Oregon Tapering Update

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February 27, 2019

Disclosures

Change Management Consulting is on contract with the Oregon Health Authority to maintain and promote a state website www.OregonPainGuidance.org which includes maintaining pain treatment guidelines.

Any statements concerning Oregon state tapering policies are my own and should not be construed as official OHA statements.

Topics to cover

- Tapering Guidelines & Tools – from Oregon Pain Guidance (OPG) work group on tapering
- OHA Health Evidence Review Commission (HERC) policies & proposals (not official statements)
- OHA Tapering Task Force

OPG Workgroup on Tapering

Members

- Dr. Jane Ballantyne – University of Washington Dept. of Anesthesia & Pain Medicine
- Dr. Roger Chou – OHSU Department of Medical Informatics & Clinical Epidemiology and Department of Medicine
- Dr. Paul Coelho – MD Salem Health
- Dr. Ruben Halperin – Providence, Dept. of Medical Education and OHSU Affiliate Associate Professor, Dept. of Medicine
- Dr. Anna Lembke – Stanford University School of Medicine, Psychiatry and Behavioral Sciences and Addiction Medicine
- Dr. Jim Shames – Jackson County Health and Human Services
- Mark Stephens – Change Management Consulting
- Dr. David Tauben – University of Washington Dept. of Anesthesia & Pain Medicine

Tapering Guidance & Tools

Work group charter

- Compile best practice and evidence based guidelines
- Identify relevant tools and resources
- As a last resort, develop new guidance drawing on experience of work group members
- Keep guidance short and actionable
- Work on wide spread dissemination to primary care providers

Work started in June 2018, published on OPG website December 2018

NOTE – OHA/HERC public controversy occurred in August 2018

Tapering Guidance & Tools

Key Components

- Risk Benefit Assessment
- Opioid Tapering Flowchart
- Incorporates new proposed diagnosis “Complex Persistent Opioid Depedence” (CPOD)
- BRAVO Protocol

HOME | PAIN TREATMENT GUIDELINES | TOOLS | SIX BUILDING BLOCKS | RESOURCES | OHA | STATE ORGS | REGIONS | ORCRM

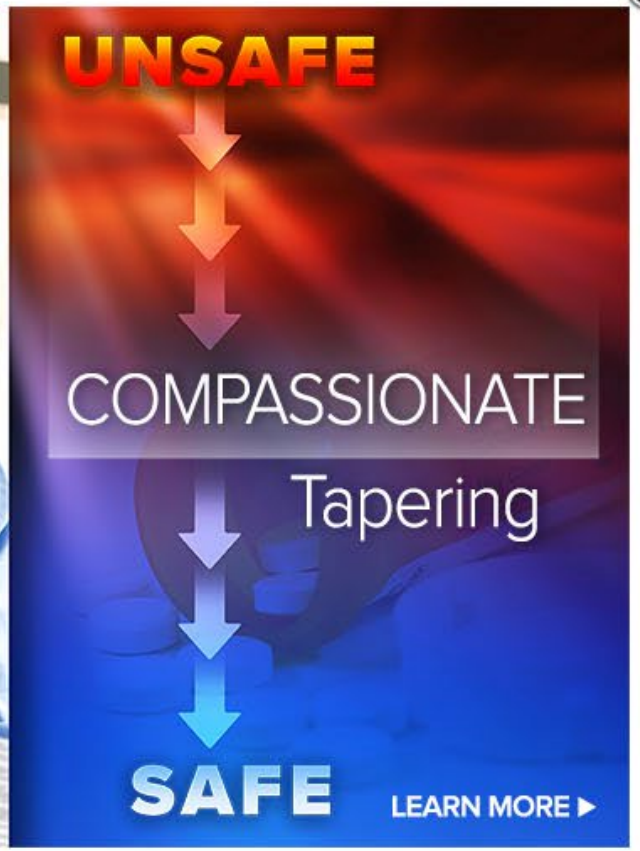
OPG
OREGON PAIN GUIDANCE
The Oregon state resource for healthcare professionals treating pain

Select Language

PAIN EDUCATION TOOLKIT

Improve your health and help manage pain with the
PAIN EDUCATION TOOLKit
Find educational videos and handouts on:

HOW PAIN WORKS | MOOD | FOOD | SLEEP



Updates ▸

NEWS

February 26, 2019
FDA Announces 2019 Agenda for Continued Action to Address Opioid Abuse

Tri-Counties
Tri-County Opioid Dental Provider Collaborative

Tapering – Guidance & Tools

Guidance & Tools Overview

Over the last 20 years, the liberal prescribing of opioids for chronic pain has created a population of patients who been on long term opioid therapy (LTOT) for several years if not decades. Many patients are on doses well above the CDC recommended upper limit of 90 Morphine Equivalent Dose (MED) for new starts. Patients, however, may be reluctant to taper, fearing withdrawal and increased pain. Prescribers are also asking whether or not tapering is necessary if the patient is stable and compliant on their current dose. Yet, overdose rates continue to be high compared to historical standard and it is well established that patients on high doses of opioids are at increased risk for a variety of side effects, serious morbidities, and death. Quality of life may be adversely affected, despite the fact that the patient perceives benefit in terms of pain relief. Recent research found no significant difference for pain relief between opioid and non-opioid treatment. (ref. The SPACE Randomized Clinical Trial)

For this legacy patient population, prescribers need to carefully assess the risks versus the benefits of continued opioid therapy. In some cases, where the risks are minimal and the patient appears to be doing well, continued opioid therapy may be justified. In many cases though a *thorough and systematic risk benefit assessment* (RBA) will reveal continued pain and dysfunction that indicate that a taper should be initiated and other non-opioid therapies some be employed, including referral to behavioral health or other specialists. A Systematic Review of 67 studies suggests that several types of interventions may be effective to reduce or discontinue LTOT and that pain, function, and quality of life may improve with opioid dose reduction, but the evidence is of very low quality (ref. A Systematic Review, by Frank et al 2017). It's important to recognize that tapering is an art, not an exact science and the speed and duration of the taper should be tailored to the individual needs of the patient.

Below are some guidelines and tools that will help prescribers assess and weigh risks versus benefits, and decide whether tapering is indicated. For tapering to be successful, clinicians must approach the

Risk Benefit Assessment

Risk Benefit Assessment & Flowchart

Assessing the Risks and Benefits

We recommend that all legacy patients have a systematic assessment of the risks and benefits of continued opioid therapy. In some cases, where the risks are minimal, and the patient appears to be doing well, continued opioid therapy may be justified. In many cases though a *thorough and systematic risk benefit assessment* (RBA) will reveal continued pain and dysfunction that indicate that a taper should be initiated, in conjunction with increased use of non-opioid therapies and possible referral to behavioral health or other specialists.

The patient should be monitored carefully, with a risk – benefit assessment performed quarterly. The following is a list of potential benefits and risks:

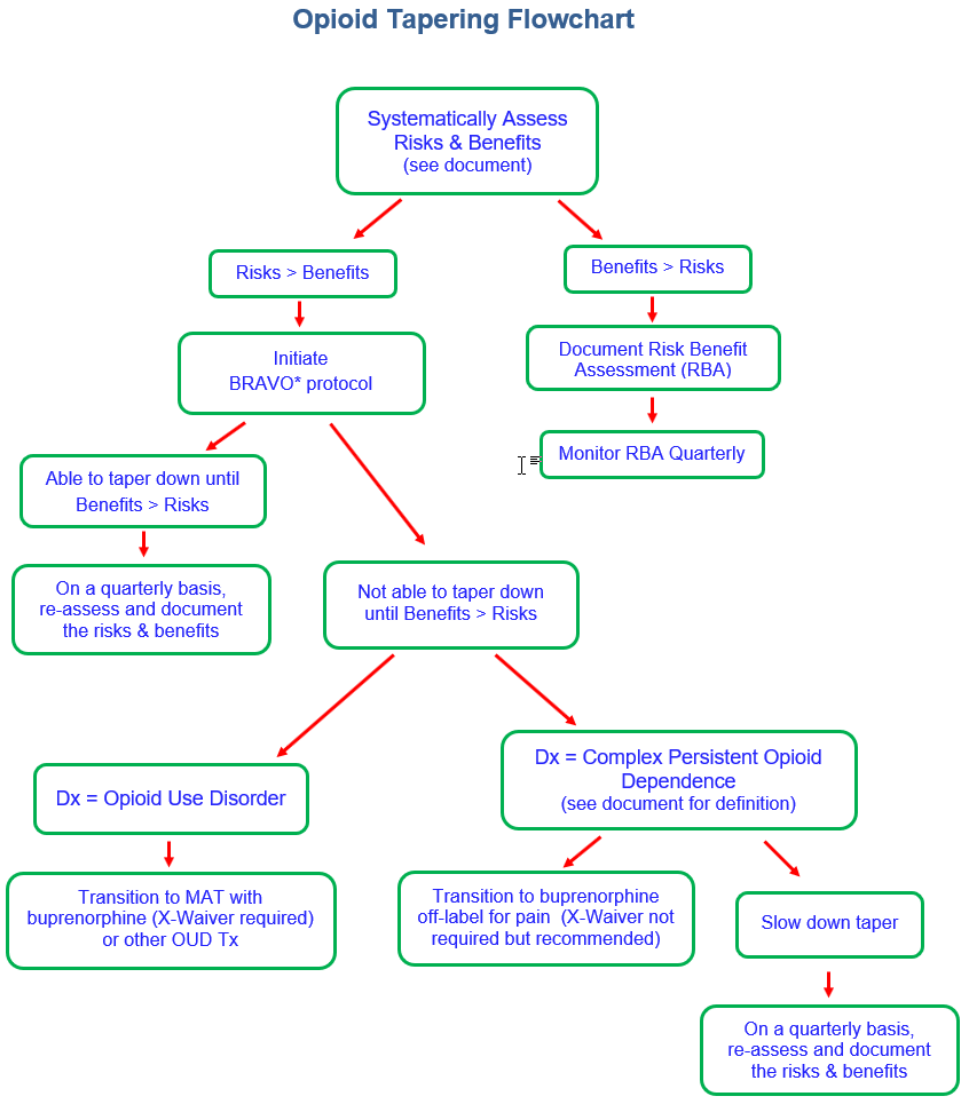
Benefits of Opioid Therapy

- **Improved quality of life** – Check if patient is engaged in more activities, has more social interactions, improved sleep, and improved mood. (Screening tools: PEG, Oswestry)
- **Improved pain relief** – Check if patient benefits from significant pain relief and that pain is less likely to interfere with activities. Note – While it is difficult to assess, patients may confuse pain relief with relief of withdrawal symptoms between doses. (Screening tools: pain scores, PEG)

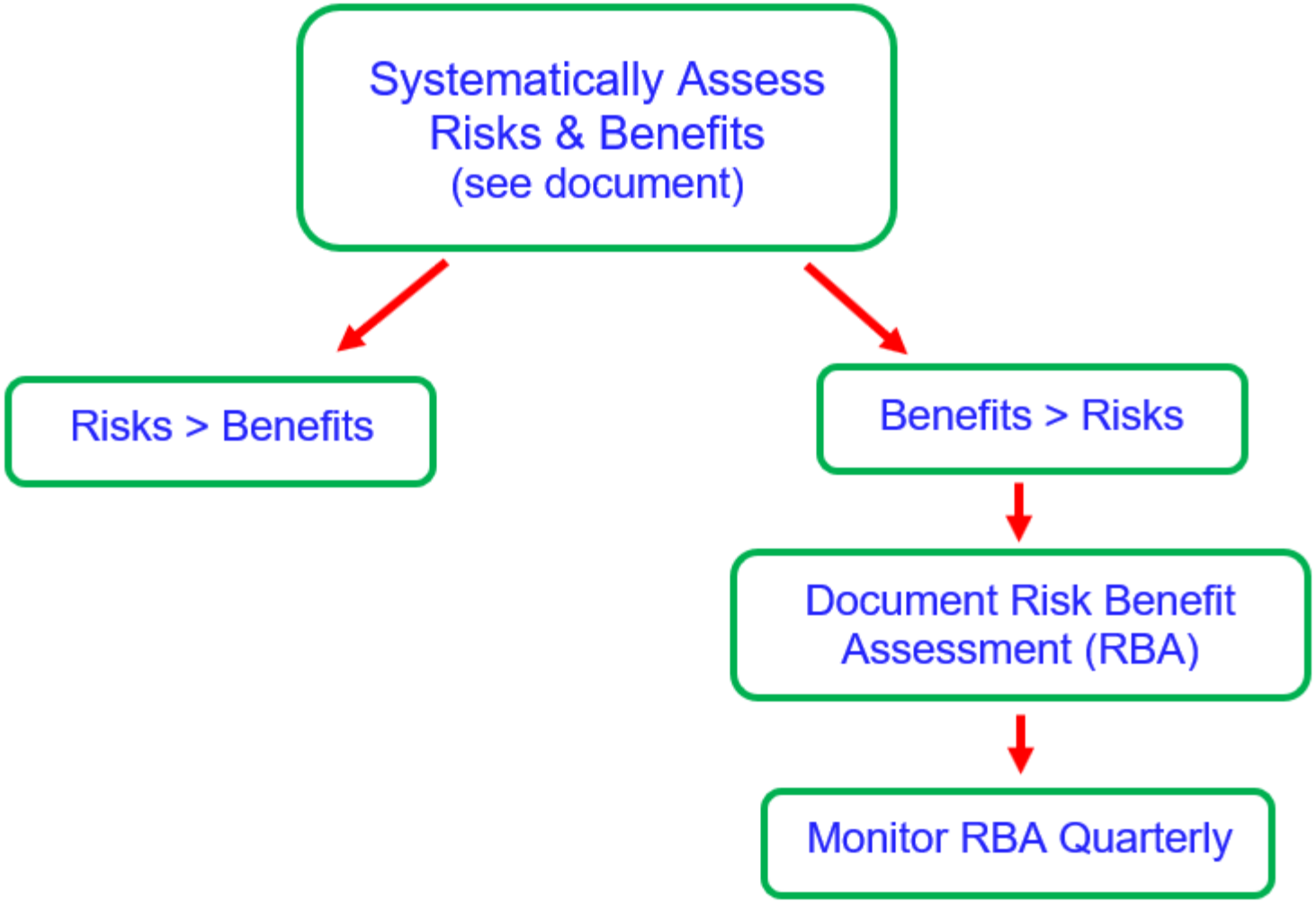
Risks of Opioid Therapy

- **OUD or CPOD** – Check if patient meets criteria for a diagnosis of Opioid Use Disorder (OUD) diagnosis or Complex Persistent Opioid Dependence (CPOD). *See definitions below.*
- **Dose over 90 MED** – This factor should prompt consideration of tapering to a lower dose.
- **Addiction and mental health disorders** – Past history, family history, and psycho-social stressors are all risk factors predicting a poor response to opioids. (Screening tools: ORT, SOAPP-R, SOAPP-8)
- **Co-morbid conditions** – Co-morbid conditions can increase the risks from opioids: respiratory disease (COPD, Sleep Apnea, etc.), abnormalities in the endocrine system (depressed testosterone, hypoxemia), cardiac arrhythmias, obesity, dementia, fibromyalgia, depression, anxiety, substance use disorder, history of drug overdoses. (Screening tools: PHQ-9, GAD-7, PC-PTSD, STOP-Bang)
- **Opioid adverse effects** – Ask about opioid related adverse effects such as: constipation, lethargy, sexual dysfunction, confusion, depression, increased risk for falls and fractures, immune suppression, and respiratory depression. These adverse effects may affect quality of life or present risk for serious medical consequences.
- **Co-prescribed sedative hypnotics**. Benzodiazepines, alcohol, carisoprodol and other substances can increase the risks of serious side effects and death when combined with opioids. (Check the

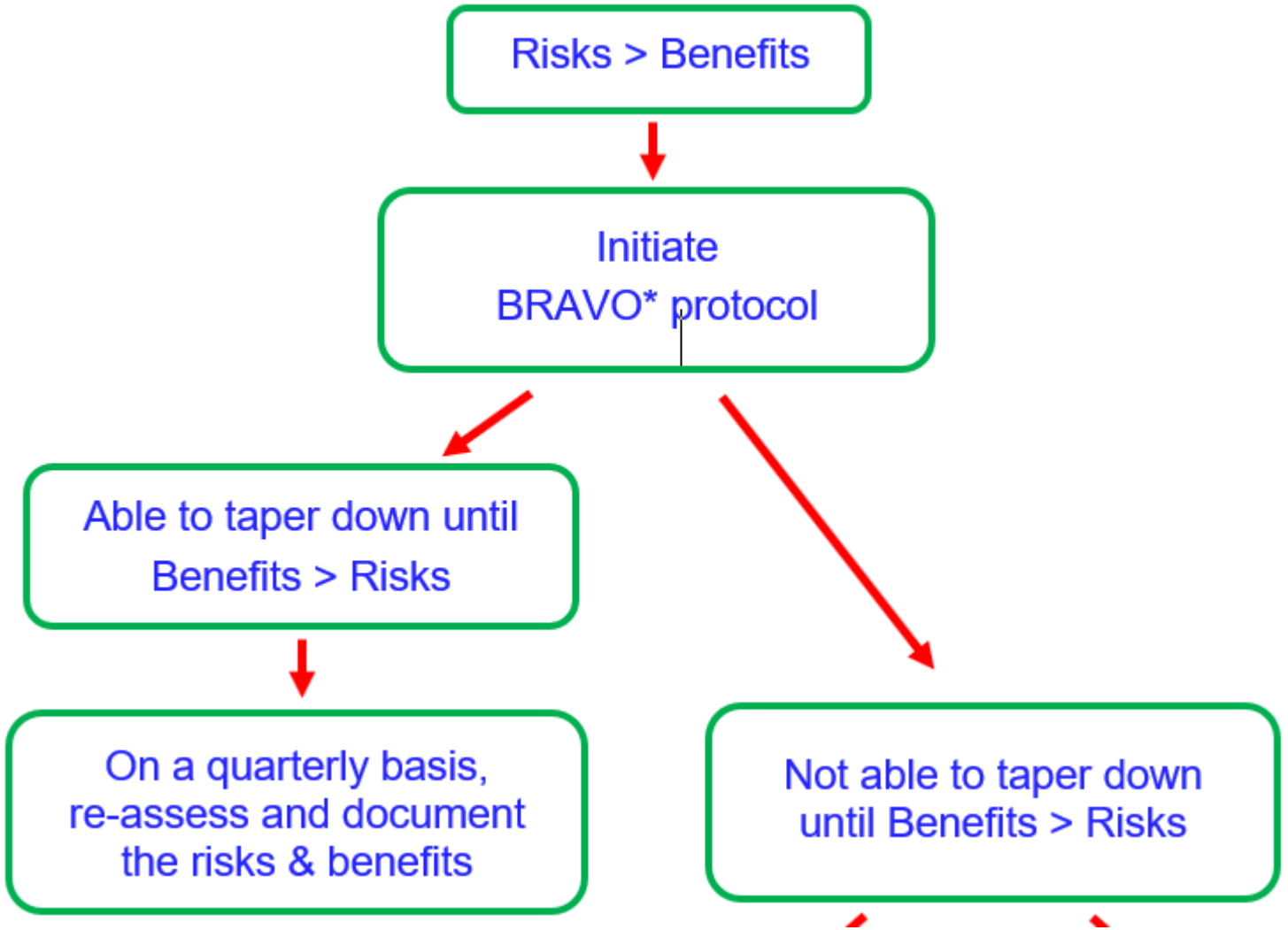
Tapering Flowchart



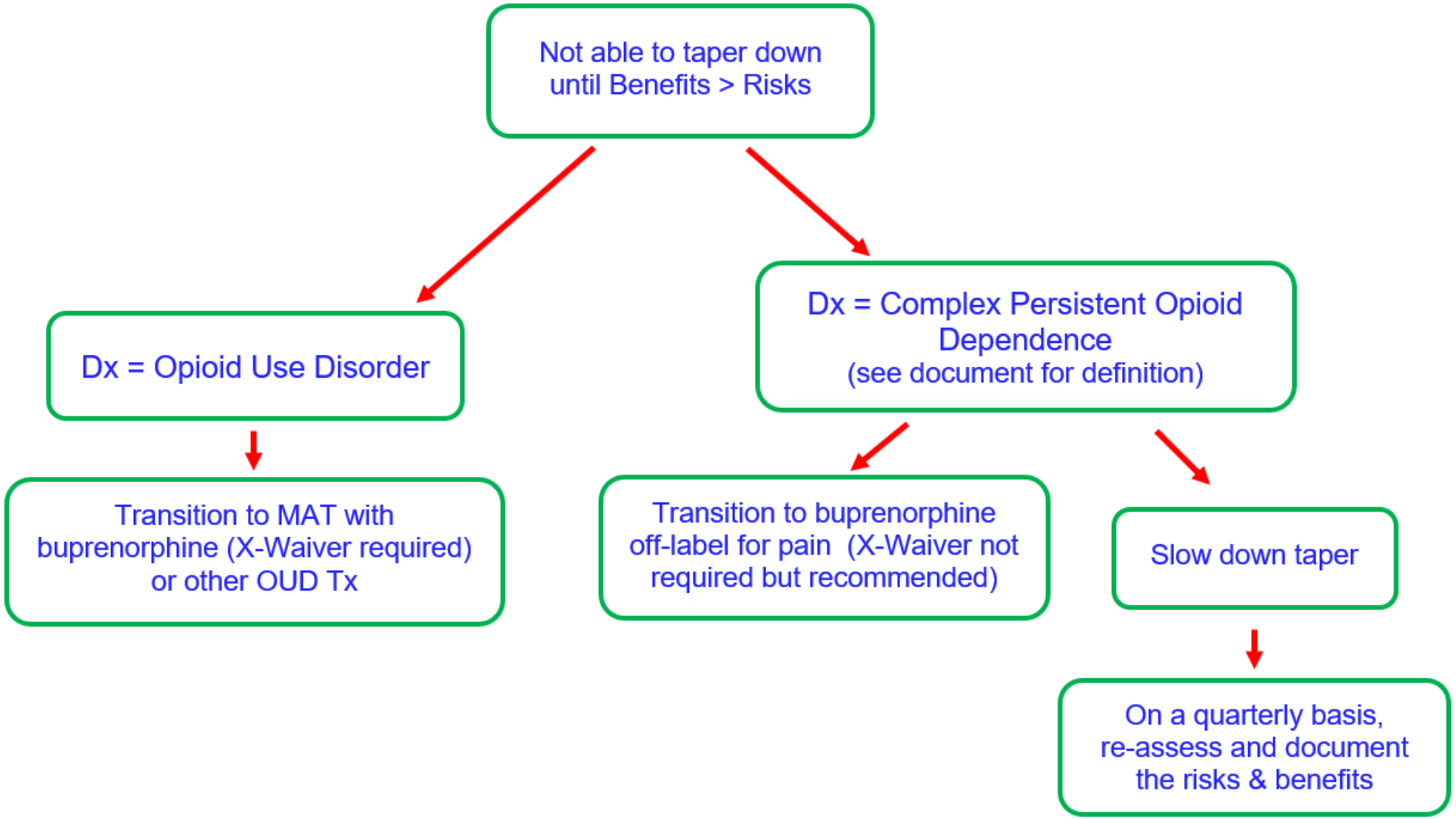
Tapering Flowchart



Tapering Flowchart



Tapering Flowchart



Complex Persistent Opioid Dependence

- **Complex Persistent Opioid Dependence (CPOD)**
- ***Complex***: Dependence is complicated by desire to continue taking opioid for the treatment of pain. Withdrawal is complicated by anhedonia and hyperalgesia which, unlike classic 'physical' symptoms, may not reverse within days.
- ***Persistent***: Tapering is poorly tolerated. Tapering, therefore, may fail, or is highly protracted (takes months or years).
- ***What distinguishes CPOD from OUD*:**
  - No craving
  - No compulsive use
  - No harmful use that is not medically directed (patient takes opioid exactly as prescribed)
  - Social disruption is attributed to pain and not to OUD

Credit: Dr. Jane Ballantyne

BRAVO Protocol – Dr. Lembke, Stanford

Broaching the Subject

→ Schedule enough time with your patient to have a discussion on this difficult topic
→ Anticipate the patients strong emotional reaction
→ Identify the feelings, normalize those feelings and express empathy with the concerns they may have

Risk-Benefit Calculator

→ When assessing benefits, weigh a patients' pain relief against their functionality
→ Involve family members for more objective views on a patient's opioid use
→ Track common risks such as tolerance & opioid-induced hyperalgesia
→ Include all of these factors with discussing reasons for tapering off opioids

Addiction Happens

→ Addiction is defined by The Three C's: *Compulsive use, Continued use despite consequences, and use that is out of Control*
→ Dependence happens when a body relies on a drug to function normally
→ Dependence and Addiction are not equivalent

BRAVO Protocol – Dr. Lembke, Stanford

Velocity Matters—and So Does Validation

→ Go Slowly, take the necessary time to ease your patients down on their doses
→ Let the patient be involved when deciding how much to decrease & at what time
→ It is O.K. to take breaks in lowering the dosage
→ Never go backwards; your patient's tolerance will increase & progress will be lost

Other Strategies for Coping with Pain

Teach patients these three Dialectical Behavior Therapy (DBT) practices:

→ STOP: *Stop, Take a breath, Observe internal & external experiences, & Proceed mindfully*
→ Opposite Action Skills: acting opposite to a negative emotional urge in the service of pursuing values or goals
→ Radical Acceptance: accepting reality as it is and not as we wish it would be

These materials are part of the Stanford Medicine Center for Conitinuing Medical Education (CME) Online Activity: *How to Taper Patients Off of Chronic Opioid Therapy*

Stanford | MEDICINE

Oregon Opioid Taper Task Force

OHA is seeking experts and community members willing to serve on the Oregon Opioid Taper Guidelines Task Force, an approximately five-month process to identify tapering best practices.

OHA has a continued interest in transparency, so the taper guidelines task force members will meet in public, as have all prior opioid guidelines task forces convened by the agency.

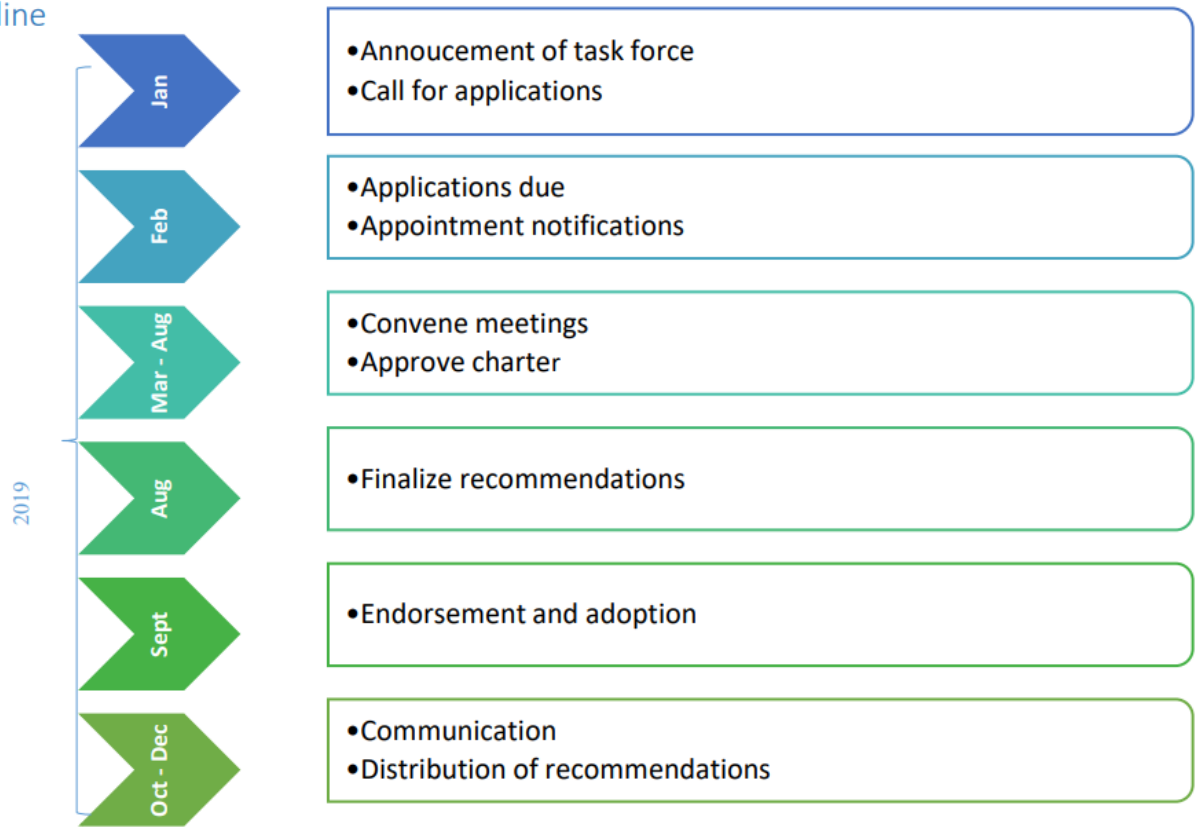
The resulting guidelines will provide a framework for clinicians and patients looking to develop their own taper plans, as well as a starting point for dialogue between patient and provider.

Oregon Opioid Taper Task Force

Oregon Health Authority
Oregon Opioid Taper Guidelines Task Force
OVERVIEW

Oregon Health Authority

Timeline



OHA Health Evidence Review Commission

The Health Evidence Review Commission (HERC) reviews medical evidence in order to:

- prioritize health spending in the Oregon Health Plan and to
- promote evidence-based medical practice statewide through comparative effectiveness reports, including coverage guidances and multisector interventions, health technology assessments and evidence-based practice guidelines.

Website: https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/index.aspx

Coverage Guidance Process

https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Coverage-Guidance-Process.aspx

Schedule

- Opioid Tapering Task Force completes recommendations (September 2019)
- Communicate and distribute recommendations (Oct – Dec 2019)
- HERC completes coverage guidances – after Tapering Task Force recommendations

Q & A

Thanks!