for a patient while waiting for more info (if no diversion, no OUD, no impairment)*	Primary care taper plans are associated with increased likelihood of **sustained opioid taper**. **taper plan = documentation in notes or prescription*

Case Study

The patient continues to come to clinic and a strong patient-provider relationship develops.

Multiple treatments for pain, mental health and methamphetamine use disorder have been attempted however the patient continues to use meth.

A patient-centered taper is recommended.

- Eventually, the patient becomes open to trying a taper and likes the idea of having some control.

Fourth Poll

Steps of a taper

1. Get to know the patient's stressors, needs, and pain:
   - don't rush to start a taper immediately: patient buy-in is important
   - individualize the taper plan (see "Example tapers for opioids")
2. Discuss the risks of tapering.
3. Involve patient in the selection of a taper speed and frequency of dose reduction (see "Example tapers for opioids").
4. Tapering should **not** result in withdrawal. However, in some circumstances, you may prescribe adjunctive medications to treat withdrawal symptoms.

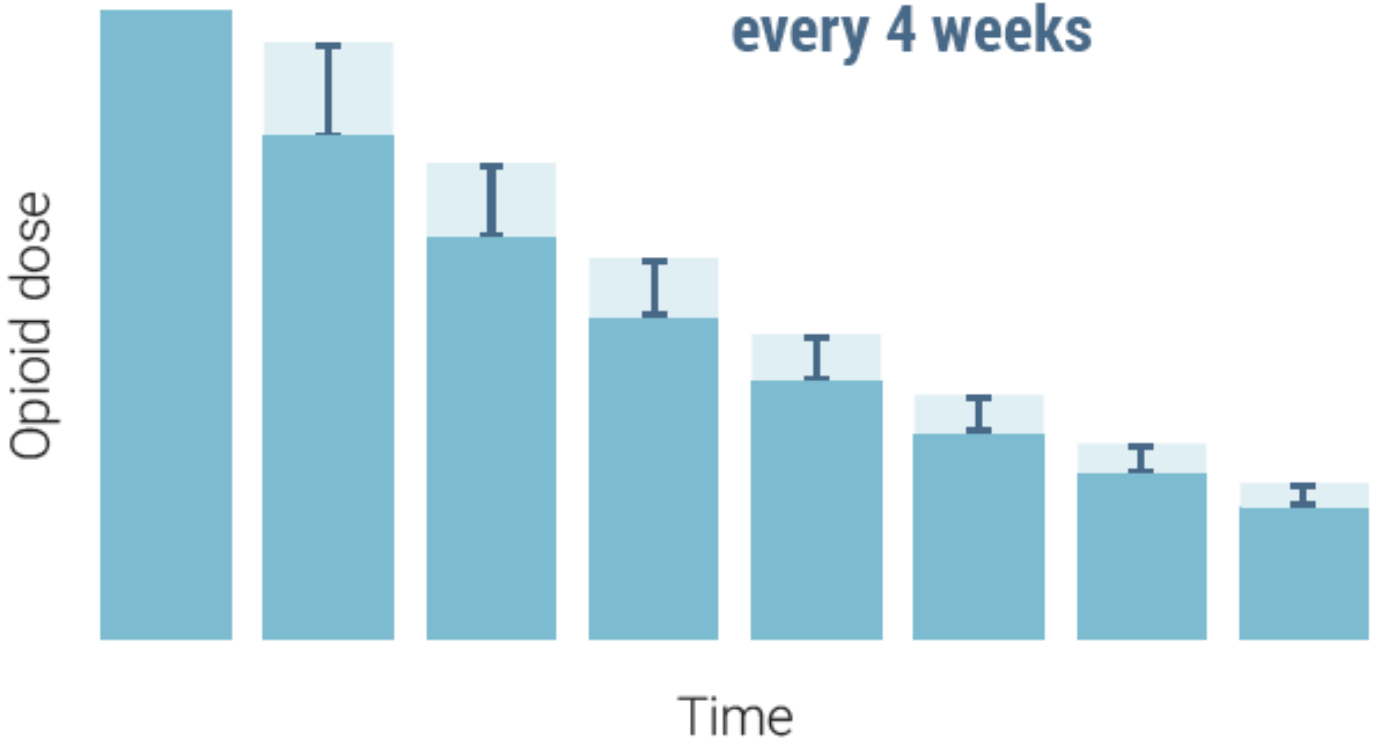
Symptom	Medication
Cold sweats, chills, feeling "jittery"	Clonidine: 0.1 mg tablet
Anxiety, problems sleeping	Hydroxyzine: 50 mg tablet
Nausea or vomiting	Ondansetron: 4 mg tablet
Diarrhea	Loperamide: 2 mg tablet
Body aches or muscle pain	NSAIDS or Acetaminophen

For example, tell the patient "You get to decide when we decrease the dose next, as the provider I'll determine how much."

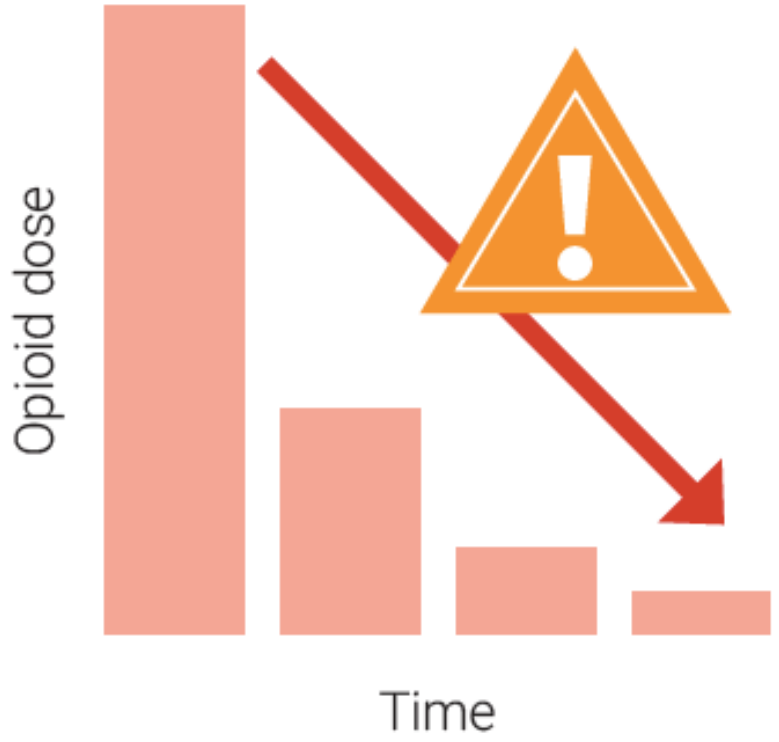
Opioids and Chronic Pain Guidebook (page 11)

TAPER GOALS

Most commonly, opioid tapers will involve dose reduction of 5-20% of original dose every 4 weeks



Abrupt tapers (>20% of original dose) should be avoided whenever possible



Successful tapers look different for each patient and often include pauses, stops, and dynamic goals. Any reduction may be considered a success.

Slowest taper (over years)

Reduce by 2% to 10% every 4 to 8 weeks with pauses in taper as needed.

Consider for patients taking high doses of long-acting opioids for many years.

Ex: **morphine SR 90 mg q8h = 270 MED***

Month 1: 90 mg SR qAM, 75 mg noon, 90 mg qPM [5% reduction][a]
Month 2: 75 mg SR qAM, 75 mg noon, 90 mg qPM
Month 3: 75 mg SR (60 mg+15 mg) q8h
Month 4: 75 mg SR qAM, 60 mg noon, 75 mg qPM
Month 5: 60 mg SR qAM, 60 mg noon, 75 mg qPM
Month 6: 60 mg SR q8h
Month 7: 60 mg SR qAM, 45 mg noon, 60 mg qPM
Month 8: 45 mg SR qAM, 45 mg noon, 60 mg qPM
Month 9: 45 mg SR q8h[b]

Standard taper (over months or years) — MOST COMMON

Reduce by 5% to 20% every 4 weeks with pauses in taper as needed.

Ex: **morphine SR 90 mg q8h = 270 MED**

Month 1: 75 mg (60 mg+15 mg) SR q8h [16% reduction]
Month 2: 60 mg SR q8h; **Month 3**: 45 mg SR q8h
Month 4: 30 mg SR q8h; **Month 5**: 15 mg SR q8h
Month 6: 15 mg SR q12h; **Month 7**: 15mg SR qhs, then stop

Faster taper (over weeks)	
Reduce by 10% to 20% every week.	Ex: **morphine SR 90 mg q8h = 270 MED** **Week 1**: 75 mg SR q8h [16% reduction] **Week 2**: 60 mg SR (15 mg x 4) q8h; **Week 3**: 45 mg SR (15 mg x 3) q8h **Week 4**: 30 mg SR (15 mg x 2) q8h; **Week 5**: 15 mg SR q8h **Week 6**: 15 mg SR q12h; **Week 7**: 15 mg SR qhs x 7 days, then stop
Rapid taper (over days) – RARELY INDICATED	
Reduce by 20% to 50% of first dose if needed, then reduce by 10% to 20% every day.	Ex: **morphine SR 90 mg q8h = 270 MED** **Day 1**: 60 mg SR (15 mg x 4) q8h [33% reduction] **Day 2**: 45 mg SR (15 mg x 3) q8h; **Day 3**: 30 mg SR (15 mg x 2) q8h **Day 4**: 15 mg SR q8h; Days 5-7: 15 mg SR q12h **Days 8-11**: 15 mg SR qhs, then stop

[a] Continue the taper based on patient response.

[b] Continue following this rate of taper until off the morphine or the desired dose of opioid is reached.

***MED** = morphine equivalent dose

Opioids and Chronic Pain Guidebook (page 12)

Case Study

The nurse practitioner asks the patient which opioid he wants to taper first or if he would like to convert his hydrocodone prn to morphine.

- Extended-release morphine to be tapered first but keep hydrocodone prn.

During month 1, the patient agrees to decrease his dose by approximately 10%.

Eventually, the patient reaches morphine sulfate 15mg BID and hydrocodone 5mg prn #10 tablets per month. His pain is better controlled with yoga and cognitive behavioral therapy. Meth use infrequent now.

Takeaways

- Keeping the patient engaged in care is a top priority.
- Just because a patient uses an illicit substance does not mean they need to be tapered immediately.
- Use patient-centered approaches to conversations about tapering and involve the patient in decision-making.

Academic Detailing Mock Session

What to watch for…

Steps of a Visit

- Introduction
- Needs Assessment
- Key Messages/Benefits
- Handling Objections
- Summary/Close Visit

Thank you!

www.ciaosf.org - ciao.sf@sfdph.org

SAN FRANCISCO DEPARTMENT
OF PUBLIC HEALTH

CENTER FOR INNOVATION
IN ACADEMIC DETAILING
ON OPIOIDS

Centers for Disease Control and Prevention
OD2A / P2P