UVM Project ECHO
Safer Opioid Prescribing:
Compassionate Tapers and Buprenorphine Transitions

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University of Vermont
Larner College of Medicine

Didactic presentation is recorded. Registered participants will receive the link.

Project ECHO

Series Objectives

Learning objectives for this ECHO series include the ability to:

1. Identify patients with chronic pain at higher risk of complications of opioid treatment
2. Develop strategies to compassionately taper opioids in appropriate patients
3. Understand the pharmacology and potential benefits to transitioning patients to buprenorphine.
4. Incorporate buprenorphine into practice for patients with chronic pain treated with opioid therapy

CMIE Disclosures

Interest Disclosures: As an organization accredited by the ACCME to sponsor continuing medical education activities, UVMCMIE is required to disclose any real or apparent conflicts of interest (COI) that any speakers may have related to the content of their presentations.

Meeting Disclaimer: Regarding materials and information received during this educational event, the views, statements, and recommendations expressed during this activity represent those of the authors and speakers and do not necessarily represent the views of the University of Vermont.

CMIE Disclosures

The Robert Larner College of Medicine at The University of Vermont is accredited by the American Nurses Credentialing Center (ANCC), the Accreditation Council for Pharmacy Education (ACPE), and the Accreditation Council for Continuing Medical Education (ACCME), to provide continuing medical education for the healthcare team.

The University of Vermont has approved your application and designates each session a maximum of **1.0 *AMA PRA Category 1 credit(s)***™.

This program has been reviewed and is acceptable for up to **1.0 Nursing Contact Hours**.

The Robert Larner College of Medicine University of Vermont has been authorized by the American Academy of PAs (AAPA) to award AAPA Category 1 CME credit for activities planned in accordance with AAPA CME Criteria. This activity is designated for **1.0 AAPA Category 1 CME credits**.

As a Jointly Accredited Organization, The Robert Larner College of Medicine at the University of Vermont is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. The University of Vermont maintains responsibility for this course. Social workers completing this course receive 1.0 continuing education credits.

This activity was planned by and for the healthcare team, and learners will receive 1.0 Interprofessional Continuing Education (IPCE) credit for learning and change.

Participants should claim only the credit commensurate with the extent of their participation in the activity.

Session Agenda

- Welcome
- Objectives
- Didactic Presentation (~35 min)
  - Q&A
- Case presentation overview
  - Example case/questions
- Closing Announcements
  - Topic and cases for next session
  - Feedback and evaluation

ECHO Model: All Teach, All Learn

Cohort-based learning on ZOOM

- Have your camera on as much as possible, especially when joining the meeting and during discussions
- Questions and comments are welcome – use the “raise hand” feature or put them in the chat
- This is not a webinar! Participation is key

Case-based learning

- 1-2 participant cases presented/discussed at each session
- Contact Mark Pasanen to present a case

Opioids for Chronic Pain:
Compassionate Approaches to Tapering

Mark E. Pasanen, MD

Associate Professor of Medicine

Vice Chair of Education, UVMHN Dept of Medicine

University of Vermont
Larner College of Medicine

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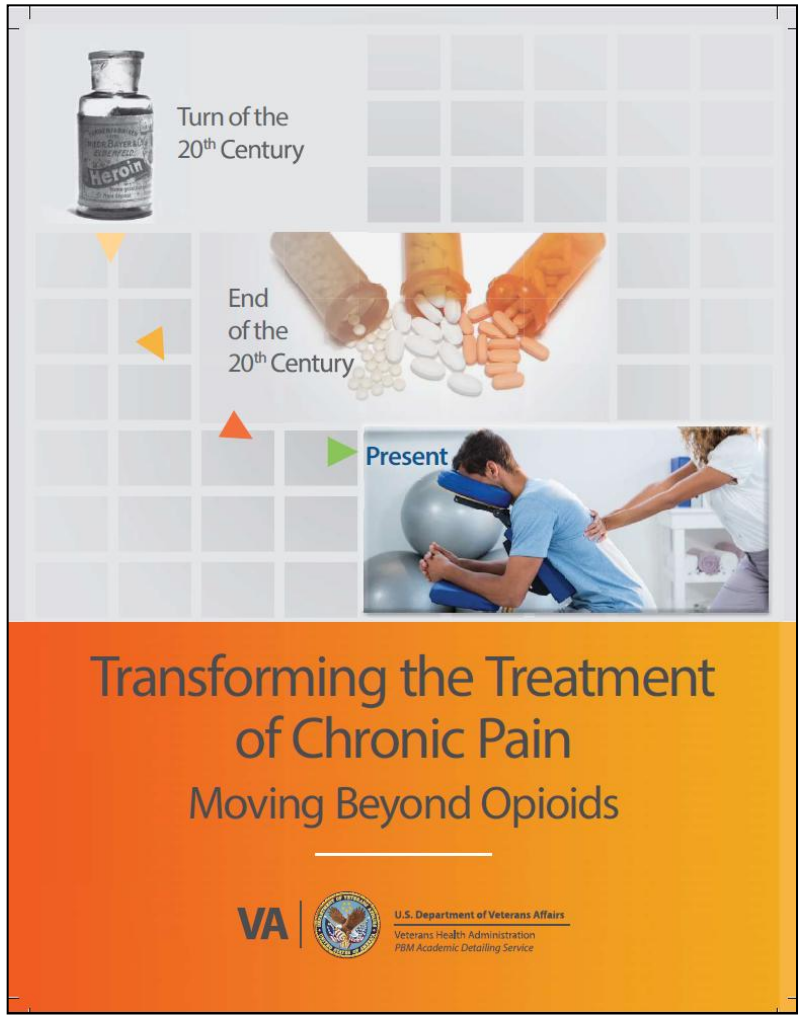
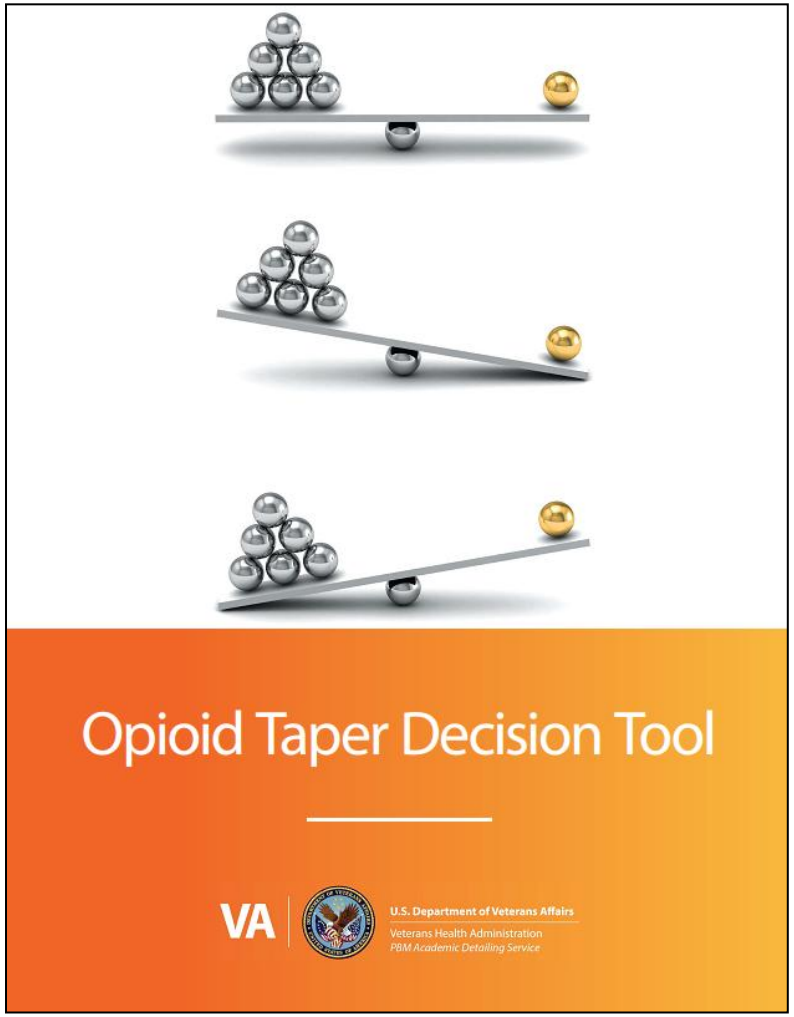
Session Objectives

Learning objectives for this ECHO session include:

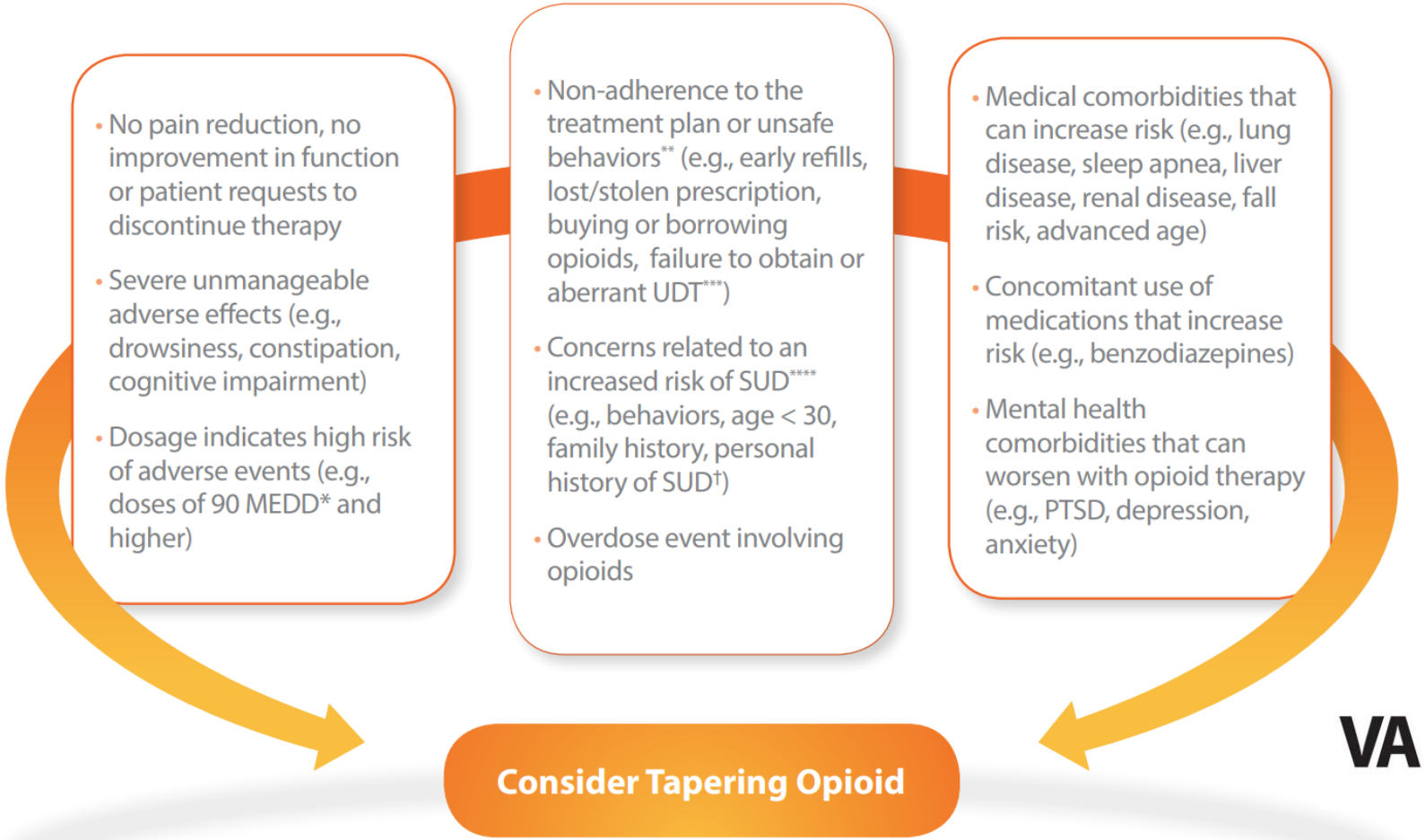
- Identify candidates for opioid tapering
- Patient-centered discussions around tapering
  - Rationale for taper
- Approaches to tapering
  - Goal of taper
  - Duration of taper
  - Manage withdrawal symptoms

Two resources from the VA





Possible reasons to re-evaluate the risks and benefits of continuing opioid therapy:



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Higher Risk Populations

High risk for traditional opioid therapy[1,3,5]

- History of drug overdose
- Concurrent use of CNS depressants
- Severe respiratory instability, sleep disordered breathing
- Acute psychiatric instability, high acute suicide risk, mental health disorders
- Prescribed long-term (>90 days) or high dose opioids (>120 mg morphine equivalent daily dose [MEDD])*
- Opioid tolerance but does not meet criteria for opioid use disorder (OUD)
- Under age 30
- Traumatic brain injury

Is there an opioid use disorder?

- Tolerance/Dependence:
  - Physiologic response to prescribed long-term opioids
  - Should not be used to diagnose OUD when prescribed opioids
- Is uncontrolled pain a contributing factor?
  - Larger amounts/longer duration
  - Excessive time spent obtaining

TABLE 1 Summarized DSM-5 diagnostic categories and criteria for opioid use disorder

Category	Criteria
Impaired control	• Opioids used in larger amounts or for longer than intended • Unsuccessful efforts or desire to cut back or control opioid use • Excessive amount of time spent obtaining, using, or recovering from opioids • Craving to use opioids
Social impairment	• Failure to fulfill major role obligations at work, school, or home as a result of recurrent opioid use • Persistent or recurrent social or interpersonal problems that are exacerbated by opioids or continued use of opioids despite these problems • Reduced or given up important social, occupational, or recreational activities because of opioid use
Risky use	• Opioid use in physically hazardous situations • Continued opioid use despite knowledge of persistent physical or psychological problem that is likely caused by opioid use
Pharmacological properties	• Tolerance as demonstrated by increased amounts of opioids needed to achieve desired effect; diminished effect with continued use of the same amount • Withdrawal as demonstrated by symptoms of opioid withdrawal syndrome; opioids taken to relieve or avoid withdrawal

Tapering evidence

Effectiveness of pain medication tapering in chronic pain patients: a systematic review and meta-analysis

- 57 articles in systematic review
- Looked at pain medication tapering in chronic non-cancer pain
- Overall benefit to tapering:
  - Pain intensity, headache disability, anxiety, depression, pain interference
- No significant improvement:
  - Physical function, QOL (physical or mental health) and pain self-efficacy
- High risk of bias/mixed studies

Wuyts E, et al. British Jnl of Anaesthesia 133(5) 2024

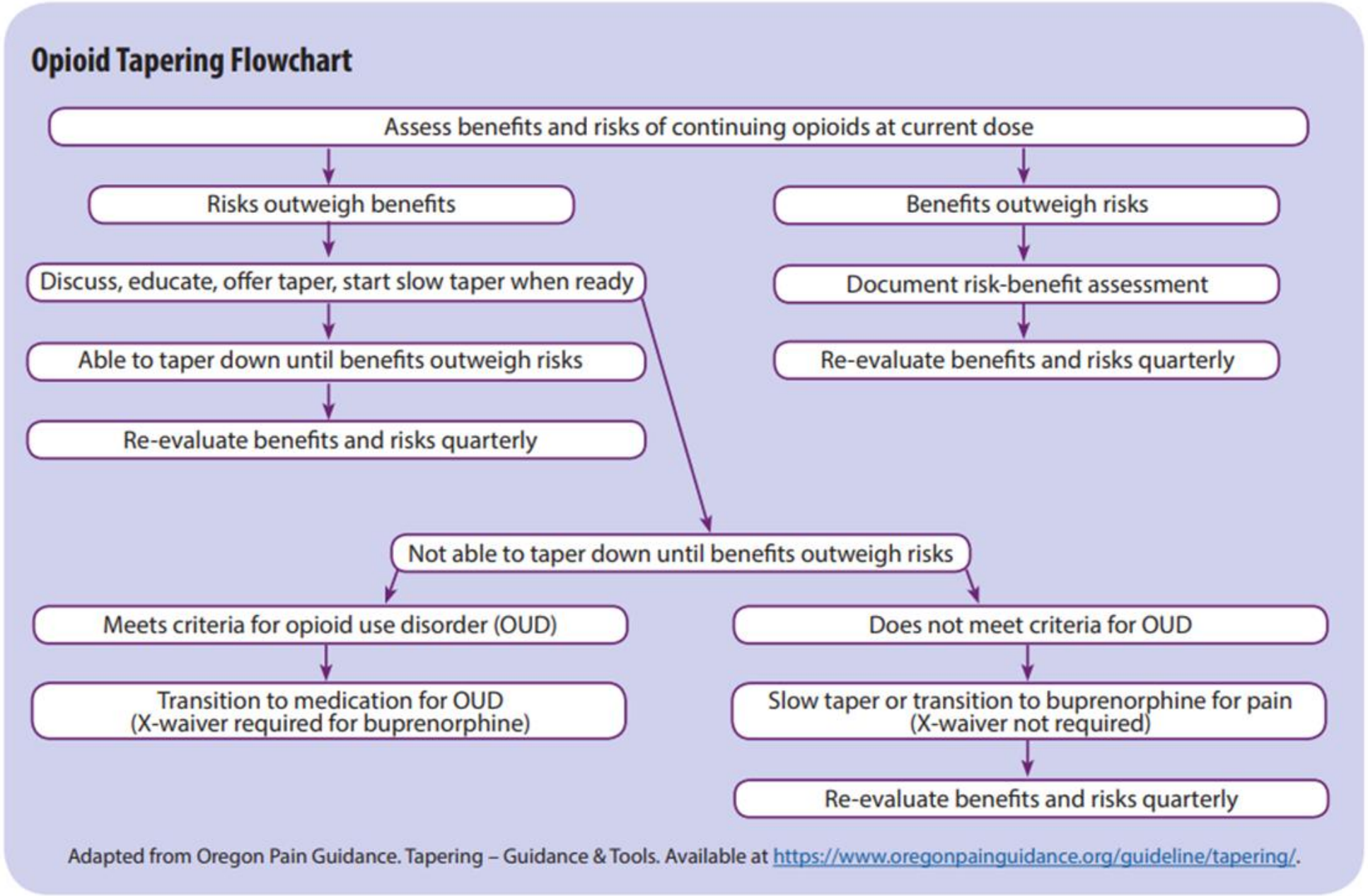
So how should we taper?

Opioid Tapering Practices—Time for Reconsideration?

Marc Larochelle, MD; Pooja A. Lagisetty, MD; Amy S. B. Bohnert, PhD

JAMA August 3, 2021 Volume 326, Number 5

It is increasingly clear that opioid tapering needs to be approached with caution. In almost all cases, rapid or abrupt discontinuation should be avoided. Achieving the goals of minimizing risk yet also improving pain and function will require individualizing care and evidence-based approaches with more nuanced strategies that embrace the clinical complexity of the population of patients with chronic pain.


Opioid Tapering Flowchart
Assess benefits and risks of continuing opioids at current dose
Risks outweigh benefits
Benefits outweigh risks
Discuss, educate, offer taper, start slow taper when ready
Document risk-benefit assessment
Able to taper down until benefits outweigh risks
Re-evaluate benefits and risks quarterly
Re-evaluate benefits and risks quarterly
Not able to taper down until benefits outweigh risks
Meets criteria for opioid use disorder (OUD)
Does not meet criteria for OUD
Transition to medication for OUD
(X-waiver required for buprenorphine)
Slow taper or transition to buprenorphine for pain
(X-waiver not required)
Re-evaluate benefits and risks quarterly
Adapted from Oregon Pain Guidance. Tapering – Guidance & Tools. Available at https://www.oregonpainguidance.org/guideline/tapering/.

How to approach tapering discussion

- Be clear WHY taper is appropriate
- Consider goal of taper (safety, improved function, concern for OUD)
- If discussing overdose, be sure to discuss unintentional overdose
  - Age, declining renal/liver function, multiple other meds, etc.
- Take responsibility
  - “It would be easier to just continue the medication, but I am concerned that the treatment is not effective, as we’re not seeing the goals we targeted”
  - “I was hoping that the treatment would help – but that’s not been the case as shown by your continued severe pain/poor function/etc”
  - “I believe it is unsafe to continue because …”
  - “I am worried the treatment I’m prescribing may be increasing your pain.”
- Avoid “Insurance won’t allow me” or “CDC says …”
  - Use your relationship in caring for the patient as the primary driver

Tapering

- Avoid insisting on opioid tapering or discontinuation when opioid use may be warranted
  - treatment of cancer pain, pain at the end of life, or when benefits outweigh risks of opioid therapy
- Avoid misinterpreting cautionary dosage thresholds as mandates for dose reduction.
- Some patients using both benzo and opioids may require tapering of one or both medications to reduce risk for respiratory depression.
  - If benzodiazepines are tapered, they should be tapered gradually due to risks of withdrawal (anxiety, hallucinations, seizures, delirium tremens, and, in rare cases, death)

How to approach tapering discussion

- Make it clear you believe the patient has pain
- Remind them you are judging the treatment, not the patient
  - Not abandoning the patient, but you are changing an ineffective or potentially harmful treatment
  - Be clear you still want to care for the patient, and work on improving pain and function
  - We know more about the benefits and risks
- Don’t always feel like you need to substitute one medication for another
  - More options for chronic pain then we did in past
- When talking logistics, involve the patient
  - Decrease morning or evening medication first?
  - Benzo or opioid?

Tapering Strategies

- Rationale for taper
  - Lack of benefit?
  - Side effects?
  - Concern for misuse?
- Estimate physiologic dependence
  - Duration/dosing of opioid use
  - Any issues with withdrawal with missed doses?
- Patient input
- Immediate vs Rapid vs Slow

How patients may respond

- Fear of worsening pain
- Concern of withdrawal
- Concern of being abandoned, may get upset

Possible statements:

- “Only thing that has ever helped”
- “Why are you doing this to me?”
- “Maybe we should increase dose if not working?”

Tapering Endpoint

- Taper to OFF required if:
  - High risk for opioid-related harm
- For other reasons:
  - Consider this a “trial”
  - May be able to taper off completely
  - “Lowest” effective dose
    - Safer, less side effects
  - If feeling improved, continue slow taper

4 Strategies Based on Scenarios

1) The cooperative patient – interested in taper, willing to try other pain treatments other than opioids
2) The uncooperative patient – not willing to taper and/or not interested in other treatments
3) Aberrant behavior – you are no longer comfortable prescribing opioids for this patient and your plan is to eventually discontinue
4) Addiction or possibly diversion – you are pretty sure one or both of these is occurring

Levels of Compassion

Disengagement

- Disconnected
- Negative reactions for patient and provider
- Under-prescribing of opioids

Reactive compassion

- Knee jerk compassion
- Perceived as positive by patient and provider
- Over-prescribing of opioids

Conscious compassion

- Mindful compassion
- Perceived as positive by patient and provider
- “Goldilocks” prescribing → Prescribing of opioids is just right

Courtesy of Rich Pinckney, MD

1. Cooperative Patient Strategy

- Everything is negotiated
  - Rate of taper based on patient comfort and motivation
    - Recommend 5-10% drop in dose per month if patient has been on opioids for years
    - Can be 10% weekly if both agreeable
  - Other treatments could be done before taper, during taper, or as pain arises during the taper
  - Commonly overlooked evidence-based pain treatments
    - Mind-body medicine
    - Acupuncture

2. Uncooperative Patient Strategy

- Common scenario, especially in patients on higher doses
- It's generally better to taper with patient cooperation – better to have several meetings to engage patient in a cooperative plan
- If patient still is uncooperative:
  - Practice conscious compassion (what's goal of taper?)
  - Do an evaluation for aberrant behavior to try to determine the underlying reason they are not interested in a taper
  - Consider an involuntary taper

2. Uncooperative Patient: The Involuntary Taper

- Your goal may be either to get the patient to:
  - a lower/safer dose i.e. < 90 morphine equivalent dose
  - invest in other pain management strategies
  - be off opioids completely
- Gradually lower dose until your goal is achieved
  - <10% reduction per month if patient on opioids for years
  - 10 – 20% per week in patients on opioids for shorter durations
  - If patient fails pill count or confirmation, evaluate and consider following the aberrant behavior pathway for tapers or addiction/diversion pathway

VA recommendations

- Reduce by 5-20% per month
  - 10% of original MME each week will take 10 weeks; 5% will take 20 weeks
  - Some may require a slow taper of 2-5% per month
  - Consider slowing rate when at 25-30% of original dose
- Consider a pause for 2-4 weeks between some steps
- Team approach with mental health

3. Aberrant Behavior Strategy

- Disclaimer : Not all patients with aberrant behavior require a taper, this pathway is for those whom you are concerned that opioids are now contraindicated in this patient due to a risk of some sort of misuse
- This are situations where you don’t want to continue prescribing opioids due to patient behaviors, but you haven’t been able to figure out why …

3. Aberrant Behavior Strategy

- Goal is to prevent withdrawal, no longer to treat pain
- Bubble pack meds with regular pill counts. Urine confirmations may also be helpful
- Taper between 10%-25% per week depending on how long the patient has been on opioids
- If patient fails pill count or urine confirmation then addiction/diversion is highly likely

4. Addiction/Diversion Strategy

- Don’t taper – you may be “pouring gas on the fire”
- Seek out help for SUD
  - Consider transition to buprenorphine
- Stop meds – but practice conscious compassion
- Explore reasons for diversion
  - With diversion, physical dependence may not be an issue but hard to know

More on tapering …

- Advise patients that there is an increased risk for overdose on abrupt return to a previously prescribed higher dose
- Strongly caution that it takes as little as a week to lose tolerance and that there is a risk of overdose if they return to their original dose
- Provide opioid overdose education and consider offering naloxone
- Risks to non-collaborative tapering in physically dependent patients includes acute withdrawal, pain exacerbation, anxiety, depression, suicidal ideation, self-harm, ruptured trust, and patients seeking opioids from high-risk sources

General Approach to Evaluating the Patient

Situation	Characteristics	Goal	Strategy
Voluntary			
Patient: *"I don't want to take this anymore."*	Patient interested in tapering and willing to try pain management strategies other than opioids	Dose reduction or discontinuation	Everything is negotiated, including taper speed.
Involuntary			
Patient: *"Nothing else works for me."*	Not interested in tapering and not willing to try pain management strategies other than opioids	Dose reduction or discontinuation	Attempt to taper with cooperation (e.g. use motivational interviewing to create a plan). If patient is unwilling to engage in a plan, proceed with involuntary taper. Consider use of bubble packs to monitor taper.
Aberrant (unclear)			
Provider: *"I don't know what's going on, but opioids don't feel like a good choice for this patient."*	Provider is no longer comfortable prescribing opioids for this patient.	Discontinuation	Involuntary taper to prevent withdrawal. Consider use of bubble packs to monitor taper and consider a faster taper speed.
Aberrant (diversion or addiction)			
multiple lost prescriptions, early refill requests, "red flag" in urine screen, etc.	Would not be responsible for provider to prescribe opioids	Discontinuation	Do not prescribe opioids. If patient has a substance use disorder, call local Hub or Community Health Team social worker for evidence-based treatment

Example Tapers for Opioids[5-9]

Slowest Taper (over years)	Slower Taper (over months or years)	Faster Taper (over weeks)****	Rapid Taper (over days)****
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*	Reduce by 5 to 20% every 4 weeks with pauses in taper as needed **MOST COMMON TAPER**	Reduce by 10 to 20% every week	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 MEDD **Month 1:** 90 mg SR qam, 75 mg noon, 90 mg qpm [5% reduction]* **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**	Ex: morphine SR 90 mg Q8h = 270 MEDD **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***	Ex: morphine SR 90 mg Q8h = 270 MEDD **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***	Ex: morphine SR 90 mg Q8h = 270 MEDD **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***

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Risks of rapid opioid taper

- Opioids should not be tapered rapidly or discontinued suddenly due to the risks of significant opioid withdrawal.
- Risks of rapid tapering or sudden discontinuation of opioids in physically dependent[ii] patients include acute withdrawal symptoms, exacerbation of pain, serious psychological distress, and thoughts of suicide.[1] Patients may seek other sources of opioids, potentially including illicit opioids, as a way to treat their pain or withdrawal symptoms.[1]
- Unless there are indications of a life-threatening issue, such as warning signs of impending overdose, HHS does not recommend abrupt opioid dose reduction or discontinuation.

JAMA | Original Investigation

Association of Dose Tapering With Overdose or Mental Health Crisis Among Patients Prescribed Long-term Opioids

Alicia Agnoli, MD, MPH, MHS; Guibo Xing, PhD; Daniel J. Tancredi, PhD; Elizabeth Magnan, MD, PhD; Anthony Jerant, MD; Joshua J. Fenton, MD, MPH

CONCLUSIONS AND RELEVANCE Among patients prescribed stable, long-term, higher-dose opioid therapy, tapering events were significantly associated with increased risk of overdose and mental health crisis. Although these findings raise questions about potential harms of tapering, interpretation is limited by the observational study design.

JAMA August 3, 2021 Volume 326, Number 5

Withdrawal Symptoms

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Not life-threatening

Withdrawal symptoms are not life-threatening and may not be seen with a gradual taper.

First 5 to 10 days

Early symptoms generally resolve 5 to 10 days following opioid dose reduction/cessation but may take longer depending on the half-life of the opioid (e.g., methadone).

Weeks to months

Some symptoms of withdrawal (dysphoria, insomnia) and prolonged craving may take longer.

Improvement over time

Patients with chronic pain may find that symptoms, such as fatigue, mental functioning, pain, and general well-being, improve over time.

Early Symptoms (hours to days)	**Late Symptoms** (days to weeks)	**Prolonged Symptoms** (weeks to months)
• Anxiety/restlessness • Rapid short respirations • Runny nose, tearing eyes, sweating • Insomnia • Dilated reactive pupils	• Runny nose, tearing eyes • Rapid breathing, yawning • Tremor, diffuse muscle spasms/aches • Piloerection • Nausea, vomiting, and diarrhea • Abdominal pain • Fever, chills • Increased white blood cells if sudden withdrawal	• Irritability, fatigue • Bradycardia • Decreased body temperature • Craving • Insomnia

Pharmacologic Management of Withdrawal

- Autonomic (sweating, tachycardia)
  - Clonidine 0.1 mg every 6-8 hr OR tizanidine 4 mg every 8 hrs
- Anxiety
  - Hydroxyzine 25-50 mg TID PRN
- Sleep disturbance
  - Trazodone 25-100 HS
- Nausea/Abdominal cramping:
  - Antiemetics, dicyclomine 20 mg every 6-8 hrs PRN
- Diarrhea
  - Loperamide or Bismuth

Tapering opioids Resource

- SCOPE of Pain video
  - https://www.scopeofpain.org See “Supplemental training”
  - A 28-minute video that summarizes an approach to tapering opioids (CME credit)

Conclusions

- Identify appropriate patients for tapering
- Be clear as to goal and rationale for tapering
  - Voluntary, involuntary, aberrant use, concern for OUD, diversion
- Engage the patient in the process
- Remember you're judging the treatment, not the patient
- Reaffirm you will continue to care for patient
- Determine taper plan
- Reassess regularly
- Watch for withdrawal

As we look at cases:

- What are indications/goals of taper?
- How can we minimize withdrawal symptoms?
- What other options for pain management?
- Any other ongoing symptoms that:
  - Need attention?
  - Might impact success of taper?
- Do we need any help?
  - Pain management, SUD expertise, psychologic support

UVM Office of Primary Care and AHEC Program

University of Vermont Project ECHO

Safer Opioid Prescribing: Compassionate Tapers and Buprenorphine Transitions

FALL SERIES – MONDAYS FROM 12:00-1:00pm *(All sessions facilitated by Mark Pasanen, MD)*

WHO SHOULD ATTEND?
Primary care providers, nurses, and social workers/case managers who care for adults and work in primary care practices as individual or practice teams.

SCHEDULE	
Oct 20	Opioids for Chronic Pain: Balancing Risks and Benefits
Nov 3	Compassionate Tapering Strategies
Nov 17	Transitioning to Buprenorphine: Introduction
Dec 1	Transitioning to Buprenorphine: Putting into Action
Dec 15	Advanced Case Discussions of Transitions to Buprenorphine

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Closing Announcements

- Slides are posted at www.vtahec.org
- Recording of didactic portion will be sent by email to the full cohort
  - **All recordings are for the use of registered participants only**
- Please complete the evaluation survey
- CMIE information and session QR code auto-send after evaluation
- Please contact us with any questions, concerns, or suggestions:
  - Mark.Pasanen@uvm.edu
  - Patti.Smith-Urie@uvm.edu