



mnhealth
COLLABORATIVE
activated by **icsi.**

Demystifying Opioids Package

Opioid Use Disorder Algorithms
&
Tapering Frequently Asked Questions (FAQs)

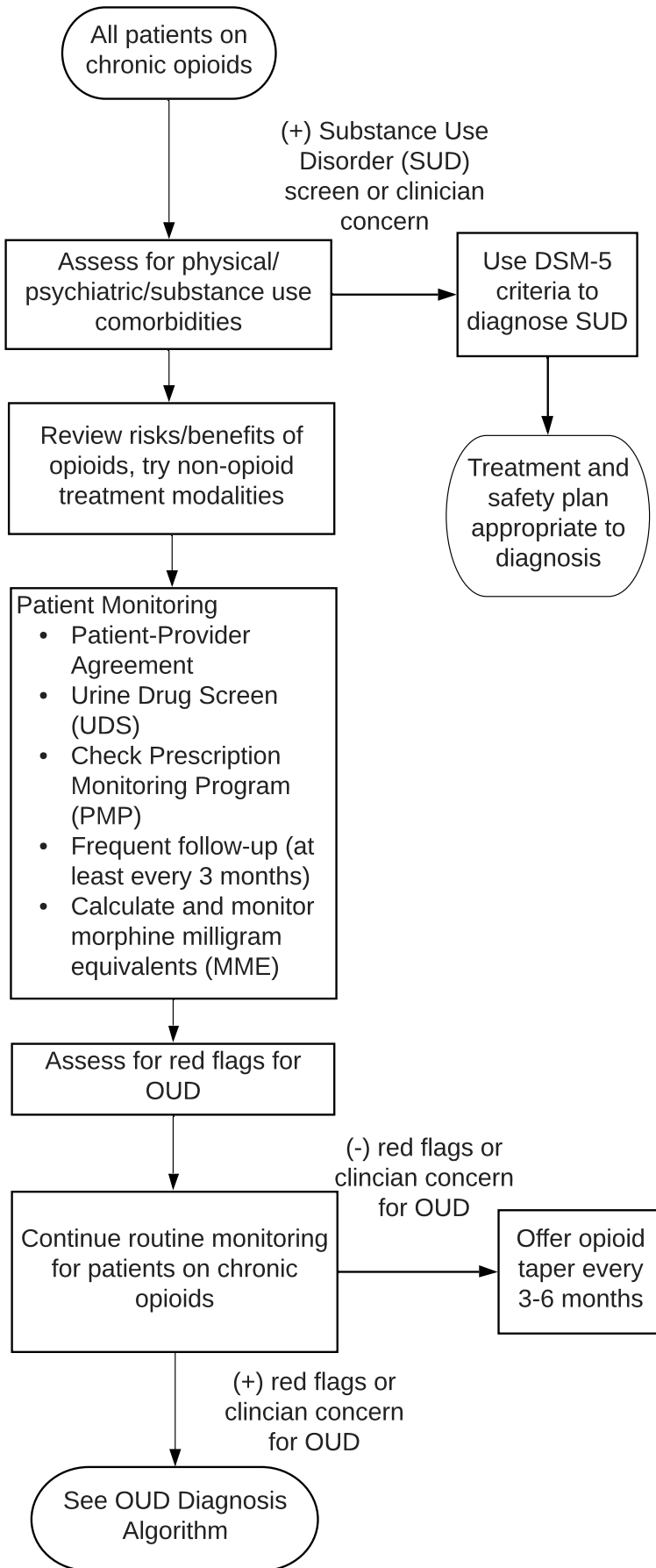
March 2019

Table of Contents

Opioid Use Disorder Algorithms

Screening.....	2
Diagnosis.....	3
Treatment.....	4

Frequently Asked Questions.....	5
---------------------------------	---



Red Flags for Opioid Use Disorder

*indicates diagnostic criteria for OUD

1. Signs of **impaired control**

- Running out of opioids early, with possible evidence of withdrawal*
- Using medical channels to obtain more opioids inappropriately*
- Multiple providers writing prescriptions, using multiple pharmacies, multiple similar names in PMP, forgery of or tampering with prescription*
- False reports to medical staff with the intent of obtaining/protecting supply of opioids*
- Urine toxicology revealing non-prescribed opioids or refusal to provide*
- Recurrent lost prescriptions, requests for specific opioids, or frequent early prescription requests*
- Using non-medical channel to obtain opioids (e.g., stockpiling pills, buying/stealing/borrowing/trading/obtaining online)*

2. Signs of **social impairment**, causing relationship conflicts

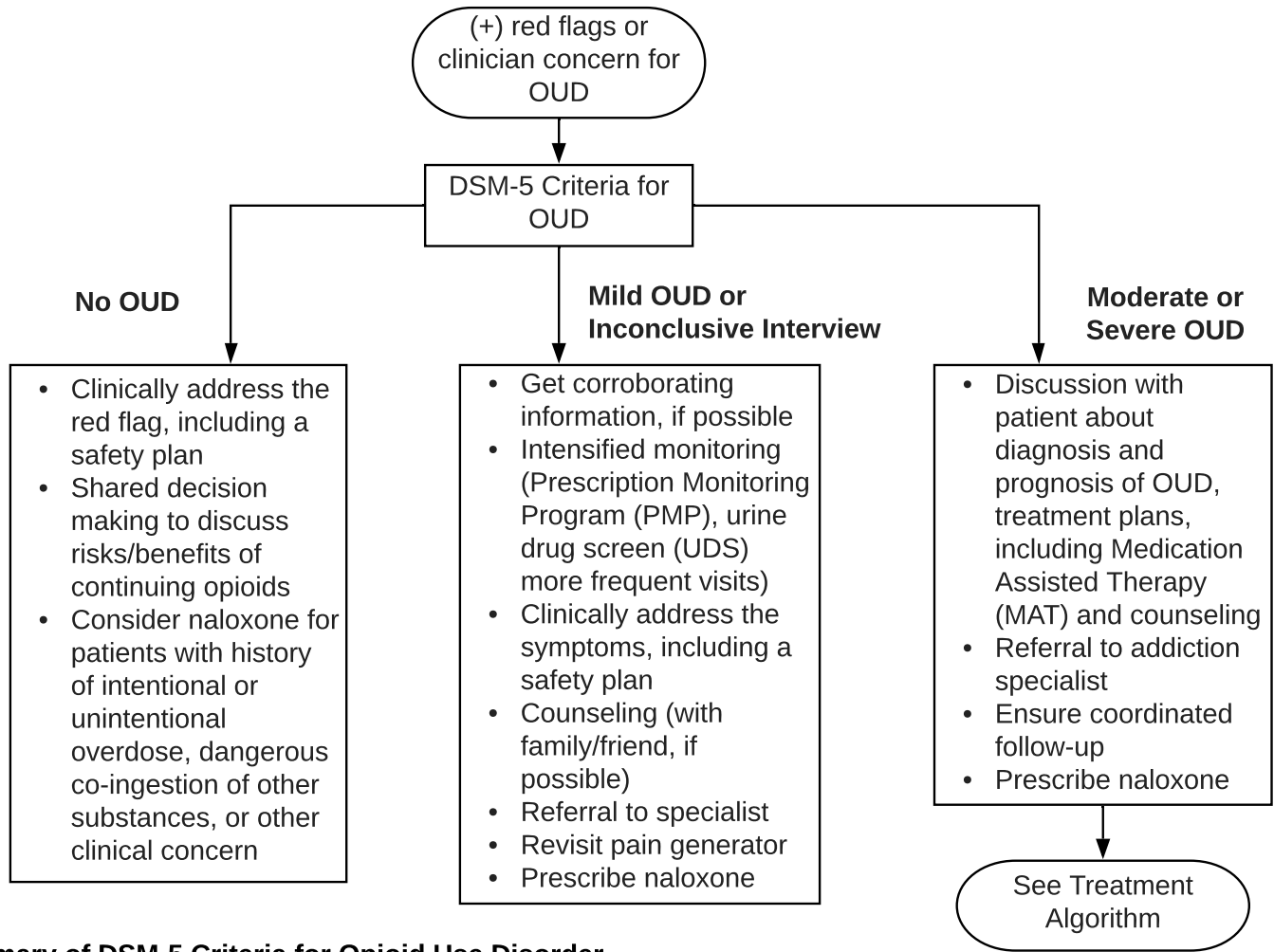
- Argument with providers, discharge from clinic, worsening/ongoing pain reports despite objective signs of clinical improvement*
- Criminal activity or charges relating to opioids
- Loved ones expressing concern about patient opioid use*

3. **Risky use** of opioids despite existing or threatened harms

- History of overdose*
- Over sedation or intoxication*
- Mixing prescriptions with non-prescribed substances*
- Very high dose opioids
- Opioid/benzodiazepine combination
- Unconventional opioid prescription
- Use of opioid in situations such as driving
- Altering route of administration (snorting, crushing, licking patches, injecting)*

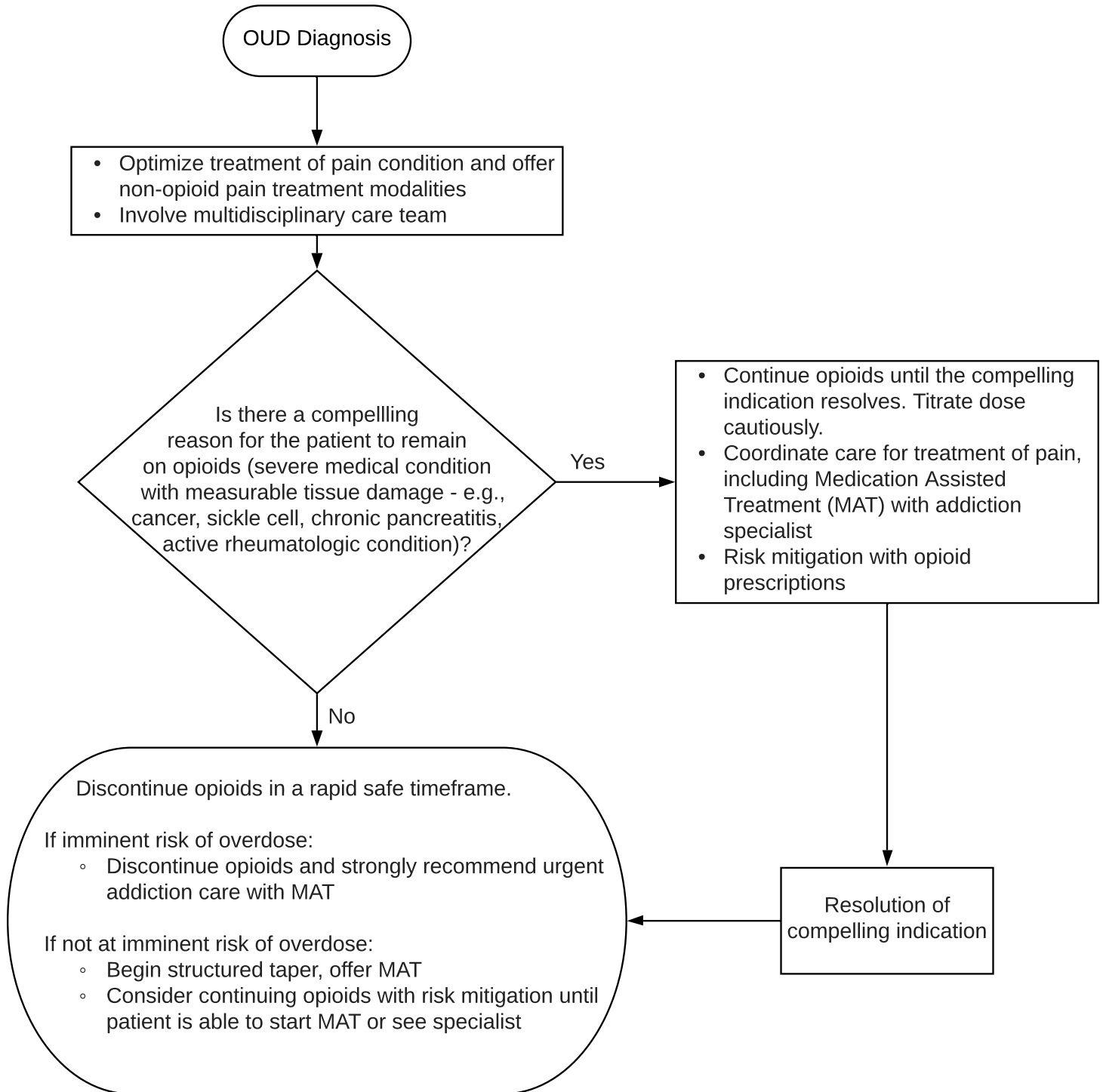
4. **Predisposition to addiction** identified in the patient.

- Any SUD other than OUD
- Family history of SUD in first degree relative
- Urine toxicology screen concerning for other addictive behavior
- Use for relief of psychiatric symptoms or for euphoria



Summary of DSM-5 Criteria for Opioid Use Disorder

Mild: 2-3 criteria in 12-month period	
Moderate: 4-5 criteria in 12-month period	
Severe: 6 or more criteria in 12-month period	
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 physical hazardous situations
	Continued opioid use despite knowledge or persistent physical or psychological problem that is likely caused by opioid use
Pharmacologic 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 symptoms; opioids taken to relieve or avoid withdrawal
*Patients on chronic opioids may have tolerance/withdrawal, therefore these criteria should not be used to diagnose OUD in these patients	



Risk Mitigation Strategies When Prescribing Opioids for Patients with OUD

- Consider a short supply of opioids, multiple fills with frequent provider/nurse visits
- Involve family/friends in controlling medications
- Prescribe naloxone
- Ensure patient chart is updated with care plan, controlled substance list, and OUD on problem list
- Continually reevaluate compelling indication for opioids
- Reevaluate formulation and type of opioid

Contact: Jodie Dvorkin (jdvorkin@icsi.org)

Opioid Tapering: Frequently Asked Questions

1. Which patients should get a taper?

For patients on chronic opioids, prescribers should offer a taper every 3-6 months, regardless of duration of therapy, associated diagnosis, and total daily dose. Patients at high risk should be more emphatically and frequently advised to taper.

2. Should the goal of my tapers be to completely discontinue opioids?

Complete opioid discontinuation is desirable, but may not be appropriate or achievable for every patient. Tapering opioids to the lowest possible dose may be the goal for some patients. The risk of mortality is linearly proportional to the opioid dose, thus every achievable decrease in dose has significant benefit. For patients unable to taper completely, try to taper to at least <50 morphine milligram equivalents (MME) per day, with lower being better. Avoid doses >90 MME per day.

3. Who is the best prescriber to oversee an opioid taper with the patient?

Tapers should start with the clinician who is prescribing the ongoing opioids. All prescribers of opioids should be able to comfortably discuss the risks and benefits of lowering opioid doses, and know how to initiate a taper. For some patients, the current opioid prescriber may need assistance from a trained pharmacist, nurse, or a pain or addiction specialist.

4. What do I tell patients who ask how their pain will be controlled if opioids are tapered?

Discuss non-opioid medication options, psychiatry support, physical/occupation therapy, and pain medicine. Reassure the patients that the underlying condition will still be addressed, with a focus on improving functionality and quality of life rather than just pain. Share with patients that many people discover, to their surprise, that their pain can be managed without opioids.

5. How do I begin a taper? What are the increments to decrease? How many days?

Voluntary tapers should be tailored for each specific patient. Keep in mind, a taper that is too aggressive often sabotages the long-term goal and can discourage patients from continuing.

General Tips:

- A successful initial decrease is important. A 10-20% dose reduction from the baseline dose is a reasonable place to start. On average, taper durations may be as short as a couple months and may extend six months or longer in some cases.
- You may taper by extending the interval between doses (e.g., 4x/day → 3x/day) or decrease the dose, or both. This depends on patient preference and medication dosing availability.
- In general, use the original dose to calculate each dose reduction until you reach about ~30% of the original dose. Then recalculate dose reduction using new dose.

Opioid Tapering: Frequently Asked Questions

- After each decrease, give plenty of time for the patient to physiologically and behaviorally adapt to the new dose before the next step. In general, dose reductions could be made weekly or monthly, individualized to the patient.
- It is okay to leave a patient on the same dose for a long period of time, if necessary.
- Towards the end of the taper (approximately 30% of original dose), the rate of tapering may need to be decreased.
- Often, what governs the taper percent reductions are the practical dose formulations available for the medication the patient is discontinuing.
- Avoid changing the type of opioid for the purpose of tapering. Changing the type of opioid during a taper can cause confusion for the provider and patient due to the incomplete cross tolerance of different opioids.
- Consider stopping the opioid completely when it is taken less frequently than once a day.
- Rapid tapering should be reserved for patients at high risk for opioid related adverse effects or those demonstrating aberrant behaviors (for example, consider lowering the dose by ~50% in the first week).

6. Which patients should have opioids stopped without a taper?

For the following patients, there is generally no concern for withdrawal:

- If length of therapy is less than 10 days
- Patients who are not taking their opioids
- Patients past the window of withdrawal (in general, that window is one week for most opioids, two weeks for all opioids)
- If total daily opioid dose is <30 MME, taper is optional depending upon length of therapy, patient-specific characteristics, and clinical judgment.

For the following patients, the harms of continuing opioids outweigh the risks of discontinuing (i.e., withdrawal, turning to other illicit drugs). These patients may need an emergency treatment program:

- Patients who are in danger of death if opioids continue
- Active mental crisis
- Patients for whom there is evidence of diversion
- Patients with positive urine toxicology for illicit substances and clinician concern

7. What to taper first: Long-acting opioids or short-acting opioids?

Generally, try to taper the short-acting first followed by long-acting. This is definitely appropriate for a forced, rapid taper. However, for a collaborative slow taper, it is reasonable to use shared decision making and allow taper of the long-acting first if that is what the patient is more willing to do.

Opioid Tapering: Frequently Asked Questions

8. What to taper first: benzodiazepines or opioids?

There is not a clear right answer to this question. In general, taper first what is safest and what the patient will do. If the patient is at high risk of benzodiazepine withdrawal, consider tapering opioids first. Or, if patient is on low dose benzodiazepines and it is appropriate to stop, consider starting with the benzodiazepine. However, before tapering a benzodiazepine, it is important to determine the underlying reason the patient is on it (e.g., psychiatric illness) and if they should come off. As pain needs to be managed by an alternative when an opioid is stopped, so too does psychiatric illness when a benzodiazepine is stopped. Also, keep in mind that benzodiazepines cause amnesia and disinhibition, which may complicate the patient's executive ability to carry out a taper.

9. Do you need to evaluate for opioid use disorder (OUD) or substance use disorder (SUD) before starting a taper?

If the patient has not previously been evaluated for OUD/SUD, or if not done recently, you should evaluate for these disorders before starting a taper. Tapering a patient who has undiagnosed OUD/SUD could lead to severe withdrawal symptoms.

10. What are withdrawal symptoms? How can they be managed?

Withdrawal symptoms may include nausea, diarrhea, restlessness, sweating, tremors, insomnia, and/or pain not otherwise explained. Slow tapers will prevent or minimize the symptoms of withdrawal, while patients on fast tapers may be symptomatic. Patients should be educated about these symptoms prior to starting and throughout the taper. It is important to monitor for withdrawal symptoms and adjust the taper accordingly. Some patients may benefit from targeted management for withdrawal symptoms. Prescribers may simply ask patients about symptoms or use more formal tools such as the Clinical Opiate Withdrawal Scale (COWS).

11. Does Tramadol need to be tapered?

Tramadol is an opioid and may need to be tapered depending on the calculated MME and prescriber judgment. For reference, 50mg Tramadol is approximately 5 MME.

12. Should my patient be given naloxone during the taper?

Yes, consider prescribing naloxone for an opioid taper. This is in case the patient seeks illicit drugs during the taper or if they return to higher doses of opioids for which they no longer have tolerance.

13. What should I do if my patient takes illicit drugs during the taper?

- Perform a diagnostic addiction interview
- Consult with an addiction specialist
- Consider accelerating the taper

14. Why do patients resist or fear tapering opioids?

Patients may worry about loss of control, pain, and withdrawal. For some, opioids have become part of their coping with life and they may fear the pain returning without a viable alternative. Prescriber messaging around opioids has changed in recent years and

Opioid Tapering: Frequently Asked Questions

patients may wonder why safety is a concern now when it wasn't before. Patient education and effective messaging is paramount to success.

15. What is the best approach to convincing a patient resistant to tapering to give it a try?

Reassure them that other pain management modalities are available. Demonstrate empathy, validate their pain, and educate on the risk of death and addiction with opioids. Go small and slow. It is better to take many small steps, each of which are successful, than it is to take big steps that fail and are not well tolerated.

16. If my patient struggles to carry out a taper are they likely to have an addiction?

No. While addiction may be a cause of a failed taper, there are other reasons why tapers do not succeed, including untreated mental health disorders, flare of the underlying pain condition, discomfort with withdrawal, and lack of social support. If symptoms of addiction emerge (evident loss of control over opioid use), a diagnostic evaluation is warranted.

17. What are the biggest pitfalls to a taper?

- Going too fast
- Inadequate, infrequent follow-up
- Not incorporating patient preferences
- Not educating the patient throughout the process
- Not identifying/treating addiction or underlying mental health disorder

Note: The above guidance is based on current evidence, as well as expert consensus from our working group. Stay tuned as new evidence emerges.

References

1. Centers for Disease Control and Prevention. CDC guideline for prescribing opioids for chronic pain – United States, 2016. MMWR 2016;65:1-49.
2. Hooten M, Thorson D, Bianco J, Bonte B, Clavel Jr A, Hora J, Johnson C, Kirksson E, Noonan MP, Reznikoff C, Schweim K, Wainio J, Walker N. Institute for Clinical Systems Improvement. Pain: Assessment, Non-Opioid Treatment Approaches and Opioid Management. Updated August 2017.
3. Minnesota Opioid Prescribing Guidelines, First Edition 2018.

Resources

1. Minnesota DHS Provider Education: <https://mn.gov/dhs/opip/provider-education/>
2. Minnesota Medical Association, Pain, Opioids, and Addiction Lecture Series: <https://www.mnmed.org/advocacy/Key-Issues/Pain-Opioids-and-Addiction-Lecture-Series>

Contact: Jodie Dvorkin (jdvorkin@icsi.org)