
Bree Collaborative | Opioid Prescribing in Older Adults Workgroup

December 8, 2021 | 3:00 – 4:40 p.m.

Virtual

MEMBERS PRESENT

Gary Franklin, MD, MPH (Co-chair), Washington State Department of Labor and Industries	Association
Angie Sparks, MD, Kaiser Permanente Washington	Jason Fodeman, MD, Washington State Department of Labor and Industries
Carla Ainsworth, MD, MPH, Iora Primary Care – Central District	Jaymie Mai, PharmD, Washington State Department of Labor and Industries
Clarissa Hsu, PhD, Kaiser Permanente Washington Research Institute	Mark Sullivan, MD, PhD, University of Washington
Darcy Jaffee, Washington State Hospital Association	Pamela Stitzlein Davies, MS, ARNP, FAANP, University of Washington
Debra Gordon, RN, DNP, FAAN, University of Washington School of Medicine	Rose Bigham, Patient Advocate, Co-Chair Washington Patients in Intractable Pain
Gina Wolf, DC, American Chiropractic	Shelly Gray, PharmD, UW School of Pharmacy
	Steven Stanos, DO, Swedish Medical Center

STAFF AND MEMBERS OF THE PUBLIC

Nick Locke, MPH, Bree Collaborative	Diana Vinh
Monica Salgaonkar, MHA, Washington State Medical Association	Satoru Ito
Lee Brando, Graduate Student	Yuliya Shriokova
	Jinha Park

WELCOME

Gary Franklin, MD, MPH (Co-chair), Medical Director, Washington State Department of Labor and Industries welcomed members to the workgroup and discussed next steps. At this meeting (December) the workgroup will review evidence and draft recommendations for the tapering and de-prescribing long-term opioids sub-group. The workgroup will reconvene in January and February of 2022 to compile draft recommendations and review last-minute topics including intermittent opioid use. From there, the draft will be sent out for public comment in March, and the workgroup will reconvene in April to review public comments and develop a final draft.

Dr. Franklin also introduced and reviewed October minutes.

Action: To adopt the minutes

Result: Unanimously approved

Evidence Review: Tapering Long-Term Opioids

Mark Sullivan, MD, PhD, presented the literature and studies in-progress about long-term opioid tapering and deprescribing.

- Several studies are in-progress or have been recently completed to determine if tapering is possible for patients without Opioid Use Disorder (OUD).
 - The POTS study involved three parts: engagement, psychiatric consultation, and skills training before gradual tapering
 - Some focus on CBT or shared decision making to engage patients before tapering.

- Others focus on pharmacist assistance or electronic health record nudges to encourage providers to engage in conversations with patients about deprescribing.
- There are some controversies around deprescribing:
 - If tapering/de-prescribing is implemented abruptly, short-sighted, or not patient centered there is the potential for harm, including overdose and mental health crises associated with a rapid reduction in opioids.
- Draft recommendations for tapering include:
 - Think about risks involved with the taper characteristics and the patient selected for the taper.
 - Make sure the taper is supported and as patient-centered as possible, including providing peer supports to patients, mental health/behavioral health support, and ensure that the taper is always optional.

Those present discussed the initial recommendations on tapering:

- These studies did not specifically target older adults, but ended up with participants who were mostly older adults.
- A reasonable timeline for tapering is likely 10% reduction a month. Some studies that aimed for 10% reduction a week found that they were too fast.

Carla Ainsworth, MD, MPH, presented on the experience and perspective of providers working to taper opioids for long-term opioid users.

- More research is needed for: how to identify patients at risk of adverse events while tapering, what approaches are helpful for providers and patients to engage in shared decision making around opioids, and the role of buprenorphine for older adults
- A technical brief from AHRQ discussed how providers can engage with tapering opioids
 - How to frame the conversation around benefits of tapering opioids, including Improved quality of life, reduction of side effects
 - Improving patient education material for providers
 - Increasing availability of tools to identify patients at risk of opioid misuse
- Providers need clinical decision support, behavioral health support, pharmacist engagement, and patient collaboration to be successful at tapering and deprescribing.

Those present discussed the provider perspective and how to address concerns in the final recommendations.

- Both presenters described electronic health record nudges as being helpful to encourage providers to deprescribe. However, providers often see nudges as disruptive and time-consuming. Nudges must be thoughtful and brief to reach providers but do work, especially in the field of advanced care planning and opioid prescribing.
- Several providers on the call discussed how they would like to transfer patients from opioids to buprenorphine, which is usually tolerated and has fewer side effects than opioids, but patients are often hesitant due to stigma related to buprenorphine. On the other hand, evidence for the use of buprenorphine for chronic pain is poor for patches although relatively stronger for sublingual tabs and films

Clarissa Hsu, PhD, described patient perspectives for opioid taper initiation and speed, as described in interviews with patients who had either chosen to taper their opioids or had their opioids tapered due to shifting medication requirements.

- The patient perspective is that most long-term opioid tapers are provider initiated, and many of them are too abrupt or too fast (at least with data from the VA).

- Patients are often offered little support during the taper process – especially a lack of information about physiology of opioids, understanding opioid dependency, being offered buprenorphine, or being offered behavioral health services for emotional risks with tapering.
- Many patients who are successful at tapering draw on intrinsic motivation – protecting children, avoiding cognitive impairment.
- Recommend increase in shared decision making and motivational interviewing

Angie Sparks, MD, described elements of a successful taper initiative from the health system perspective. This material was developed in collaboration with Diana Vinh

- Leadership support, Data, Education, Access, and Research are essential.
 - Leadership support involves clear expectations and support for accountability for prescribers.
 - Data involves developing sufficient metrics, using transparent data, and having evidence-based peer-comparisons to continue to benchmark.
 - Education involves providing material for patients, family members, care givers, and prescribers.
 - Access involves improved referrals, partnerships with health plans, and engagement with pharmacists
 - Research involves increased studies on how to effectively intervene and how to understand the risk/benefits of opioids against the desires of the patient.
- Recommendations include improving reimbursement models for coordinated care and other non-pharmacologic treatments, developing support for mental health and pharmacy.

Those present discussed:

- The incidence of returning to opioids after tapering (about 30%) and the importance of increasing funding for multi-disciplinary teams, including pharmacists
- The relevance of these recommendations for patients with dementia or enrolled in hospice or palliative care. There was agreement that these recommendations should not apply to patients in hospice or palliative care (or end of life care) due to the lack of informed consent. We may need to include information about engaging caregivers and patients at the early stages of dementia or mild cognitive impairment.

Dr. Sullivan wrapped up the presentation by describing how tapering long-term opioids can be positive when tapers are collaborative, gradual, supported, and multimodal. When this is done correctly, tapering can be maintained over years, but a substantial minority of patients restart opioid therapy.

PUBLIC COMMENT AND GOOD OF THE ORDER

Dr. Franklin extended the meeting by 10 minutes to allow for final presentations and discussion on the patient perspective and the health system perspective. Dr. Franklin then invited public comment then thanked all for attending and adjourned the meeting. The workgroup's next meeting will be on Wednesday, January 12th, 2022.