

**Action Collaborative on
Countering the U.S. Opioid Epidemic**

Best Practices, Research Gaps, and Future Priorities to Support Tapering Patients on Long-Term Opioid Therapy

**Friday, December 18, 2020
4:30 – 6:00 pm ET**



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Webinar Agenda

4:30 – 4:40 pm et

Welcome and Introductions

- **Aisha Salman, MPH**, Interim Director, Action Collaborative on Countering the U.S. Opioid Epidemic, National Academy of Medicine
- **Helen Burstin, MD, MPH, FACP**, Executive Vice President and Chief Executive Officer of the Council of Medical Specialty Societies

4:40 – 5:20 pm et

Panel Presentations

- **Robert “Chuck” Rich, Jr., MD, FAAFP**, Family Physician at Bladen Medical Associates and Adjunct Associate Professor at Campbell University
- **Ada D. Stewart, MD, FAAFP**, President of the American Academy of Family Physicians
- **Liz Bentley, MSJ, PharmD, BCPS**, Director of Clinical Pharmacy Services at Kaiser Permanente – Northwest Region
- **David O’Gurek, MD, FAAFP**, Associate Professor at the Lewis Katz School of Medicine at Temple University

5:20 – 6:00 pm et

Moderated Discussion and Audience Q&A

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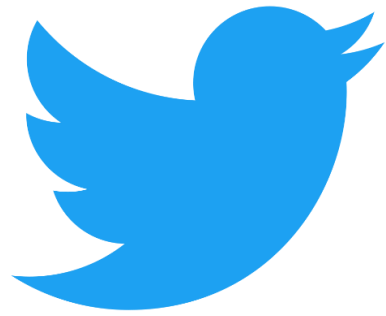
Questions from the Audience

Questions are welcome throughout the webinar and will be addressed at the end of the presentation.

Please use the comment box on your screen to enter a question.

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Overview of the Action Collaborative

Aisha Salman, MPH

*Interim Director,
Action Collaborative on Countering the U.S. Opioid Epidemic,
National Academy of Medicine*

The Action Collaborative is a public-private partnership of over 60 members from the public, private, and non-profit sectors.

Mission: To convene and catalyze public, private, and non-profit stakeholders to develop, curate, and disseminate multi-sector solutions designed to reduce opioid misuse, and improve outcomes for individuals, families, and communities affected by the opioid crisis.

Goals:

- Identify and raise the visibility of complex challenges, outstanding research gaps and needs of the opioid crisis that require a collective, multi-sectoral response.
- Elevate and accelerate evidence-based, multi-sectoral, and interprofessional solutions to improve outcomes for those affected by the opioid crisis.
- Catalyze action on shared priorities and solutions to help overcome the crisis and improve outcomes for all.

Leadership: Steering Committee co-chaired by NAM, Aspen Institute, HHS, HCA Healthcare

Four priority focus areas (working groups): Health professional education and training; Pain management guidelines and evidence standards; Prevention, treatment, and recovery services; and Research, data, and metrics needs

Overview of the Pain Management Working Group



Helen Burstin, MD, MPH, MACP

*Chief Executive Officer
Council of Medical Specialty Societies*

*Co-Lead, Pain Management Guidelines and Evidence
Standards Working Group*

Pain Management Guidelines and Evidence Standards

Mission: Highlighting and advancing the opportunities to strengthen critical aspects of pain management, including patient-centered and evidence-based tapering guidance, multidisciplinary pain management approaches, and judiciously implementing pain guidelines into practice.

Focus Areas and Objectives

1. Identify the evidence and related best practices for when opioids are indicated, should be tapered, or discontinued
2. Highlight evidence-based approaches to integrative pain management, including strategies to support broader implementation
3. Support the implementation of pain guidelines into practice while monitoring intended and unintended consequences

Chronic Pain and Tapering

- Recognize the management of chronic pain is a public health issue
- Prescription opioids for pain have declined, but continue to contribute to morbidity and mortality
- Opioid tapering is an approach to support the safety and well-being of some patients; however, tapering is complex and the decision to taper should be made collaboratively
- Today we will explore key considerations, best practices, and tools and resources for effective tapering

Webinar Speakers

Moderator



Helen Burstin
MD, MPH, MACP
Chief Executive Officer
Council of Medical
Specialty Societies



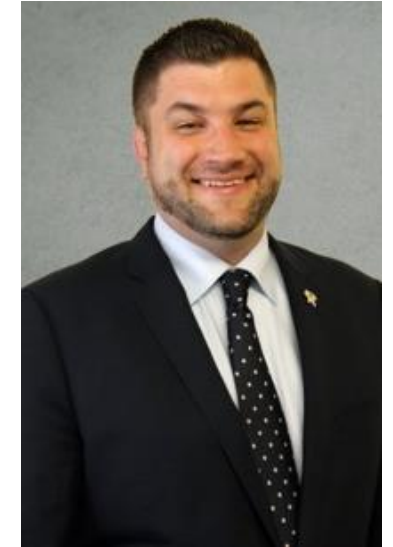
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Robert “Chuck” Rich, Jr., MD, FAAFP

*Medical Director, Bladen Medical Associates & Adjunct
Associate Professor, School of Osteopathic Medicine,
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Best Practices, Research Gaps, and Future Priorities to Support Tapering Patients on Long-Term Opioid Therapy for Chronic Pain in Outpatient Settings

A summary of Key Points, Future Priorities and Research Opportunities

Background

- Treatment of chronic non-cancer pain(CNCP) over past 2 decades evolved to include a high rate of opioid analgesics
- Evidence base for opioid use in CNCP slim and harms associated with use
- Guidelines subsequently developed to guide opioid use for CNCP
- Guidelines do not completely address the “legacy” patient already on chronic opioid therapy, often high dose or in combination with benzodiazepines or hypnotics
- Providers and patients subsequently left with decisions to taper and/or discontinue chronic opioid therapy and opioid/benzodiazepine/hypnotic combination therapy

Key Points

- There are benefits to be tapering Long-term Opioid Therapy (LOT) in the patient with CNCP including possible improved pain and functioning, lessened risk of accidental overdose and death, lessened side effects from LOT, lessened impairment of disease processes in patients with lung disease & liver disease, and improved risk profile in high risk populations such as youth and pregnant women
- There are similarly possible risks to tapering including worsened pain, unmasked opioid dependency, unmasked behavioral health conditions in those patients not previously diagnosed, and precipitated withdrawal syndrome in those patients undergoing tapering or abrupt discontinuation
- A significant percentage of CNCP patients on LOT have underlying behavioral health disorders including depression, anxiety and substance abuse disorders that increase the risk of accidental overdose and death and those same disorders may complicate efforts to taper or discontinue LOT

Key Points, continued

- Patient concerns about tapering include concerns about worsened pain and function, the development of withdrawal symptoms and possible stigma associated with a withdrawal syndrome
- Opioid tapering should be initiated via a supportive, shared decision making strategy, addressing patient concerns about the taper and will often require repeated efforts to obtain patient buy-in
- There exists little evidence to guide the speed of tapering, how to taper the patient on combinations of opioids and other high risk medications and how to determine the endpoint of a successful taper which may require months to years

Key Points, continued

- Adjunctive therapies, both pharmacologic and nonpharmacologic should be maximized before and during the tapering process to manage chronic pain as well as underlying behavioral health disorders
- Tapering should be guided by ongoing assessments of pain, function and may benefit from the use of assessment tools to guide that process. Similarly, the use of a tapering agreement may also facilitate that process by improving communication between patient and healthcare provider
- Tapering can be slowed or paused but should not be reversed without maximizing adjunctive therapies to manage pain and underlying behavioral disorders. Reversal must be guided by reassessment of risks versus benefits in a shared decision making process and may be an ideal time to obtain additional consultation, particularly in the primary care setting.

Research Gaps – Speed of Taper

- Recommendation: “Identify the appropriate taper speed for individual patients within distinct patient populations, beginning with those patients on high-dose opioid therapy (greater than 90 MME per day); patients with suspected opioid use disorder; and patients with coexisting behavioral health disorders”
- Little research exists to guide decision-making about the speed of tapering in categories of CNCP patients and the individual patient
- Current recommendations primarily based on consensus recommendations with rule of thumb the longer that the patient has been on LOT, the longer the taper

Research Gap – Adjunctive Therapies

- Recommendation: “Determine the optimal non-opioid pharmacologic and nonpharmacologic treatments to manage pain for different patient populations, beginning with the use of CBT in tapering; use of antidepressant therapy in tapering, specifically in patients with and without behavioral health disorders; and use of gabapentinoids in tapering”
- Research has demonstrated use of pharmacologic and nonpharmacologic treatments for chronic pain but little exists to guide their use in tapering as their timing and/or sequence in tapering
- Research particularly needed for nonpharmacologic treatments, including which therapies are beneficial for tapering and how they should be used
- Improved evidence base for which adjunctive therapies are useful could then expand insurance coverage for those therapies

Research Gap – Interdisciplinary Teams

- Recommendation: “Determine the efficacy around use of interdisciplinary teams in opioid tapering”
- Longer studies are needed with larger patients pools to validate the utility of interdisciplinary teams in tapering
- Research is also needed regarding which personnel should participate as part of a tapering team, which type of integrative care is beneficial and when that care should be employed in the tapering process
- Improved evidence for integrative care should help expand insurance coverage for those services

Research Gap – The Role of OUD Therapies in Tapering

- Recommendation: “Determine how best to employ opioid agonists in patients with OUD and chronic pain and on the use of buprenorphine and methadone in patients with persistent opioid dependence”
- In patients with coexisting SUD, these medications are increasingly used to transition patients off LOT for the purpose of tapering
- Gaps exist regarding whether the therapies should be considered as primary therapies in patients on LOT without OUD, at what point to transition the LOT to these therapies, the speed of tapering once transitioned to these therapies, use of maintenance therapies once tapered off LOT with these therapies, as well as data comparisons looking at complications, dose re-escalations and other endpoints when using these therapies compared to usual therapies
- Similarly, if OUD therapies are found to be effective in opioid tapering, the policy question exists regarding whether waiver training would then be required to implement OUD therapy by providers who are using it for tapering only

Research Gap – Polypharmacy Patients

- Recommendation: “Identify best practices to taper opioids in polypharmacy patients”
- A significant portion of patients on LOT are receiving polypharmacy including benzodiazepines, hypnotics, muscle relaxants and other sedating medications increasing risk of adverse events including accidental overdose and death
- Significant research gaps exist regarding how to handle polypharmacy in the CNCP patient on LOT including which medication to taper first, whether to taper concurrently, whether one category of medication should be tapered prior to starting the LOT tapering, the speed at which to taper these medications and further best practices in tapering LOT

Research Gap – Management of Behavioral Health Issues

- Recommendation: “ Identify optimal treatments for concomitant behavioral health conditions in patients undergoing an opioid taper”
- Research is needed to better define the management of behavioral health disorders in chronic pain and opioid tapering, which behavioral health therapies are beneficial to tapering, when to start those therapies, how long to continue those therapies, and their role in maintenance therapy after a successful taper
- Research is also needed to better define those measures of tapering which are positively impacted by behavioral health therapies and which therapies produce the most benefit in tapering

Research Gap – Evidence Surrounding Risks vs. Benefits

- Recommendation: “ Strengthen the evidence behind associated benefits and risks of opioid tapering”
- The evidence base for the benefits of opioid tapering is limited in terms of quality and duration of such studies whereas the evidence base for the risks of tapering is even more limited, consisting of primarily anecdotal reports
- Research is needed of a higher quality and longer duration (greater than 1 year) into the risks versus benefits of tapering to aide decision making for healthcare providers caring for the CNCP on LOT



Ada D. Stewart, MD, FAAFP

*President
American Academy of Family Physicians*

AAFP Represents Family Physicians

- The professional organization for family physicians in the United States
- 55 chapters representing states, territories, and Uniformed Services
- Family physicians provide comprehensive continuous primary health care to patients regardless of gender, age, or issue

www.aafp.org

AAFP is Dedicated to Health

The Vision of the AAFP is to transform health care to achieve optimal health for everyone.

The Mission of the AAFP is to improve the health of patients, families, and communities by serving the needs of members with professionalism and creativity.

Chronic Pain Management and Opioid Use

- The primary goals of pain management are patient improvement and maintaining function
- Chronic non-cancer pain management remains a challenge
 - Increased opioid use for pain relief correlated to significant spike in opioid misuse, abuse, and dependence
- For patients on long-term opioid therapy, family physicians can focus on patient engagement and shared decision-making by:
 - Facilitate conversations about pain and treatment goals
 - Standardize evaluation and treatment of patients with chronic pain
 - Identify and mitigate risk

Shared Decision Making and Patient Engagement Before, During, and After a Taper

- Objective of an opioid taper is to prevent significant withdrawal symptoms while reducing or discontinuing opioid use
- Many reasons to taper long-term opioid therapy dosage
 - Patient request; lack of improvement; nonadherence to treatment plan; signs of misuse or abuse; serious adverse events
- Discussing tapering can sometimes cause patients extreme stress or anxiety

Shared Decision Making and Patient Engagement Before, During, and After a Taper

Before a taper

- Use tools like a [Brief Pain Inventory](#), [Functional Goals](#) list, and [Action Plan](#) to:
 - Standardize evaluation, learn about your patient's pain and treatment goals
 - Maintain an open dialogue about lack of improvement in pain or function
 - A [Work Productivity and Activity Impairment Questionnaire](#) and [PHQ9 Mental Health Assessment](#) can also help monitor and assess treatment
- Plan to spend more time when you discuss tapering; be prepared and empathetic for their reaction
- Focus on treatment goals and outcomes; use motivational interviewing to guide the conversation; listen and address concerns

Shared Decision Making and Patient Engagement Before, During, and After a Taper

During a taper

- There is no evidence to support one tapering strategy over another. Any tapering protocol should be individualized through careful consideration with the patient
- The AAFP [Tapering Resource](#) and [Opioid Conversion Table](#) can help guide conversations around tapering and record and manage tapering doses
- Go slow, provide encouragement and support, and monitor for symptoms of withdrawal
 - Not all patients will experience the same withdrawal symptoms. The AAFP [Tapering Resource](#) lists additional treatments that may help with specific symptoms

Shared Decision Making and Patient Engagement Before, During, and After a Taper

After a taper

- A taper is considered complete once it reaches a point that has been agreed on by the patient and their physician (i.e., a decreased dosage or complete cessation)
- Physicians should continue to monitor their patient using the previously-mentioned evaluation tools, with particular attention to re-escalation of opioid dosage

Gaining Patient Buy-In

- Every taper should be initiated through a supportive, shared decision-making strategy
- Patients should be aware of the rationale for the taper, the protocols involved, and expectations for various stages
 - A tapering action plan can help define expectations, minimize misunderstanding, and facilitate adherence
- Motivational interviewing can be effective at assessing readiness, increasing patient desire to taper, and alleviating concerns

Engaging with Families and Caregivers

- Families and caregivers can provide a stable and supportive environment for the patient undergoing opioid tapering
- Individualized care and patient preference should be a component of family and caregiver inclusion in shared decision-making

How to Navigate Difficult Situations

- The AAFP encourages family physicians to obtain a waiver and incorporate medication-assisted treatment (MAT) into practice
 - For patients on high dose or multiple opioids, a single long-acting opioid or some form of opioid substitution treatment can be considered
- Regularly monitor and evaluate patient progress during a taper and be ready and willing to respond by:
 - Temporarily maintaining at a tapered dosage
 - Starting or referring to additional behavior health support
 - Assessing/reassessing the patient for an opioid use disorder



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*Director, Clinical Pharmacy Services
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Pharmacists' Role in Opioid Tapering

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Kaiser Permanente - Background

- Kaiser Permanente noted growing use of opioids for pain management in the late 2000s
- Opioid stewardship programs focus on:
 - Limiting opioid prescriptions overall
 - Providing effective pain management alternatives
 - Prescribing lower doses and shorter courses when opioids are medically necessary
 - Helping patients on opioid medications reduce or discontinue use as appropriate
 - Increasing access to naloxone
 - Robust pharmacy support (e.g., tapering, detailing, monitoring)

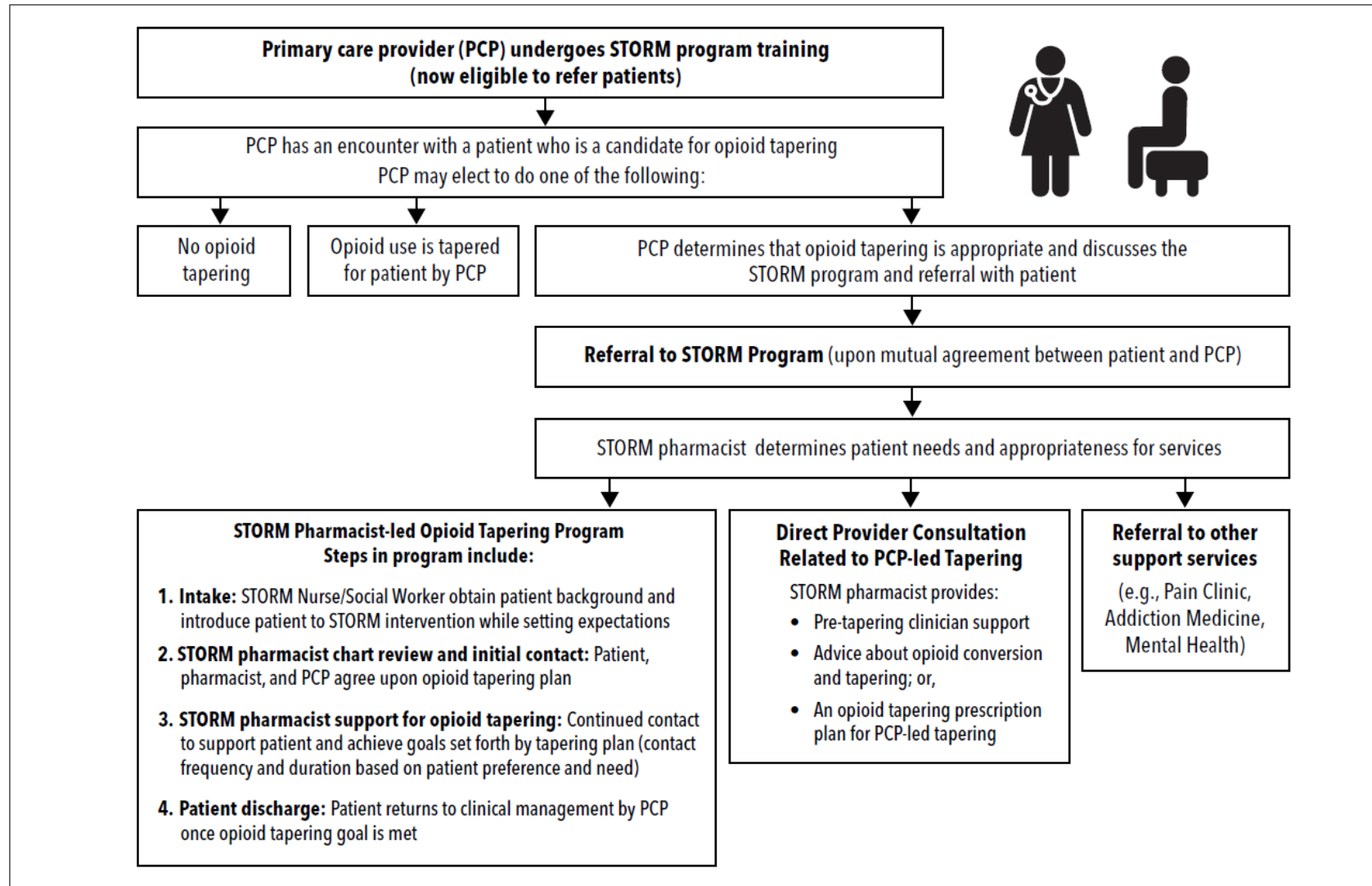
8 Regions
12.4M Members
39 Hospitals
719 Medical Offices

Pharmacist Roles – Opioid/Pain Management

- Provide services for management of pain and opioid use disorder
- Screen for and provide preventative measures for opioid misuse
- Participate in evidence-based evaluation of treatment options
- Recommend and implement multimodal pain management treatments
- Participate in pain management and opioid stewardship programs

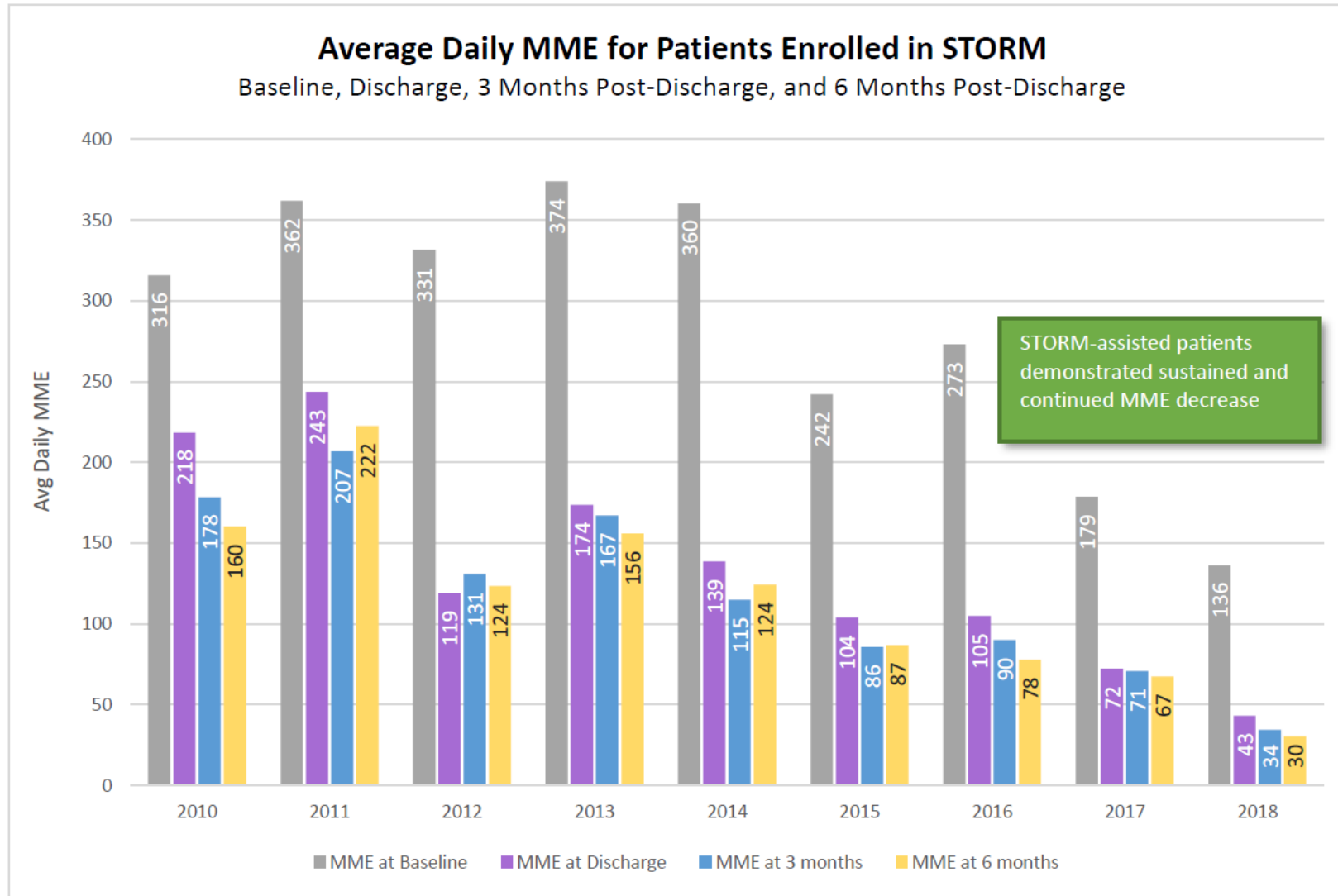
Report of the ASHP Opioid Task Force. *Am J Health Syst Pharm.* 2020 Jul 15;77(14):1158-1165.

Pharmacist Opioid Tapering – Telephonic Program



Kuntz JL, Schneider JL, Firemark AJ, et al. A pharmacist-led program to taper opioid use at Kaiser Permanente Northwest: Rationale, design, and evaluation. *Perm J* 2020;24:19.216. Image used by permission of Kaiser Permanente Northwest Center for Health Research.

Opioid Tapering - Results



STORM = Support Team Onsite Resource for the Management of Pain; MME = morphine milligram equivalents; STORM is a pharmacist-led pain management team in Kaiser Permanente Northwest

Opioid Tapering – Patient Feedback

Improved Patient Safety Testimonial:

“I am relieved to be off of opioids. When I was on high dose morphine, I would frequently fall asleep in my chair while smoking a cigarette, which would drop and burn holes in my clothes. After tapering, this no longer happens. I sleep well at night, feel rested during the day, and am able to be up doing chores around the house instead of sleeping all day.”

Patient Feedback about STORM Support:

“I feel like I got my life back!”

“My wife thanks you. I am able to participate in more family activities and I am my old self again.”

Patient Feedback on STORM Support:

“And I know myself. And I wouldn’t have...I wouldn’t have been able to go through with the process at all without that extra help that they provided. Just the support. Just to know that they care. And they really do care.”

Additional Pharmacist Roles in Tapering

Naloxone

- Pharmacists provide naloxone (either by independently prescribing or through a collaborative practice agreement) as allowed by state regulations
- State of Oregon passed legislation in 2017 to allow pharmacists to independently prescribe medication on a state-approved drug formulary, and Kaiser Permanente adopted this practice
- Number of patients with a prescription for naloxone increased 64% from 2017-19 at Kaiser Permanente Northwest

Medication Monitoring

- Pharmacists at Kaiser Permanente Northwest monitor patients on opioid therapy (including buprenorphine/naloxone) in partnership with the treating physician and the rest of the care team to assess:
 - Visit frequency
 - Urine drug screens
 - Medication fill histories
 - Therapy plan compliance
 - Signs of opioid misuse/abuse

From the team social worker

"People are petrified. They don't want to taper. They're angry about it. They're scared about it. And I'm the first person to reach out. ... [W]hat I'm doing for a 60-minute telephone call is I am building trust and confidence and rapport in this buy-in, so that when the pharmacist comes along behind me and calls the patient—there's a second call—then the patient is now, basically, willing to try to taper."

Kuntz JL, Schneider JL, Firemark AJ, et al. A pharmacist-led program to taper opioid use at Kaiser Permanente Northwest: Rationale, design, and evaluation. *Perm J* 2020;24:19.216.



Role of the Team Social Worker

- Introduce patient to tapering program
- Provide counseling to set expectations
- Obtain information about pain location, level of pain, perceptions
- Review non-pharmacologic strategies
- Screen patient for depression by administering the Patient Health Questionnaire-9
- Follow-up with physician or additional mental health resources as appropriate
- Triage patient needs throughout the tapering process (ad hoc)

Kuntz JL, Schneider JL, Firemark AJ, et al. A pharmacist-led program to taper opioid use at Kaiser Permanente Northwest: Rationale, design, and evaluation. *Perm J* 2020;24:19.216.



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Behavioral Health Integration into Tapering Process

"...we are not ourselves when nature, being oppressed, commands the mind to suffer with the body."

Shakespeare, *King Lear*

Healing Centered Engagement: Addressing the Systemic Aspects of Chronic Pain

- Among patients in specialty treatment for chronic pain, 1/3-2/3 have been diagnosed with PTSD or report significant levels of trauma-related symptomatology

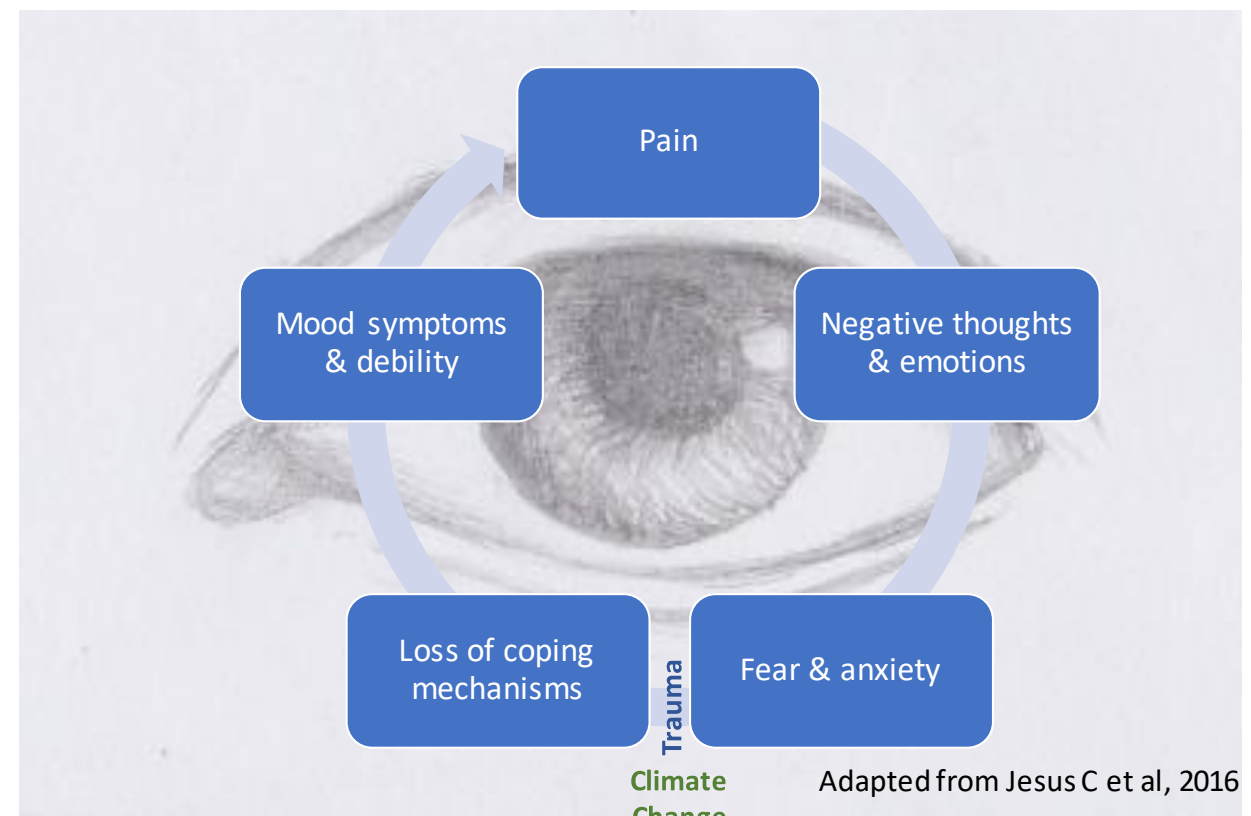
Asmundson, et al 2009

- Persons with chronic pain and PTSD are more distressed and impaired than those experiencing only one of these conditions

Geisser, et al 1996

- Persons experiencing both do not respond as well to standard treatment

Otis, et al 2003



Climate Change
Lack of Integration
Stigmatizing Language
Heteronormative rules
Inadequate Housing
Binary Gender Biases
Unclean Water
Lack of Safety
Debt
Racism
Violence
Unemployment
Stress
Poor Access To Care
Income inequality
Food Insecurity
Low Literacy

Gets angry in clinic?

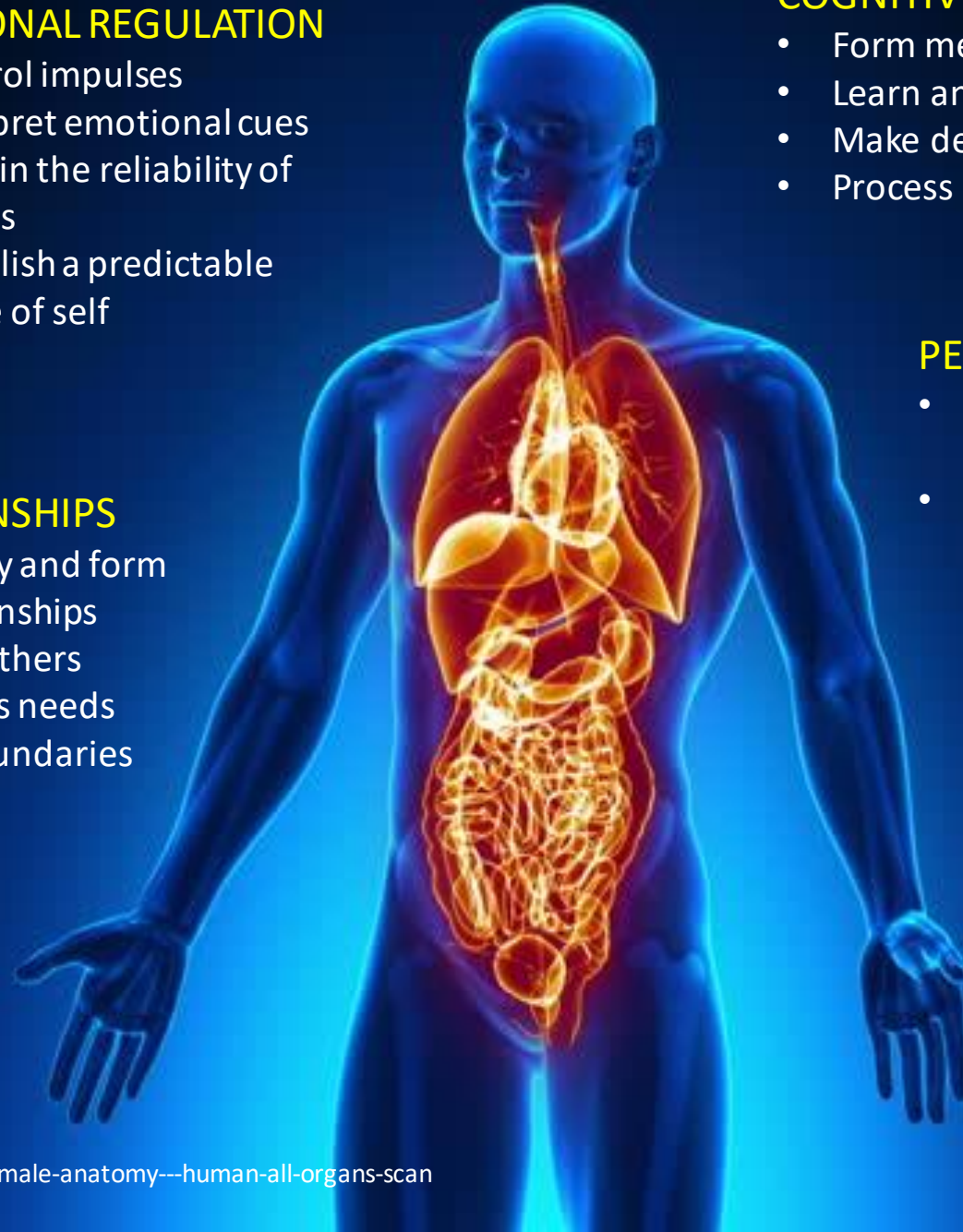
EMOTIONAL REGULATION

- Control impulses
- Interpret emotional cues
- Trust in the reliability of others
- Establish a predictable sense of self

Isn't forthcoming with information requested?

RELATIONSHIPS

- Identify and form relationships
- Trust others
- Express needs
- Set boundaries



COGNITIVE FUNCTIONING

- Form memories
- Learn and concentrate
- Make decisions
- Process and express

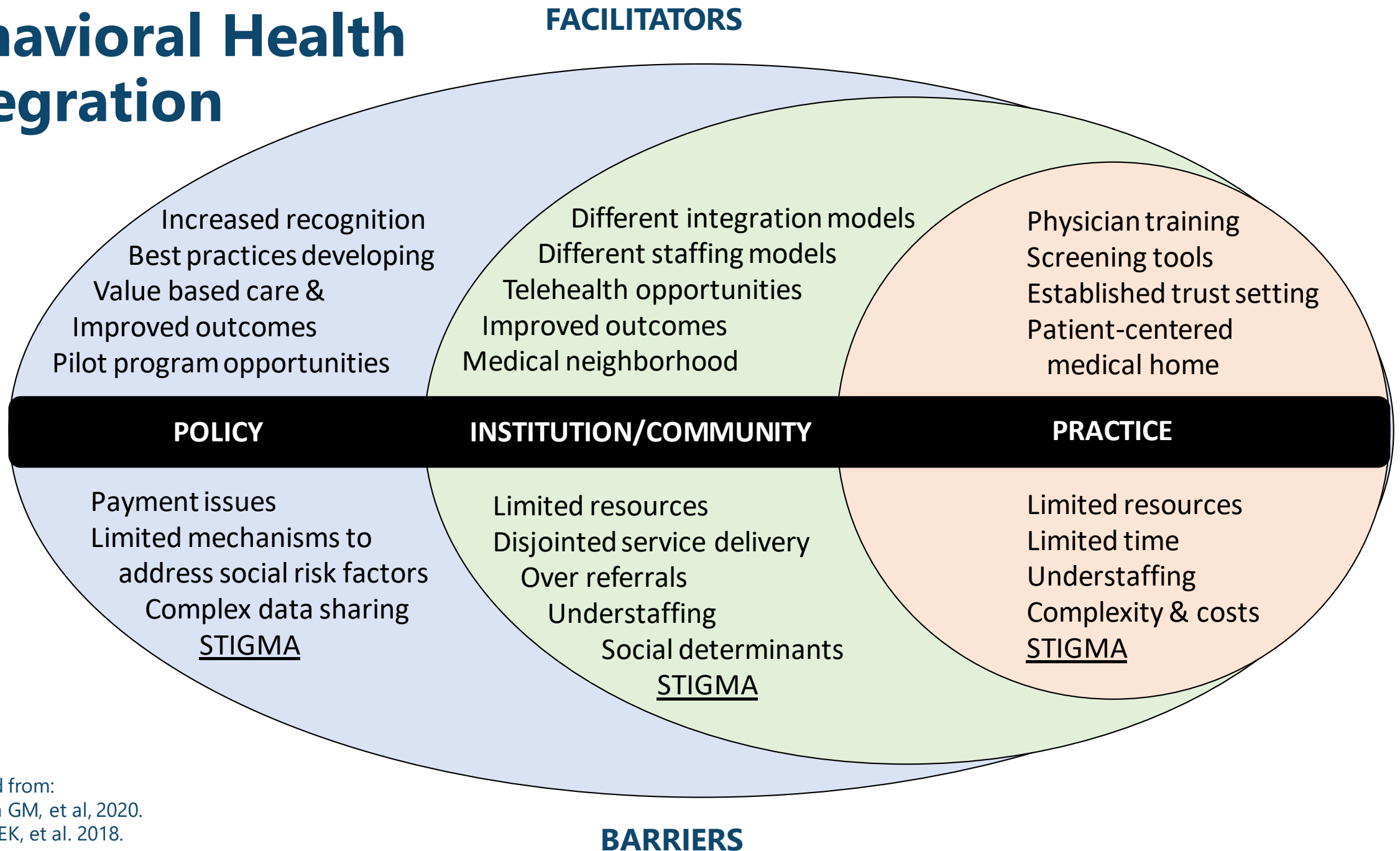
Misses doses of medication prior to visit for UDS?

PERCEPTIONS & BELIEFS

- Core beliefs about self, others and the world
- Ability to hope

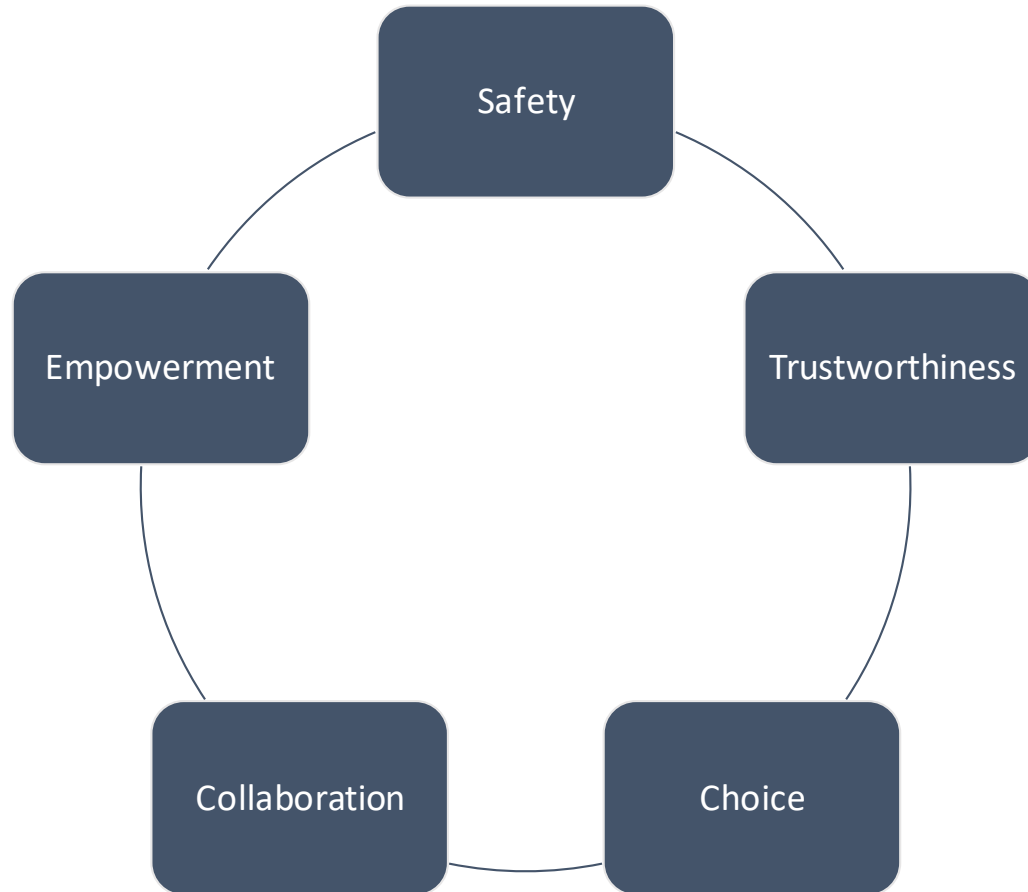
Struggles with focusing on anything positive or anything but pain

Behavioral Health Integration



Adapted from:
Esponda GM, et al, 2020.
Wakida EK, et al. 2018.

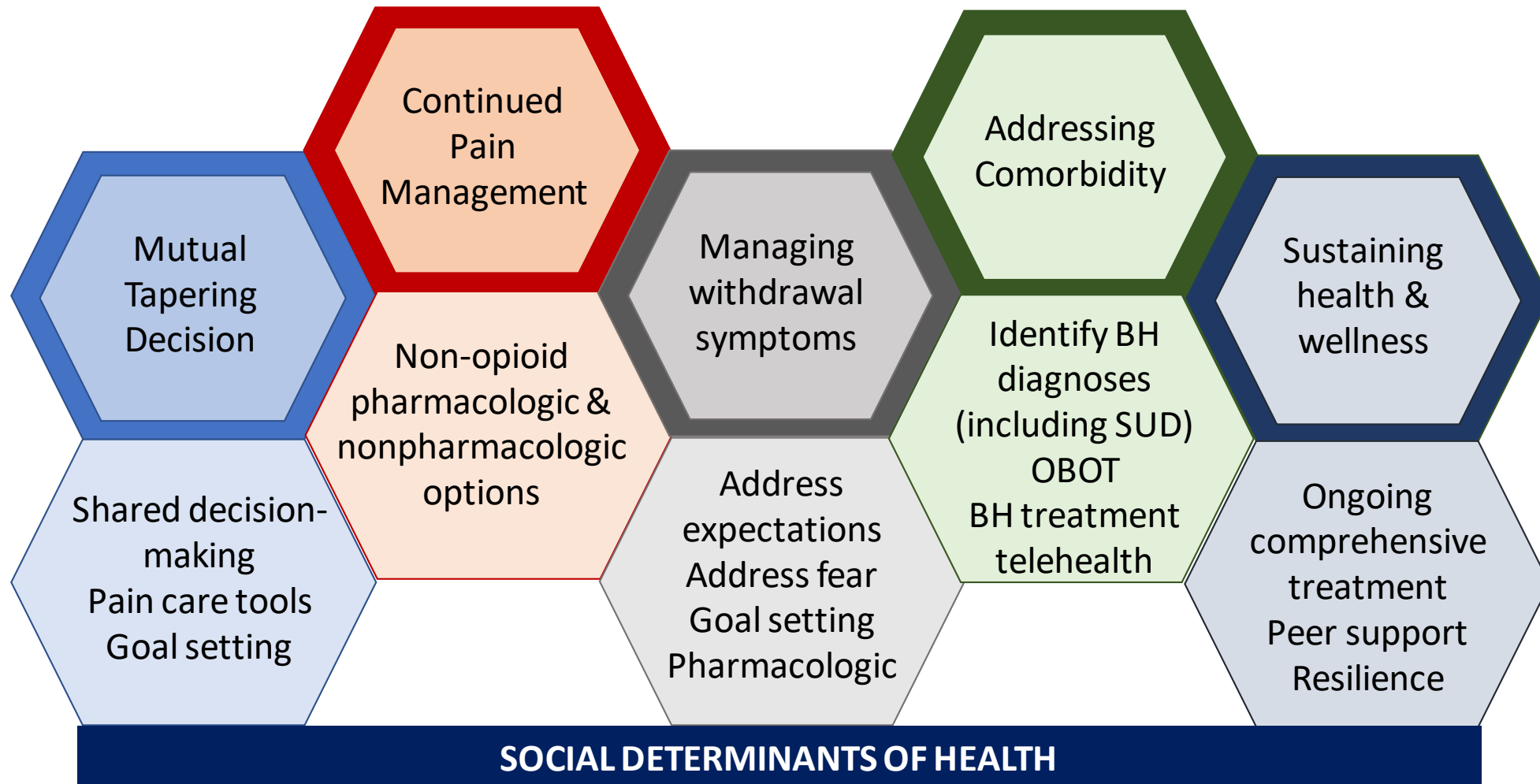
Addressing Stigma: Building a Culture of Healing



Adapted from
2019 The Institute on Trauma and Trauma-Informed
Care

- Extends from prior to initiation of opioids through the tapering process & beyond
- Motivational interviewing opportunity
- Language is critical
- Harm reduction approach
- Avoid reinforcing that referral or involvement of behavioral health means “it’s all in my head”

Opportunities in Tapering Care Continuum



Key Take-Aways

- Behavioral health supports for the tapering process are rooted in the needs for behavioral health supports for prevention and treatment of chronic pain
- Different integration models, increased attention on payment models, and existing resources within primary care can facilitate some of this care even in the most resource-limited areas (eg building a trauma sensitive culture and office-based opioid treatment)
- Current research does not recommend one single approach; rather, use individual patient-centered and informed approach
- Telehealth opens opportunities for further exploring integration and partners in building a medical neighborhood

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- Wakida EK, Talib ZM, Akena D, et al. Barriers and facilitators to the integration of mental health services into primary health care: a systematic review. *Systematic Reviews* 2018;7:211.

Moderated Discussion

Moderator



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Audience Q&A

Please use the comment box on your screen to enter a question.

Thank you!

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