Safe Prescribing Action Group:

The Art and (very little) Science of Tapering Opioid Medications

CALIFORNIA HEALTHCARE FOUNDATION

California Improvement Network

Better Ideas for Care Delivery

Agenda

- Housekeeping & Accreditation
- The Art and (very little) Science of Tapering Opioid Medications
- Progress and bright spots
- Planning for March 24, in-person convening

Faculty

Andrea Rubinstein, MD
Kaiser Santa Rosa Medical Center
Chief, Department of Chronic Pain
Department of Anesthesiology
Local Research Chair - Santa Rosa
Assistant Clinical Professor of Family and Community Medicine UCSF

Housekeeping

- This session will be recorded
- Slides and recording will be posted on action group website (Basecamp) within a week
- To ask a question:
  - Logistical questions: Use CHAT to the Host
  - Questions for Speakers : Use CHAT to ALL
- Webinar Evaluation: please take a moment at the end of the webinar to give feedback

Accreditation Information

Physicians

Boston University School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Boston University School of Medicine designates this live activity for a maximum of ***1.5 AMA PRA Category 1 Credits™***. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Target audience: Residency Programs Across California

- **Educational Objectives:**
  - Identify situations when tapering is appropriate
  - Learn to design most appropriate type of taper for particular patients
  - Gain skills at trouble shooting taper problems to avoid derailing

FOR CME CREDIT: Complete evaluation

Faculty

CME Course Director: Daniel Alford, MD, MPH, FACP, FASAM

- Dr. Alford has nothing to disclose with regard to commercial interests.

Andrea Rubinstein, MD

- Dr. Rubinstein has nothing to disclose with regard to commercial interests. She does not plan on discussing unlabeled/investigational uses of a commercial product.

The Art and (very Little) Science of Tapering Opioid Medications

Who, Why, When and How

Andrea Rubinstein, MD
Chief, Department of Chronic Pain
Santa Rosa

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Objectives

- Identify situations when tapering is appropriate
- Learn to design most appropriate type of taper for particular patients
- Gain skills at trouble shooting taper problems to avoid derailing

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Disclosure

All persons involved with the planning and presenting of this activity have not had any financial relationships in the past 12 months with any commercial interest or any proprietary entity producing health care goods or services that is relevant to this CME activity.

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THE Soapbox
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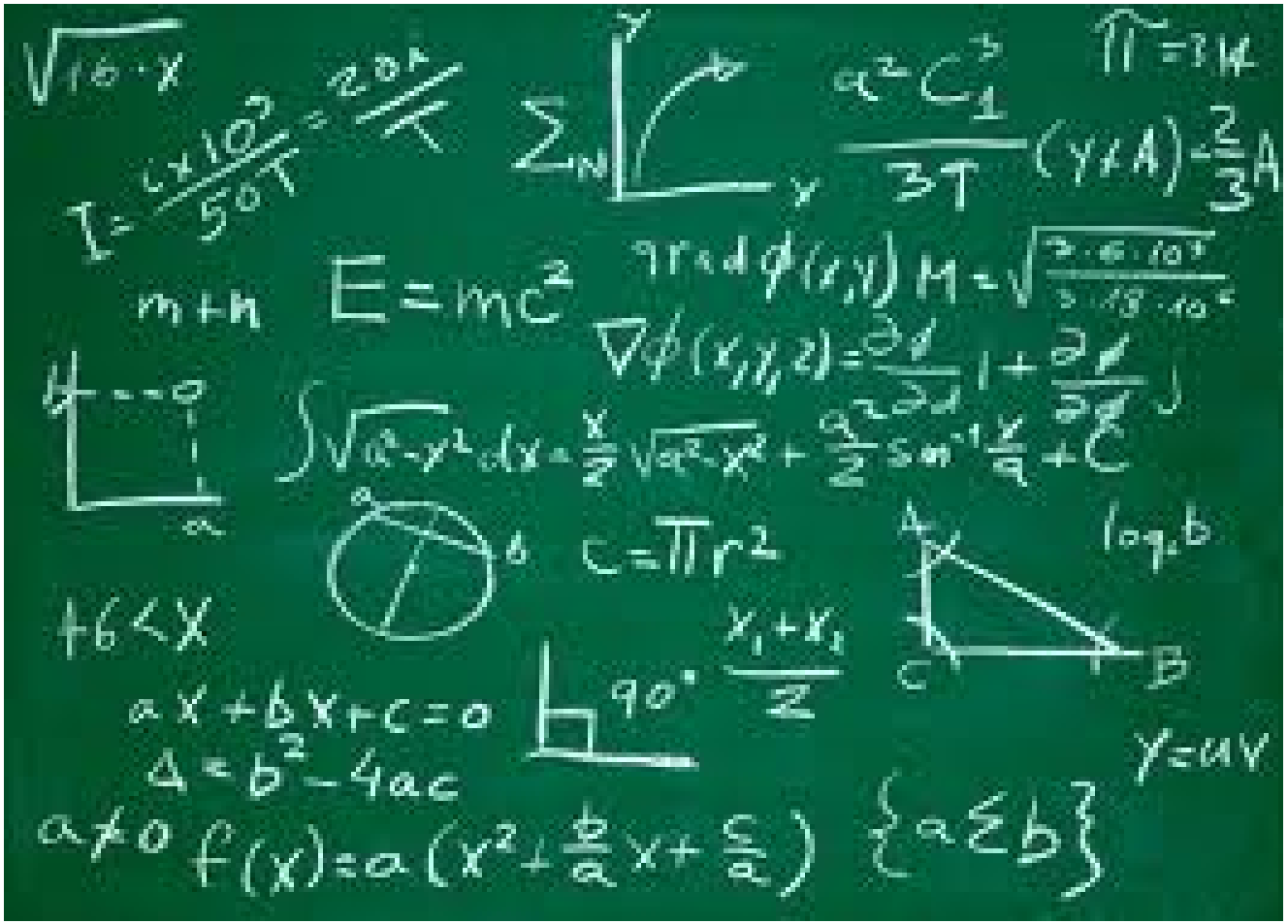
SOAPBOX SOX

Warning



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Survey #1

I believe opioids are safe and effective in selected patients when used long-term

A. True

B. False

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Survey #2

How confident are you that you could create and execute a taper plan for a patient on opioids?

A. Very confident

B. Somewhat confident

C. Not confident

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What is an Opioid Taper?

A opioid taper is a progressive decrease in the amount of opioid taken

with a goal of leading to reduced risk and or opportunity for greater overall quality of life

for the patient.

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The Bottom Line:

Do not start a medication you do not know how to stop.

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When to Taper

When what the drug is doing TO the patient is more than what the drug is doing FOR the patient.

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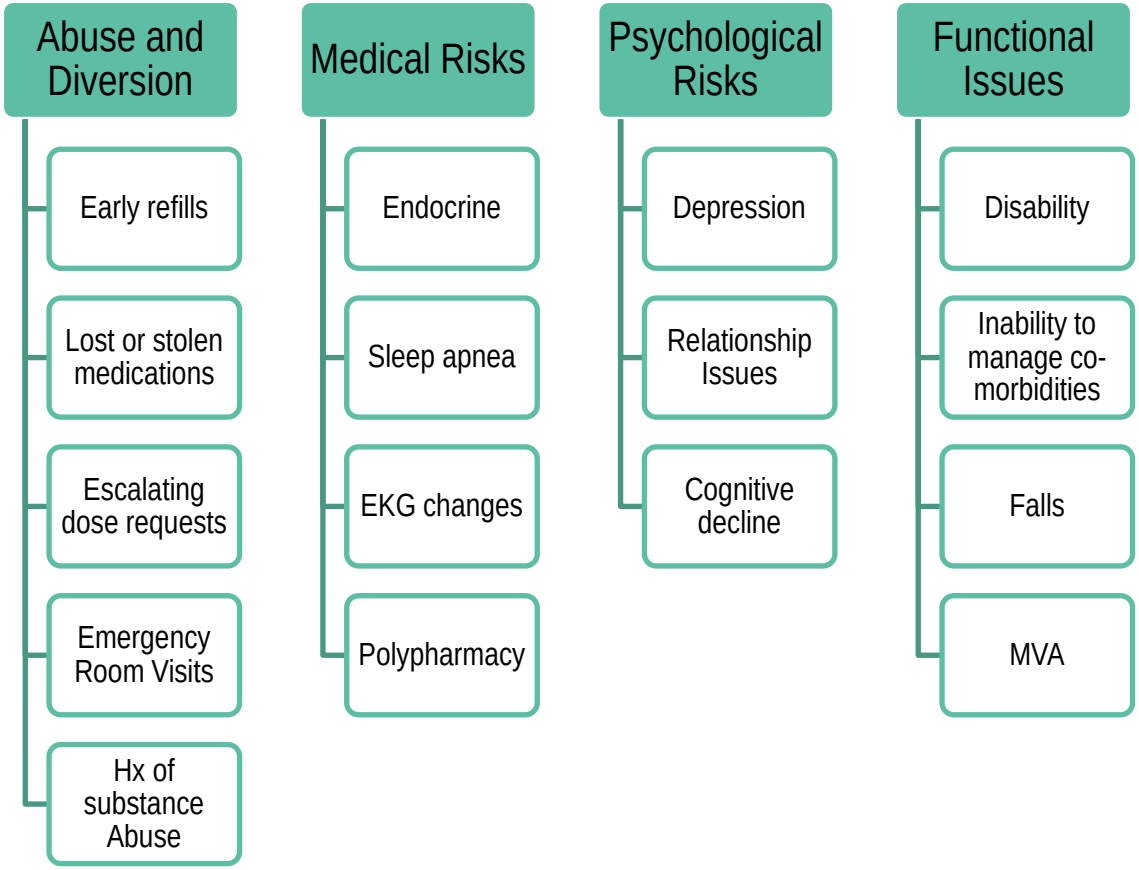
Identifying Clinical Risk of Opioid Use



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Who to Consider for Taper

- Motivated patients
- Young patients
- Patients who say “it’s not working” or “it takes the edge off”
- Patients with diagnosable hyperalgesia
- Patients with declining function despite opioids
- Patients on opioids and complex polypharmacy
- Patients whose underlying pain issue may have resolved

Who not to taper

- Addicted patients
- Palliative care patients
- Psychiatrically fragile or unstable patients
- Pregnant patients

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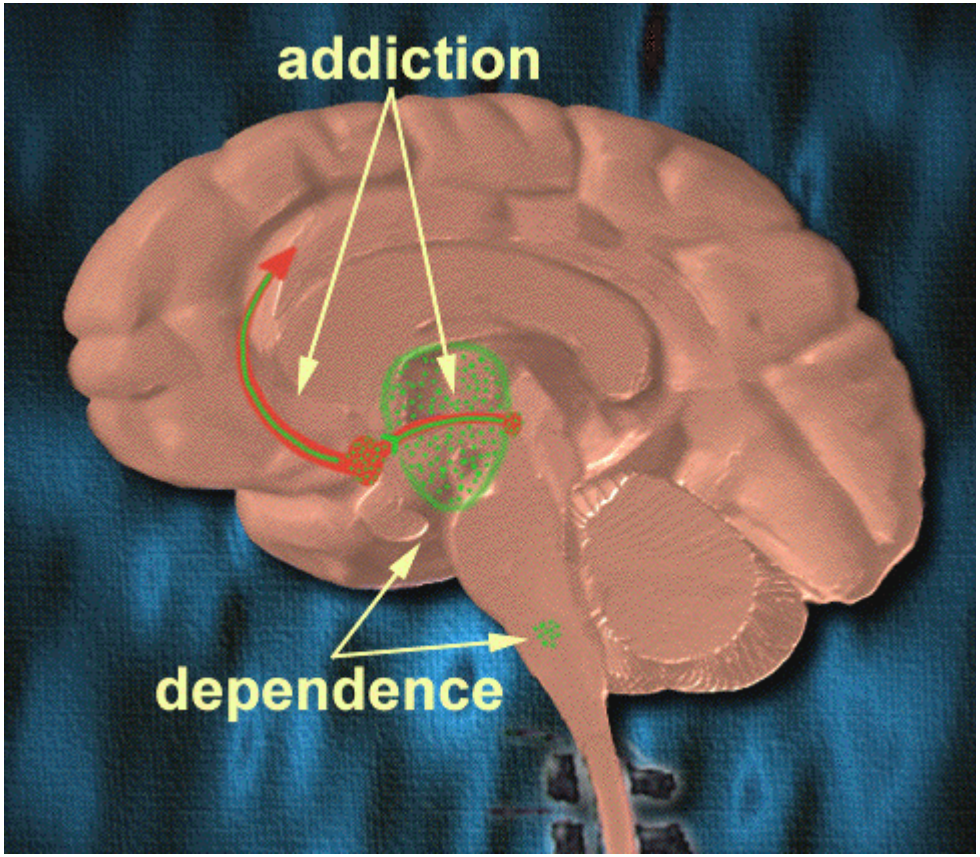
Digression: Dependence vs. Addiction



National Institute of Drug Abuse 2007

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Reasons NOT to not taper

- “It takes the edge off….”
- “I have more pain when I skip a dose so I know it is doing something…”
- “I tried to stop before and my pain got out of control”
- “It is the only thing that lets me work 16 hours per day”
- “I cant figure skate competitively without this”

Opioids are not performance enhancing drugs

And avoidance of withdrawal is not a reason to remain on opioids long-term

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Survey #3

- Titrating opioid doses up over time to compensate for tolerance can be a successful long-term strategy for helping chronic pain patients manage their pain
  A. Agree
  B. Disagree

Types of Tapers

- Physician Directed Taper
- Patient Directed Taper
- Rapid Taper
- Group Taper
- Inpatient Taper

Rules of Thumb for Tapering

1. The longer on opioids the slower you go
2. Medications not used daily can be stopped without a taper
3. Use only one “small currency “ opioid
4. Down is easier than off
5. Rule of thirds
6. Most patients tolerate 10% reductions
7. Virtually no one tolerates 25% reductions well
8. Going slowly is always better than stopping or giving up
9. The best taper is the one that works
10. Once off, many patients return to opioid use within a few years

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Case #1: Complex Comorbidities vs. Iatrogenesis Multiforme

- 55 year old man new to KPNC with axial low back pain since 1980's.
- S/P anterior fusion with prosthetic disk 2002, 2006. Constant low back pain without radiation.
- New chest wall pain since falling off the toilet. Difficulty urinating, permanently disabled.

Past Medical History:

- 9 knee surgeries
- Hx of melanoma 1991
- Hx of interstitial nephritis requiring dialysis
- Hx of alcohol abuse, in AA since 1983
- Hx. of abusing: carbisoprodol, diazepam, codeine, oxycodone

Medications

Medication Detail

	Quantity	Refills
METHADONE 10 MG ORAL TAB **(Discontinued)**	1800	0/0

Sig : Take 15 tablets orally 4 times a day
Route: Oral
Reason for Discontinue: Continue Therapy
Class: Fill Now
Order #: 135085156

2 Years Ago: methadone 40 mg QID

400% increase in 2 years

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Digression #1: Opioids and Low Back Pain

No evidence of efficacy for opioid medication for axial low back pain past 16 weeks

Axial low back pain is one of the most difficult to treat pain conditions and *rarely if ever* responds to pharmacotherapy

Comorbidities:

Hypertension – hydrocholothiazide, metoprolol

Hyperlipidemia – on simvistatin

Depression – on citalopram 60 mg PHQ9=19

No libido and poor sexual function

Sleep apnea (refusing CPAP)

Bladder outlet problem – on tamsulosin

Chronic nausea – on promethazine

History of melanoma and interstitial nephritis

Case 1: The Physical Exam

- Alert, oriented and appropriate
- Pale, puffy, slightly feminized features
- Overweight
- Walks with a cane
- Some allodynia generally to light touch
- Examination maneuvers painful
- Exquisitely tender along mid axillary line
- Extreme de-conditioning

The “B.E.S.T” Workup

- Bone Density
- EKG
- Sleep study
- Testosterone, total AM

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The Workup:

469	Qtc
41	Total Testosterone
75	SpO2
-2.4	T score

Digression: QT prolongation

Center for Substance Abuse Treatment Consensus Panel Recommendations:

- Inform patient of risk
- Clinical history
  - structural heart disease, arrhythmia, and syncope
- Obtain EKG
  - Pretreatment
  - After 30 days
  - Annually
- More frequent EKG
  - Dose > 100 mg daily
  - unexplained syncope or seizure
- *QTc>450 and < 500*
  - More frequent EKG
  - Risks vs. benefits
- *QTc> 500*
  - Discontinuation ?
  - Contributing factors?
  - Alternative?
- *Be aware of interactions*
  - SSRI
  - antibiotics
  - Psychotropics
  - antiemetics

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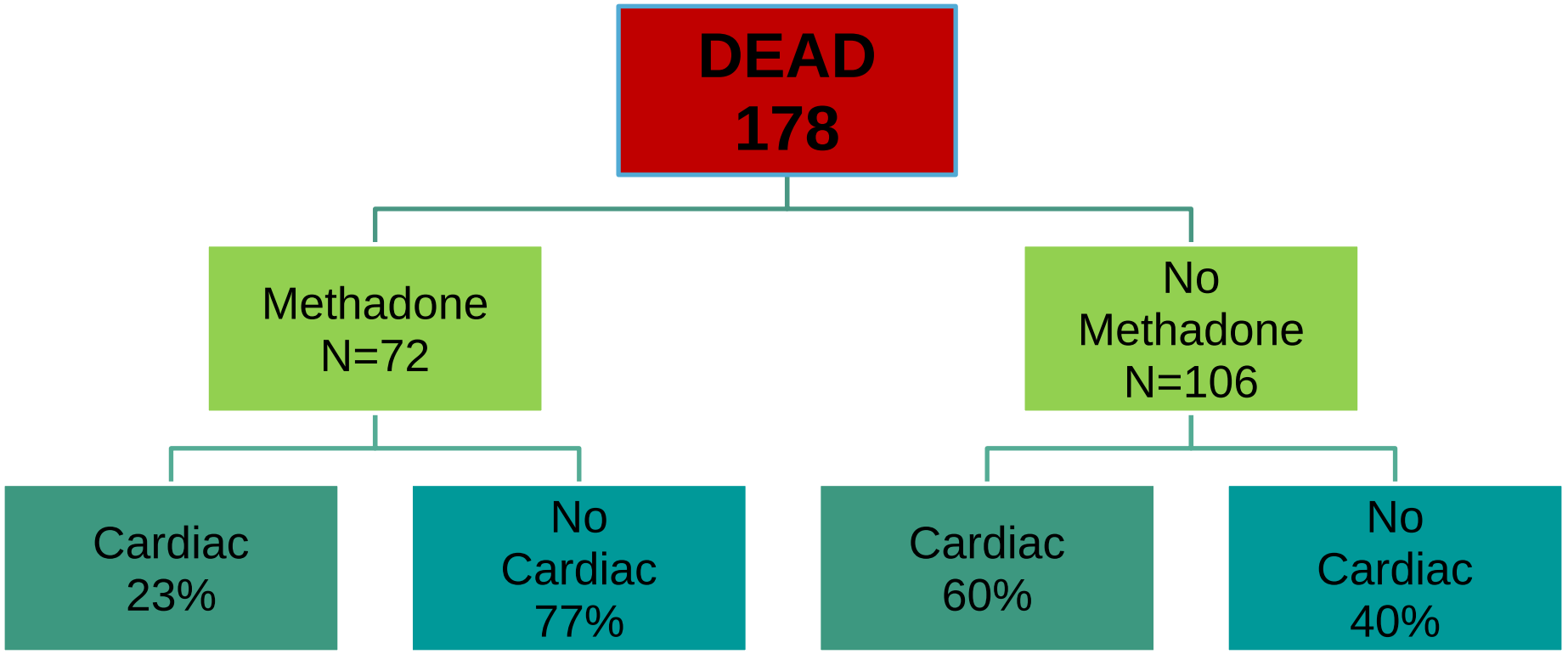
Sudden Cardiac Death and Methadone



Chugh SS, et.al. *A community-based evaluation of sudden death associated with therapeutic levels of methadone*. Am J Med 2008

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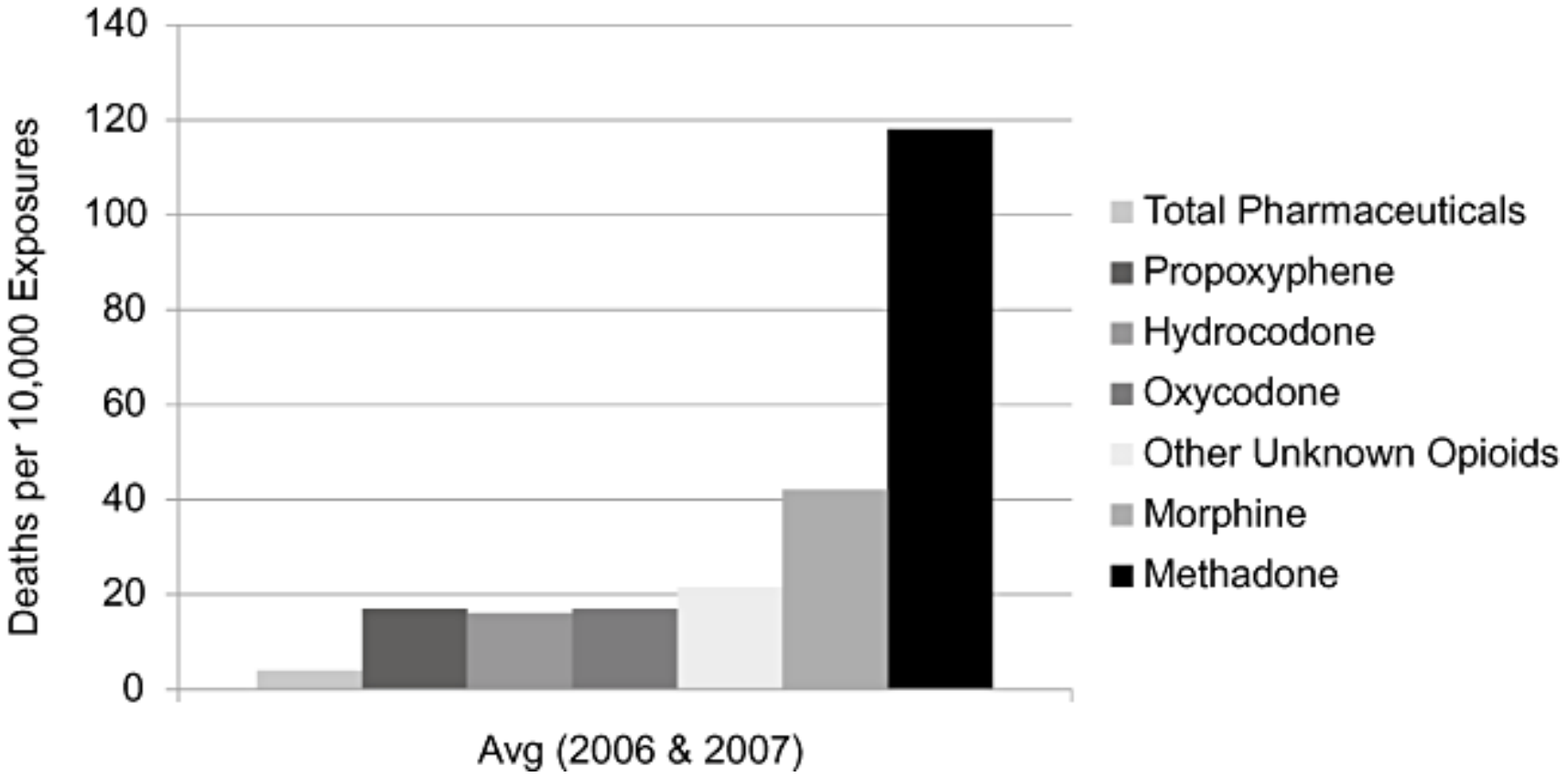
An Analysis of the Root Causes for Opioid-Related Deaths the United States



Pain Medicine
pages S26-S35, 13 JUN 2011 DOI: 10.1111/j.1526-4637.2011.01134.x
http://onlinelibrary.wiley.com/enhanced/doi/10.1111/j.1526-4637.2011.01134.x/

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Androgen Deficiency

- Common
- Quick
- Profound
- Reversible (usually)

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THE AMERICAN JOURNAL of MEDICINE®

Elucidating Risk Factors for Androgen Deficiency Associated with Daily Opioid Use

Andrea Rubinstein, MD,[a] Diane M. Carpenter, MPH[b]

[a]Kaiser Permanente Medical Group, Santa Rosa, Calif; [b]Kaiser Permanente Division of Research, Oakland, Calif.

	Odds Ratio	Confidence Interval
Duration of Action		
long vs. short	5.78	2.44 -13.67
Dose		
10 mg short	1.24	1.07 -1.44
10 mg long	1.02	1.00 -1.03
Age	1.01	0.99 – 1.04

Adjusted Odds Ratios for Androgen Deficiency in Patients with BMI <30, No Diabetes, No Hypertension, and No Hyperlipidemia

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Does Opioid Use for Pain management Warrant Routine Bone Density Screening in Men?

Testosterone Range	Normal	Osteopenic	Osteoporotic	Total
hypogonadal	11(50%)	9 (41%)	2 (9%)	22 (27%)
Non-hypogonadal	34(58%)	20 (34%)	5 (8%)	59 (73%)
total	45(56%)	29 (36%)	7 (8%)	81 (100%)

Fortin JD et. al. Pain Physician 2008; 11:4: 539-541

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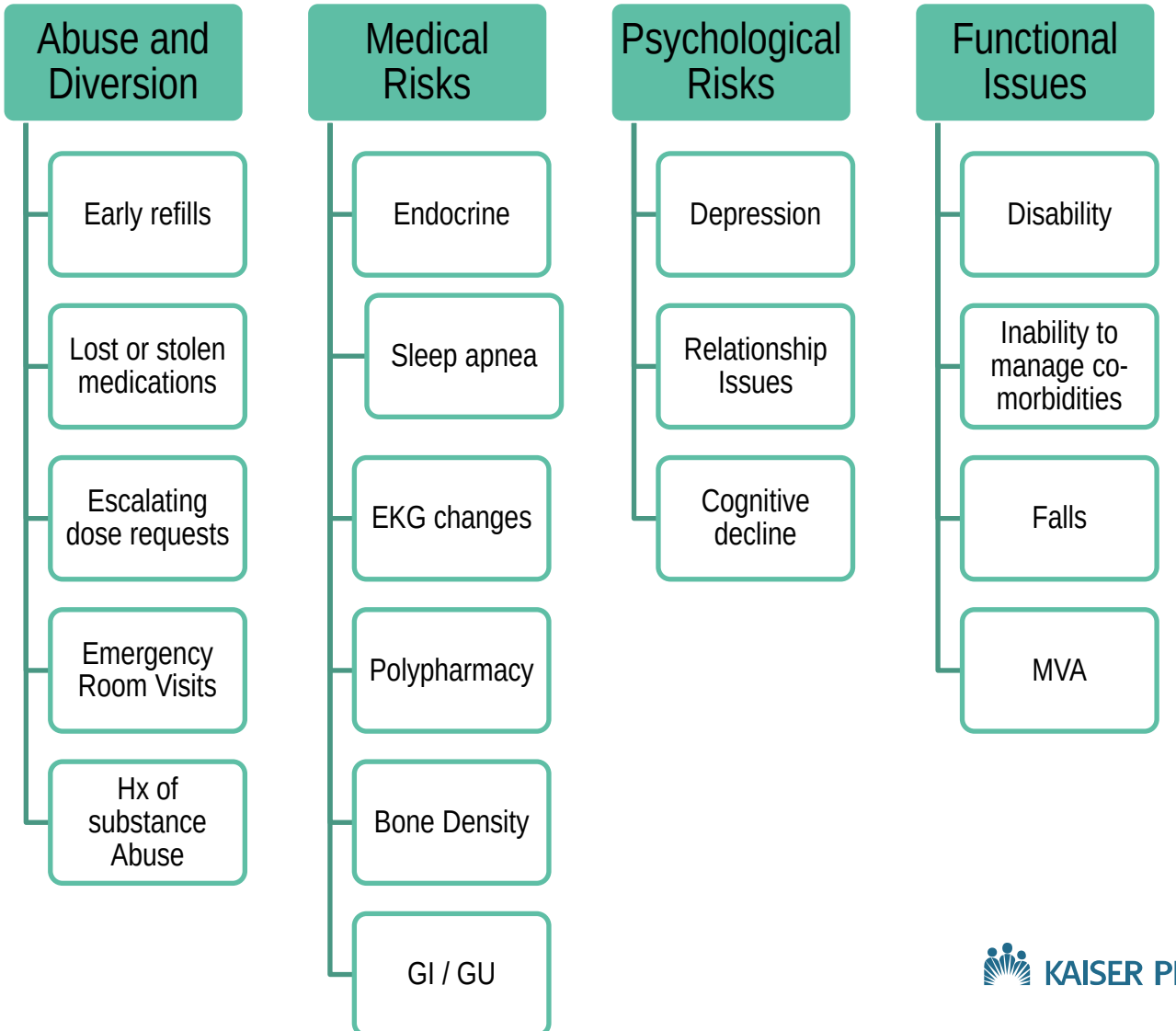
Risk Benefit Analysis



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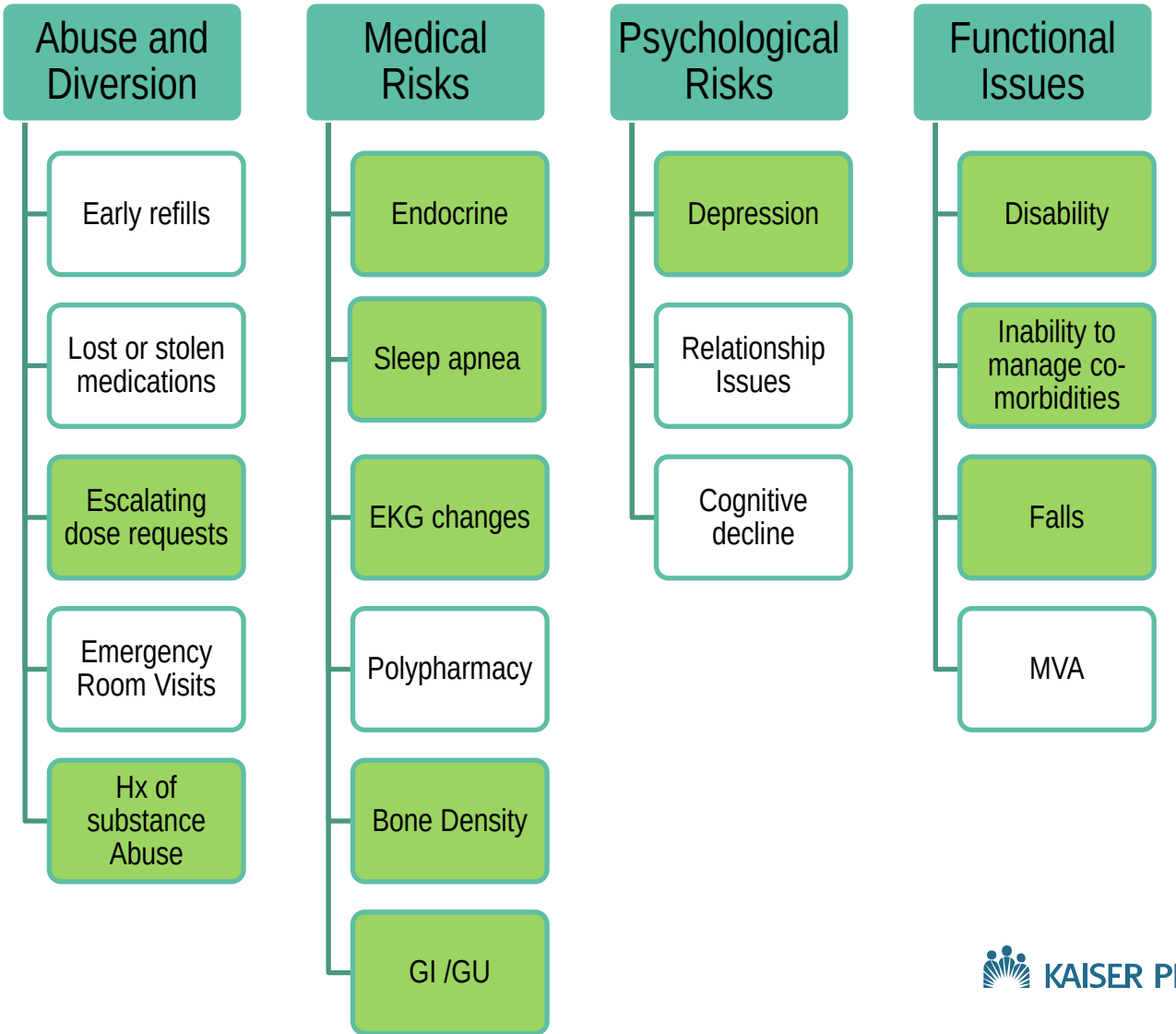
Risk Benefit Analysis



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And of Course…

Patient Expectations of Pain Relief with Opioids (20 women and 27 men)

Domain (PCOQ)	Patients Criteria (mean)	Reduction obtained	T	Cohen's d
Pain	50.91	11.93	10.89	3.21
Emotional distress	34.62	-0.43	8.25	2.44
Fatigue	40.62	3.89	10.25	3.02
Interference	49.34	10.04	8.91	2.63

Pain Res. 2012; 5: 15–22.

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Taper?
Don’t Taper?

STEP 1: The Buy in

- Forwarn
- Option to return
- Reassure
- Educate and Encourage
- Support
- Treatment Plan in Writing

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Physician Directed Taper

Name: SS

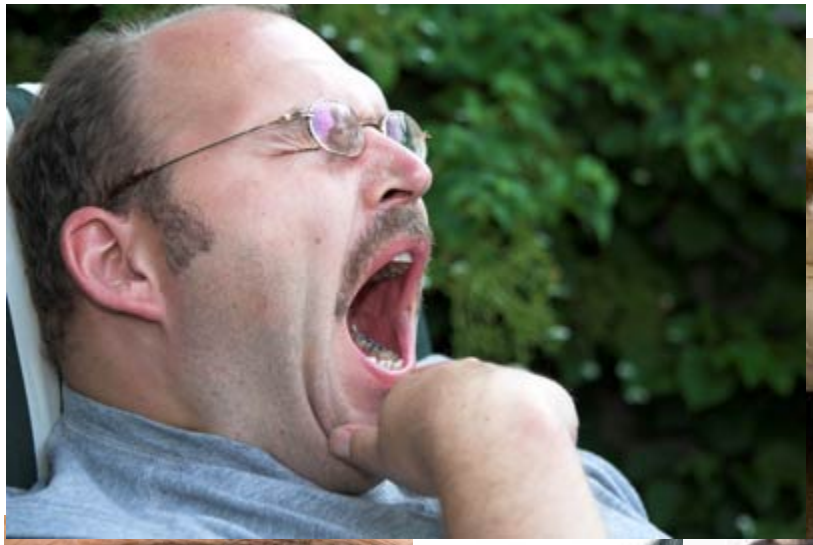
DRUG TO TAPER	PILLS SIZE	dosage	# TIMES DAILY	TOTAL DAILY DOSE
MORPHINE	30	8	4	960
	15			

GOAL DOSE	INTERVAL	start date	% reduction min	% reduction maximum
100	1	5/3/2013	5	15

Friday MORPHINE Taper Schedule for SS

date	% drop	Daily mg	#/DAY	# RX	mg change
5/3/2013	5	900.0	30.0	210	60.00
5/10/2013	5	855.0	28.5	200	45.00
5/17/2013	5	810.0	27.0	189	45.00
5/24/2013	6	765.0	25.5	179	45.00
5/31/2013	6	720.0	24.0	168	45.00
6/7/2013	6	675.0	22.5	158	45.00
6/14/2013	7	630.0	21.0	147	45.00
6/21/2013	7	585.0	19.5	137	45.00
6/28/2013	8	540.0	18.0	126	45.00
7/5/2013	8	495.0	16.5	116	45.00
7/12/2013	9	450.0	15.0	105	45.00
7/19/2013	10	405.0	13.5	95	45.00
7/26/2013	11	360	12.0	84	45.00
8/2/2013	13	315	10.5	74	45.00
8/9/2013	14	270	9.0	63	45.00
8/16/2013	6	255	8.5	60	15.00
8/23/2013	6	240	8.0	56	15.00
8/30/2013	6	225	7.5	53	15.00
9/6/2013	7	210	7.0	49	15.00
9/13/2013	7	195	6.5	46	15.00
9/20/2013	8	180	6.0	42	15.00
9/27/2013	8	165	5.5	39	15.00
10/4/2013	9	150	5.0	35	15.00
10/11/2013	10	135	4.5	32	15.00
10/18/2013	11	120	4.0	28	15.00
10/25/2013	13	105	3.5	25	15.00
11/1/2013	14	90	3.0	21	15.00
11/8/2013	17	75	2.5	18	15.00

Withdrawal



Troubleshooting the Taper

- Reassure Reassure Reassure
- Adjuvant medications
  - Clonidine
    - 0.1-0.2 mg BID or TID
  - Immodium
  - Benzodiazepines only at the last 7 days
- Hold or slow the taper at 1/3s
- Watch the clock
- The lower the dose the slower you go
- PAWS

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Buprenorphine

- *If a physician prescribes, dispenses or administers buprenorphine (Suboxone®/Subutex®) for the treatment of pain or for any other reason, a DEA registration is required because both products are Schedule III controlled substances. The DATA waiver specifically authorizes qualified practitioners to treat narcotic dependent patients, using FDA approved Schedule III-V narcotic controlled substances for maintenance and detoxification. The DATA waives the requirement for obtaining a separate DEA registration as a narcotic treatment program for physicians using the approved drugs for maintenance and* detoxification; however, it does not apply to physicians using Suboxone® or Subutex® for the treatment of pain. A physician using Suboxone® or Subutex® for the treatment of pain would be required to register with DEA as practitioner with Schedule III privileges.

Sincerely, Patricia M. Good, Chief, Liaison and Policy Section, Office of Diversion Control, Drug Enforcement Administration,
U.S. Department of Justice

http://www.helpmegetoffdrugs.com/wst_page9.html

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Case 2

- 58 y.o. woman with chronic pain on opioids. First evaluated in Pain clinic in 2011. She says she has had chronic pain since the age of 2 and estimates she has been on opioids for more than half her life. She states she has had 13 concussions, the first at age 2 and the most recent 3 months ago.
- She is the caregiver for her grown daughter who was sexually assaulted and now requires round the clock care.
- Pain is 10/10 now, though she looks comfortable and goes as high as 15-20/10

- Her sleep is described as good, sleeping from 11 p.m. to 9 or 10 a.m. with a 2-hour nap during the day. No history of sleep apnea. Bowel function described as normal. Mood is described as good. Memory is described as very good though she admits it used to be better.
- PHYSICAL EXAMINATION:
  She is well groomed but with somewhat pressured speech rambling and unfocused when answering questions. She arrived 40 minutes late for our appointment because she got lost. Cranial nerves II-X appear intact but she's extraordinarily sensitive to even light pressure on her scalp. Sensory and motor appear to be intact.

- Current Medications:
  - Lorazepam 8 mg daily
  - Oxycodone-IR 30 mg 8 tablets 5 times daily
  - Fentanyl Patch 250 mcg/hr
  - Pseudoephedrine 30 mg tablets, two tablets three times a day.
  - Bupropion 300 mg XL

Opioid Escalation

- 2005
  - Oxycodone IR 80 mg /day
- 2008
  - Oxycodone 960 mg per day
  - Fentanyl 250 mcg/hr
  - Lorazepam 1 mg per day
- 2009
  - Lorazepam 2 mg per day
- 2010
  - Lorazepam 4 mg per day
- 2011
  - Lorazepam 8 mg per day
  - Oxycodone 1200 mg per day
  - Fentanyl 250 mcg

Total morphine equivalent:
2300 mg/day

Total diazepam equivalent:
40 mg/day

Taper recommended

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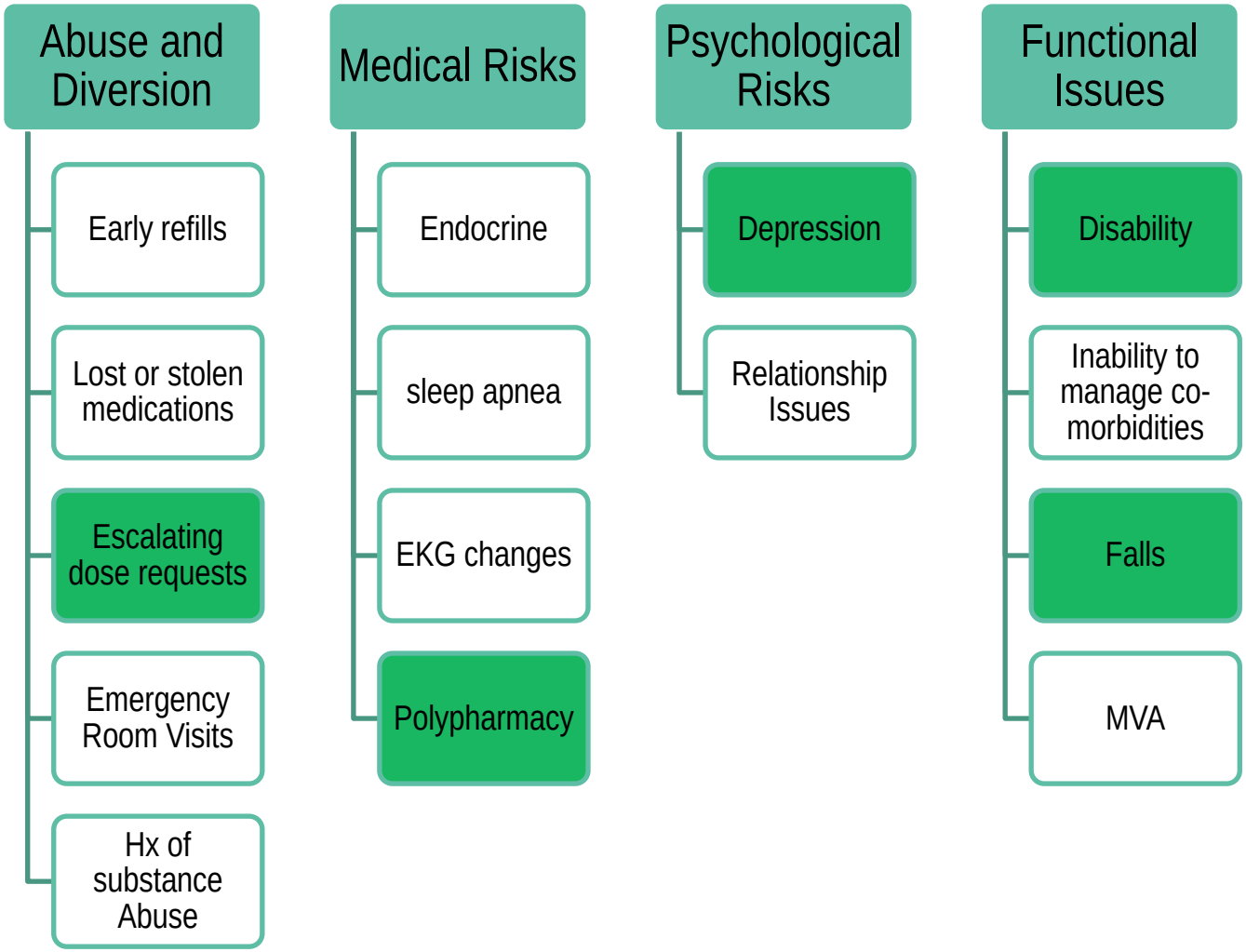
2014

- Pharmacy calls that patient is claiming pharmacists are writing secret messages on her pill bottle and calling her an addict and laughing at her behind her back
- Patient re-evaluated
  - Lorazepam now 20 mg per day
  - Oxycodone now 1560 mg per day
  - Fentanyl 250 mcg/hr

Identifying Clinical Risk of Opioid Use



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Patient does not want to taper

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Taper schedule

Name:

DRUG TO TAPER	PILLS SIZE	dosage	# TIMES DAILY	TOTAL DAILY DOSE
OXYCODONE	30	10	5	1500
	7.5			

GOAL DOSE	INTERVAL	start date	% reduction min	% reduction maxin
0	1	9/12/2014	10	20

Friday OXYCODONE Taper Schedule for

date	% drop	Daily mg	#/DAY	# RX	mg change
9/12/2014	10	1350.0	45.0	315	150.00
9/19/2014	10	1215.0	40.5	284	135.00
9/26/2014	11	1080.0	36.0	252	135.00
10/3/2014	13	945.0	31.5	221	135.00
10/10/2014	14	810.0	27.0	189	135.00
10/17/2014	17	675.0	22.5	158	135.00
10/24/2014	10	607.5	20.3	142	67.50
10/31/2014	11	540.0	18.0	126	67.50
11/7/2014	13	472.5	15.8	111	67.50
11/14/2014	14	405.0	13.5	95	67.50
11/21/2014	17	337.5	11.3	79	67.50
11/28/2014	11	300.0	10.0	70	37.50
12/5/2014	13	263	8.8	62	38.00
12/12/2014	14	225	7.5	53	38.00
12/19/2014	17	188	6.3	44	38.00
12/26/2014	12	165	5.5	39	23.00
1/2/2015	14	143	4.8	34	23.00
1/9/2015	16	120	4.0	28	23.00
1/16/2015	19	98	3.3	23	23.00
1/23/2015	15	83	2.8	20	15.00
1/30/2015	18	68	2.3	16	15.00
2/6/2015	11	60	2.0	14	8.00
2/13/2015	13	53	1.8	13	8.00
2/20/2015	14	45	1.5	11	8.00
2/27/2015	17	38	1.3	9	8.00
3/6/2015	20	30	1.0	7	8.00
3/13/2015	25	23	0.8	6	8.00
3/20/2015	33	15	0.5	4	8.00

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December 2015

- Pain is the same 10/10 though patient claims she is completely non-functional but still cares for her daughter appears well groomed and dressed. Arrives on time to pick up medications monthly.

Lorazepam 6 mg per day

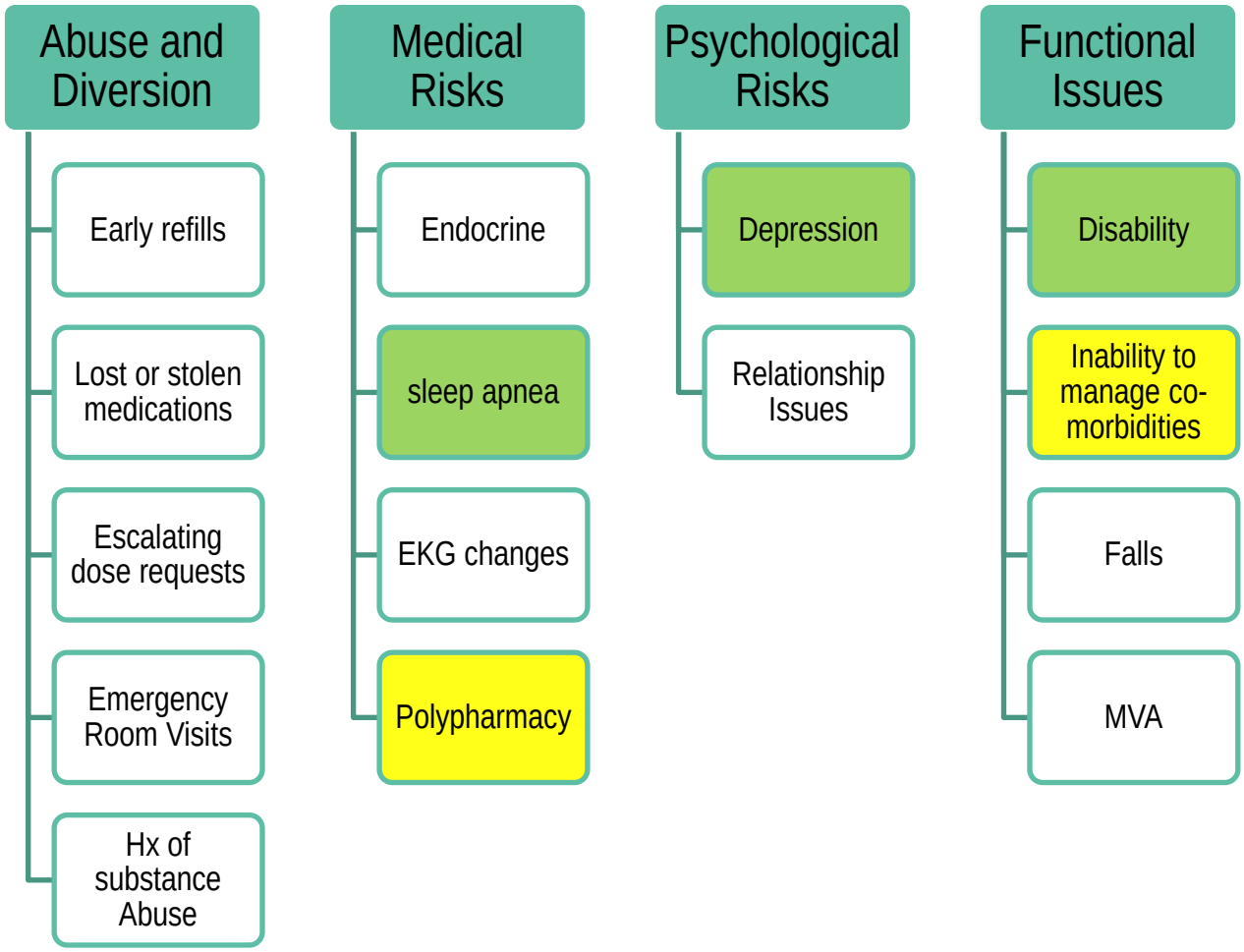
Oxycodone 270 mg per day

Fentanyl 250 mcg/hr

Case 3

- BL is 64 y.o. morbidly obese woman with axial low back pain. Pain is worse with exercise, walking, standing and lying down.
  Alleviating Factors: “Pain is better with meds.”
- Uses Norco 10/325 4 tablets daily
- Also uses alprazolam daily 0.5 mg
- Dose is stable and modestly effective
- Depressed with daily crying
- Very limited function even before opioid usage due to weight. Requires a walker to walk.
- DOES NOT WANT TO TAPER

Identifying Clinical Risk of Opioid Use



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Taper?

Don’t Taper?

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Our Plan:

- Sleep Apnea: CPAP titration to good effect
- Weight loss plan to reduce risk
  - Weighs in before picking up her prescription
  - Weight must be less than preceding month

Case 2

Monthly weigh ins:

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Opioid dose the same, Patient is Better

- > 10% of her body weight (38 lbs.) lost in 9 months.
  - Reducing diabetes risk > 58%
  - Reduced risk of hypertension
  - Reduced load on knees may be 4 x weight loss

    Messier SP, et. al Weight loss reduces knee-joint loads in overweight and obese older adults with knee osteoarthritis. Arthritis Rheum. 2005 Jul;52(7):2026-32
  - Mood is 100% better
- Can walk better
- Offered her the option to return to her PCP for ongoing opioid but she chooses to stay with me even though she must continue to weigh in.

Summary:

- Received bilateral hip replacements at 250#
- Self discontinued all opioids

"I have a whole new life. I am not going to stop losing weight until I weigh less than 200 lbs.

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Summary

- The goal is to make the patient better
- Risk benefit assessment
- Design appropriate taper type
- Modify the taper as appropriate
- Goal is not always off
- Sometimes opioids are not the biggest problem

How confident are you that you could create and execute a taper plan for a patient on opioids?

A. Very confident

B. Somewhat confident

C. Not confident

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Bright Spots – Opioid Review Committees

Chronic Opiate Review and Evaluation Committee (CORE) Referral Form

Patient Initials:_____ MRN:_____ DOB:_____

PCP:_____ Date of Referral _____

What is your reason for referral?

_____

_____

Aberrant medication related behaviors

Please list any aberrant medication related behaviors.
See back of referral sheet for examples.

_____

_____

Latest urine drug screening: _____, Were results congruent with prescribed medication? □Yes □No
Latest Patient Drug Monitoring Program report: _____. Were results congruent with prescribed medication? □Yes □No
History of prior incongruous urine drug screens or abnormal PDMP activity? □Yes □No
Naloxone prescription written for? □Yes □No
ICD10 XXXXXX assigned to chart for CORE registry? □Yes □No

Risk Factors for Opioid Abuse/Diversion/Overdose

	Yes	No	Unknown
History of substance abuse/addiction, including nicotine and alcohol			
Family history of substance abuse/addiction			
ADHD, ADD, PTSD, Schizophrenia, Bipolar disorder, OCD			
Depression			
History of over sedation with medication			
History of overdose			
History of physical or sexual abuse			

Pain Management History

Diagnosis/cause of pain: _____

(Required) Current medication list, especially opioids, up to date in EMR? ☐Yes ☐No

Has pain improved with opioid therapy? ☐Yes ☐No ☐Unknown
Please explain:_____

Has function improved with opioid therapy? ☐Yes ☐No ☐Unknown
Please explain:_____

Has quality of life improved with opioid therapy? ☐Yes ☐No ☐Unknown
Please explain:_____

What non-opioid approaches to pain has the patient tried (eg. medications, PT, injections, massage, counterstrain, pain group, psychotherapy, surgery)? _____

_____

_____

Chronic Opiate Review and Evaluation Committee (CORE) Recommendations Form

Patient Initials:_____ MRN:_____ DOB: _____ PCP: _____
Date of Referral: _____ Date Sent to Reviewer: _____ Reviewer: _____
Committee Review Date: _____ Date Sent to PCP: _____

Completed	Recommended	
Medications		
		Opioids:
		Muscle relaxants:
		SSRI:
		SNRI:
		TCA:
		AEDs/Lyrica:
		Topicals:
		Immune modulators:
Procedures		
		Joint Injection
		Trigger point injection
		Ice/Heat
		Neurosurgery referral for epidural injection
		Referral to Pain management for local block or pump
		TENS/PENS
Complementary and Alternative Medicine		
		Massage
		Counter-strain
		Chiropractic
		OMM
		Yoga
		Tai Chi
		Acupuncture
		Anti-inflammatory eating pattern
		Herbs or supplements
		Meditation
		Gratitude journal
Referrals		
		Rheumatology:
		Pain Medicine (Required if on >100 mg morphine equivalent for non-cancer pain):
		Physical Therapy:
		Orthopedics:
		Neurosurgery:
		Psychiatry:
		Imaging:
Safe Prescribing		
		Taper medications:
		Methadone clinic referral
		Buprenorphine referral
		Withdrawal symptom pack: Clonidine 0.1 mg BID PRN malaise/anxiety; Loperamide PRN Diarrhea; Ondansetron 4mg q8 PRN nausea; Trazadone 50mg qHS PRN insomnia.

Gearing up for March 24 Convening

- Help shape the agenda http://goo.gl/forms/g38uYcPHXs
  - Non-opioid pain management strategies
  - PT/OT approaches
  - How to avoid new starts
  - Other topics…

- Each residency program will have an opportunity to share (5m)
  - Pecha Kucha - show 15 images, each for 20 seconds. The images advance automatically and you talk along to the images.
  - Share your successes (5 images), challenges (5 images), and lessons learned (5 images), with colleagues.
  - http://www.pechakucha.org/

Residency Action Group 2015-16 Calendar

	July	August	September	October	November	December	January	February	March
Webinars 90 min	7/22 12pm	8/28 12pm Password: chcf Code: 668 818 809	9/8 12:30pm Password: chcf Code: 668 610 299		11/9 12pm Password: chcf Code: 661 331 076	12/14 12pm Password: chcf Code: 665 897 286	1/11 12pm Password: chcf Code: 663 298 057	2/8 12pm Password: chcf Code: 669 393 250	
In-person				10/1 9-5pm					3/24 9-5pm
Topics	Addiction and pain	QI and Change Mgmt	Behavioral Health	SCOPE, Team planning	Patient engagement, self-care, integrative medicine	Art and (very little) science of opioid tapering	Medication-assisted treatment	Interventional therapies	Harvest our learnings
Coaching	Monthly	Monthly	Monthly	Monthly	Monthly	Monthly	Monthly	Monthly	Monthly

California Improvement Network Better Ideas for Care Delivery

Please Fill Out the Evaluation (CME Credit)

http://goo.gl/forms/uL2Vbjt7Ig

Questions?

- Kristene Cristobal, coach and project manager

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- Kelly Pfeifer, MD, Project Lead

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