Opioid Prescribing Work Group

Minutes — June 18, 2020
12:00 pm – 3:00 pm
WebEx Video Event

Members present: Nathan Chomilo, Kurtis Couch, Julie Cunningham, Sen. Chris Eaton, Dana Farley, Tiffany Elton, Rebekah Forrest, Ifeyinwa Igwe, Brad Johnson, Chris Johnson, Ernest Lampe, Matthew Lewis, Murray McAllister, Richard Nadeau, Adam Nelson, Charlie Reznikoff, Saudade SammuelSon, Charles Strack, Lindsey Thomas

Members absent:

DHS employees: Ellie Garrett, Jessica Hultgren, David Kelly, Sarah Rinn

Guests: Charisse Colombe (MHA), Audrey Hansen (ICSI), Jeyn Monkman (ICSI), Tracy Radtke (MHA),

Welcome and Introductions

Julie Cunningham called the meeting to order and welcomed members. OPWG members and DHS staff introduced themselves.

DHS updates

Ellie Garrett provided a general overview of DHS legislative efforts during the special session. She also addressed work around health disparities at DHS. OPIP staff plan to analyze opioid prescribing data by race, and will present the analysis when it is complete. Garrett cautioned that certain federal rules prevent state Medicaid agencies from collecting detailed race/ethnicity/language data from enrollees, so the data is incomplete.

Nathan Chomilo addressed the recent murder of George Floyd and the impacts of that event on our communities. He called for a moment of silence. Chomilo added there is a DHS bill under review would extend some of the telehealth flexibility granted by CMS during the COVID state of emergency.

Approval of minutes

Cunningham called for a motion to approve the May minutes. Lindsey Thomas moved to approve. Charlie Reznikoff seconded the motion. May minutes were approved.

Program updates

Rinn provided two program updates. The next OPWG meeting will be August 27, 2020 from 12:00 to 3:00 p.m. At the request of the member, Rinn also reviewed the charge of the group for the last term which is two-fold. One is to develop threshold standards for provider disenrollment from MHCP based upon opioid prescribing behavior. Second is to collect ongoing input on OPIP's quality improvement (QI) program within the MHCP

provider community. The QI program is in development stages which will likely last throughout the calendar year. During this time, the OPWG will determine what is successful completion of the QI program as well as what is expected for attestation.

Opportunity for public comment

Rinn shared a CDC article submitted by Sheila Grabosky. No other public comment was given.

Quality Improvement (QI) presentations

Statement about opioid prescribing during COVID-19

Rinn read proposed statement. A member commented that a lot of patients don't want to go to the pharmacy and thus requesting longer prescriptions to avoid going to the Pharmacy. Another member provided an anecdote about her own experience with her provider tapering her off another prescription. A brief discussion ensued about patient and provider resources for telemedicine. DHS staff will revised the statement and circulate for review.

Taper guidance revision

Work group members were asked to review the clinical recommendations as the first step for revising the taper guidance. Members will have the opportunity to provide comment on the introduction and the discussion once the clinical recommendations are in a final draft version. A member noted the importance of the introduction in setting the tone of the document.

Rinn introduced the first draft clinical recommendation: *Do not abruptly discontinue chronic opioid analgesic therapy. Abrupt discontinuation can cause acute opioid withdrawal, and poses a significant risk to patients.* This is a new recommendation based on requests from the chronic pain patient community and emerging evidence of abrupt discontinuation in the medical literature. Members briefly discussed the proposed recommendation, citing concerns about what to do when a fast taper is clinically indicated. A member suggested changing the language from "do not abruptly taper opioids" to "avoid abruptly tapering opioids". A brief discussion ensued about the tone and appropriateness of addressing rapid tapers in this guidance. Members indicated the need to make the statement about avoiding rapid tapers are strong as possible, while acknowledging that rapid tapers may be clinically appropriate.

Discussion turned to the second draft clinical recommendation: *Using motivational interviewing, discuss tapering or discontinuing opioid therapy with patients, regardless of their risk of harm, at least every three months. Tapering will be more successful with the patient's input and collaboration. Introduce the idea well in advance of any medication changes, patient safety permitting.* A member suggested revising the statement so that it applies to "all COAT patients" and that the discussion should occur in a "non-threatening manner". A brief discussion ensued about using motivational interviewing techniques to set the appropriate tone during the conversation. Another member commented that requiring providers to discuss tapering means that in practice a taper could be discussed at every face to face visit. This may create undue stress for the patient. Discussion ensued about normalizing the taper conversation so that it serves as a status check in, in part to minimize the anxiety that can occur. A member commented that she approaches the taper discussion similar to how she approaches quitting smoking among her patients.

Members reviewed the third proposed recommendation: *Carefully assess and document the risks and benefits of continued long-term opioid therapy at least every three months. Recommend tapering opioid therapy to a reduced dose or to discontinuation when the risks of continued opioid therapy outweigh the benefits.* Discussion followed about the importance of emphasizing the risk-benefit analysis, and consensus emerged about highlighting both the risk benefit analysis and shared decision making in the guidance.

Discussion turned to the fourth draft recommendation**:** *Evaluate patients for opioid use disorder or substance use disorder prior to initiating a taper, and continuing during the taper process. Treat or refer patients to treatment for any active mental health crisis prior to initiating a taper, unless there is a risk of imminent harm from continued opioid therapy.* A brief discussion ensued and members requested adding a recommendation to prescribe naloxone to the statement.

Members discussed the fifth draft recommendation: *The taper protocol must be individualized to the patient's circumstances. A taper protocol slow enough to minimize opioid withdrawal symptoms and signs should be used. Unless the patient is in imminent danger or requests a rapid taper, a slow taper of 10% per month or slower is a reasonable starting point. Continued taper progress, even if small reductions, may be considered successful.* A member pointed out that dose reductions and velocity are two different variables, and can be employed separately during a taper. A brief discussion ensued about the recommended percent decrease – these numbers are arbitrary. Consensus began to emerge around de-emphasizing a certain percent reduction when planning a taper. Members recommended using the term "faster" versus "rapid" when discussing a more aggressive taper rate. A member asked for clarification around the term "imminent danger", and renal failure or COPD exasperation were provided as examples.

Members reviewed the final recommendation: *Use non-opioid and non-pharmacological therapies to treat pain that may re-emerge during the taper and to treat any withdrawal symptoms that occur during the taper. Patients will likely benefit from Cognitive Behavioral Therapy (CBT) during the taper process.* Members agreed upon changing the word "use" to "offer".

The discussion turned to the overall goal of the taper. A member commented that emphasizing the taper implies that COAT is somehow inherently wrong. Another member responded and stated that taper should only be done in the best interest of the patient – and it must be guided based on shared decision making around whether the patient is meeting his or her goals on opioids. The overall goal of tapering is to save lives by lower dosage.

Meeting Adjourned.