

Opioid Tapering

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Disclosures

- Site Director for the EMPOWER clinical trial at the Phoenix VA
 - Funded by PCORI, coordinated by Stanford University
- Local Site Investigator for the Phoenix VA for the SCEPTER trial
 - Funded by VA
- Views are my own and not those of the federal government or the Department of Veterans Affairs

Objectives

- Formulate a person-centered opioid tapering plan that will maximize the likelihood of positive outcomes
- Explain the importance of screening for opioid use disorder when considering opioid tapering



Michelle:

New patient in distress

- Michelle is a 65 y/o female with chronic neck and low back pain on **LTOT who presents as a new patient**
- Michelle reports that she is **struggling with opioid withdrawal symptoms**
- She reports that her PCP reduced her dose **from oxycodone 30mg TID to 15mg TID** 1 week ago as part of a plan to taper her off over 3 months

What is
your next
step with
Michelle?

- 1) Tell Michelle that **you don't manage chronic pain with opioids** and she will need to find a different provider
- 2) Tell Michelle you will take over opioid prescribing at 10mg TID and **taper her off over the next 2-3 months**
- 3) **Screen for OUD and Assess for Risks and Benefits of LTOT**

7 Ps for Whole Person Care for Patients on LTOT

Paradigm Shift

Prepare self, team, patient

Person centered

Protect patient and team

Partner with patient and other disciplines

Power of the Pause

Paradox of Change

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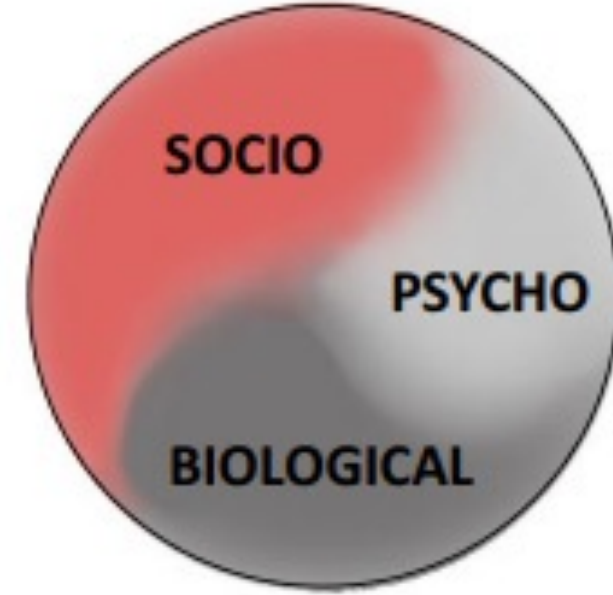
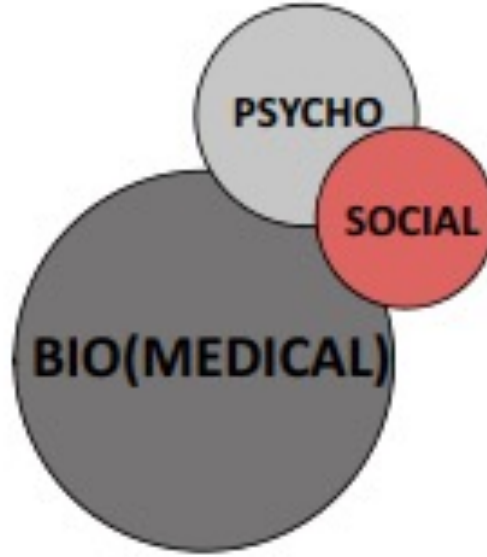
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“Quick Fix”



Whole Health System





Mardian et al, *Pain Med*, 2020



**DISCOVER
WHAT MATTERS
TO YOU.**

Live Whole Health.

VA



U.S. Department
of Veterans Affairs

va.gov/wholehealth

MEETING

APPLY IT


- Use the PHI as PDF or an App

Live Whole Health. VA | U.S. Department of Veterans Affairs
Veterans Health Administration

PERSONAL HEALTH INVENTORY

Use this circle to help you think about your whole health.

- "Me" at the center of the circle: This represents what is important to you in your life, and may include your mission, aspirations, or purpose. Your care focuses on you as a unique person.
- Mindful awareness is about noticing what is happening when it happens.
- Your everyday actions make up the green circle. Your options and choices may be affected by many factors.
- The next ring is professional care (tests, medications, treatments, surgeries, and counseling). This section includes complementary approaches like acupuncture and yoga.
- The outer ring includes the people, places, and resources in your community. Your community has a powerful influence on your personal experience of health and well-being.



Rate where you feel you are on the scales below from 1-5, with 1 being not so good, and 5 being great.

Physical Well-Being	<input type="radio"/> 1 NOT SO GOOD	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5 GREAT
Mental/Emotional Well-Being	<input type="radio"/> 1 NOT SO GOOD	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5 GREAT
Life: How is it to live your day-to-day life?	<input type="radio"/> 1 NOT SO GOOD	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5 GREAT

What matters most to you in your life right now? Write a few words to capture your thoughts:

[Personal Health Inventory \(va.gov\)](https://www.va.gov/wholhealth/)



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Opioid Exposed ≠ Opioid Naïve

**Long-term opioid therapy
changes the brain and requires
a careful and individualized approach
to reduce opioid-related risks.**

Continuum of Neurobiological Effects with LTOT



Continuum of Neurobiological Effects with LTOT

Physiologic
Dependence



- Withdrawal
- Tolerance
- few days – few weeks
- Easy to stop opioid use



Continuum of Neurobiological Effects with LTOT



Loss of Control

- Using **larger amounts** or over a **longer period** than intended
- Persistent desire or **inability to cut down** on or control opioid use
- Spending a lot of **time** to obtain, use, or recover from opioids

Craving

- Craving or strong desire or urge to use opioids

Use despite Consequences

- **Failure to fulfill obligations** at work, school, or home
- Continued use despite **social or interpersonal problems**
- **Activities are given up/reduced**
- Recurrent use in **physically hazardous** situations
- Continued use despite **physical or psychological problems**

Physiological Criteria

- Tolerance*
- Withdrawal*

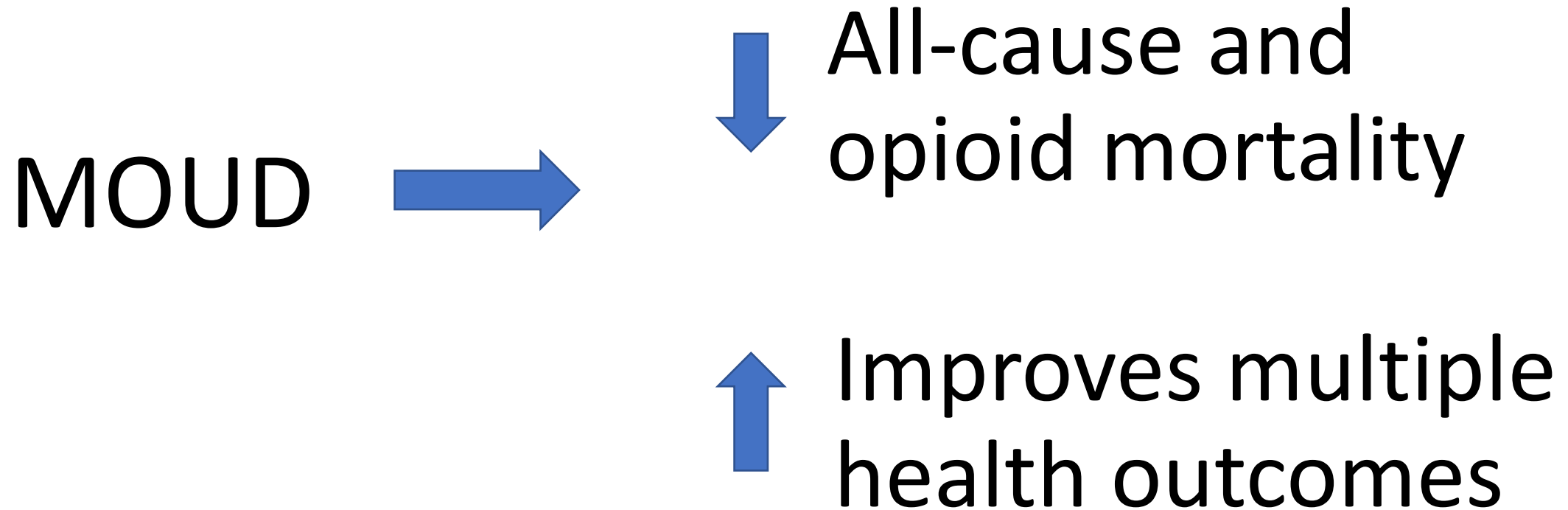
2-3 = mild OUD

4-5 = moderate OUD

≥ 6 = severe OUD

*tolerance and withdrawal are not counted if patient taking medications as prescribed

Medications for OUD



Medications for OUD

Buprenorphine

Methadone

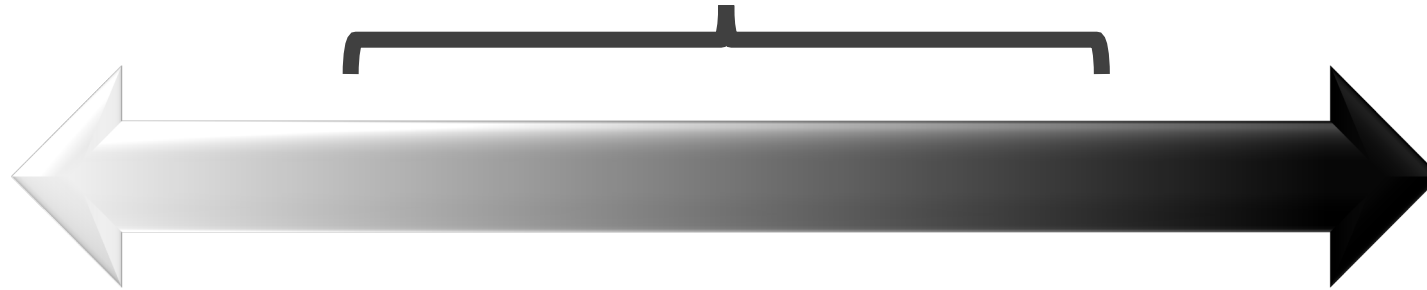
Naltrexone

Mechanism of Action	Partial agonist at the mu opioid receptor	Full agonist at the mu opioid receptor	Antagonist at the opioid mu opioid receptor
Restrictions on Prescribing for OUD	X Waiver needed OR federally licensed OTP	federally licensed OTP	None
Data on mortality benefit	Reduction in opioid overdose and all cause mortality	Reduction in opioid overdose and all cause mortality	Not available
Formulations	Sublingual tablet and strip (with/without naloxone) long-acting injection, subdermal implant	Tablet, liquid	Capsule and long-acting injection

Continuum of Neurobiological Effects with LTOT

Gray Area/Complex
Persistent Dependence

Physiologic
Dependence



Opioid Use
Disorder

- Withdrawal
- Tolerance
- few days – few weeks
- Easy to stop opioid use

- 2+ (of 9) sx – not including withdrawal and tolerance
- More persistent
- Very difficult to stop opioid use

Continuum of Neurobiological Effects with LTOT

Gray Area/Complex
Persistent Dependence

Physiologic
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Opioid Use
Disorder

- Withdrawal
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Taper May Be Appropriate

- 2+ (of 9) sx – not including withdrawal and tolerance
- More persistent
- Very difficult to stop opioid use

Gradual, Collaborative Taper

- **Gradual and individualized taper pace**
 - “Micro dose reductions” – e.g. 2.5mg reduction Q 1-2 months
 - No rush
 - Individualize plan for patient and their unique life circumstances
 - Maintain flexibility during taper
 - Maximize patient choice points – timing, formulation, pace



If Opioids are Tapered or Discontinued → Do Not Taper or Discontinue Treatment and Support

Non-Opioid Treatment and Psychosocial Support Should be Increased

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Obtain X waiver

- Training no longer required to obtain X Waiver when prescribing for 30 or fewer patients
- Still need to request X Waiver through SAMHSA
 - [SAMHSA DATA Waiver](#)
- Training is helpful and available online for free
 - [Applying for Your Waiver - PCSS \(pcssnow.org\)](#)

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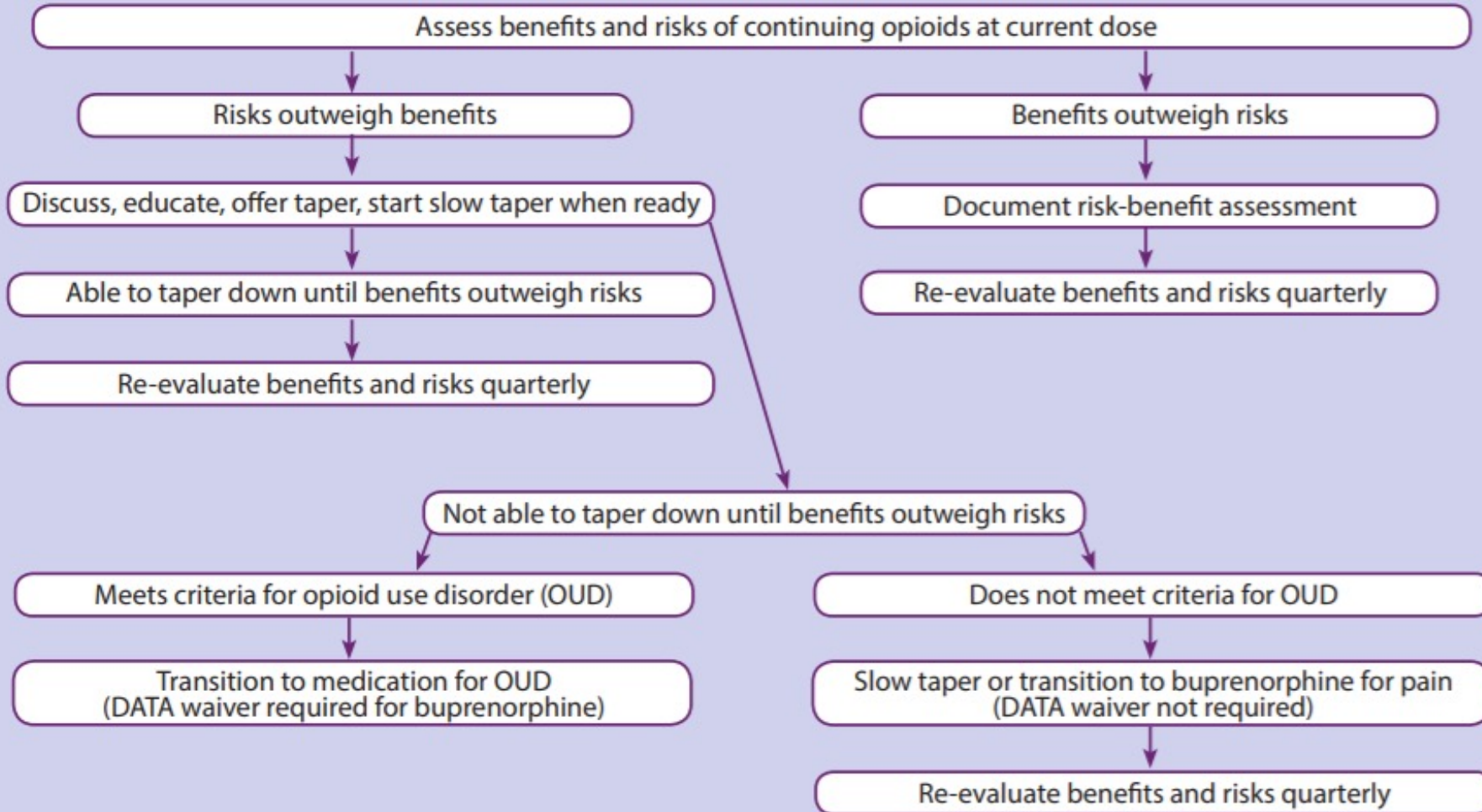
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Opioid Tapering Flowchart



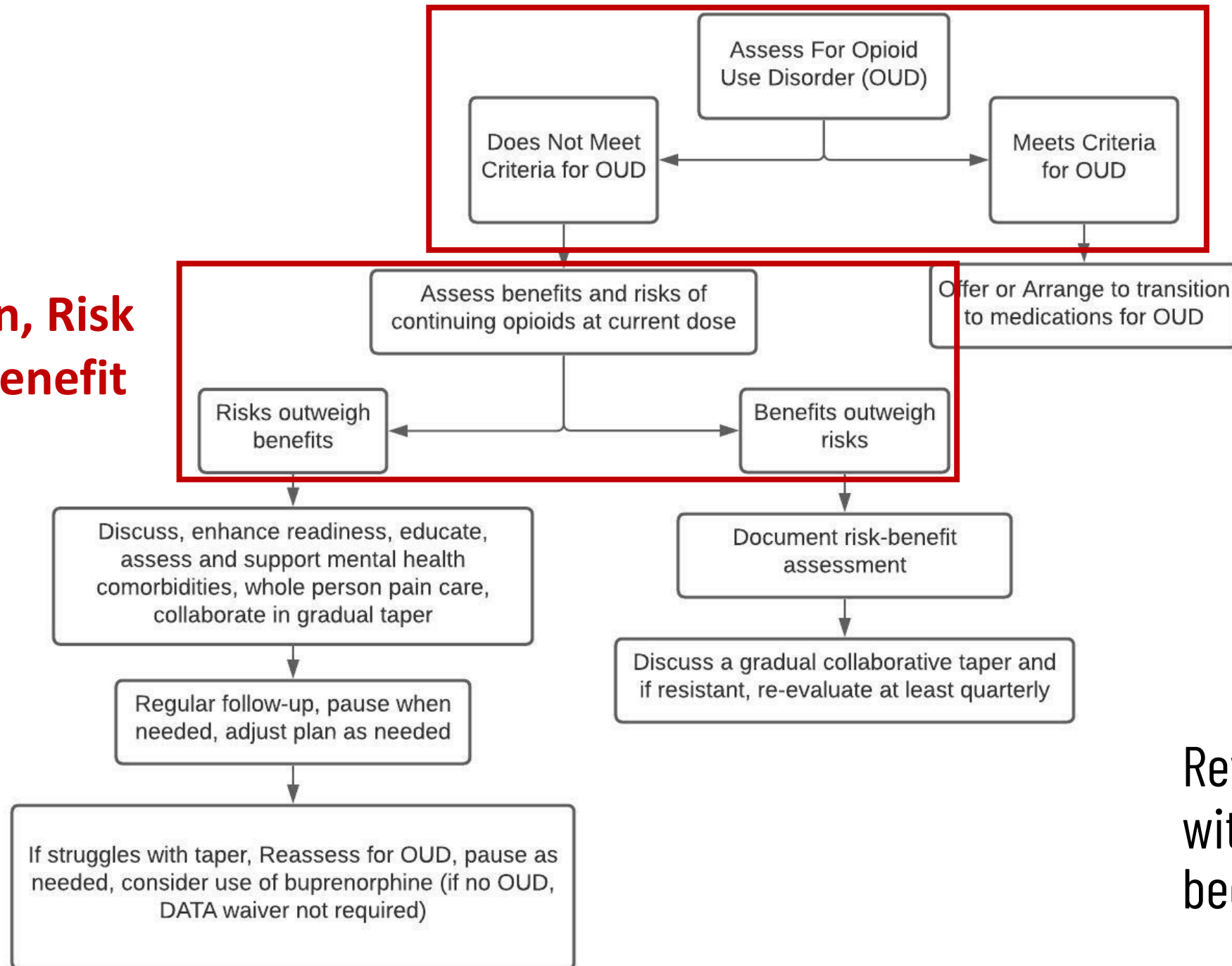
Adapted from Oregon Pain Guidance. Tapering – Guidance & Tools. Available at <https://www.oregonpainguidance.org/guideline/tapering/>.

HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics

https://www.hhs.gov/opioids/sites/default/files/2019-10/Dosage_Reduction_Discontinuation.pdf

**Then, Risk
vs Benefit**

**Assess for
OUD first**



Revised Flowchart
with OUD screen at
beginning

APPLY IT

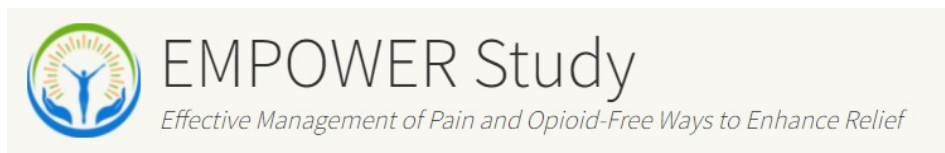
- **Screening tool: NIDA QUICK SCREEN**



- **Screening tool: TAPS**



- **Screening tool: EMPOWER Consensus Method**



<https://www.frontiersin.org/articles/10.3389/fmed.2021.591201/full>

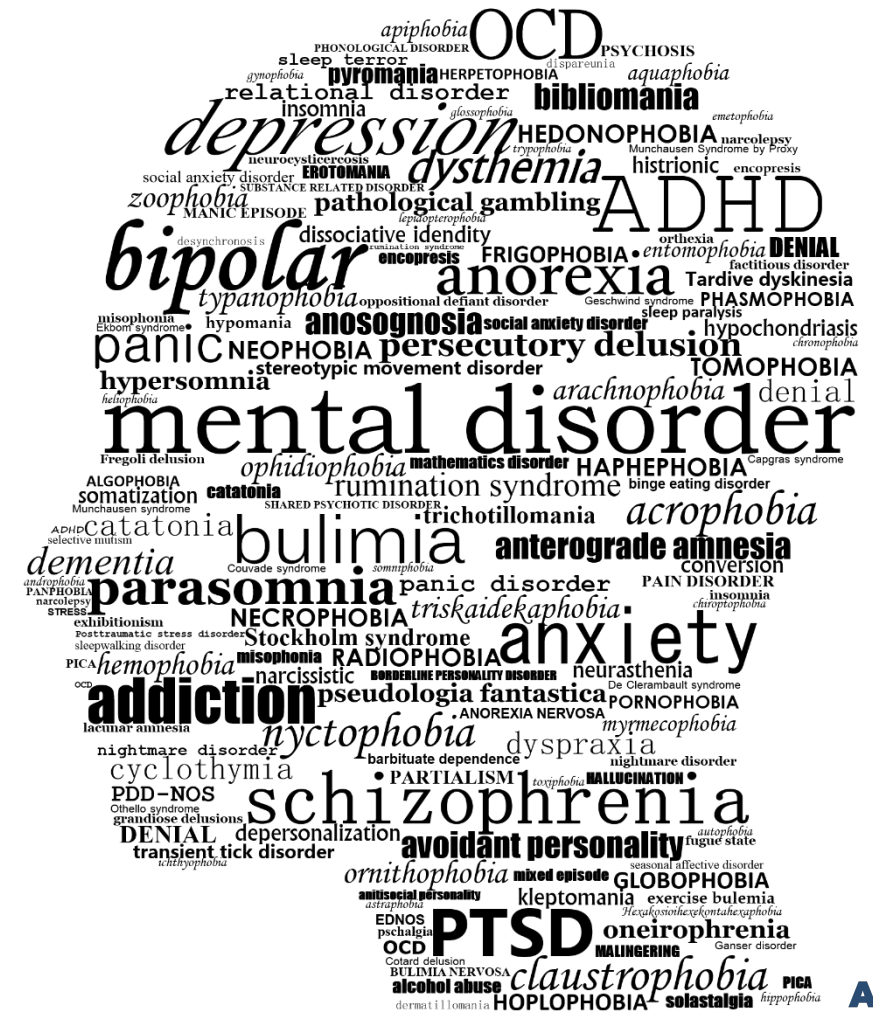
A Brief Screening Tool for Opioid Use Disorder: EMPOWER Study Expert Consensus Protocol

Dokyoung S. You¹, Aram S. Mardian^{2,3}, Beth D. Darnall¹, Chwen-Yuen A. Chen⁴, Korina De Bruyne⁵, Pamela D. Flood¹, Ming-Chih Kao¹, Anita D. Karnik⁶, Jennifer McNeely⁷, Joel G. Porter⁸, Robert P. Schwartz⁹, Richard L. Stieg^{10†} and Sean C. Mackey^{1*}



Responsibility	Percentage
Current government	45%
Previous government	35%
Global economic factors	20%

-
- | Responsibility | Percentage |
|-------------------------|------------|
| Current government | 45% |
| Previous government | 35% |
| Global economic factors | 20% |



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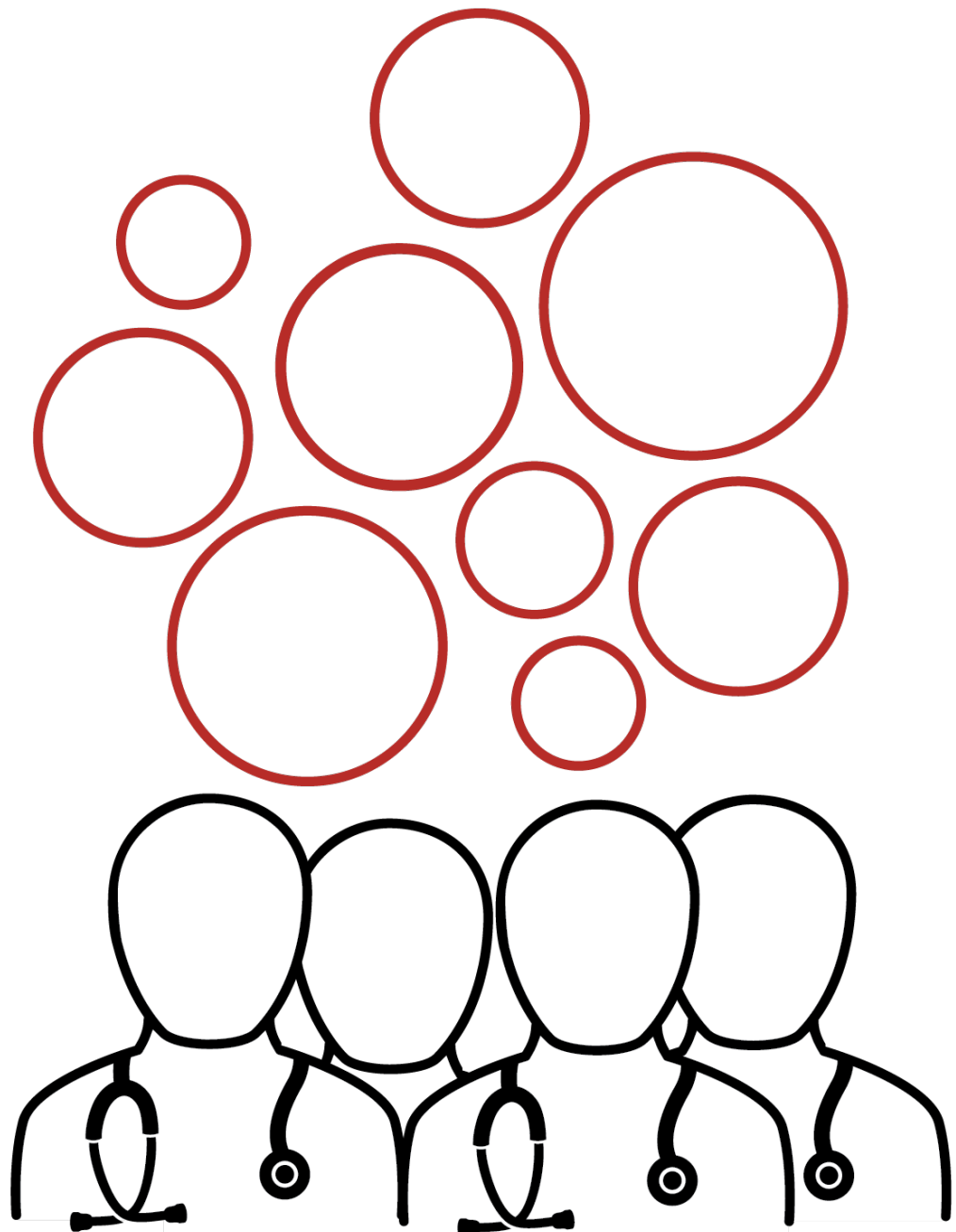
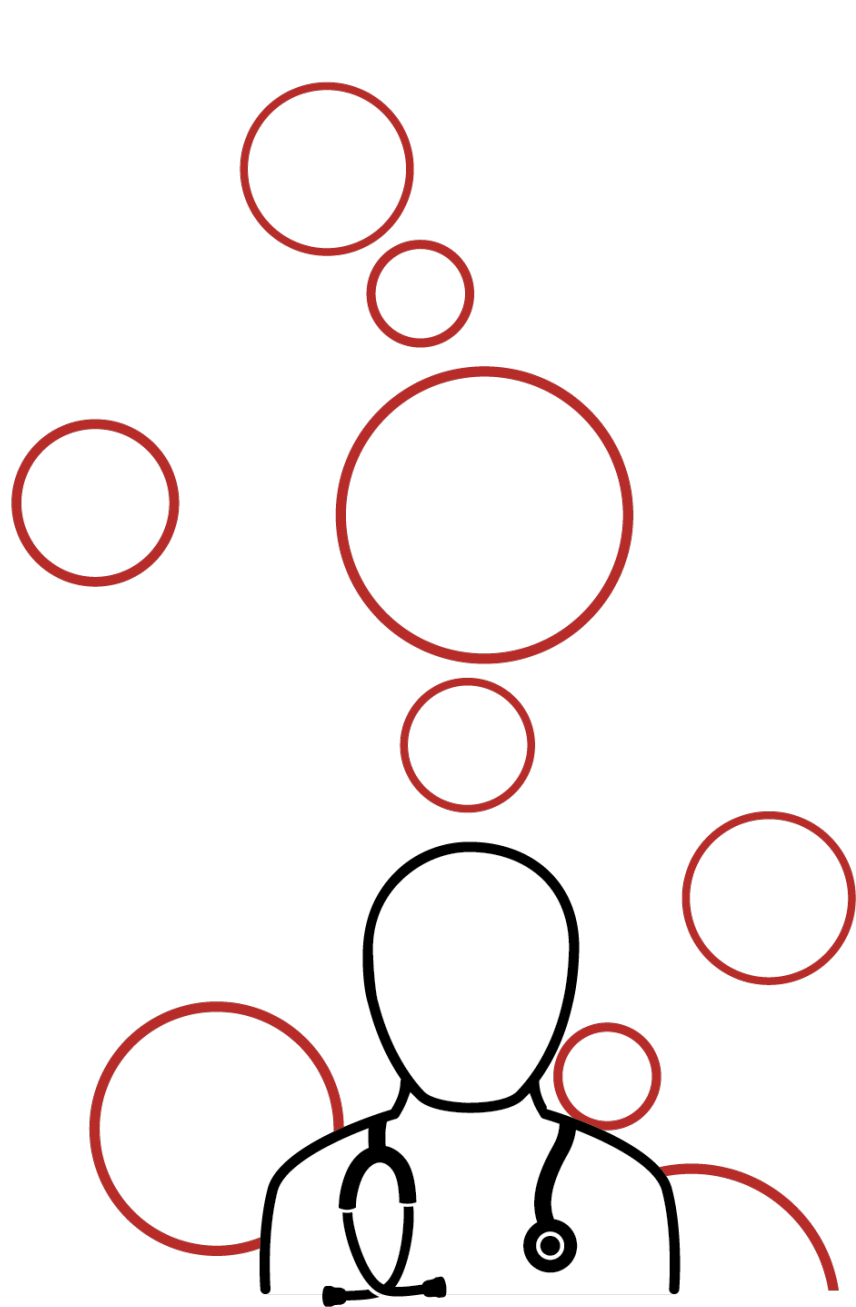
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SHIFT FROM

Management of Chronic Pain and Addiction occurs within siloed disciplines.

TO

Management of Chronic Pain and Addiction is provided in a collaborative, team-based approach.



Who do I add to my team?

- Movement specialist
 - Physical therapist
 - Yoga, tai chi, core strengthening, any movement the patient enjoys
- Behavioral Medicine Specialist
 - Psychologist, Master's level therapist
- Addiction Specialist
 - Addiction Medicine or Addiction Psychiatry
 - Provider with X waiver

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Expectations and Fears

- Enhance positive expectations
 - “Studies show and my experience is that if we partner together on this, reduce slowly, and add in other treatments to improve your health, you will feel better on lower doses or off opioids and your pain levels will be about the same as they are now or a little better overall.”
- Validate anxiety/fears
 - “I would be surprised if you didn’t have some anxiety about lowering your opioid dose.”
 - “Our goal is that we reduce so slowly that your body isn’t even aware of the changes. If you do have any symptoms, they should be mild and we can always slow down the pace.”
- Commit to working together and individualizing the plan
 - “I will work with you through the entire process and we have multiple options to address any bumps in the road that may occur as we work together”

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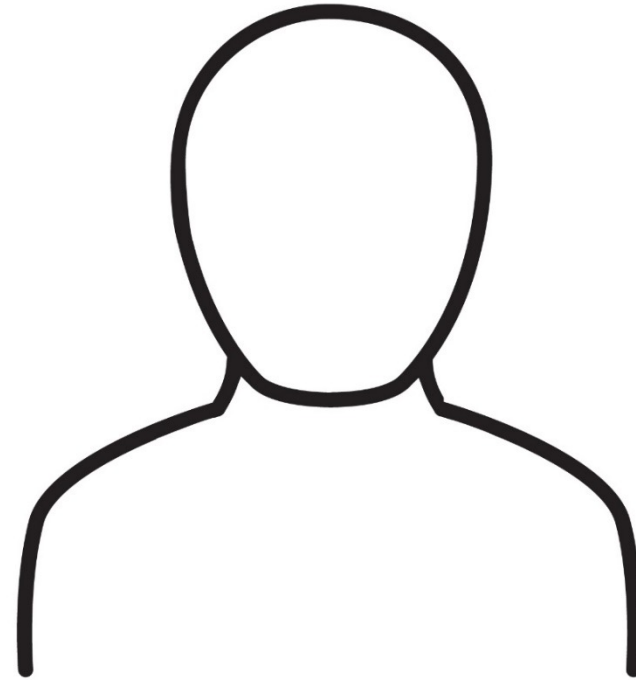
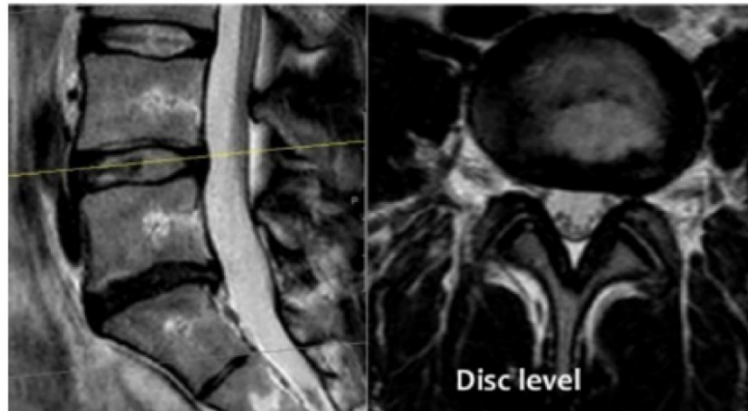
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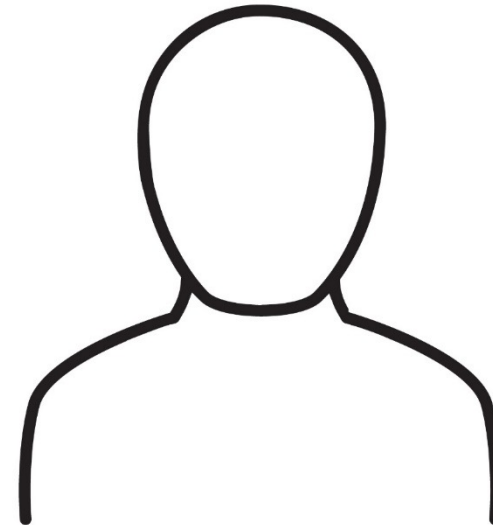
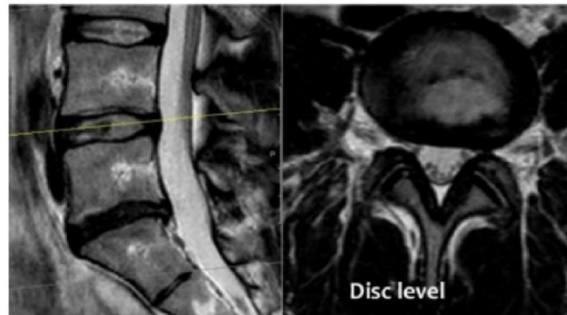
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THE ARIZONA PAIN AND ADDICTION CURRICULUM



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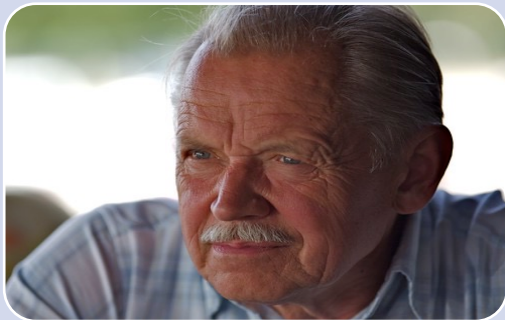
Paradox of Change

Engagement in Prescription Opioid Tapering Research: the EMPOWER Study and a Coproduction Model of Success

Aram Mardian, MD¹, Luzmercy Perez, BA², Ting Pun, PhD³, Matthias Cheung, PhD, RPh⁴, Joel Porter, MD⁵, Korina De Bruyne, MD⁶, Ming-Chih Kao, PhD, MD⁷, Pamela Flood, MD⁷, Nathaniel Moore, MD⁸, Luana Colloca, MD^{9,10}, Eric Cramer, MS², Claire E. Ashton-James, PhD¹¹, Kate Lorig, DrPH¹², Sean C. Mackey, MD, PhD⁷, and Beth D. Darnall, PhD² 



Patients



No control,
No Voice,
Pain will
increase

Clinicians



Unsure about
tapering
process,
patients
overwhelming

Clinician/Patient Relationship



Mutual
distrust,
Imbalanced
Decision
Making

Assess Risk vs. Benefit





**Risk vs.
Benefit**

**Current Level
of Function**

**Risk vs.
Risk**

Weighing Risks



Patient outcomes after opioid dose reduction among patients with chronic opioid therapy

Sara E. Hallvik^{a,*}, Sanae El Ibrahim^{a,b}, Kirbee Johnston^c, Jonah Geddes^c, Gillian Leichtling^a, P. Todd Korthuis^d, Daniel M. Hartung^c

Abstract

The net effects of prescribing initiatives that encourage dose reductions are uncertain. We examined whether rapid dose reduction after high-dose chronic opioid therapy (COT) associates with suicide, overdose, or other opioid-related adverse events. This retrospective cohort study included Oregon Medicaid recipients with high-dose COT. Claims were linked with prescription data from the prescription drug monitoring program and death data from vital statistics, 2014 to 2017. Participants were placed into 4 mutually exclusive dose trajectory groups after the high-dose COT period, and Cox proportional hazard models were used to examine the effect of dose changes on patient outcomes in the following year. Of the 14,596 high-dose COT patients, 4191 (28.7%) abruptly discontinued opioid prescriptions, 1648 (11.3%) reduced opioid dose before discontinuing, 6480 (44.4%) had a dose reduction but never discontinued, and 2277 (15.6%) had a stable or increasing dose. Discontinuation, whether abrupt (adjusted hazard ratio [aHR] 3.63; 95% confidence interval [CI] 1.42-9.25) or with dose reduction (aHR 4.47, 95% CI 1.68-11.88) significantly increased risk of suicide compared with those with stable or increasing dose. By contrast, discontinuation or dose reduction reduced the risk of overdose compared with those with a stable or increasing dose (aHR 0.36–0.62, 95% CI 0.20-0.94). Patients with an abrupt discontinuation were more likely to overdose on heroin (vs. prescription opioids) than patients in other groups ($P < 0.0001$). Our study suggests that patients on COT require careful risk assessment and supportive interventions when considering opioid discontinuation or continuation at a high dose.

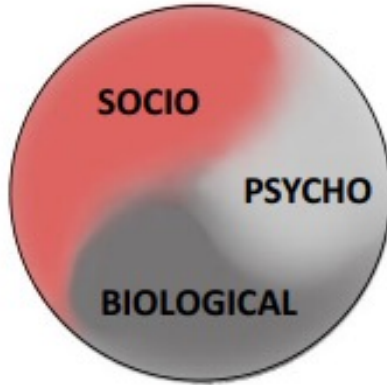
Keywords: Opioids, Opioid dose reduction, Opioid discontinuation, Suicide, Overdose, Opioid adverse events

Discontinuation:

↑ Risk of suicide

↓ Risk of overdose

Universal Risk Mitigation Strategies



Arizona State Board of Pharmacy
Controlled Substances Prescription Monitoring Program



Treatment Agreement +
Informed Consent

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Person centered


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Partner with patient and other disciplines

Power of the Pause

Paradox of Change

Engagement in Prescription Opioid Tapering Research: the EMPOWER Study and a Coproduction Model of Success

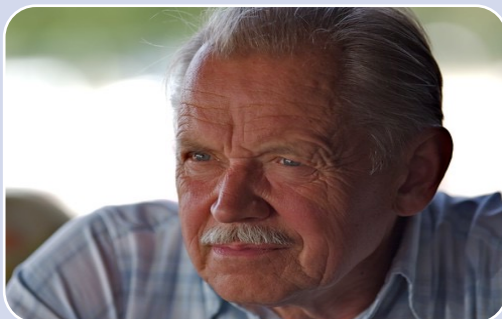
Aram Mardian, MD¹, Luzmercy Perez, BA², Ting Pun, PhD³, Matthias Cheung, PhD, RPh⁴,
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EMPOWER Study

Effective Management of Pain and Opioid-Free Ways to Enhance Relief

Patients



No control,
No Voice,
Pain will
increase

Clinicians



Unsure about
tapering
process,
patients
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Clinician/Patient Relationship



Mutual
distrust,
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Power of the Pause

Paradox of Change

-
- Anxiety/Irritability
 - Sleep Disturbance
 - Cravings
 - Unable to adhere to prescription
 - Suicidal ideation
 - Seeking illicit opioids





Power of the Pause

When there is diagnostic or therapeutic **uncertainty** and **NO** imminent risks

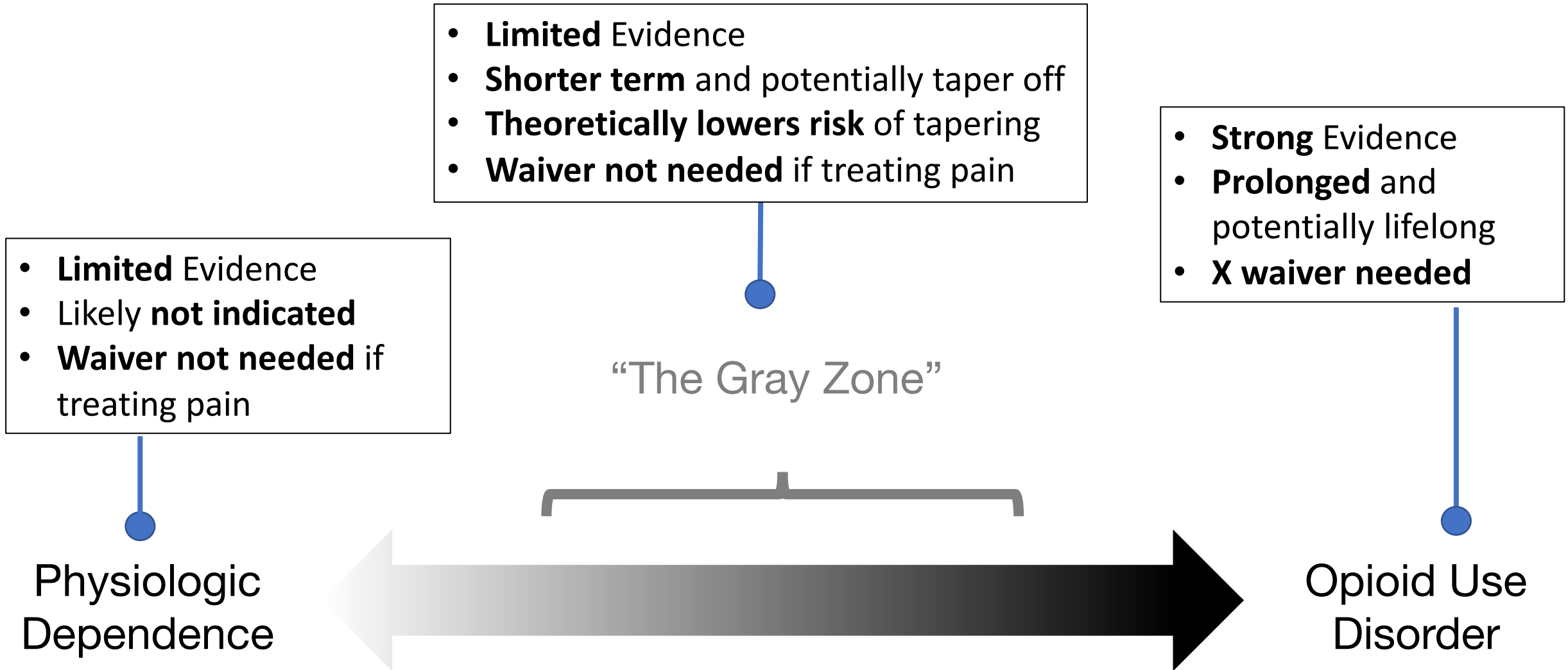
Err on the side of allowing additional time



Power of the Pause

- Allows time to **enhance buy-in**
- Allows time to **build team-based support**
- Allows time for **neurobiological changes** of opioids to adjust
- Allows time for patient to **improve self-regulation skills**
- Builds in space to **consider alternate treatment pathways**

Use of buprenorphine with the opioid exposed patient



and Practical Approach

Addiction Medicine

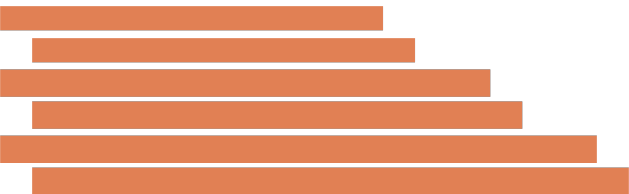
2021 Epub

Alyssa M. Peckham, PharmD, BCPP, Jeanette M. Tetrault, MD, and Kenneth L. Morford, MD

[illegible]

What is
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Michelle?

- 1) Tell Michelle that **you don't treat chronic pain** and she will need to find a different doctor
- 2) Tell Michelle you will take over opioid prescribing at 10mg TID and **taper her off over the next 2-3 months**
- 3) Screen for OUD and Assess for Risks and Benefits of LTOT**



Treatment Planning

- OUD screen
- Assess risks Vs benefit
- Learn about Michelle's overall health goals
- Partner with Michelle and other disciplines
- Discussed plan to take over prescribing at a dose between current dose and prior dose, hold dose for 1-2 months and the proceed with gradual taper
 - Collaborative decision to **prescribe oxycodone 20mg TID for 1-2 months**
 - Proceed with **2.5mg/d reductions every 1-2 month**

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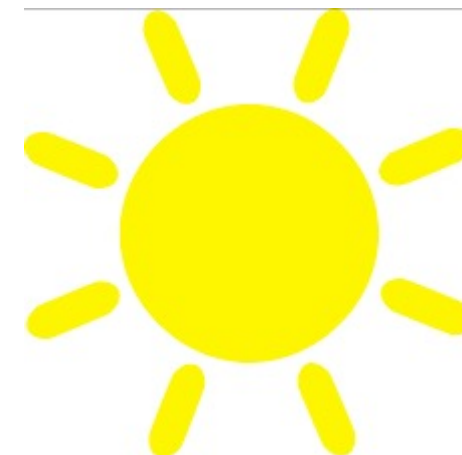
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