Opioid Prescribing Work Group

Minnesota Department of Human Services

Minutes — August 18, 2016
noon – 3:00 p.m.
444 Lafayette Building, St. Paul

Members present: Julie Cunningham, Chris Eaton, Tiffany Elton, Dana Farley (non-voting), Ifeyinwa Nneka Igwe, Chris Johnson, Ernest Lampe, Matthew Lewis, Pete Marshall, Murray McAllister, Richard Nadeau, Mary Beth Reinke (non-voting), Jeff Schiff (non-voting), Matthew St. George, Lindsey Thomas

Members absent: Rebekah Forrest, Charles Reznikoff, Alvaro Sanchez

DHS employees: Charity Densinger, Sara Drake, Ellie Garrett, Dave Hoang, Melanie LaBrie, Andrew Riehle

Guests: Keith McCoy (Pfizer), Juliana Milhofer (MMA), Aimee Schaefer Kruepper (citizen), Lisa Wichterman (DLI)

I. Welcome and Introductions

Chris Johnson called the meeting to order. Johnson welcomed members and guests, and introductions were made around the room.

Jeff Schiff provided updates on opioid-related efforts at the state level. Schiff and Sarah Rinn presented the background of DHS' opioid work and the draft OPWG prescribing protocols to the Department of Labor and Industry's Medical Services Review Board on August 11. The DHS Alcohol and Drug Abuse Division (ADAD) is waiting to learn whether the state will receive any of the three SAMHSA grants for which we applied. The Department of Health (MDH) received a portion of the CDC Preventing Drug Overdose grant. Dana Farley updated the group on the naloxone protocol for pharmacists. The draft protocol is currently under review by the Board of Pharmacy.

Sarah Rinn provided a brief overview of the agenda for the meeting.

II. Approval of Minutes

No corrections were offered to the July meeting minutes. **Thomas motioned to approve the minutes, and Eaton seconded the motion. The minutes were approved unanimously.**

III. Opportunity for Public Comment

Aimee Schaefer Kueppers provided public comment. She suffers from chronic pain that initiated with podiatric surgery. Ms. Kueppers shared her history of pain management, and the numerous difficulties she has encountered. Her questions to the group focused on current research into nerve pain, insurance coverage of non-opioid pain management, and assistance for individuals who incur high costs associated

with multi-modal pain management. DHS staff will follow up with Ms. Kueppers about connecting her to efforts at the state level that address pain management more broadly.

IV. Post-Acute Pain Prescribing Recommendations

The work group reviewed the revisions discussed during the July OPWG meeting. Members agreed to change the word "determined" to "found" in Recommendation 4 – Pain Education (last sentence of the third paragraph). Discussion then turned to issues related to Recommendation 6 – Risk Assessment. Richard Nadeau informed the group that his colleagues have expressed concern about effectively administering risk assessment tools. Dental providers are not trained to conduct these types of assessment, and there is concern among the community about appropriate management, follow-up and medical-legal issues. Nadeau's comment prompted a broader conversation about the intended audience of the protocols and related materials. One member commented that an important purpose of the post-acute prescribing guide is to create a higher standard in terms of expectations around risk assessment, follow-up and treatment. The recommendations should create the expectation that prescribers constantly assess the risk/benefit ratio of opioid use in each patient.

One member questioned whether the prescribing guide indicates that the follow-up visit must be an office visit. The member commented that some providers conduct follow-up visits and assessments via the phone. The expectation is that the screenings occur, and while a face-to-face visit is not required, certain assessments require an office visit, e.g., tissue healing. One member commented that the Drug Enforcement Agency (DEA) requires an office visit in order to prescribe a Schedule II controlled substance.

Discussion then turned to the timeframes provided within the prescribing guide. Members recommended clarifying the index event within the document. Members reached consensus that the index event is the day the patient receives his or her first opioid prescription following an injury or procedure. This may or may not be the same day as the injury or procedure occurs, depending on whether the acute event requires a hospital stay. One member clarified that the recommended 7-day duration (or multiples of 7 days) is based on convenience for the patient and prescriber.

Discussion then turned to taper recommendations in the post-acute prescribing period. Members agreed to develop distinct taper recommendations for the post-acute prescribing period and for the chronic pain period. There was consensus on the following topics: including a taper recommendation in this time frame is important, not all patients will require a taper regimen, the need for a taper is based on the patient's symptomology, and a patient's symptomology should guide the taper rate. If a taper is needed, the taper rate for opioid naïve patients and patients on long-term opioid therapy with acute pain (acute on chronic) should be the same. The goal should be for everyone to taper off opioids or return to their baseline dose within the same period. Consensus emerged among group members that when a taper is required, a two-week period is a reasonable amount of time to taper in the post-acute period. The group stressed the importance that not all patients will require a taper, especially those exposed to a short duration of opioids.

One member commented that the taper recommendation does not address complicated scenarios. The recommendations should also address the appropriate course of action when pain continues after tissue healing has occurred. Another member recommended moving the statement about referral to a pain specialist to the beginning of the recommendation. Another member commented that using tissue healing to guide decisions about discontinuing opioids rather than pain resolution is more consistent

with the tone of the recommendations. If pain persists after tissue healing is sufficiently resolved, then refer the patient to a pain specialist.

Discussion then turned to the tapering guidance within the post-acute prescribing guide. Members recommended that the guide convey the following messages: 1) certain patients are able to discontinue use without a taper regimen; 2) a patient's symptomology should guide the taper rate; and 3) refills may occur while the patient is tapering his or her dose. Add asterisks to the indicators in rows 2 and 4 under the heading Taper, and provide additional explanation of tapering considerations below the chart. The group recommended changing the column heading to "Taper".

Members then discussed Recommendation 11--Referral and Consultation. Under Recommendation 11a (Consultation or referral to an addiction specialist), members recommended removing the first clause in the second bullet ("Refer a patient who has difficulty tolerating opioids"). Members also recommended revising the language to state, "Consultation or referral is indicated for the following conditions", and co-management by primary care provider is preferred. Discussion then turned to reducing the risks of opioid-related harm when referring a patient to a specialist. Providers should have some accountability for the referral, and should determine whether the referral visit occurred. A member commented on the harm caused by blaming patients for dependency and addiction, and the use of judgmental language among providers. A member recommended addressing this issue—and that tolerance is an expected side effect of opioid use--in the preamble of the guidelines.

A member commented that the mental health conditions listed in Recommendation 11d consist of traditional mental health problems. This is not consistent with previous recommendations that highlight understanding pain from a mental health perspective, notably the transition from acute to chronic pain. This recommendation should emphasize the emotional experience of pain, and the possibility that patients will have to address disability, work loss and other major life events associated with the pain experience. The group recommended revising this recommendation to include these considerations.

Discussion then turn to Recommendation 12 -- Naloxone. Members recommended adding a statement that acknowledges everyone is potentially at risk for overdose, and highlighting the populations known to be at high risk for harm. Members recommended adding geriatric patients, pediatric patients, and morbidly obese individuals. In addition, a statement will be added about the specific risks to patients referred to pain medicine or addiction specialists.

V. Provider Peer Group Methodology

Rinn presented two options for developing provider peer groups for reporting prescribing data. One option is to use provider specialty data provided on the Minnesota Health Care Program provider enrollment forms. The second option presented is to use providers' National Provider Identifier (NPI) primary taxonomy codes. Rinn presented an initial analysis of using the NPI provider taxonomy codes. A copy of her slides is available upon request.

A brief discussion ensued about developing provider peer groups. Ellie Garrett clarified that oncology and palliative/hospice care are excluded from the OPIP data reporting, per the legislation. Members had a general conversation about the appropriate level of granularity for the data reporting. Consensus emerged that the provider groups proposed should be reviewed in combination with prescribing data in order to understand whether more granularity is needed. Members agreed that Physician Assistants and Nurse Practitioners should be included with physicians, and organized by specialty. DHS will conduct further analysis, and present the provider groups with prescription data to the group at a future meeting.

VI. Saving Lives Summit Discussion

The group held a brief discussion about the upcoming Saving Lives: Innovative Solutions to the Opioid Crisis meeting. Johnson and Dana Farley will participate during a panel discussion on Minnesota interventions. The presentation is on September 8 during the lunch hour. Johnson and Farley requested feedback on key messages to share during the presentation. Discussion ensued about the appropriate boundaries between the patient/physician relationship and law enforcement. One member commented that health care providers cannot serve as surrogates for law enforcement. Another member concurred, but added that physicians are not prohibited from sharing information with law enforcement when they witness a crime or are victims of a crime (e.g., stolen DEA numbers). Members discussed the importance of highlighting the medical and public health nature of the problem, and the role of law enforcement as first responders in the event of an opioid overdose.

Meeting adjourned.