Overcoming the Challenges to Treating Patients on Concomitant Opioid and Benzodiazepine Therapy

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Today's Speaker

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- Graduate of UNMC College of Pharmacy 2016
- Completed a one-year managed care residency at the health plan
- Developed an interest in the opioid epidemic
- Collaborates with Nebraska DHHS and NMA
- Enrolled at UNMC College of Public Health

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Disclosure

Kyle Stirewalt, Pharm.D.

Dr. Stirewalt has listed no relevant financial relationship that would be considered a conflict of interest.

I will be describing the off-label use of medications.

Objectives

1. Discuss the morbidity and mortality associated with concomitant opioid and benzodiazepine therapy
2. Summarize the evidence to support therapies for the treatment of anxiety, insomnia, and pain
3. Evaluate strategies for tapering opioid analgesics and benzodiazepines
4. Discuss strategies to engage patients in difficult conversations and outline appropriate patient selection for referral to specialty care

Part 1

Morbidity and Mortality

Opioid Analgesics

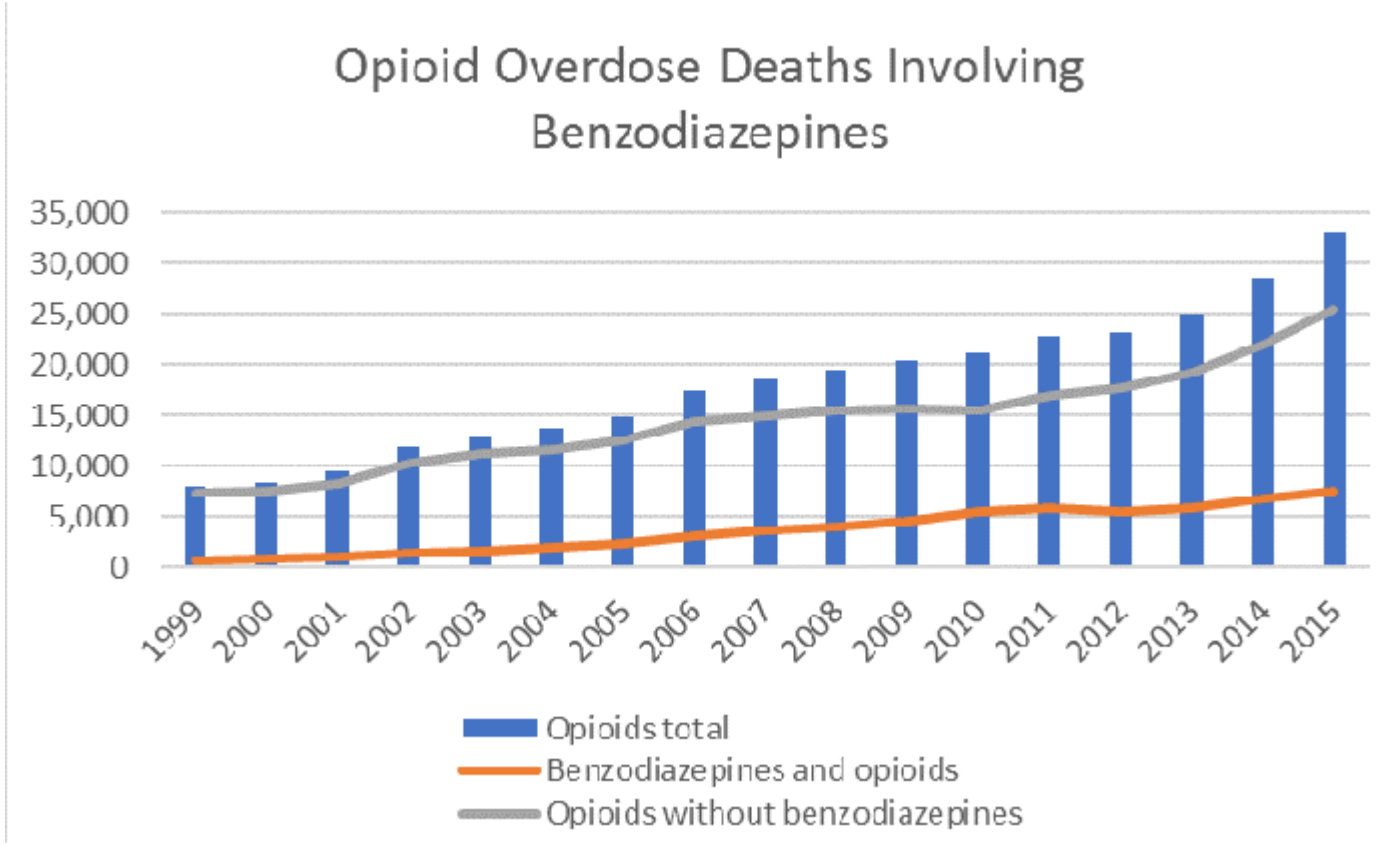
- Opioid analgesics are commonly used for the treatment of moderate to severe pain
  - Includes natural opiates (e.g., morphine), semi-synthetic opioids (e.g., oxycodone, hydrocodone, heroin), and synthetic opioids (e.g., fentanyl)[1]
- Opioids interact with μ, κ, and δ receptors in the central nervous system (CNS), altering the perception of pain while producing several other central and peripheral effects[1]
  - Actions at the μ-receptors are thought to produce pain relief while mediating abuse potential[1]
- Inhibition of the respiratory centers via the μ and δ-opioid receptors produce respiratory depression[1]
  - Respiratory depression is the primary mechanism of opioid-related overdose death[1]

Benzodiazepines

- Benzodiazepines are used for their anxiolytic, sedative, hypnotic, and anticonvulsant effects
  - Examples include alprazolam, clonazepam, diazepam, and lorazepam[1]
- The effects of benzodiazepines are thought to be mediated through the inhibition of the neurotransmitter γ-aminobutyric acid (GABA)[1]
- Inhibitory GABA receptors are highly concentrated in CNS respiratory centers, allowing benzodiazepines to alter respiratory frequency[1]
- The pharmacodynamic drug interaction that occurs with the co-administration of opioids and benzodiazepines leads to a synergistic increase in respiratory depression, increasing the risk of drug overdose death[1]

Morbidity and Mortality

- The increase in opioid overdoses involving benzodiazepines has been associated with a portion of the increased rate of drug overdoses observed over the past decade[2]
- In 2011, benzodiazepines were involved in 31% of opioid-related overdose deaths, up from 13% of opioid-related deaths in 1999[2]
- The rate of emergency room visits involving both opioid therapies and benzodiazepines increased from 11 per 100,000 population in 2004 to 34.2 per 100,000 in 2011[3]
- During this same period, drug overdose deaths involving the combination of these therapies increased from 0.6 per 100,000 population to 1.7 per 100,000[3]
- Recent studies have found benzodiazepines to be involved in 68.4% of prescription opioid-related deaths in New York City, while the rate of overdose death in North Carolina was ten times higher for patients co-prescribed opioids and benzodiazepines versus opioids alone[4,5]



Source: Centers for Disease Control and Prevention (CDC)[6] Multiple Cause of Death, 1999-2015

Recent Warnings and Guidelines

- In 2016, the U.S. Food and Drug Administration (FDA) required updated labeling of benzodiazepines to warn about their risks when combined with opioids[7]
- The Center for Disease Control and Prevention (CDC) recommends avoiding the concomitant use of opioids and benzodiazepines whenever possible[8]
- In 2017, the Nebraska Department of Health and Human Services published the Nebraska Pain Management Guidance Document in collaboration with an expert advisory task force, active providers, and state officials[9]
- This document included several of the CDC recommendations for opioid therapies, along with several additional resources for treating patients who are receiving concurrent benzodiazepine and opioids[9]

Survey of Prescribers Perspectives

- Providers have reported several barriers that contribute to continued co-prescribing of opioids and benzodiazepines despite a strong agreement with clinical practice guidelines[10]
- In a study surveying primary care and mental health prescribers in the Pacific Northwest, 40% of providers indicated that co-prescribing opioids and benzodiazepines continues because patients appear stable on therapy and tapering is too difficult[10]
- Other barriers listed include the difficulty of addressing patients who refuse to discontinue treatment and the lack of alternative treatments[10]

Needs Assessment of Nebraska Physicians

- In coordination with the Nebraska Medical Association, a survey was distributed to Nebraska physicians in February 2019 to assess current challenges to treating patients prescribed opioids and benzodiazepines
- There were 79 survey responses received
- The most common reported physician specialties were:
  - Family Medicine (43.6%)
  - Internal Medicine (9%)
  - Surgery (6.4%)
  - Psychiatry (6.4%)
- The majority of respondents practiced in urban settings (71.1% urban vs. 28.9% rural)

Needs Assessment of Nebraska Physicians

- Respondents indicated the following contribute to patients remaining on concomitant opioids and benzodiazepines
  - 63.3% agreed or strongly agreed that patients appear stable on these medications with no adverse effects
  - 63.3% agreed or strongly agreed that it is difficult to coordinate with other prescribers to taper therapies
  - 26.6% agreed or strongly agreed that the benefits of concomitant opioids and benzodiazepines appear to exceed the risks
- Respondents indicated there are limited alternative treatments for anxiety and pain and a lack of practical methods for tapering opioids and benzodiazepines
- In free response sections of the survey, respondents stated they frequently meet resistance from patients unwilling to taper
- Respondents stated they would like information on discussing these topics with patients

Part 2

Recommended Treatment of Generalized Anxiety, Panic Disorder, and Insomnia Disorder

Generalized Anxiety Disorder and Panic Disorder

- Generalized anxiety disorder (GAD) and panic disorder (PD) are some of the most common mental health disorders in the United States[11]
- GAD is characterized by excessive and out-of-control worrying while PD is associated with recurrent panic attacks[11]
- There are a range of psychosocial and pharmacological treatments for GAD and PD[11,12]
- Psychotherapy can be as effective as medication for GAD and PD[11,12]
  - Cognitive behavior therapy (CBT) has the best level of evidence[11,12]
- CBT may involve applied relaxation, breathing, cognitive restructuring, or education[11,12]
- There is evidence that the combination of medication and psychotherapy may be more effective than either treatment alone[11,12]

Medications for GAD and PD

- First-line therapies for the treatment of GAD and PD include:[11,12]
  - Selective serotonin reuptake inhibitors (SSRIs) such as sertraline and fluoxetine
  - Serotonin-norepinephrine reuptake inhibitors (SNRIs) such as duloxetine and venlafaxine ER
    - Duloxetine only adequately evaluated in GAD
  - Buspirone
    - Does not appear to be effective in PD
- Second-line therapies include:[11,12]
  - Tricyclic antidepressants (TCAs) such as amitriptyline
    - Better studied for PD, but likely effective for both GAD and PD. Adverse effects limit their use in some patients.
  - Hydroxyzine
    - Minimal data in PD, may be considered alternative to benzodiazepine due to rapid onset of action.
  - Antiepileptics, antipsychotics, monoamine oxidase inhibitors (MAOs)

Benzodiazepines in GAD and PD

- Benzodiazepines can be used adjunctively with antidepressants to treat residual anxiety symptoms or used first-line for certain patients with impairing symptoms in which rapid symptom control is needed[11]
- When used with antidepressants, benzodiazepines may speed recovery from anxiety symptoms but do not improve longer-term outcomes[11]
- High doses of benzodiazepines are associated with memory impairment, while long-term use may be associated with declined cognitive function[12]
- Dependence and tolerance can be problematic with longer-term use[11]
- Short-acting benzodiazepines such as alprazolam are not preferred as they have a higher risk of addiction and adverse effects[11]

Insomnia

- Insomnia disorder is characterized as the complaint of trouble initiating or maintaining sleep with associated daytime consequences[13]
- Insomnia is not attributable to environmental circumstances or inadequate opportunities to sleep[13]
- The disorder is considered ‘chronic’ when it has persisted for at least three months while occurring at least three times per week[13]
  - If less than three months, it is considered short-term insomnia
- The American College of Physicians (ACP) and the American Academy of Sleep Medicine (AASM) recommend patients receive CBT as initial treatment for chronic insomnia disorder[13,14]
- A shared decision-making approach should be used to discuss the benefits, harms, and costs of short-term use of medications if CBT alone was unsuccessful[13,14]

Medications for Insomnia

- The following therapies are recommended for sleep onset insomnia in adults (weak):[13]
  - "Z-drugs": eszopiclone, zaleplon, or zolpidem
  - Benzodiazepines: triazolam, temazepam
  - Ramelteon (Rozerem®)

- The following therapies are recommended for sleep maintenance insomnia in adults (weak):[13]
  - "Z-drugs": eszopiclone or zolpidem
  - Benzodiazepines: temazepam
  - Suvorexant (Belsomra®)
  - Doxepin (Silenor®)

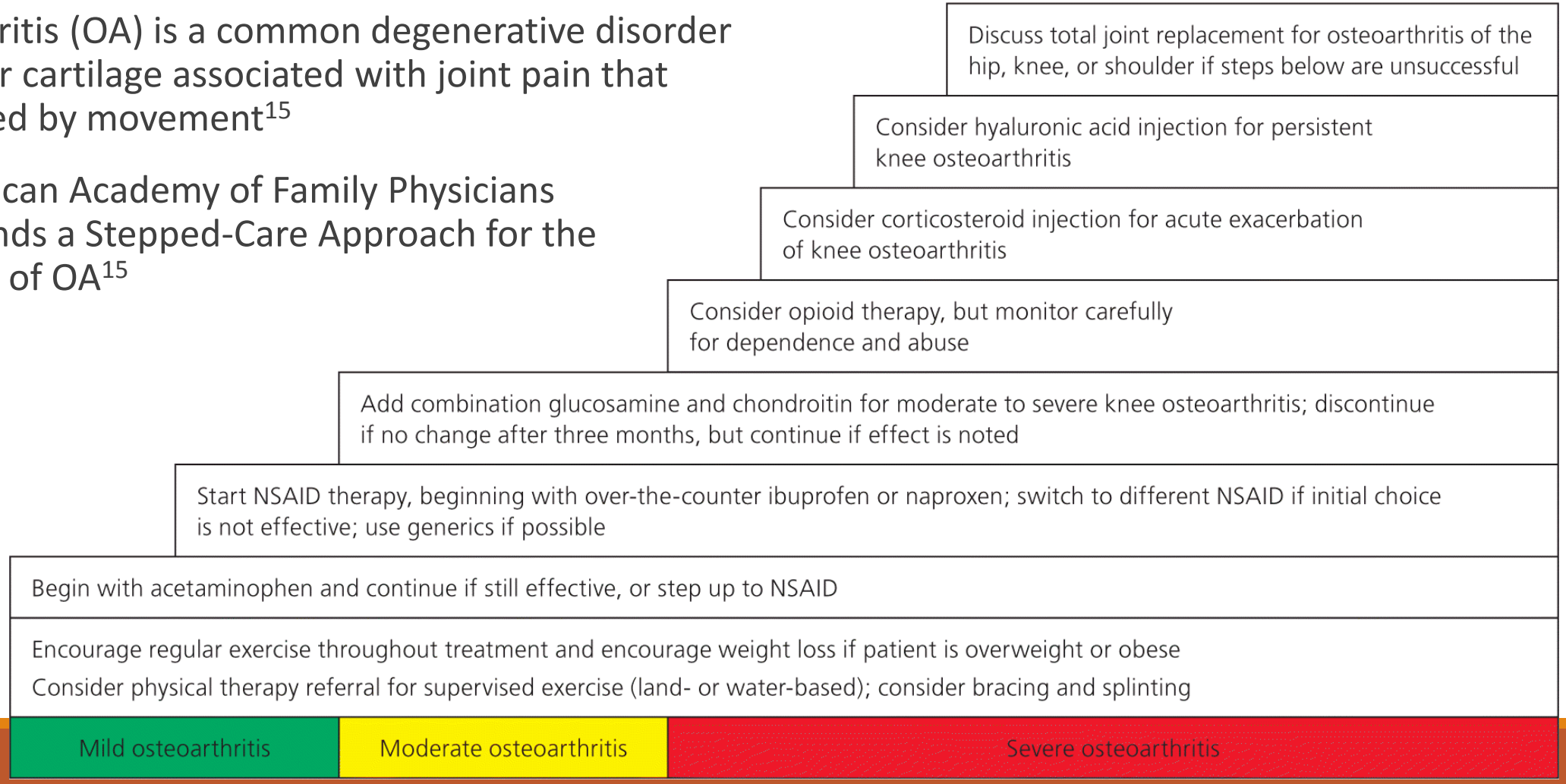
- Therapies not recommended: trazodone, tiagabine, diphenhydramine, melatonin, tryptophan, valerian[13]

Part 3

Recommended Treatments for Common Types of Chronic Pain

Osteoarthritis

- Osteoarthritis (OA) is a common degenerative disorder of articular cartilage associated with joint pain that is worsened by movement[15]
- The American Academy of Family Physicians recommends a Stepped-Care Approach for the treatment of OA[15]



Osteoarthritis

- The American College of Rheumatology recommends several different non-pharmacological and pharmacological treatments for the treatment of hand, hip, and knee OA [16]
- Select Recommendations for **Hand OA**
  - Instruct joint protection techniques and use of thermal modalities, provide splints if appropriate
  - Topical capsaicin, topical NSAIDs, oral NSAIDs, tramadol

Select Recommendations for **Knee OA**

- Participate in aerobic and/or resistance exercise, aquatic exercise, and lose weight (if overweight)
- Acetaminophen, topical NSAIDs, oral NSAIDs, tramadol, intraarticular corticosteroid injections

- Select Recommendations for **Hip OA**
  - Participate in aerobic and/or resistance exercise, aquatic exercise, and lose weight (if overweight)
  - Acetaminophen, oral NSAIDs, tramadol, intraarticular corticosteroid injections

Migraine – Acute Treatment

- Migraine is a common and disabling condition that has been experienced by about 44.5 million adults in the US and is the fourth most common cause of Emergency Department visits[17]
- Recommended first-line acute treatments include NSAIDs for mild to moderate migraine and triptans (such as sumatriptan) for moderate to severe migraine[17]
  - Second line treatments include dopamine antagonists such as prochlorperazine and metoclopramide[17]
  - Dihydroergotamine, magnesium, valproate, and opioids should be reserved for refractory migraine[17]
- Eletriptan may be more likely to produce sustained responses compared to other triptans[18]
- Tritpans plus NSAIDs may be more beneficial than either drug alone[19]
- Subcutaneous sumatriptan may be more effective than oral sumatriptan at the cost of increased adverse events[20]

Migraine – Prophylactic Treatment

- Studies suggest that while 38% of migraine patients may benefit from prophylactic therapy, only 3%-13% currently use it[21]
- The American Academy of Neurology recommends divalproex, sodium valproate, topiramate, metoprolol, propranolol, and timolol as effective treatments for the prevention of migraine[21]
  - Treatments recommended as 'probably' effective include venlafaxine and amitriptyline[21]
  - Botox is an effective alternative option for the prophylactic treatment of chronic migraine[21]
  - New calcitonin gene-related peptide (CGRP) antagonists are effective at preventing migraine[22-24]
- Excessive use of acute treatments for migraine may lead to worsening headaches over time[25]
- Patients that use acute treatments for migraine more than 10 days per month for at least 3 months meet diagnostic criteria for medication overuse headache (MOH) [25]
- In these patients, acute treatments should be tapered and prophylactic therapy should be initiated
  - Topiramate has been studied as a prophylactic therapy for migraine in MOH[25]
  - Other therapies can be used to treat withdrawal symptoms from tapering the acute treatment[25]

Neuropathic Pain

- Neuropathic pain is a chronic condition with varying etiologies that requires a different treatment approach compared to nociceptive pain[26]
  - An estimated 6.9-10% of the general population are affected by neuropathic pain[26]
- While treatment depends on the type of neuropathic pain, most approaches rely on TCAs (such as amitriptyline), SNRIs (such as duloxetine and venlafaxine) and gabapentin or pregabalin[26]
- AEDs such as carbamazepine can be effective for the treatment of trigeminal neuralgia[26]
- Topical lidocaine can be effective for post-herpetic neuralgia[26]
- Tramadol is recommended as a second-line option for several types of neuropathic pain prior to the use of stronger opioids[26]

Fibromyalgia

- Fibromyalgia is a chronic condition associated with generalized pain, fatigue, insomnia, anxiety, and unknown etiology[27]
  - Often diagnosed after excluding other conditions (such as neurological syndromes or depression)
- May impact between 0.5% to 5.8% of people in North America and Europe[27]
- Exercise has been shown to significantly improve pain and function[28]
- Other first-line non-pharmacologic therapies found to be effective include tai chi, massage therapy, and acupuncture[28]
- Recommended pharmacologic therapies include amitriptyline, gabapentin, pregabalin (Lyrica®), duloxetine, and milnacipran (Savella®)[27]
- Therapies that may not be effective include acetaminophen, NSAIDs, anxiolytics, and opioids[27]

Low Back Pain

- Low back pain is one of the most common reasons for physician visits in the US[29]
- About a quarter of US adults reported low back pain in the previous three months[29]
- The American College of Physicians (ACP) recently developed guidelines for the non-pharmacologic and pharmacologic non-invasive treatment of low back pain[29]
- These guidelines provide recommendations for acute, subacute, and chronic low back pain[29]
  - Acute back pain is defined as lasting less than 4 weeks
  - Subacute back pain is defined as lasting between 4 to 12 weeks
  - Chronic back pain is defined as lasting more than 12 weeks
- In general, non-pharmacological treatments are recommended as first-line therapy for acute, subacute, and chronic back pain

Low Back Pain

- Recommended treatment of acute and subacute back pain:[29]
  - Non-pharmacologic therapy with superficial heat is recommended with moderate-quality evidence
    - Low-quality evidence supports massage, acupuncture, or spinal manipulation
  - If pharmacological therapy is desired, NSAIDs or skeletal muscle relaxants are recommended
- Recommended treatment of chronic low back pain:[29]
  - For initial therapy, moderate-quality evidence supports the use of exercise, multidisciplinary rehabilitation, acupuncture, and mindful-ness based stress reduction
  - Low-quantity evidence supports the use of tai chi, yoga, CBT, spinal manipulation, and other therapies
  - In patients with inadequate response to non-pharmacologic therapies, NSAIDs are recommended as first-line therapy while duloxetine or tramadol are recommended as second line therapy
  - Opioids should be considered only if the above therapies have been tried and failed

Post-Operative Pain

- The majority of patients who undergo surgery experience inadequate postoperative pain relief[30]
- Conversely, studies show that patients often receive more opioids for home use than necessary after surgery[30]
- The American Pain Society, with input from the American Society of Anesthesiologists, published guidelines to promote evidence-based, effective, and safer postoperative pain management[30]
- These guidelines provide strong recommendations for the following practices:[30]
  - Patients and/or their caregivers should receive education on the postoperative pain management plan and goals
  - Providers should conduct a preoperative evaluation for comorbid conditions and current medications
  - Providers should consider giving a preoperative dose of celecoxib when not contraindicated
  - Multimodal analgesia combined with non-pharmacological interventions are recommended in many situations
  - Providers should consider gabapentin or pregabalin as components of multi-modal analgesia
  - NSAIDs and acetaminophen are recommended as part of multimodal analgesia for postoperative pain
  - Facilities should develop and refine policies and processes for effective postoperative pain control

Post-Operative Pain

- More opioids than necessary are often provided after surgery, which may result in diversion[31]
- Prolonged opioid use after surgery is associated with chronic opioid use and risk of misuse and overdose[31]
- The Bree Collaborative provides a framework for efficiently managing postoperative pain[31]
- For expected rapid recovery, ≤ 3 days of opioids (or 8 to 12 tablets) is recommended[31]
- For expected medium term recovery, ≤ 7 days of opioids (or up to 42 tablets) is recommended[31]
  - Re-evaluate patient before prescribing additional opioids and taper within 6 weeks of surgery
- For expected longer-term recovery, ≤ 14 days of opioids is recommended[31]
  - Re-evaluate patient before prescribing additional opioids and taper within 6 weeks of surgery

Part 4

Recommendations for Tapering Benzodiazepines

Tapering Benzodiazepines

- Tapering benzodiazepines is a difficult process due to the psychological and physiological dependence formed over time[32]
- During the tapering process, patients may experience several withdrawal symptoms, such as dizziness, recurrence of severe anxiety, insomnia, and others bodily symptoms[33]
- Immediate discontinuation of a benzodiazepine after long-term use can lead to severe withdrawal symptoms, such as life-threatening convulsions[33]
- In the needs assessment survey sent to Nebraska physicians, several respondents indicated that there was a lack of information on how to taper benzodiazepines in a practical setting
- Evidence to support the benefit of non-pharmacologic and pharmacologic therapies for benzodiazepine tapering are of low to very low quality[34]

General Approach

- The general approach to tapering a patient in the outpatient setting is to reduce the benzodiazepine daily dose by 5% to 25% every one to four weeks with larger reductions during the initial taper[32]
- Some guidelines state that patients can initially be switched to a longer-acting benzodiazepine (such as diazepam), however there is limited evidence to support this practice[32,33]
  - Although, the wide range of diazepam doses and formulations may aid the tapering process[33]
- Small studies suggest that CBT and patient education, such as written instructions from the provider or pharmacist counseling, can significantly increase tapering efficacy[35]
- A study of 532 patients using benzodiazepines daily for ≥6 months benefited from a primary care-based, structured, tapering intervention with follow-up visits and written instructions[36]
- There are no approved therapies for the treatment of benzodiazepine dependence, however medications can be utilized off-label in adjunct with non-pharmacological methods

Pharmacologic Treatments

- Medications such as **valproate**, **imipramine**, and **trazodone** may have benefit in improving the rate of benzodiazepine discontinuation[34]
- **Paroxetine**, **imipramine**, and **trazodone** may alleviate certain withdrawal symptoms[34]
- **Carbamazepine** and **paroxetine** may reduce the symptoms of anxiety after benzodiazepine discontinuation[34]
- **Valproate** has been shown to reduce the proportion of patients who relapse on benzodiazepines after discontinuation[34]
- **Melatonin** was well tolerated and improved sleep quality for some patients in small studies[34]
- **Hydroxyzine** has been shown to have modest effects on anxiety and can theoretically alleviate anxiety during tapering[33]

Tapering Benzodiazepine Summary

- The tapering process should be individualized to the patient with most approaches relying on a slow taper lasting up to 6 months to a year[33]
- The patient-provider relationship is crucial to success[32]
- Patient education and handouts can be useful in engaging the patients in their care plan[35]
- Frequent follow-up has been shown to be beneficial to improving tapering efficacy[36]
- Leverage community pharmacists[36]
- Utilize pharmacologic therapies as needed and as appropriate to treat symptoms[32,33,34]
  - Strongly consider starting the patient on a SSRI or TCA if not already on an antidepressant

Part 5

Recommendations for Tapering Opioid Analgesics

Tapering Opioids

- Tapering opioids is a difficult process due to strong dependence formed over time
- Tapering can be significantly hindered by a patient's comorbidities, environment, and coping skills[37]
- Discontinuing opioids is associated with significant widespread opioid withdrawal symptoms[37]
  - However, withdrawal is usually not life-threatening in patients without significant comorbidities
- Guidelines do not properly address evidence-based practices for opioid discontinuation[37]
- Several respondents to the survey distributed to Nebraska physicians indicated the following as barriers to tapering opioid therapies:
  - Patients are frequently unwilling to discontinue opioids
  - Patients dropout of care and seek other providers for opioid therapies
  - Withdrawal symptoms were noted as a significant barrier to tapering
  - Only 14.3% of respondents usually or always prescribe therapies such as hydroxyzine or clonidine for withdrawal side effects when tapering opioids

Taper Speed

- There is limited evidence to support one tapering strategy over another[37]
- A gradual reduction in dose is required to minimize withdrawal symptoms[37]
  - Duration of taper may depend on current opioid dose and duration of opioid treatment
  - Rapid tapers (within days) can be an option for certain patients without significant comorbidities
- A paper published in Mayo Clinic Proceedings recommends the following strategy to facilitate taper adherence while rarely inducing withdrawal symptoms:[37]
  - Initial dose decrease of 10% of the original dose every 5 to 7 days until 30% of the original dose is reached, then continue with weekly decrease by 10% of the remaining dose
- Taper Calculator provided by the Washington State Health Care Authority: [38] https://www.hca.wa.gov/search/site/opioid%20taper%20calculator?section=%2A

Pharmacologic Treatments

- Opioid withdrawal syndrome is associated with symptoms of sympathetic stimulation[39]
  - This is due to the decreased sympathetic antagonism by opioids
- These symptoms include irritability, insomnia, hypertension[39]
- Alpha-2 adrenergic agonists such as **clonidine** reduce sympathetic outflow from the CNS and are effective at treating certain opioid withdrawal symptoms[39]
  - A systematic review found that patients using these therapies had lower peak withdrawal scores and were more likely to stay in treatment[39]
- Other supportive therapies can be utilized for the treatment of symptoms associated with opioid withdrawal[40,41]
  - **NSAIDs** or **acetaminophen** for muscle aches or fever
  - **loperamide** or **bismuth subsalicylate** for diarrhea
  - **Ondansetron** or **prochlorperazine** for nausea
  - **Dicyclomine** for cramping
  - **Trazodone** or low dose **doxepin** for insomnia
  - **Hydroxyzine** for anxiety

Non-pharmacologic

- Patients should be thoroughly educated on expectations after opioid discontinuation[37]
  - Studies of long-term opioid treatment tapers have shown improvements in function without associated worsening in pain
  - Sensory hyperalgesia may appear immediately and briefly after opioid discontinuation and is time-limited
- Tapering agreements should include a provision for failure[37]
  - The absence of a provision for taper failure is a key predictor of opioid tapering dropout or relapse
- Psychosocial therapy may be beneficial for patients with key predictors for taper failure and is especially recommended for patients with opioid use disorder (OUD)[37]
- Hydration is important, particularly in patients suffering from nausea and vomiting symptoms
  - While symptoms are generally not fatal, death has occurred in criminal justice settings due to dehydration[42]

Monitoring During Taper

- Depression, high pain scores, and high baseline opioid doses are predictors of opioid tapering dropout or relapse[37]
  - Monitor depression, stress, and pain throughout and after the tapering process
- Opioid withdrawal symptoms usually begin 2 to 3 half-lives after the last dose of opioid, peak at around 48 to 72 hours, and resolve within 7 to 14 days[37]
  - Duration of symptoms will depend on the dose of opioid, speed of taper, and duration of use
- Providers can utilize withdrawal scales such as the clinical opiate withdrawal scale (COWS), the subjective opioid withdrawal scale (SOWS), and the objective opioid withdrawal scale (OOWS) to track symptoms while tapering[39]
- Pause or slow taper in times of stress and while treating through withdrawal symptoms[37]

Other Considerations

- Ensure patients receive pain management with non-opioid therapies[37]
- Mandatory opioid weans have been associated with increased dropout rates, particularly in patients on high levels of opioids[37]
  - An international stakeholder community of pain experts and leaders recently called for an urgent action on forced opioid tapering mandated by prescribing and health insurance policies[43]
- Patients are at an increased risk for self-harm and suicide while tapering
  - In a study of patients undergoing outpatient opioid tapering in the United Kingdom, “patient risk of mortality was as high as triple the normal mortality rate from suicide or overdose after the conclusion of a taper program”[39]
- As tolerance to opioids decreases upon discontinuation, risk for overdose increases[37]
  - Incorporate into patient education and provide prescription and counseling for naloxone use

Medication-Assisted Treatment (MAT)

- Some studies have shown decreased dropout rates when patients are referred to MAT vs. a standard tapering protocol[44]
- Evidence from several studies, including 3 randomized clinical trials and a large open-label observational study, support the benefits of MAT[44]
- Reported clinical outcomes from MAT include:[44]
  - Reduced opioid use and craving and greater percentage of urine samples negative for opioids
  - Sustained sobriety at 6 and 18 months in a majority of patients
  - Increased employment and improved functional status
  - Slight reductions in pain scores, improved sleep, and improved quality of life
- Additional notes[44]
  - Has been studied in pregnant women
  - Ceiling effect limits its use as an analgesic

Tapering Resources for Providers

- Washington State Health Care Authority contains a helpful opioid taper calculator:[38]
  - https://www.hca.wa.gov/search/site/opioid%20taper%20calculator?section=%2A
- Recommendations published in May Clinic Proceedings, including a table of medicolegal risk mitigation strategies for opioid tapering[37]
  - https://www.mayoclinicproceedings.org/article/S0025-6196(15)00303-1/pdf
- CDC Pocket guide for opioid tapering[45]
  - https://www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf
- Tapering Toolkit provider resource[40]
  - http://www.partnershiphp.org/Providers/HealthServices/Documents/Managing%20Pain%20Safely/TAPERING%20TOOLKIT_FINAL.pdf
- Opioid taper decision tool provided by the VA[41]
  - https://www.pbm.va.gov/AcademicDetailingService/Documents/Pain_Opioid_Taper_Tool_IB_10_939_P96820.pdf

Part 6

Monitoring and Engaging Patients in Difficult Conversations

Monitoring Treatment

- Standardized assessment tools and resources provide supplemental information to assess for risk and treatment outcomes while reducing bias[46]
- The sensitivity and specificity of tools may vary and should not be considered absolute determinants of treatment decisions[46]
- The 9-item Patient Health Questionnaire (PHQ-9) can be an effective measure of depression symptom severity and treatment outcome and as a screener for a current depressive episode[47]
- The 7-Item Generalized Anxiety Disorder (GAD-7) scale is a valid and efficient tool for assessing the severity of and screening for generalized anxiety disorder[48]
- The 3-Item Pain Scale (PEG) scale is a practical and useful tool to assess and monitor chronic pain[49]

Monitoring Treatment

- The Screener and Opioid Assessment for Patients with Pain (SOAPP) is a valid tool used to predict the risk for prescription opioid misuse[50]
- The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) provides criteria for determining if a patient has characteristics consistent with opioid use disorder[8]
- State-based Prescription Drug Monitoring Programs (PDMP) can be used to conduct an accurate reconciliation of medications that the patient has been dispensed[51]
  - The Nebraska PDMP includes data for all controlled AND non-controlled medications dispensed[9]
  - PDMPs have been shown to be effective at improving clinical decision-making, reducing doctor-shopping, and reducing diversion[51]
- Urine drug screens can be used to assess use of prescribed medications and illicit medications while monitoring for diversion[8]

Candidates for Taper

- Patients requesting dosage reduction or discontinuation[45]
- Opioids are no longer effective at reducing pain or improving function[45]
- Reduced quality of life and absence of progress towards therapeutic goals[37]
- Persistent nonadherence with patient treatment agreement[37]
- Patients who shows signs of opioid use disorder[45]
- Patients experiencing an overdose or serious adverse event[45]
  - Early warning signs of overdose include confusion, sedation, or slurred speech
- Significant disease risk factors such as sleep apnea or pulmonary disease[9]
- Patients concurrently taking opioids and benzodiazepines[45]

Engaging in Difficult Conversation

- While discussing the concept of tapering with patients is challenging, certain key concepts can promote productive conversation that will ultimately improve the chance of a successful taper[52]
- Individualize and tailor your discussion to the patient
  - Focus on helping the patient understand why tapering off of their therapy may be beneficial to them based on their circumstances or medical history
- Encouraging patients to have input in the tapering process
  - At a minimum, allow patients to have input on the rate of tapering to help them feel as if they have some control over their treatment
- Reassure the patient that you will stay with them through the entire tapering process
  - Patients experience tapering more positively if they felt confident that their provider would not abandon them

Engaging in Difficult Conversation

- There are several resources to help frame the conversation of opioid tapering
- Nebraska Pain Guidance Document – The Art of Difficult Conversation (page 16-17) [9]
  - http://dhhs.ne.gov/publichealth/PDMP/Documents/Nebraska%20Pain%20Management%20Guidance%20Document%20v4.0.pdf
- "I'm Not Gonna Pull the Rug out From Under You": Patient-Provider Communication About Opioid Tapering[52]
  - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6219456/

When to Refer

- The Nebraska Pain Guidance document lists the following patient selection for referral to pain specialty care:[9]
  - Patients on high doses of opioids (>90 mg MED) or on unsafe drug combinations (such as benzodiazepines and opioids) who:
    - Refuse dosage reduction
    - Exhibit substance-use disorder behaviors
    - Have significant behavioral conditions
- For patients exhibiting symptoms of severe dependence or opioid-use disorder, consider referring to MAT along with behavioral therapy if accessible [9]
- Pregnant patients with chronic opioid use or opioid use disorder should be referred to specialized multidisciplinary care [53]
- Providers should coordinate with mental health providers, when accessible, to treat patients with co-occurring mental health disorders, such as depression and anxiety [9]
- Provider Substance Misuse Quick Reference Sheet (NeDHHS)[54]
  - Includes screening tools, talking points, referral options, and other resources
  - http://dhhs.ne.gov/publichealth/PDMP/Documents/Substance%20misuse%20quick%20reference_v7.pdf

Conclusion

- Concurrent opioid and benzodiazepine use is associated with increased risk of drug interaction and drug overdose
- While opioids and benzodiazepines provide significant short term benefits, the waning benefits of long-term use are often outweighed by significant risks
- Patients should have chronic diseases optimized with alternative non-opioid and non-benzodiazepine therapies as recommended
- Patients on chronic opioid and benzodiazepine therapies should be monitored with validated tools to supplement the clinical decision-making process
- While tapering is a difficult process, available pharmacologic and non-pharmacologic interventions may increase taper efficacy and tolerability
- Resources are available to aid providers engaging in difficult conversations with their patients

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Questions?

Post-assessment and Evaluation

- Complete the post-assessment and evaluation
- Physicians will receive CMS certificate

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