Tapering Toolkit

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Introduction

While there is limited evidence to support the use of long-term opioid therapy for chronic pain (outside of end-of-life care), there is evidence that shows a high risk for serious harms associated with opioid use including:

- Overdose and death
- Respiratory depression
- Worsening obstructive sleep apnea
- Hypogonadism
- Sedation
- Abdominal pain and nausea
- Constipation
- Addiction

The HUSKY Health program is committed to supporting Connecticut Medical Assistance Program (CMAP) providers with decreasing the use of high-dose opioid medications. This tapering toolkit is designed to assist providers with engaging and managing their patients on high-dose opioids using a step-wise tapering method, and to provide guidance on the management of complications.

The steps described in this toolkit are:

1. Identifying candidates for tapering
2. Engaging the patient
3. Assessing readiness to change
4. Evaluating comorbid behavioral health and substance use conditions
5. Developing a tapering plan
6. Managing withdrawal symptoms

Identifying Candidates for Tapering

It is important to first determine if a patient is an appropriate candidate for tapering. Tapering can be initiated for patients on any dose of opioids.

Tapering of long-term opioid therapy should be considered when the patient:

- Has resolution of underlying condition or decreased pain
- Requests a dosage reduction
- Displays no clinically meaningful improvement in pain and function
- Experiences complications from high-dose opioids
- Experiences an overdose or other serious adverse event
- Displays early warning signs of overdose risk such as confusion, sedation, or slurred speech
- Is on dosages **greater than or equal to 50 MME/day without benefit**
- Takes a benzodiazepine in addition to opioid medication
- Shows signs of **opioid use disorder**
- Is not adhering to a patient treatment agreement:
  - Inappropriate use of opioid medication
  - Failure to comply with monitoring
  - Selling prescription drugs

- Forging prescriptions
- Stealing or borrowing drugs
- Aggressive demand for opioids
- Unsanctioned dose escalation
- Concurrent use of alcohol or illicit drugs
- Obtaining opioids from multiple prescribers and/or pharmacies
- Recurring emergency department visits for chronic pain management

Engaging the Patient

A successful tapering program requires the active involvement of the patient. It is important that providers engage patients in a non-threatening manner in order to establish a therapeutic alliance.

Motivational interviewing strategies offer techniques to elicit the patient's motivations and potential obstacles to success in a non-threatening fashion. Motivational interviewing is an approach that can help patients with behavioral health conditions, substance use disorders, and chronic medical conditions make positive behavioral changes to improve their overall health. Motivational interviewing is based on the following four principles:

- **Express Empathy**: to enhance self-esteem and facilitate change – reflective listening is essential
- **Develop Discrepancy**: help the patient to see that their current situation does not fit into their values and goals for the future
- **Roll with Resistance**: to prevent a breakdown in the therapeutic alliance – avoid arguing and do not directly oppose resistance – offer new perspectives but do not insist
- **Support Self-efficacy**: if a patient holds the belief that they have the ability to change, the likelihood of success is increased

Motivational Interviewing Techniques

Make affirmative statements

Affirmations are statements made in response to what a person has said. They are used to recognize strengths, successes, and efforts, and to enhance self-confidence.

Examples of affirmative statements:

- "I can see that you are really trying to stick to the tapering plan that we developed."
- "You showed a lot of strength when you told your friend that you wouldn't get high with them."
- "In spite of what happened last week, the fact that you came back today shows that you are really committed to making this change."

Be careful to avoid statements that could sound insincere such as "Wow, that's incredible," or "That's great, good job."

Providing advice/feedback/asking permission

Patients may have either too little or incorrect information about their behavior. Telling patients what to do does not work well. Presenting information in a nonjudgmental manner can empower patients to make informed decisions. Ask permission to give feedback. Patients are

more likely to discuss change when respected and asked as opposed to being told that change is needed.

- Have relevant informational handouts available
- Whenever possible, focus on the benefits of change
- Avoid using scare tactics, lectures, or severe warnings

Example: "Do you mind if we spend some time discussing…" followed by, "What do you know about the risks of taking opioid medication?" followed by, "Are you interested in learning more about these risks?"

Normalizing

Normalizing reassures the patient that ambivalence to change is not uncommon.

Example: "A lot of people are concerned about reducing the amount of opioid medication they are taking."

Using open-ended questions

Open-ended questions allow the patient to more fully describe their current situation. Providers can then reflect back or summarize in a way that communicates empathy.

Examples:

- "What brought you here today?"
- "What makes you think that it might be time for a change?"
- "What was that like for you?"

Avoid closed-ended questions which can make it seem like you are interrogating the patient.

Reflective listening

Reflective listening allows the provider to carefully listen and then paraphrase what the patient has said. The goals of reflective listening are to build empathy, encourage the patient to identify their own reasons for change, and show that the provider understands what the patient is feeling.

Examples:

- "It sounds like you are really concerned about the amount of Percocet you are taking."
- "I get the sense that you are feeling a lot of pressure from your family to stop using the fentanyl patches and Xanax, but you are afraid that you can't do it because of the difficulties you have had in the past."
- "I get the sense that you are very concerned about going into withdrawal while we are tapering the Dilaudid."

Summaries

Summaries require that providers listen carefully to what the patient is saying. Summaries are a great way to wrap up a discussion and transition to the next topic.

Examples:

- "It sounds like you are very concerned about how much Oxycontin you are taking but you are also concerned that without it your pain will get worse and the withdrawal will be unbearable."

- “Over the past few months you have been talking about decreasing the amount of morphine you are taking. It sounds like you have experienced some of the negative effects of taking this medication long term. It makes sense that you are ready to make a change.”

Change talk

Getting patients to state their reasons for wanting to change as opposed to lecturing the patient on why they must change has been proven to be more effective.

Examples:

- “How can I help you get past some of the problems you are experiencing?”
- “What would be the good things about decreasing the amount of opioids you are taking?”
- “If you do make this change, how would your life be different?”

Decisional balancing (pros and cons)

Asking patients to look at both the positive and negative effects of their current behavior helps the patient to better understand their own ambivalence. The patient sees that while there are benefits to taking opioid medication, there are negative consequences if they decide to continue using.

Examples:

- “What are some of the good things about taking opioid medication?”
- “Looking at the other side, what are some of the not so good things?”

Supporting confidence to change

Making comments and asking the patient about changes they have made can improve self-confidence.

Examples:

- “It seems that you have been sticking to the tapering plan. That is different than before. How have you been able to do it?”
- “How do you feel about the changes you have made?”

Dealing with discrepancies

Addressing discrepancies between what the patient is saying and what they are doing in a nonjudgmental manner encourages the patient to recognize and resolve discrepancies. This is a more effective approach than simply telling the patient that what they are doing does not make sense.

Example:

- “You say you want to see your daughter get married next year, but you are continuing to say you don’t need to decrease the amount of Oxycontin you are taking, and your sister had to give you Narcan twice in the last month. How can you be sure that you will live to see her get married?”

Motivational Interviewing – Points to Keep in Mind

- Listen more than you talk
- Remain sensitive and open to the patient's issues
- Invite the patient to talk about and explore their own ideas for change
- Encourage the patient to talk about their reasons for not changing
- Help the patient identify successes and challenges from their past and relate them to their present efforts
- Seek to understand the patient
- Summarize for the patient what you heard, not what you think
- Value the patient's opinion more than your own
- Remind yourself that the patient is capable of making their own choices

Assessing Readiness to Change

Assessing the patient's motivation to decrease or eliminate their opioid medication is crucial. If providers know where the patient is in terms of readiness to change they will be better prepared to work with them. Depending on where the patient is, the discussion may go in a different direction.

The Change Readiness Model suggests that patients who are potential candidates for a significant health change, including decreasing the use of opioids, typically go through the following stages:

Stage 1 – Precontemplation

In this stage, patients on high-dose opioids do not consider that their opioid use could be a problem or is no longer indicated. This may be due to the fact that they have not yet experienced negative consequences from their opioid use or they may be in denial about the severity of the consequences they have experienced.
Provider Intervention – establish trust and rapport

Stage 2 – Contemplation

In this stage, the patient begins to think about changing, decreasing, or ending their opioid use. They are more aware of negative consequences or lack of indication for ongoing treatment. The patient is weighing the pros and cons of decreasing or ending their opioid use. Patients in this stage may be more open to receiving information about possible negative consequences.
Provider Intervention – give information in a non-judgmental manner

Stage 3 – Preparation

In this stage, the patient is aware of the need for change. They are gathering information and seeking strategies to decrease or stop their opioid use.
Provider Intervention – discuss options

Stage 4 – Action

In this stage, patients believe they have the ability to change their behavior and are actively engaged with strategies to decrease or stop their opioid use. Patients in this stage are open to receiving help and are also likely to seek support from others.
Provider Intervention – taper opioid, manage complications, and offer support

Stage 5 – Maintenance and Relapse Prevention

In this stage, the patient has successfully decreased or stopped their opioid use. They are learning to use strategies to manage pain other than opioid medication.
Provider Intervention – assess and support

Stage 6 – Relapse

Patients may not be able to immediately sustain the changes they have made. Resuming opioid medication use after a period without it is common early on in the process. Resumption of use should not be interpreted as treatment failure or as lack of commitment. Resumption of use can provide new information and opportunities to enhance the patient's plan of care.
Provider Intervention – help the patient reenter the change cycle, remain nonjudgmental, and assist the patient in developing alternative coping skills

Evaluation of Comorbid Behavioral Health and Substance Use Conditions

Evaluating for potential comorbid behavioral health or substance use conditions that may complicate or prevent a successful opioid taper is crucial.

Screening Tools

Available screening tools include but are not limited to:

Patient Health Questionnaire (PHQ-9)
The Patient Health Questionnaire (PHQ-9) is an instrument for screening, diagnosing, monitoring, and measuring the severity of depression.

Generalized Anxiety Disorder 7-item (GAD-7)
The Generalized Anxiety Disorder 7 (GAD-7) is a self-reported questionnaire for screening and measuring the severity of generalized anxiety disorder.

Primary Care PTSD Screen (PC-PTSD)
The PC-PTSD is a 4-item screen designed for use in primary care settings and is currently used to screen for veterans for PTSD.

The Connecticut Behavioral Health Partnership (CT BHP) offers a toolkit to assist Primary Care Providers (PCPs) with the identification of behavioral health conditions. The PCP toolkit is available at: http://pcptoolkit.beaconhealthoptions.com/.

Opioid Use Disorder

Opioid Use Disorder is a diagnosis introduced in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders, DSM-5.

The diagnosis of Opioid Use Disorder can be applied to someone who uses opioid drugs and has at least two of the following symptoms within a 12-month period:

- Taking more opioid drugs than intended or over longer periods of time than intended
- Wanting or trying to control opioid drug use without success
- Spending a lot of time obtaining, taking, or recovering from the effects of opioid drugs
- Craving, or a strong desire or urge to use opioids
- Failing to carry out important roles at home, work, or school because of opioid use
- Continuing to use opioids, despite use of the drug causing relationship or social problems
- Giving up or decreasing participation in other activities because of opioid use
- Using opioids even when it is physically unsafe
- Knowing that opioid use is causing a physical or psychological problem, but continuing to take the drug anyway
- Tolerance for opioids as defined by either of the following:
  - A need for increased amount of opioids to achieve desired effects
  - Markedly diminished effect with the continued use of the same of amount of an opioid
- Withdrawal as manifested by either of the following:
  - **Opioid withdrawal symptoms**
  - The same (or closely related) substances are taken to avoid withdrawal symptoms

If a patient is found to have a comorbid condition, treatment should be initiated for both disorders and should occur concurrently. Providers and patients can contact CT BHP for guidance and information on counseling and adjunctive treatment options, including Medication Assisted Treatment (MAT) by calling 1.877.552.8247, Monday through Friday, 9:00 a.m. - 7:00 p.m. or visiting their website at http://www.ctbhp.com/index.html. CT BHP members and providers can also do a referral search for behavioral providers via http://www.ctbhp.com/members/mbr-findprv.html.

Behavioral Health Services

Under the CT BHP, the following services are covered:

- Medication Assisted Treatment (MAT) including methadone maintenance, buprenorphine, and naltrexone
- Ambulatory Detoxification
- Inpatient Detoxification Outpatient Counseling
- Intensive Outpatient Treatment
- Partial Hospitalization
- Residential Substance Abuse Rehabilitation
  - Covered by CT BHP, available to certain HUSKY Health members (contact CT BHP for details)
  - HUSKY D has services for Residential Substance Abuse Rehab covered by Advanced Behavioral Health, which can be reached at 1.800.606.3677, Monday through Friday, 8:30 a.m. - 5:00 p.m.

Medication Assisted Treatment

To date, Medication Assisted Treatment (MAT) is the most effective treatment for patients with opioid use disorder. MAT combines medications and behavioral therapy to provide a holistic approach to the treatment of opioid use disorder. The HUSKY Health program covers a number of medications used in the treatment of opioid use disorders.

The following medications are currently covered without Prior Authorization (PA):

- Buprenorphine HCL tablet (sublingual)
- Methadone
- Naltrexone oral
- Suboxone film (sublingual)
- Vivitrol (extended release naltrexone injectable) – covered without PA effective 7/1/18

The following medications are currently covered with PA:

- Buprenorphine/naloxone tablet (sublingual)
- Bunavail buccal strip*
- Zubsolv tablet (sublingual)*
- Probuphine subdermal*
- Sublocade (extended-release buprenorphine injection)

*These medications are not covered for HUSKY B members

MAT providers can be located at https://public.tableau.com/views/CTBHPMedicaidMATProviderMap/TreatmentProviders?:embed=y&:display_count=yes&:showVizHome=no.

To learn more about MAT, providers and patients can contact the CT BHP at 1.877.552.8247, Monday through Friday, 9:00 a.m. - 7:00 p.m. or access the CT BHP MAT Resources page at http://www.ctbhp.com/medication-assisted-treatment.html.

Developing a Tapering Plan

Tapering plans should be person-centered and should minimize the symptoms of opioid withdrawal while ensuring adequate pain treatment through the use of non-pharmacologic treatments and non-opioid medications.

How to Taper

There are multiple strategies for tapering opioid medications that range from slow tapers to more rapid regimens. Patients on high-dose opioids require special attention as a rapid taper may trigger withdrawal symptoms. Tapering plans should take a person-centered approach and should minimize the symptoms of opioid withdrawal while providing adequate pain control with non-pharmacologic therapies and non-opioid medications.

Non-pharmacologic Therapies for Chronic Pain

Under the HUSKY Health program medical benefit, the following services are covered:

- Physical and occupational therapy

- Naturopath services
- Transcutaneous Electrical Nerve Stimulation (TENS) units
- Chiropractic manipulation
- Acupuncture

Non-opioid Medications for Chronic Pain

The following is a list of non-opioid medications suggested by the Centers for Disease Control and Prevention (CDC) as possible first-line pharmacologic treatment:

- Acetaminophen
- Nonsteroidal Anti-Inflammatory Drugs (NSAIDs)
- Gabapentin/pregabalin
- Tricyclic antidepressants and serotonin/norepinephrine reuptake inhibitors
- Topical agents (lidocaine, capsaicin, NSAIDs)

Recommendations:

1. Consider sequential tapers for patients who are on chronic benzodiazepines and opioids. Co-manage care with other prescribers.
2. Do not use ultra-rapid detoxification or antagonist-induced withdrawal under heavy sedation or anesthesia. The effectiveness of this treatment has not been established and potential risks are high.
3. Base the rate of taper on patient safety:
    a. Institute a more rapid taper if the patient has had a severe negative outcome e.g., overdose, is diverting, or is using street drugs
    b. Taper slowly if no acute safety concerns. Start with a taper of ≤ 10% of the original dose per week and assess the patient's functional and pain status at each visit.
    c. Use extra caution during pregnancy – coordinate with specialists
4. Discuss the increased risk for overdose if patients quickly return to a higher dose.
5. Adjust the rate, intensity, and duration of the taper based on the patient's response (e.g. emergence of **opioid withdrawal symptoms**)
6. Take the following into consideration when making a decision to continue, pause, or discontinue the taper:
    a. Assess for aberrant behaviors that may be suggestive of addiction
    b. Address pain with the use of non-pharmacologic and non-opioid medications
    c. Evaluate for symptoms of behavioral health disorders (i.e., anxiety, depression and opioid use disorder). Ensure patients are receiving adequate psychosocial support.
7. Do not reverse the taper. The rate may be slowed or paused while managing withdrawal symptoms.
8. Once the smallest available dose is reached, the interval between doses can be extended and opioids may be stopped when taken less than once a day.
9. Use non-benzodiazepine medications to treat withdrawal if needed.
10. Consider inpatient withdrawal management if the taper is poorly tolerated.

Opioid Dose Calculator

http://www.agencymeddirectors.wa.gov/opioiddosing.asp

Managing Withdrawal Symptoms

Opioid withdrawal syndrome is characterized by the signs and symptoms of sympathetic stimulation including: anxiety, restlessness, diaphoresis, tremor, nausea, abdominal cramps, diarrhea, myalgia or arthralgia, and insomnia.

The Clinical Opiate Withdrawal Scale can be used to rate common signs and symptoms of opiate withdrawal and monitor these symptoms over time.

Consider using non-opioid and non-benzodiazepine medications during the taper to reduce withdrawal symptoms if needed.

Symptoms	Treatment
Restlessness, diaphoresis, tremors	Clonidine
Nausea	Anti-emetics such as ondansetron, prochlorperazine
Diarrhea	Loperamide or anti-spasmodics such as dicyclomine
Myalgia, arthralgia, neuropathic pain, or myoclonus	NSAIDs, gabapentin or muscle relaxants such as cyclobenzaprine, tizanidine, or methocarbamol
Insomnia	Sedating antidepressants (e.g. nortriptyline, mirtazapine, trazodone). **Do not use benzodiazepines or sedative-hypnotics**

References

- **Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain – United States, 2016**
  https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm
- **CDC Pocket Guide: Tapering Opioids for Chronic Pain:**
  https://www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf
- **Enhancing Motivation for Change in Substance Abuse Treatment – Treatment Improvement Protocol (TIP) 35:**
  https://store.samhsa.gov/shin/content//SMA13-4212/SMA13-4212.pdf
- **Interagency Guideline on Prescribing Opioids for Pain:**
  http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf
- **Mayo Clinic Review of Opioid Tapering:**
  http://www.mayoclinicproceedings.org/article/S0025-6196(15)00303-1/pdf
- **Motivational Interviewing:**
  https://www.integration.samhsa.gov/clinical-practice/motivational-interviewing
- **Motivational Interviewing Assessment:**
  https://www.drugabuse.gov/sites/default/files/files/MIA-STEP_Factsheet.pdf
- **Motivational Techniques and Skills for Health and Mental Health Coaching/Counseling:**
  http://www.nova.edu/gsc/forms/mi-techniques-skills.pdf
- **Pharmacologic Guidelines for Treating Individuals with Post-Traumatic Stress Disorder and Co-Occurring Opioid Use Disorders:**

https://www.samhsa.gov/sites/default/files/topics/mental_substance_disorders/pharmacologic-guidelines.pdf

- **Stages of Change and Treatment: Comparing Models:** http://www.ct.gov/dmhas/lib/dmhas/publications/CSP-StagesChangeTx.pdf
- **U.S. Department of Veterans Affairs Pain Management Opioid Taper Decision Tool:** https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Pain_Opioid_Taper_Tool_IB_10_939_P96820.pdf