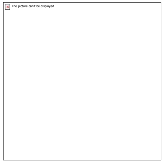
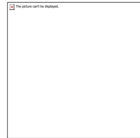
WELCOME
Addiction Medicine ECHO Clinic



The session will begin promptly at **12 pm**.



Please **mute** the audio on your device.

Sessions take place **Thursday on the 2cd and 4th week of the month**.

Please connect your **camera**.

Need technical assistance? Call 907.729.2622 or text your phone number into the chat.

ALASKA NATIVE
TRIBAL HEALTH
CONSORTIUM

Foundation *for*
Opioid Response Efforts

Recording

We will record the **didactic portion** of every session. After the session, the didactic portion of this clinic will be available on the ANTHC Addiction Medicine ECHO page.

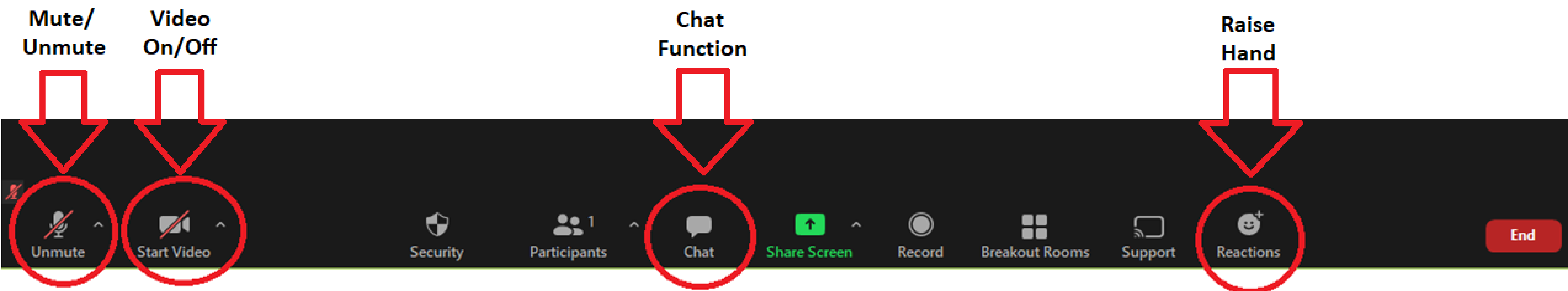
By participating in this clinic you are consenting to be recorded.

If you do not wish to be recorded, please email behavioralhealth@anthc.org at least one week prior to the ECHO Clinic you plan to attend.

Some Helpful Tips

- Please mute microphone when not speaking
- Use chat function
- Position webcam effectively
- Test both audio & video

Need technical assistance? Use the chat function or call 907-317-5209



ANTHC Clinical ECHO Series

Approved Provider Statements:

ANTHC is accredited by the Washington State Medical Association to provide continuing medical education for physicians.

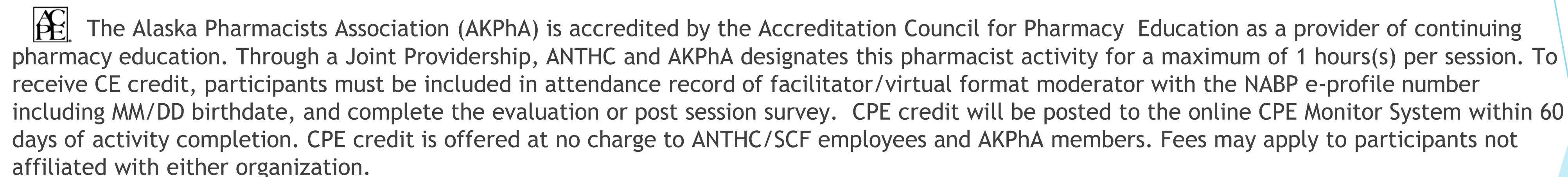
ANTHC is approved as a provider of nursing continuing professional development by the Montana Nurses Association, an accredited approver with distinction by the American Nurses Credentialing Center's Commission on Accreditation.

AKPhA is accredited by the Accreditation Council for Pharmacy Education as a provider of Continuing Pharmacy Education.

Contact Hours:

ANTHC designates this Live/Virtual Activity for a maximum of 12 AMA PRA Category 1 Credit(s) ™ for the entire series, provided in 1 credit/session certificates. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

ANTHC designates this activity as meeting the criteria for one nursing contact hour credit for each hour of participation up to a maximum of 12 hour(s) for the entire series, provided in 1 contact hour certificates/session attended.



ACPE The Alaska Pharmacists Association (AKPhA) is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education. Through a Joint Providership, ANTHC and AKPhA designates this pharmacist activity for a maximum of 1 hours(s) per session. To receive CE credit, participants must be included in attendance record of facilitator/virtual format moderator with the NABP e-profile number including MM/DD birthdate, and complete the evaluation or post session survey. CPE credit will be posted to the online CPE Monitor System within 60 days of activity completion. CPE credit is offered at no charge to ANTHC/SCF employees and AKPhA members. Fees may apply to participants not affiliated with either organization.

Approved for 1 CHAP CE

Conflict of Interest Disclosures:

None of the presenters and planners for this educational activity have any relevant relationship(s) to disclose with ineligible companies whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

Requirements for Successful Completion:

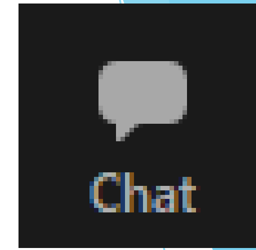
To receive CE credit be sure you are included in attendance record as directed by the facilitator/session moderator, and complete the course evaluation or post session survey via this link: https://forms.gle/QhwCeGTf4zLNwpBX7

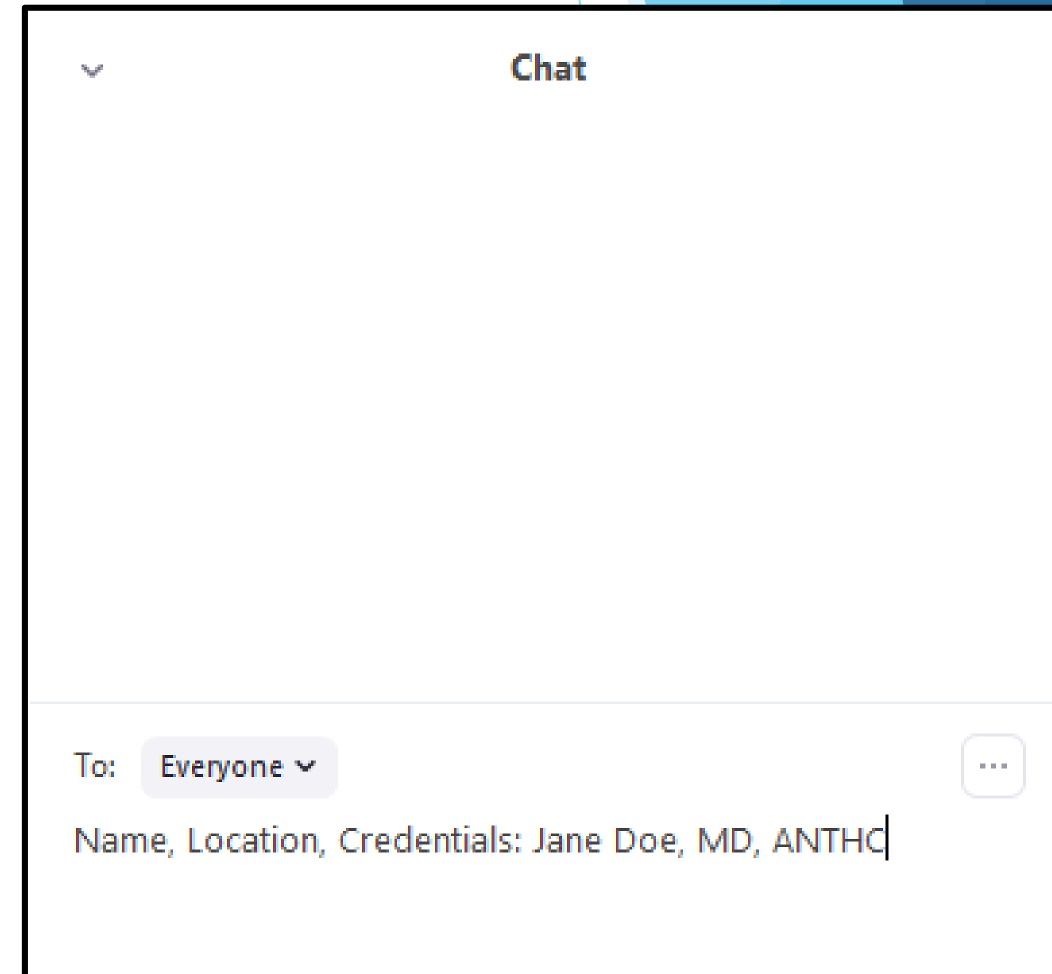
For more information contact Jennifer Fielder at jlfielder@anthc.org or (907) 729-1387

Introductions

Addiction Medicine ECHO

- Please introduce yourself in the chat :
  - Name
  - Location
  - Profession/Credentials
  - *Note*: The chat will be saved as our attendance record for continuing education credits.





Tapering and discontinuing medications for addiction treatment

ANTHC Addiction Medicine ECHO

5/13/2021

Sarah Spencer, DO, FASAM

Objectives

Participants will be able to initiate conversations with patients about medical considerations for discontinuing medication-assisted treatment.

Participants will have the ability to educate patients about opioid overdose prevention, including naloxone rescue kits.

Conflict of Interest Disclosure

- N/A

Recommended length of
medication treatment for OUD

2. ***Minor Revision*** Opioid withdrawal management (ie, detoxification) on its own, without ongoing treatment for opioid use disorder, is not a treatment method for opioid use disorder and is not recommended. Patients should be advised about the risk of relapse and other safety concerns, including increased risk of overdose and overdose death. <u>Ongoing maintenance medication, in combination with psychosocial treatment appropriate for the patient's needs, is the standard of care for treating …There is no recommended time limit for pharmacological treatment.</u>

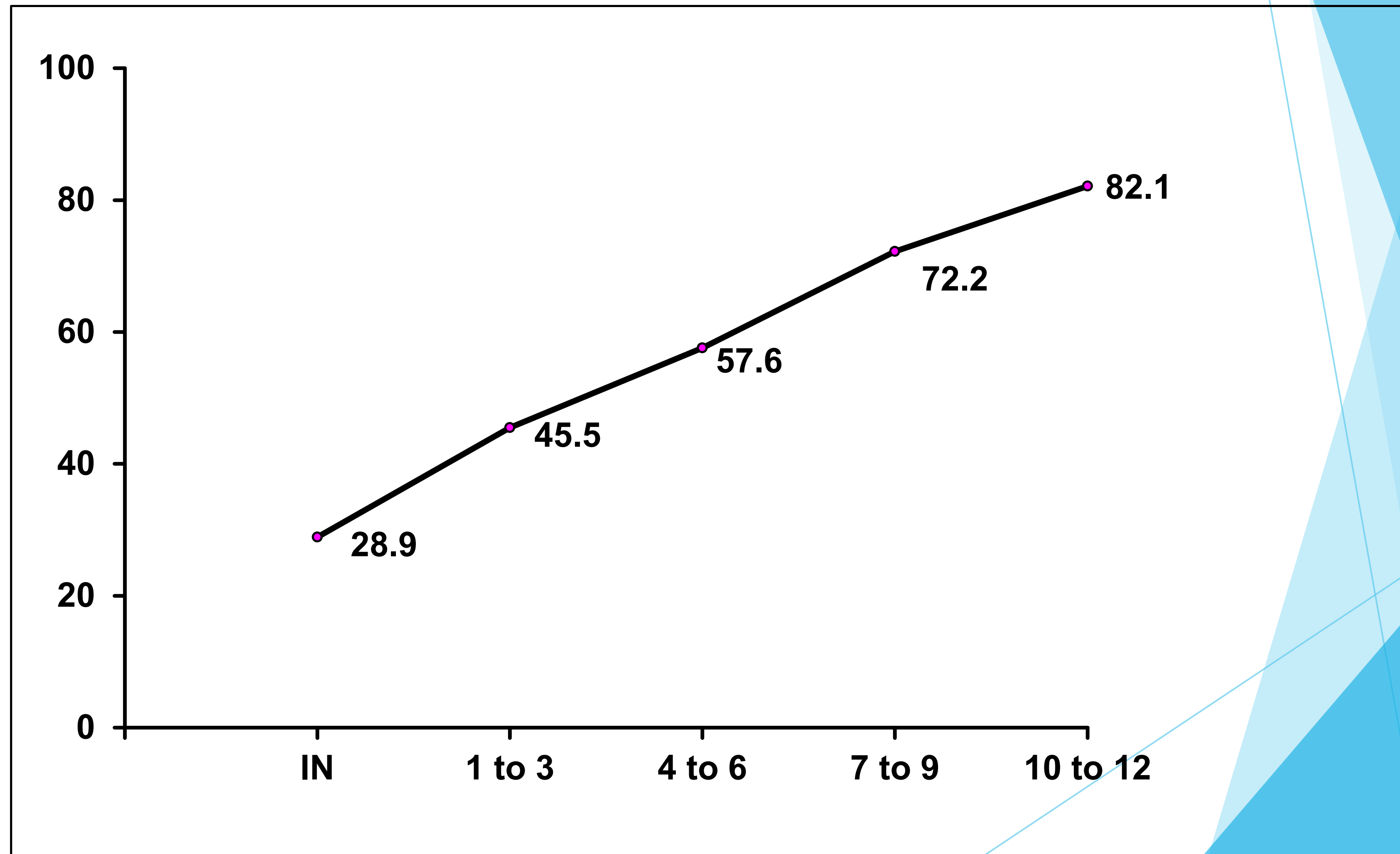
ASAM 2020 Guidelines

Clinical evidence shows that people may need treatment with medications for long periods of time to achieve a sustained recovery.

Some may even need a lifetime of treatment.

<u>The FDA recently revised the labels of buprenorphine products to reflect this fact.</u>

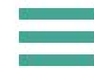
High Rate of Relapse to IV drug use after drop-out from Methadone Treatment



Adapted from Ball & Ross - *The Effectiveness of Methadone Maintenance Treatment*, 1991

RECOVERY
RESEARCH
INSTITUTE

Even 3 years into treatment, patients that stay on their medication have 2/3 less relapse
And at 5 years have ½ the relapse rate



Relapses per 100 months of treatment

Length of treatment episode in months

Buprenorphine Methadone Non-OAT Behavioral Health

Fig. 1. Relapses during treatment among MassHealth members who received treatment for opioid addiction between 2003 and 2010[1]. [1] N = 18,866 episodes of buprenorphine treatment, 24,309 episodes of methadone treatment and 31,220 episodes of non-OAT behavioral health treatment in month 1. 33% of buprenorphine episodes, 52% of methadone episodes, and 12% of non-OAT treatment episodes lasted 12 months or more. 13% of buprenorphine treatment episodes, 27% of methadone episodes, and 1% of non-OAT treatment episodes lasted 24 months or longer.

Medication Duration and Tapering

Evidence is clear that long-term or indefinite treatment with medications for OUDs is often required for effective and sustained outcomes.[48] In practice, successful tapers from methadone or buprenorphine typically occur in only about 15 percent of cases, the likely result of premature or unwarranted discontinuation of the medication regimens.[51, 68] Administering MAT for 90 days or less, which is common practice in many jails and prisons, offers no beneficial effects.[51] According to the U.S. Surgeon General, successful tapers typically occur, if at all, when individuals have been treated with MAT for at least 3 years.[69]

When to Consider Taper?

- Patient Insists (for the right reasons)
- Relapse free for a year
- Stable housing, job, family life
- No major stressors (legal, financial)
- Stable Mental Health
- Actively engaged in strong recovery network

TAPER SHOULD ALWAYS BE PATIENT INITIATED

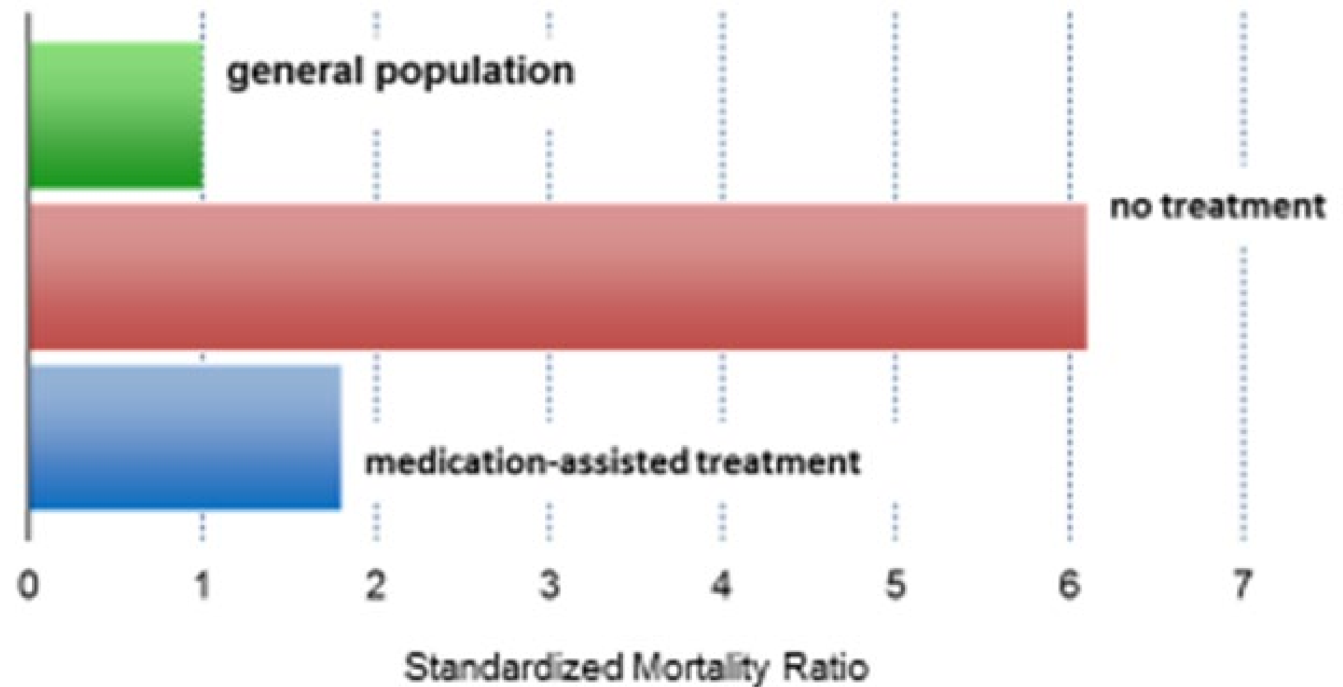
We work to counsel patient AGAINST discontinuation:

- During Pregnancy/postpartum
- During high stress times
- During surgery/hospitalization
- Due pressure from family/friends
- Because they “don’t need it anymore”

Benefits of MAT: Decreased Mortality

Death rates:

Overdose risk the first 2 weeks after leaving treatment is 10-30 times higher



Dupouy et al., 2017
Evans et al., 2015
Sordo et al., 2017

Opioid medication discontinuation and risk of adverse opioid related health care events

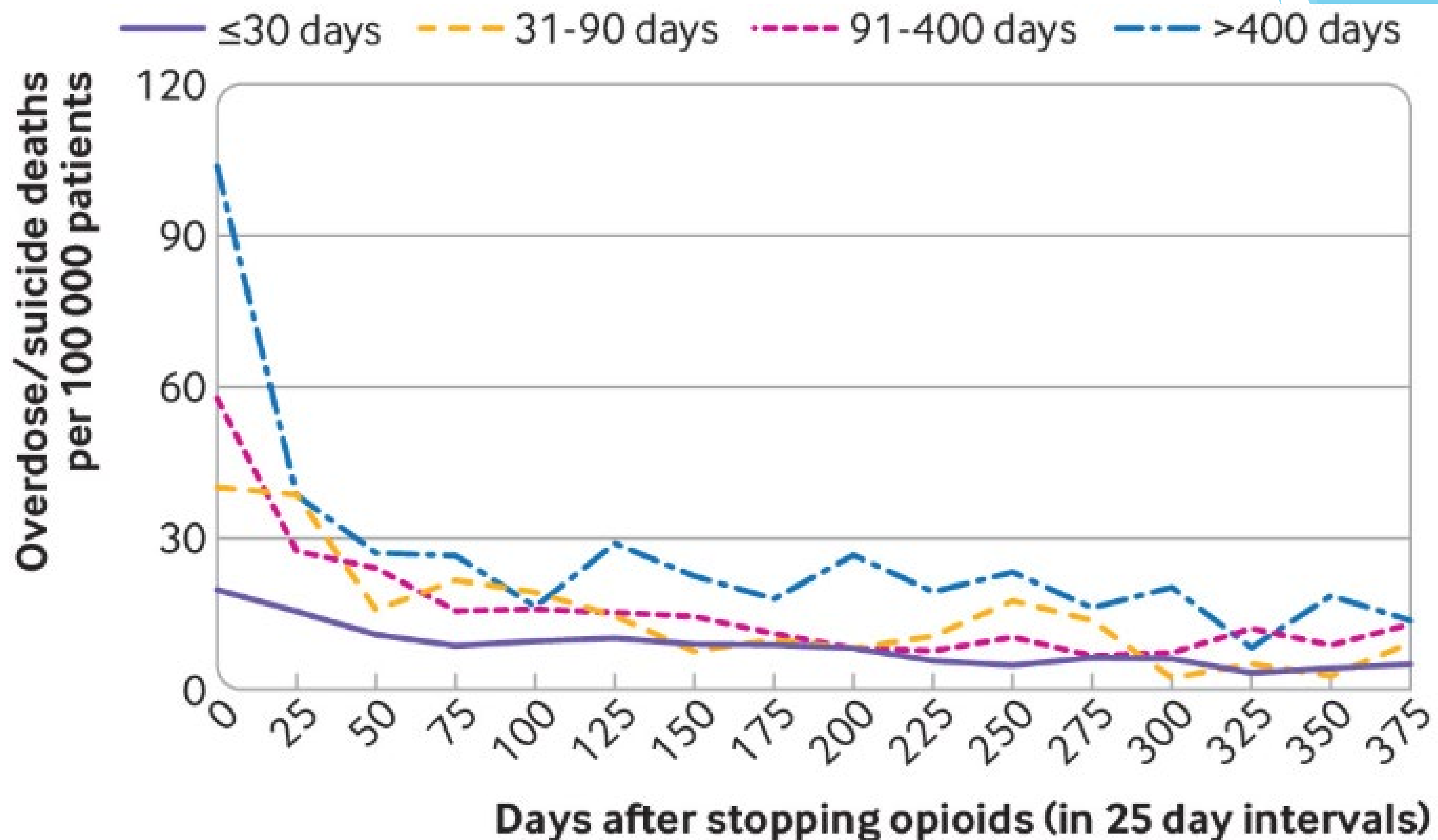
Mark et al, Journal of Substance Abuse Treatment 2019

In VT 2013-2017, 500 pts on high dose chronic opioids (>120 MME)

- 86% Rapidly discontinued(<21 days) (half were d/c with no taper)
- Half of those with rapid d/c had opioid related hospitalization or ED visit
- Each additional week of taper was associated with 7% reduction in probability of opioid related adverse event
- Although 60% dx SUD less than 1% were transitioned to MAT

https://gmcboard.vermont.gov/sites/gmcb/files/documents/Article%20-%20Opioid%20Medication%20Discontinuation%20and%20Risk%20of%20Adverse%20Opioid-related%20Health%20Care%20Events%20-%20Tami%20Mark%20and%20William%20Parish.pdf

Associations between stopping prescriptions for opioids, length of opioid treatment, and overdose or suicide deaths in US veterans



BMJ 2020; 368 doi: https://doi.org/10.1136/bmj.m283 (Published 04 March 2020)

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.

How to Taper Buprenorphine?

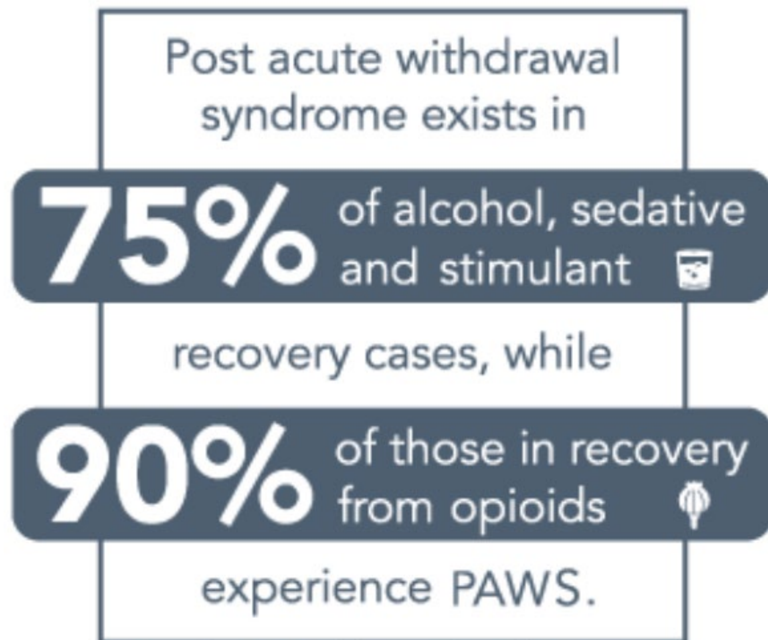
- Discontinuation of meds quickly (less than 2-4 weeks) should generally occur with inpatient withdrawal management and is discouraged
- Reduction of dose should be slow, about 10% per month, over 6-12 months
- Need to see a provider experienced in managing acute and post acute withdrawal (PAWS) which can last for a year (insomnia/mood disorders/pain)
- Ideally would always start naltrexone after detox finished
- **Always give Narcan kit**
- **Always leave the door open to return to treatment**

Off label taper with XR SQ Buprenorphine (Sublocade)

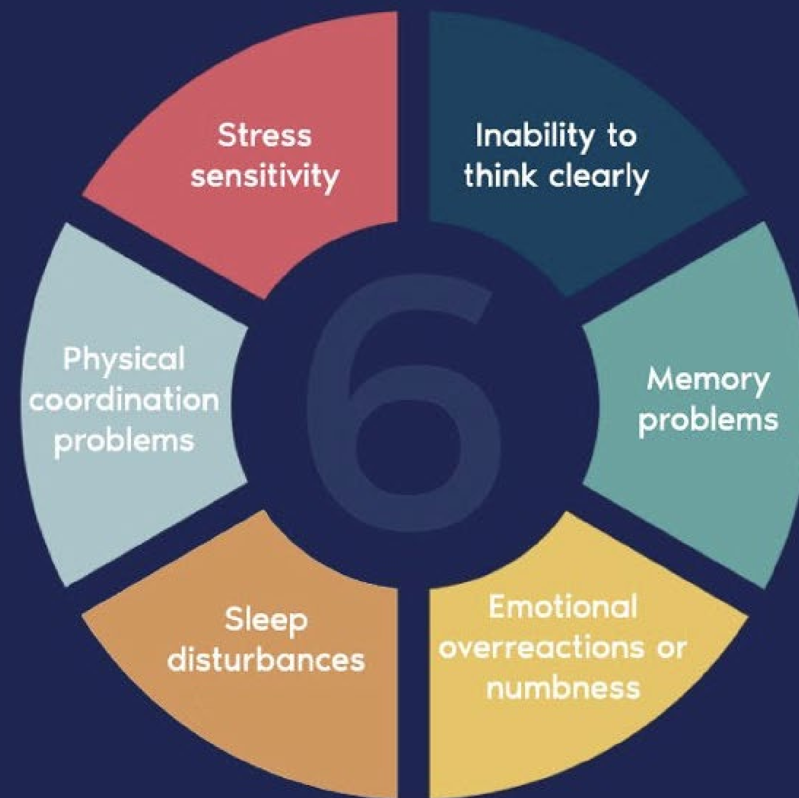
- For patients on 6mg or less of buprenorphine who have struggled with further taper
- A number of published case studies have shown good results of administering a single 100 mg dose of XR SQ buprenorphine (Sublocade)
- The depot formulation will slowly absorb resulting in gradual slow reduction in serum levels that reduce withdrawal symptoms
- Patients who have been on XR Bup (Sublocade) more than 4-6 months generally will not experience withdrawal symptoms once therapy is stopped due to long, slow natural taper that occurs over 6+ months

Supportive medications for opioid withdrawal management:

- Myalgias: NSAIDS and Acetaminophen
- Muscle spasms: Tizanidine
- Nausea: Ondansetron or Promethazine
- Restlessness and sweating: Clonidine
- Anxiety and rhinorrhea: Hydroxyzine
- Insomnia: Trazodone



Some people may experience minimal withdrawal symptoms that may last for days or just a few weeks; others will continue to experience PAWS symptoms for years.



PAWS: Manage Patient Expectations

- Help clients understand that it is normal to feel not fully recovered within the first weeks and months of abstinence.
- Tell them about possible protracted withdrawal symptoms and reassure them that these symptoms will not last forever and can be managed.
- Advise clients on how to reduce or cope with symptoms and encourage them to focus on incremental improvements.

Tapering Benzo

Effective Treatments for PTSD:

Helping Patients Taper from Benzodiazepines

Quick Facts

- Taper anyone taking benzodiazepines for 2 weeks or longer
- Withdrawal symptoms may occur after only 2-4 weeks of treatment
- Risks of recurrence or

Benzodiazepines Overview

Continuing to renew benzodiazepine (BZD) prescriptions to certain subgroups of your patients with PTSD may be a high risk practice. These medications may no longer be of benefit to your patients and carry significant risks associated with chronic use. Due to the lack of evidence for their effectiveness in the treatment of PTSD, it is worthwhile for you to implement strategies for assessing patients who are taking them to determine if a taper is appropriate. It is also important to consider alternate treatment options and to minimize new benzodiazepine prescriptions whenever possible in the veteran PTSD population.

This brochure offers you valuable resources to help you taper your patients from benzodiazepines and information on alternatives.

Despite the involved challenges, strategies to taper existing benzodiazepines prescriptions are effective.

https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Academic_Detailing_Educational_Material_Catalog/59_PTSD_NCPTSD_Provider_Helping_Patients_Taper_BZD.pdf

BENZODIAZEPINE TAPER

Basic principle: Expect anxiety, insomnia, and resistance. Patient education and support will be critical. Risk of seizures with abrupt withdrawal increases with higher doses. The slower the taper, the better tolerated.

SLOW TAPER

1. Calculate total daily dose. Switch from short-acting agent (alprazolam, lorazepam) to longer-acting agent (diazepam, clonazepam, chlordiazepoxide, or phenobarbital). Upon initiation of taper, reduce the calculated dose by 25–50% to adjust for possible metabolic variance.
2. Schedule first follow-up visit two to four days after initiating taper to determine if adjustment in initial calculated dose is needed.
3. Reduce the total daily dose by 5–10% per week in divided doses.
4. After ¼ to ½ of the dose is reached, you can slow the taper with cooperative patient.
5. With cooperative patients who are having difficulty with this taper regimen, you can extend the total time of reduction to as much as six months.
6. Consider adjunctive agents to help with symptoms: trazodone, hydroxyzine, neuroleptics, anti-depressants, clonidine, and alpha-blocking agents.

RAPID TAPER

1. Pre-medicate two weeks prior to taper with valproate 500mg BID or carbamazepine 200mg every AM and 400mg every HS. Continue this medication for four weeks post-benzodiazepines. Follow the usual safeguards (lab testing and blood levels) when prescribing these medications.
2. Utilize concomitant behavioral supports.
3. Discontinue current benzodiazepine treatment and switch to diazepam 2mg BID for two days, followed by 2mg every day for two days, then stop. For high doses, begin with 5mg BID for two days and then continue as described.
4. Use adjuvant medications as mentioned above for rebound anxiety and other symptoms.

Benzodiazepine Equivalency Chart

Drug	Half-life (hrs)	Dose Equivalent
Chlordiazepoxide (Librium)	5–30 h	25mg
Diazepam (Valium)	20–50 h	10mg
Alprazolam (Xanax)	6–20 h	0.5mg
Clonazepam (Klonopin)	18–39 h	0.5mg
Lorazepam (Ativan)	10–20 h	1mg
Oxazepam (Serax)	3–21 h	15mg
Triazolam (Halcion)	1.6–5.5 h	0.5mg
Phenobarbital (barbituate)	53 – 118 h	30 mg

https://www.oregonpainguidance.org/app/content/uploads/2016/05/Opioid-and-Benzodiazepine-Tapering-flow-sheets.pdf

Naloxone (Narcan) for overdose prevention

- Prescribe/give to patient and train on use on intake to treatment
- Repeat training and give a new kit if needed when taper planned
- Discuss high risk of overdose if return to use after stopping MAT (particularly if no opioid tolerance-naltrexone)
- Can give out in office (project HOPE), order from ANTHC pharmacy or order through local pharmacy (covered by insurances like Medicaid)

HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics

This *HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics* provides advice to clinicians who are contemplating or initiating a reduction in opioid dosage or discontinuation of long-term opioid therapy for chronic pain. In each case the clinician should review the risks and benefits of the current therapy with the patient, and decide if tapering is appropriate based on individual circumstances.

https://www.hhs.gov/opioids/sites/default/files/2019-10/Dosage_Reduction_Discontinuation.pdf

https://www.pbm.va.gov/AcademicDetailingService/Documents/Pain_Opioid_Taper_Tool_IB_10_939_P96820.pdf

Opioid Taper Decision Tool

VA

U.S. Department of Veterans Affairs
Veterans Health Administration
PBM Academic Detailing Service

Case Presentation

Project ECHO's goal is to protect patient privacy

- To help Project ECHO accomplish that goal, please only display or say information that doesn't identify a patient or that cannot be linked to a patient.
- **References: For a complete list of protected information under HIPAA, please visit www.hipaa.com**

Thank you for joining us today.
We appreciate your participation and hope to see you at the **NEXT ECHO Session:**
January 28, 2021 from 12pm -1 PM

You will be receiving a follow up survey that we hope you will complete to help us improve. If you are requesting continuing education credits, you will be required to complete the survey to receive your CMEs.

quyanaa • gunalchéesh • háw'aa • way dankoo • qağaasakung • mahsi' chin'an • 'awa'ahdah •