Opioid Tapers
Opportunities to Share and Learn

Palmer MacKie, MS MD

Oak Street Health

"Our prime purpose in this life is to help others. And if you can't help them, at least don't hurt them"

- Team Work- Not all on your shoulders
- Acknowledge the Pain & offer Hope
- Namaste
- Improved E^3
  - Evaluate, educate and engage
  - Safety and Efficacy concerns
- Replace opiocentric paradigm
- Focus on **Fun**ction
- Exercise compassion: mea culpa

Polyneuropathy

- N 2892 with polyneuropathy
  - 1464 treated with opioids < 90 days
  - 545 treated with opioids > 90 days
- Control 14435 with 780 on opioids > 90 days
- 82 % written by Int. Med and Fam. Med
- 52% for MSK pain and 24% for polyneuropathy
- > 90 day group 56% female and > co-morbidity
  - MI, CHF, PVD, CVA, *dementia*
  - DM, Renal Dz & *COPD*

No functional status markers were improved by long-term use of opioids

JAMANeurol.2017;74(7):773-779

Of all the remedies it has pleased almighty God to give man to relieve his suffering, none is so universal & so efficacious as opium

Measure	Adj. Odds Ratio
Require assist device	1.9
Trouble with ADL	1.7
No longer working	1.3
Depression	1.53
Opioid OD	5.12
Opioid Dependence	2.85
Continues with pain	2.5
Trouble bathing	1.6
Opioid Abuse	3.97

JAMANeurol.2017;74(7):773-779

Risk of SUD/Abuse

OR (adjusted) when exposed to:

122	**≥120 MED/day**
29	**36-120 MED/day**
15	**1-36 MED/day**
1	**no opioid Rx** (considered non-exposed)

Note: The risk of abusing drugs and developing a SUD dramatically increases with increasing morphine equivalent dose (MED) per day

Clin J Pain 2014; 30(7):557-564

Low Hanging Fruit?

- prevalence of opioid abuse in chronic pain patients ranges between 20-24% across health-care settings

  Pain 2010, 150(2):332–339

- Lifetime prevalence of DSM-V OUD those on chronic opioids
  - 9.7 % moderate & 3.5 % severe OUD
  - 13 % as minimum

    Substance Abuse and Rehabilitation 2015:6 83–91

Is Opioid Weaning Safe or Effective

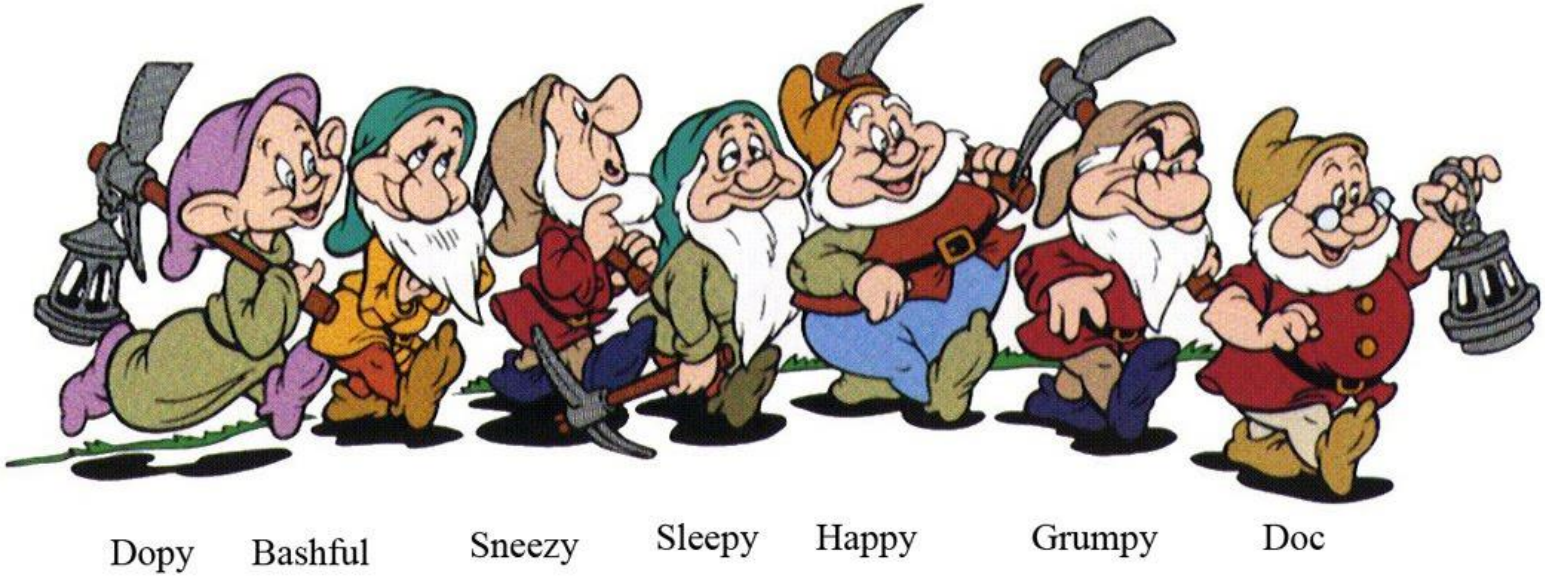
- 67 Studies evaluating LTOT tapering– limited by low-quality
- Weaning more effective if patient engaged, feels dignified and respected
- Dose reduction must be balanced with stability of pain/function, avoiding harm related to mental health or medical issues
- Common themes included team-work, emphasis on nonpharmacological intervention & self care strategies
- Findings suggest that pain, function, & quality of life may improve during and after opioid dose reduction

Ann Intern Med. 2017;167:181–191

Less Cane Do More

1. Opioid tapering for those on COT
   - Pain ↓ 24 %, average pain 7.1 to 5.4
   - Close to ½ returned to opioids but this did not result in lowering pain scores
2. Opioid taper to off
   - Reduced pain in all ages, ~ 20%
   - Accompanied by reductions in:
     - Depression and catastrophizing

Clin J Pain 2013;29(9):760-769
Pain Med 2010;11(9):1352-1364



Heigh-ho heigh-ho its off to Refill Status Quo

Enough is Enough
Opioids do Work For Some

Opioid SR and Benzodiazepines

1. greater pain, pain interference with life, and lower feelings of self-efficacy with respect to their pain
2. being prescribed "higher risk" (>200 MED)
3. antidepressant and/or antipsychotic medications
4. substance use (including more illicit and injection drug use, alcohol use disorder, and daily nicotine use)
5. greater mental health comorbidity and Health Costs

Pain Medicine 2015; 16: 356–366

Decisions, Effects & Perceptions

- I've not gone to work and don't even go out. I don't go out with my husband. I don't go out with my daughter. I don't go out with anybody… My **life** is pretty much at a **standstill**. (HQ)

- I can't do the things that I used to do and it kind of makes you ***feel like you can't do anything***… You have to depend on people to do stuff for you because, like I said, I can't even walk from here to the bus stop. (MN)

- (Pain) **affects** your **relationships** because it **affects your attitude**. Sometimes, somebody might want to talk to you or whatever and you are in pain and you don't mean to be mean and rude or not responsive.

BMJ Open 2017;0:e015083. doi:10.1136/bmjopen-2016-015083

The capacity for *hope* is the most significant fact of life. It provides human beings with a sense of destination and the energy to get started.

Norman Cousins

Anatomy of an Illness

Experiences Eskenazi Health's FQHC Primary Care with Indiana Opioid Statutes

- The new Indiana rules have been associated with decrease in the volume of prescribed opioids; the impact of the policy, however, differs by ***gender***, ***age*** and ***payer types***.
  - BMC Health Services Research Open (2018)18;29
    - Men> women, young> old, CAID/CARE > Private Insurance
  - *Addict Behav* 2010;35:1001–7
  - *Acad Emerg Med* 2014;21:1493–8.

1. Living with chronic pain is disruptive
2. New Laws and Guidelines are disruptive
3. Patient-Provider relationship Disrupted
   - Power shift toward provider
   - Disenfranchisement

BMJ Open 2017;0:e015083. doi:10.1136/bmjopen-2016-015083

No Magic Bullet

Truth should not be Punitive

"I'm not gonna pull the rug out from under you": Pt-provider communication about opioid tapering

4 major themes from these conversations:

1.Explaining — patients needed to understand *individualized* reasons for tapering in addition to general, population-level concerns

2.Negotiating — patients needed to have input, even if it was just related to the rate of tapering

3.Managing difficult conversations — when patients and providers failed to reach a shared understanding, difficulties and misunderstandings arose

4.Non-abandonment — patients needed to know their providers would not abandon them throughout the tapering process.

Journal of Pain 2017;18(11):1365

Therapeutic Weans

- Weans work and are possible
- In general
  - Safe w/ improved function
  - w/o increase in pain
- Dropout rates can be significant
- Educate and fill the empty space
- Personalize: Reason and Process
- Pre-treat/co-treat psych. confounders
- Be deliberate, compassionate, SLOW

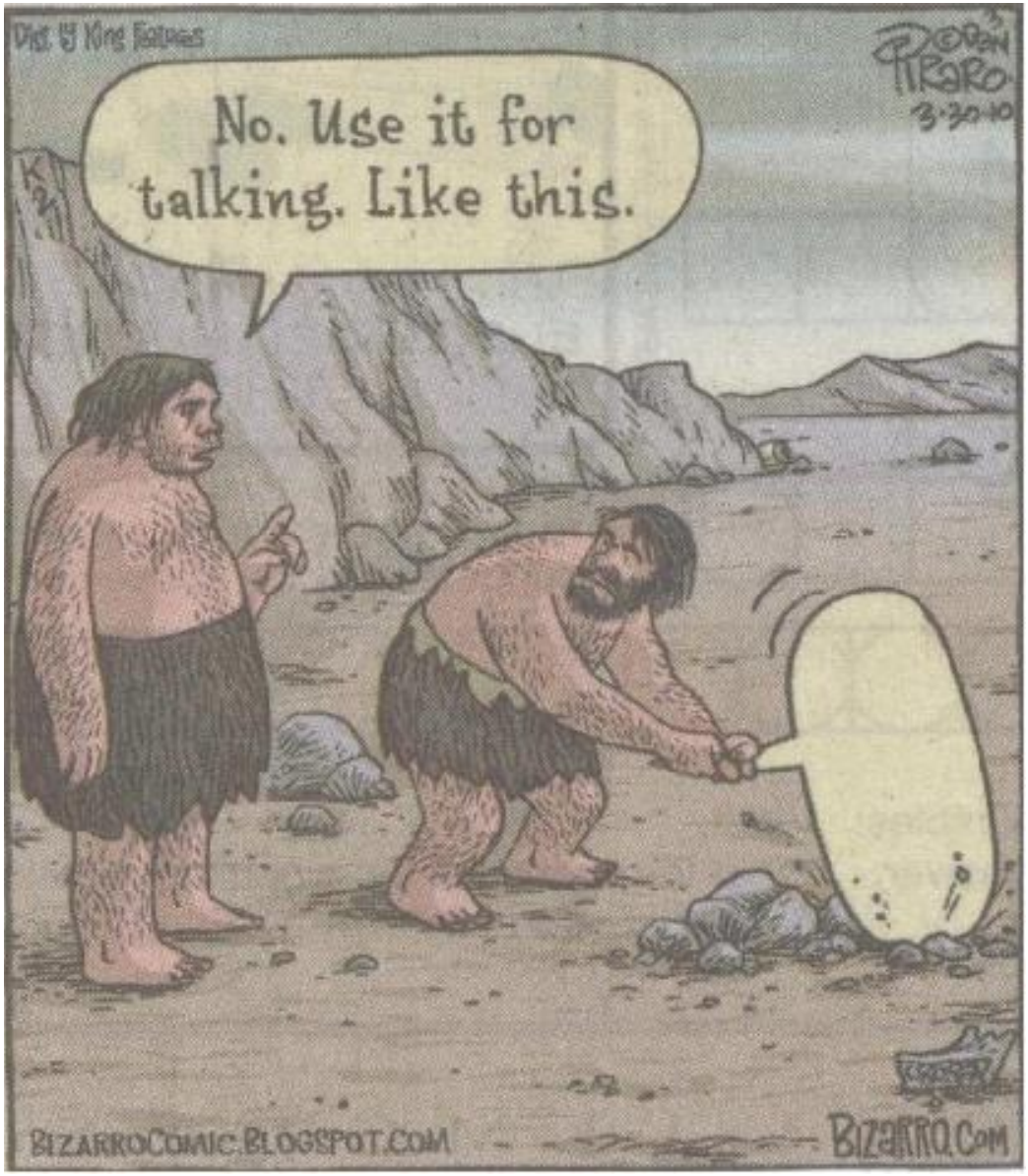
No Magic Bullet

Truth should not be Punitive

Mayo Clin Proc.2015;90(6)

The Who & The When of the Wean

- All who express interest
- Substance Use Disorder
- Clear ADR attributable to COT
- Absence of analgesia / functional gains
- Leading up to elective surgery
- Deterioration in function
- OD: intentional or unintentional
- Nonadherences to Treatment Agreement


Dist. by King Features
No. Use it for talking. Like this.
PIRARO
3-30-10
BIZARROCOMIC.BLOGSPOT.COM
BIZARRO.COM

Know mindful, No mindless

1. Know the person, know the pain
   a) Establish relationship **first**
   b) Communication and Teamwork
   c) Systems approach
      i. Pain engine(s)
      ii. Psychological engine(s)
      iii. Plant seed of recovery (HOPE) early
      iv. Motivation(s) for treatment/Rx
      v. Contextual aspects of presentation

Best Practice
Five Essential Elements in Safety

1. Risk Assessment: Assess each patient for risk of misuse up front and stratify monitoring based on risk. Repeat often
2. Treatment Agreement/Informed Consent: Educate each patient on the potential risks and benefits, the dos and don'ts of COT
3. PDMP Check: Query databases to see if the patient has collected other and or unsanctioned Rxs
4. Toxicology Screen: Confirmatory assay to best understand what the patient has taken and compare to the prescribed medication list
5. Pill Counts: Check to see if the patient has the correct amount on-hand.

Tapering: Therapeutic Wean

- Chronic Opioid person
- Identifying candidates for opioid tapering:
  - high-risk behavior
  - serious adverse events
  - opioid-related side effects
  - Poor functioning
  - patient preference
  - Patient centered
    - Relate to personally meaningful

- Provider of person on COT
  - emotional burden
  - inadequate resources
  - lack of trust between patient and provider & Bias
- Facilitators
  - empathizing with experience
  - preparing for opioid tapering
  - Education
  - individualizing Plan
  - supportive guidelines & policies

Motivational Interviewing

Pain Medicine 2017. Nov

Alterations in Chronic Pain

- Sleep
- Pain
- Affect
- Cognitive
- Energy

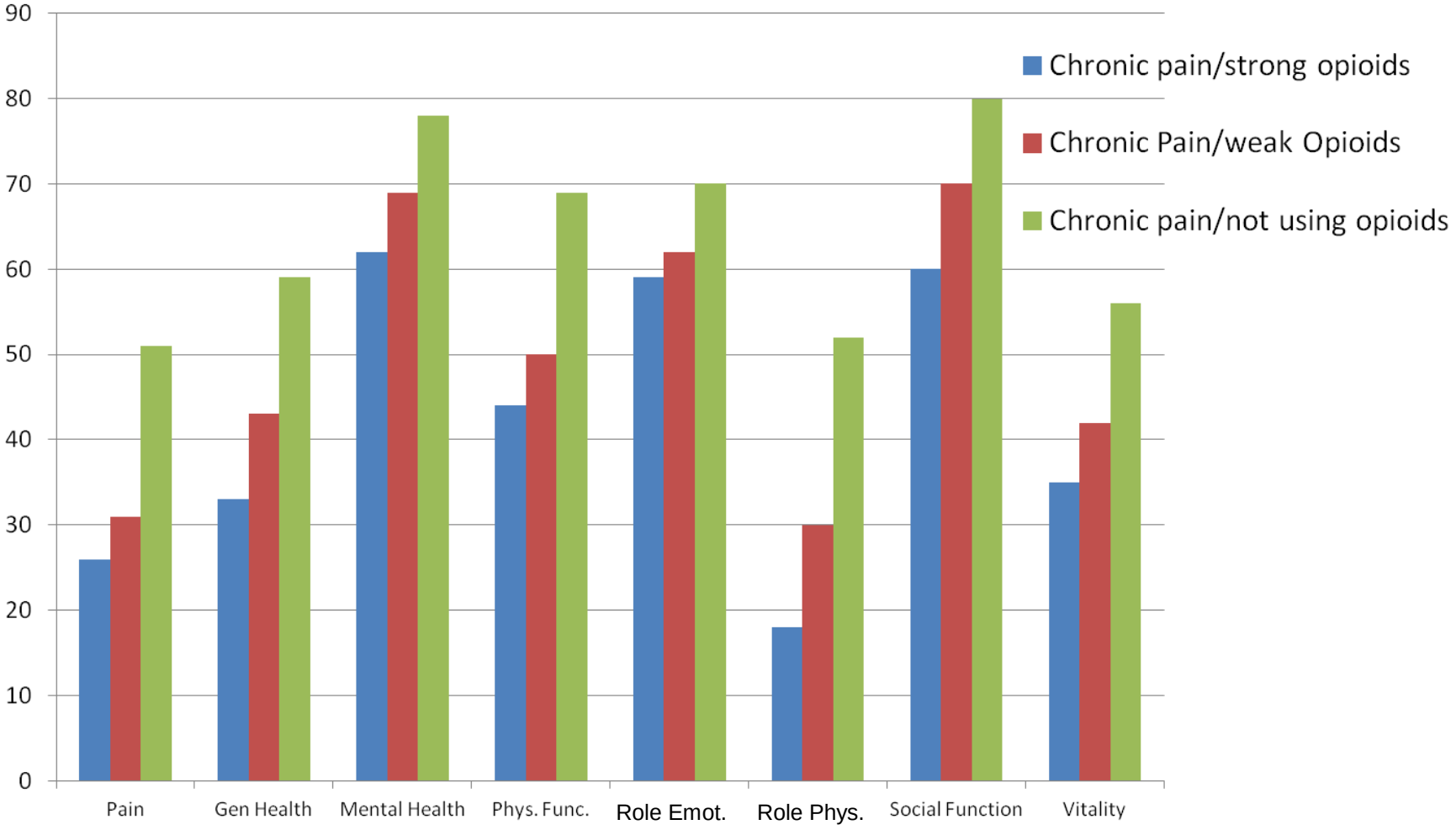
Relationships Matter- Invest

- Therapeutic Relationships & Teamwork
  - Therapeutic visits and deliverables
  - *13 mins is problematic, need more*
- Create a Packet- for office and patient
  - Teach and Teach back
  - Chronic Pain, restoration of function
  - Sleep, medications, psych. impact
  - Create Resource Guide
    - Pools, gyms, yoga, churches, CBT
    - meditation, nutrition, chiropractors
    - Books and websites

Patient Education
Long-term Opioid Risks

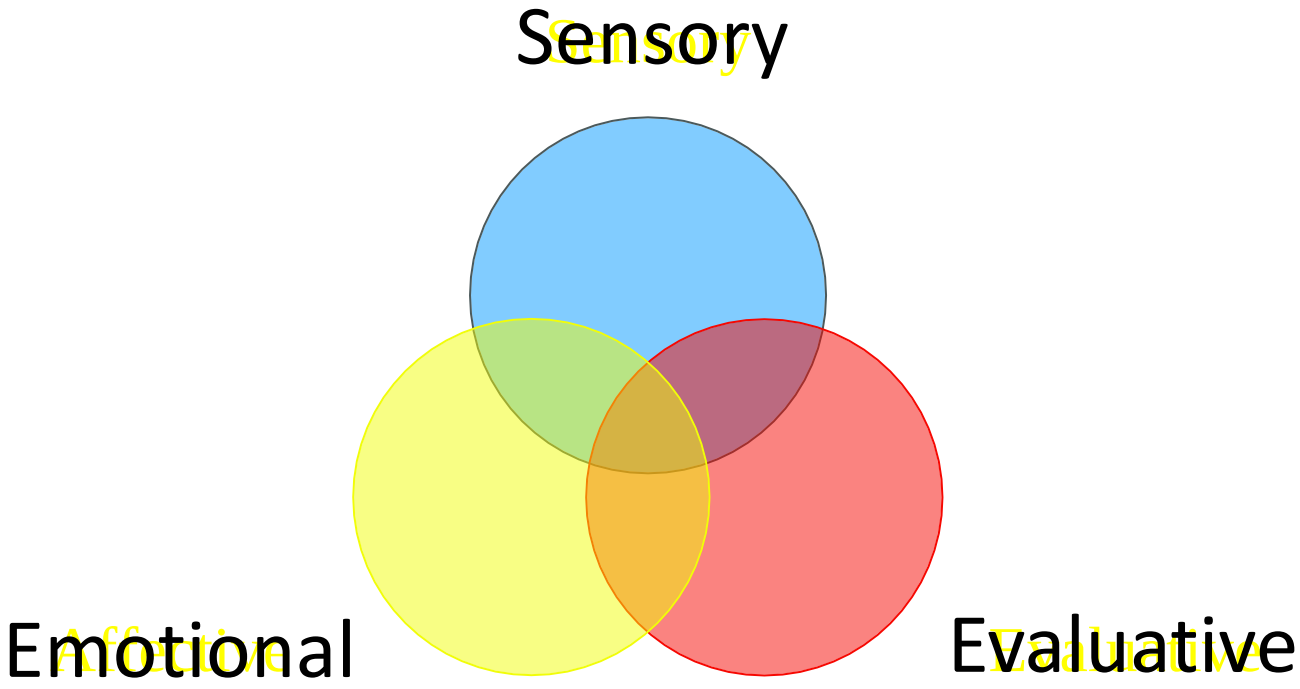
- Hyperalgesia
- Affective Challenges/illness
- Immunosuppression
- Falls/fractures
- Myocardial Infarction
- Androgen deficiency/Decreased libido
- Osteoporosis
- Opioid tolerance/dependence
- Addiction
- Respiratory Depression
- Death
- ***Iatrogenic Relapse***

Quality of Life scores according to chronic pain status and the use of opioids in 2000.

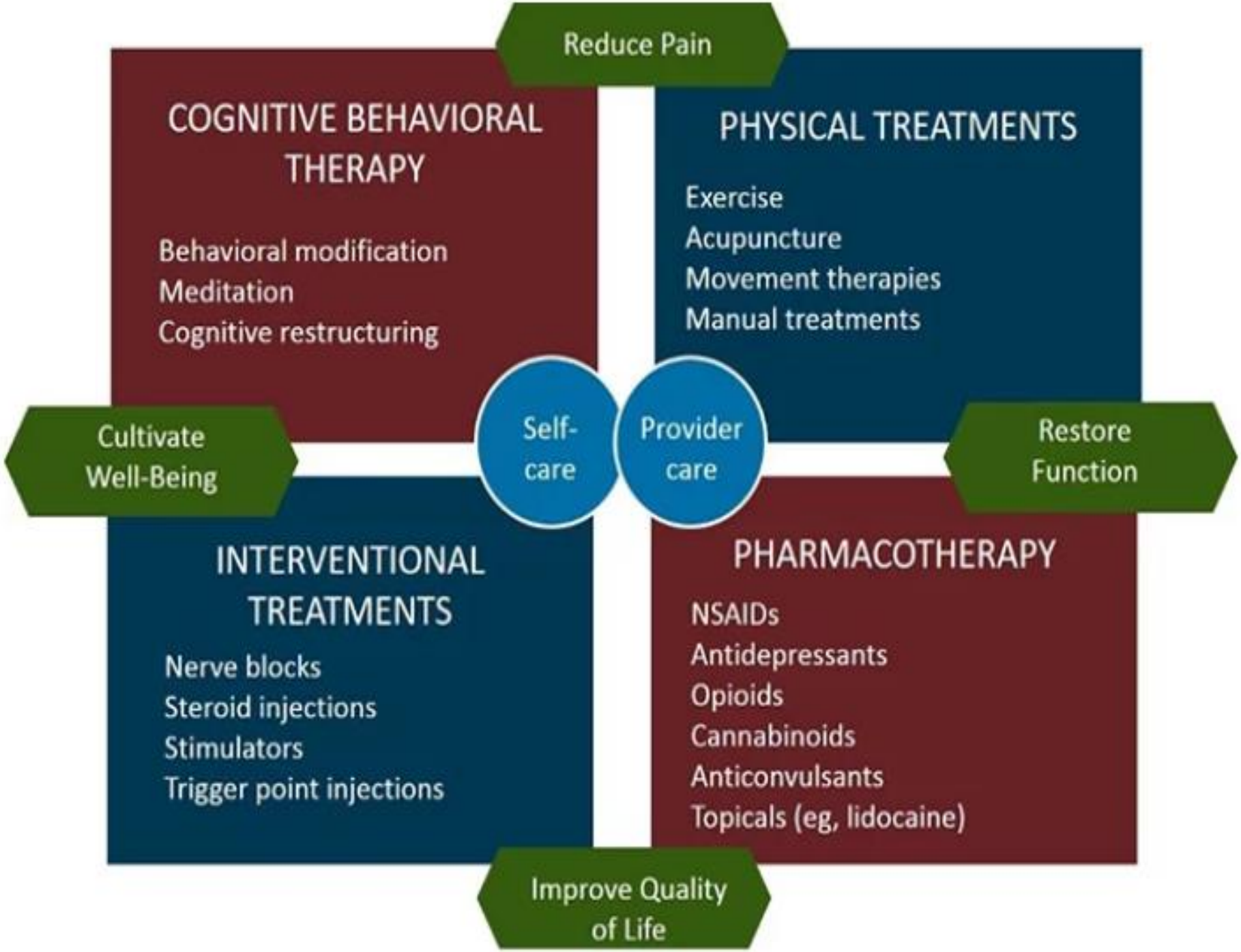


Clin J Pain Volume 26, Number 9, Nov/Dec 2010 (converted to bar)

Components of Treatment



More Control - Less Pain


Reduce Pain
COGNITIVE BEHAVIORAL THERAPY
Behavioral modification
Meditation
Cognitive restructuring
PHYSICAL TREATMENTS
Exercise
Acupuncture
Movement therapies
Manual treatments
Cultivate Well-Being
Self-care
Provider care
Restore Function
INTERVENTIONAL TREATMENTS
Nerve blocks
Steroid injections
Stimulators
Trigger point injections
PHARMACOTHERAPY
NSAIDs
Antidepressants
Opioids
Cannabinoids
Anticonvulsants
Topicals (eg, lidocaine)
Improve Quality of Life

Ways to Wean

- Therapeutic, not punitive
- If > 120 MED
  - Start with 15 % reduction
- < 100 MED
  - Lower by 10 % /4 weeks
- < 60 MED
  - Lower by 5-8 % /4 weeks
- My goal is
  - for 10 MED or less
  - But don't allow perfect to be the enemy of good

- If no risk, take your time
- Co-analgesics
  - Tizanidine, TAD, SNRI, GABA, pregabalin
- Patient Engagement
  - Purpose/motivation
  - Restorative Activities
  - CBT/Relax. Response
  - Long vs short acting
  - Hold for 1 month?
  - Opioid rotation

Tapering Example- 90 mg oxycodone SR

- 30 mg *tid* is current regimen
- She elected to keep *tid* regimen
- Reduce each 14 or 21 or 28 days

1.	30 mg	20 mg	30 mg
2.	30 mg	20 mg	20 mg
3.	20 mg	20 mg	20 mg
4.	20 mg	15 mg	20 mg
5.	20 mg	15 mg	15 mg
6.	15 mg	15 mg	15 mg

Tapering Example- 90 mg oxycodone SR

- 30 mg *tid* is current regimen
- She elected to keep *tid* regimen given handout instructions
- Reduce each 14 or 21 or 28 days

1.	30 mg	20 mg	30 mg
2.	30 mg	20 mg	20 mg
3.	20 mg	20 mg	20 mg
4.	20 mg	15 mg	20 mg
5.	20 mg	15 mg	15 mg
6.	15 mg	15 mg	15 mg

1. Could provide 5 mg to use as prn for first 5-10 days of first three reduction
2. Can hold reduction
3. Never add back
4. Slow/compassionate
5. Celebrate the work and see often

Rational Rotation
Taper Equivalent

- Effective and “invisible” reductions
- Sell the concept and rational
- COT and cross-tolerance
- Equi-analgesics at 65-75%
- “prn” optional and often helpful
- Rotate in
  - 1-2 moves if < 45 MED
  - 3 moves of 10 days each if > 45 MED
- consider doing each 6-18 months

30 mg Morphine *tid* and 5 mg hydroc./acet. *"prn" tid*

- 105 mg x 20/30 = 70 x 0.7= 50 mg oxycodone
- 105 mg x 7.5/30= 26.25 x 0.7=18.7 mg hydromorphone
- Allow patient input on regimen
  - How much short and for how long
  - Do rotations in thirds for example:

1. 30 mg MS and 15 mg oxy and 30 mg MS for 10 days
2. 30 mg MS and 15 mg oxy bid for 10 days- *prn 5 mg oxy/acet.*
3. 15 mg oxy three times daily w/ *prn* 5 *mg oxy/acet.*
   - Then wean off *prn* Rx
4. 15 mg oxycodone *tid* (90 MED to 67.5 MED)

Study on Sublingual Buprenorphine In 95 pain people referred "opioid detox."

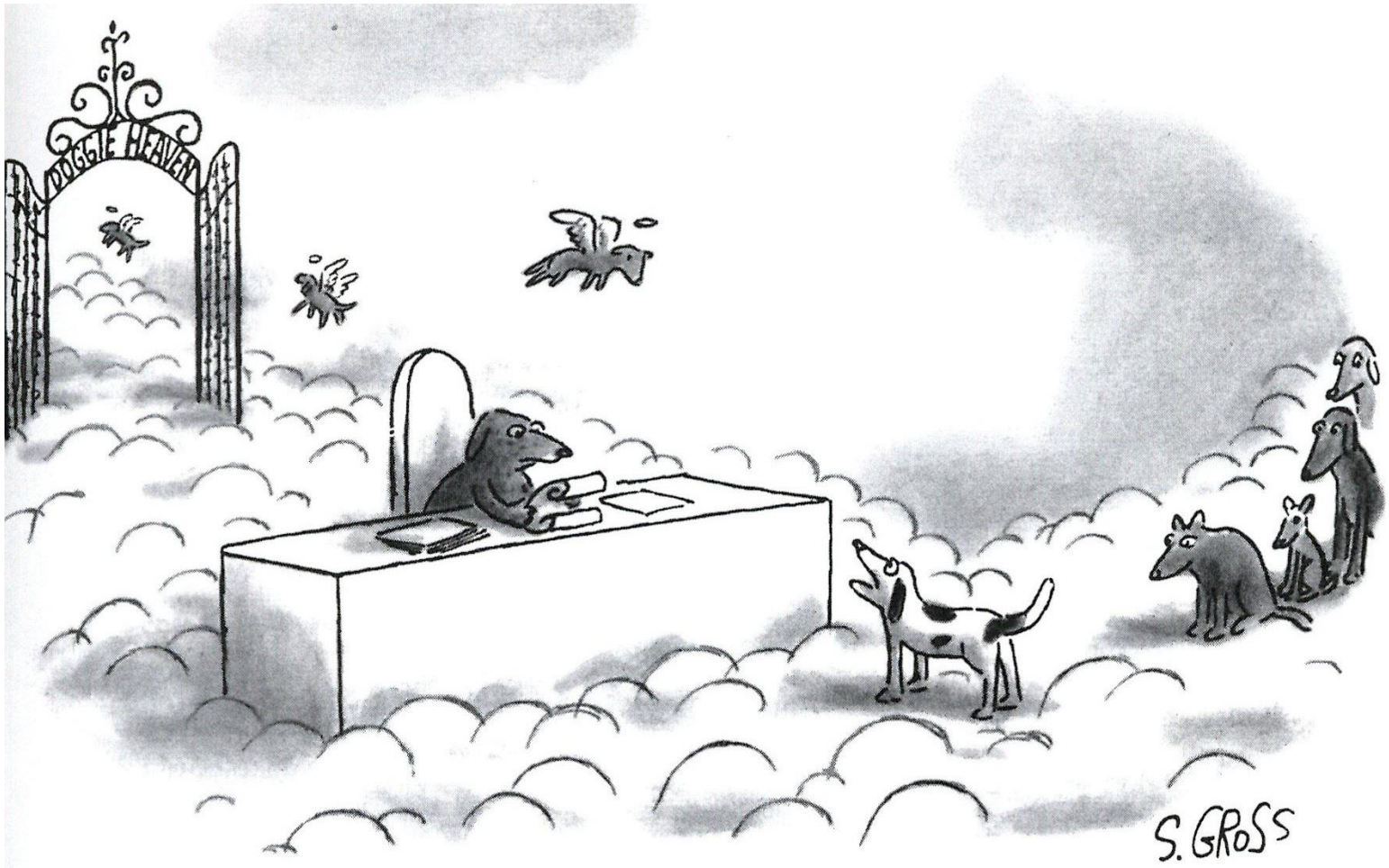
Patients not benefitting from long term opioid therapy
- Increased pain
- Decreased Functional Capacity
- Emergence of opioid use disorder (8%- curious)

Buprenorphine maintained patients with pain
- Suggested that analgesia was better if dosing was divided.

Chronic non-cancer pain treated with bup./ nalox.
- Good retention in treatment with relatively few complaining of increased pain

Malinoff H, 2005 & Heit HA ,Gourlay DL. 2008 & Pade PA, 2012

New Normal with Realistic Optimism

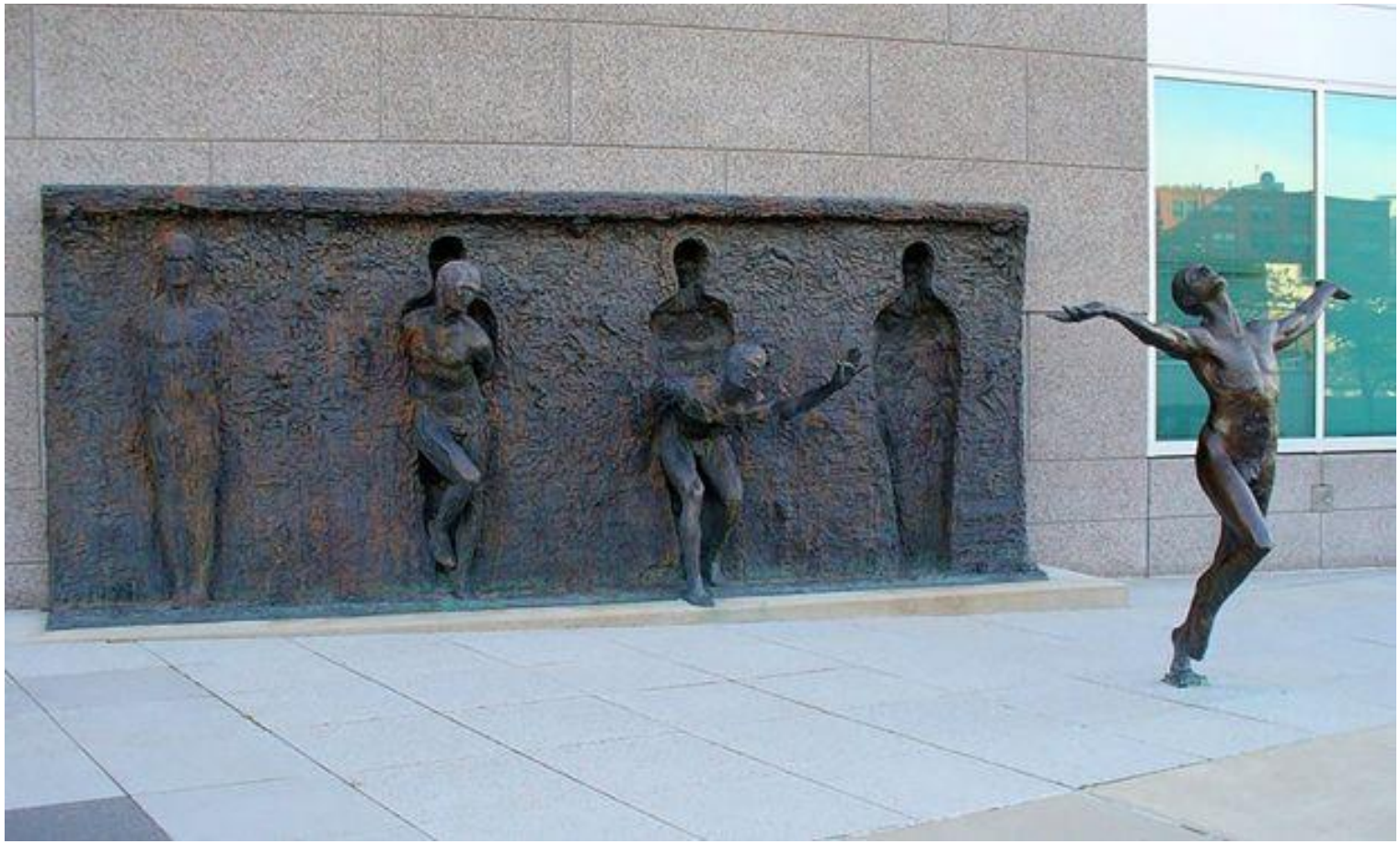


Is there any chance of getting my testicles back?

Summary

- Educate yourself and others
- Use and deliver teaching materials
- Acknowledge the challenge and build hope
- Individualize-Personalize
- Be mindful and accept difficult conversations
- Express non-abandonment- walking together
- Negotiate the wean to Win the Wean
- Proceed slowly and compassionately
- Opioid Rotation- The Invisible Wean
- Buprenorphine can be helpful (<180 MED)

The Ultimate Goal
Repatriation



palmermackie719@gmail.com

Resources

- Tame The Beast – Tamethebeast.org

  https://www.youtube.com/watch?v=ikUzvSph7Z4

- Never Give up

  https://www.youtube.com/watch?v=qX9FSZJu448

- Maria's Story

  http://site-111702.bcvp0rtal.com/?videoId=6008700637001

- Introduction to Tapering Patients off Chronic Opioid Therapy

  https://www.youtube.com/watch?v=tkrN7DW42G0

Primary Care Providers Beliefs

Table 1 GPs' agreement with managing patients experiencing CNCP (n=681)

Attitudes towards CNCP	Strongly disagree/ disagree			Neither agree nor disagree			Agree/strongly agree		
	n	%	95% CI	n	%	95% CI	n	%	95% CI
Opioid therapy should be reserved for people experiencing acute pain, cancer pain, or palliative care	219	33	29–36	84	13	10–15	368	55	51–59
Focusing on medication to reduce pain has limited benefits for peoples' quality of life and function over the long term	144	21	18–25	91	14	11–16	438	65	61–69
When caring for people who experience CNCP, screening for depression or anxiety is always important	21	3.1	2–4.7	7	1	2–4.7	647	96	94–97
Addressing sleep problems help people cope better with their pain experience	16	2.4	1.5–3.8	14	2.1	1.2–3.5	645	96	94–97

Journal of Pain Research 2019:12

Primary Care Attitudes/Beliefs

Table 2 Reported likelihood to deprescribe opioid dose to cessation in relation to various patient and resource factors (n=681)

Influences on GP decision about opioid weaning	Less likely to initiate wean			No influence on decision			More likely to initiate wean		
	n	%	95% CI	n	%	95% CI	n	%	95% CI
Patient prefers to remain on opioids	250	37	34–41	276	41	38–45	144	21	19–25
Patient expresses fear of weaning (the process or the outcome)	173	25	23–29	388	57	54–62	107	16	13–19
Patient has low score on quality of life measure or functional outcome measure	242	36	33–40	221	32	29–37	208	31	28–35
Patient has poor psychological health	227	33	30–38	201	30	26–34	242	36	33–40
Lack of availability of effective alternate treatment	526	77	75–81	129	19	16–22	19	2.8	1.8–4.4
Lack of availability of access to or support from specialist care	351	52	49–56	294	43	40–48	26	3.8	2.7–5.6

Journal of Pain Research 2019:12

Risk Stratification
More Than Classic Aberrancy

- Physical
- Family history
- Social/Domestic
- Mental Health
- PDMP
- ***Rx*** Combinations
- Stable housing?
- Toxicology data
- Releases from Providers
  - "fired"
- Age <45, esp. < 25
- Tobacco (first 30 min)
- Chaos/ Life Trauma Hx
- Legal history
  - Web inquiries EZ
  - DOC-site
- Abuse (sexual) history
  - Esp. when young
- Repeated traumas
  - Non-sports related

Table 2. Demographic Characteristics and Risk Profiles for Opioid-Related Harms of Patients Receiving Chronic Opioids

	Patients on Chronic Opioids, n = 902 (%)[a]	Patients Not on Chronic Opioids, n = 84,027 (%)[a]	*P* Value
Demographic characteristics			
Sex, female	591 (65.5%)	50,575 (60.2%)	<.01
Race			
Asian/Asian American	6 (0.7%)	6,034 (7.2%)	<.01
Black/African American	389 (43.1%)	12,377 (14.7%)	
White	435 (48.2%)	48,200 (57.4%)	
Other	20 (2.2%)	4,509 (5.4%)	
Declined	52 (5.8%)	12,907 (15.4%)	
Ethnicity, Hispanic	12 (1.4%)	3,576 (5.4%)	<.01
Medical comorbidities			
Sleep apnea	194 (21.5%)	7001 (8.3%)	<.01
Depression or anxiety	537 (59.5%)	23,693 (28.2%)	<.01
Substance use disorder	118 (13.1%)	1,802 (2.1%)	<.01
Hepatic insufficiency	153 (17.0%)	4,020 (4.8%)	<.01
Renal insufficiency	174 (19.3%)	2,439 (2.9%)	<.01
Concurrent benzodiazepine prescription	216 (24.0%)	714 (8.3%)[b]	<.01

Ann Fam Med 2019;17:200-206