Opioid Prescribing Work Group

Minutes — October 22, 2020
12:00 pm – 3:00 pm
WebEx Video Event

Members present: Ralph Bovard, Nathan Chomilo, Kurtis Couch, Julie Cunningham, Kurt DeVine, Sen. Chris Eaton, Dana Farley, Rebekah Forrest, Chad Hope, Brad Johnson, Chris Johnson, Matthew Lewis, Murray McAllister, Richard Nadeau, Adam Nelson, Charlie Reznikoff, Saudade SammuelSon, Charles Strack, Lindsey Thomas

Members absent: Tiffany Elton

DHS employees: Ellie Garrett, Jessica Hultgren, Sarah Rinn

Guests: Amber Bullington, Beth Darnall (Stanford University), Sheila Grabosky, Audrey Hansen (ICSI), Cammie LaValle, Jennifer Wenzler

Welcome and introductions

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

Approval of minutes

Cunningham called for a motion to approve the September minutes. Sarah Rinn announced that Lindsey Thomas submitted two copy edits to the minutes ahead of the meeting. Thomas moved to approve the minutes as amended, Richard Nadeau seconded the motion. The minutes were approved unanimously.

DHS updates

Ellie Garrett provided a brief update on the federal State Opioid Response grant. The request for proposals (RFP) for the funding is expected to be published in early November.

Opportunity for public comment

Rinn introduced Dr. Beth Darnall and informed the work group that DHS staff reached out to Dr. Darnall based upon a recommendation from a community member. Dr. Darnall is a pain psychologist and an associate professor in the department of anesthesiology, perioperative and pain medicine at Stanford University. She is the principal investigator for the PCORI-funded EMPOWER study, a 4-state study on voluntary opioid tapering and behavioral medicine treatments for pain. Darnall thanked DHS and the OPWG for inviting her to comment. She informed the group that she also worked on the Department of Health and Human Services (HHS) 2019 tapering guidance, is an appointed member of the Centers for Disease Control and Prevention (CDC) Opioid Work Group and is working on the 2021 CDC chronic pain guideline revisions.

Darnall provided an overview of the pilot study for the EMPOWER study. The pilot focused on voluntary participation, and helping patients get to the lowest comfortable dose. The study does not use pre-set dosages or taper methods, rather it is focused on working with patients to achieve the patient's best medical outcome. Darnall stressed the importance of avoiding a one –size-fits-all approach to opioid tapers. A member asked Darnall to address the outcomes of the pilot study. She shared that 110 patients enrolled, and 57 completed the study. The majority of the participants were able to reduce dose by 50% over 4 months, but there were also patients whose dose increased. Patients with high levels of depression were less likely to participate. Among patients who were located for follow-up, the reduced dosage was sustained.

Another member inquired about the implications of race in the study. Darnall responded that the patient population in the EMPOWER study is mostly white. Marketing efforts have been directed towards minorities, especially African Americans, but it has been difficult to attract a diverse group of participants. The study has been expanded to new geographies with larger minority populations in order to recruit a more diverse population.

OPWG members than reviewed the three documents that were submitted as part of the public comment period. First, the group briefly reviewed the letter the American Medical Association (AMA) sent to the CDC in response to the request for public comments on the CDC guideline revision. The second article was *Trends in prescription opioid use and dose trajectories before opioid use disorder or overdose in US adults from 2006 to 2016: A cross-sectional study.*[1] Reznikoff cautioned that the findings can be misleading, as they are not weighted for the number of people in each category. Many more patients receive low daily doses, so even if the incidence of opioid use disorder or overdose is lower the actual numbers will be higher.

Cammie LaValle commented that she self-tapered her opioid therapy in 2016-2017. She used Dr. Darnall's research to assist with the taper, and asked her to speak to the OPWG.

Taper guidance revision

Rinn introduced the taper guidance and explained that the work group members will review the language of the clinical recommendations. DHS staff will then make any adjustments, and the guidance will be posted on the DHS web site for public comment for 30 days.

Members reviewed the language included in the "Characteristics of a Successful Taper" call-out box on the first page of the section. A member asked the rest of the group whether the guidance should address using buprenorphine during tapers. Members discussed the pros and cons of including it in the guidance. Although the members recognize the role that buprenorphine can play in tapers, there was concern that the guideline could be misapplied and providers would dump patients on providers who prescribe buprenorphine. In addition, if buprenorphine is listed, then other modalities should be listed as well. Another member commented that if buprenorphine is referenced, there will need to be significant education about using buprenorphine. There is not enough education about using buprenorphine in family practice. A member suggested that buprenorphine could be listed with other treatment modalities used to support tapers.

[1] Wei YJ, Chen C, Fillingim R, et al. Trends in prescription opioid use and dose trajectories before opioid use disorder or overdose in US adults from 2006 to 2016: A cross-sectional study. 2019 PLoS Med; 16(11): e1002941.

The discussion turned to whether the guidance should address outcomes of a successful taper. Several members commented that patients seek a thorough understanding of the taper process, including what will happen when they experience increased pain and the criteria used to evaluate the taper progress. A member suggested than an outcome can be that the patient learns whether, if and how a small dosage reduction affects their health. Patients want to know how the process ends, but also when do you stop, slow down or abandon the taper because it is not working. A member commented that he has the conversations up front, prior to beginning the taper. These conversations are included in the motivational interviewing section of the guidance. A member commented that a successful taper is described well, but commented that the following questions are not addressed: what does it look like when the taper is done? How is the patient improved? How is their health improved? We need to depict how health is improved when the taper is complete, and the patients learn to self-manage their pain. Members did not reach consensus about including this content in the guidance. Several people expressed concerns about capturing this in guidance, given that success is so individualized and should be personal or unique to the patient. Members briefly discussed the need to keep the guidance clear and concise.

Rinn proposed that DHS explore whether language to include in the call-out box about defining the items discussed above, and quickly turn it around to the group. The group agreed, and DHS staff will bring proposed language to the group before the November OPWG meeting.

Discussion moved on to the clinical recommendations. Rinn explained that the group will review each clinical recommendation, discuss any changes, and then vote on the entire set of recommendations at the end.

Reduce opioid dosage only when it improves the patient's risk-benefit ratio, ideally employing shared decision making with the patient. Providers should not taper a patient for their own convenience or solely to comply with system or state policy. No changes were proposed by the work group members.

Chronic opioid analgesic therapy should not be abruptly discontinued unless it is medically indicated. Abrupt discontinuation can cause acute opioid withdrawal and poses a significant risk to the patient. Clinical situations that warrant an abrupt discontinuation of opioid therapy or a dramatic (~50%) dose reduction include: proven opioid diversion, acute encephalopathy, acute respiratory failure, sudden change of medication clearance resulting in build-up of medication, and an imminent risk of overdose due to a diagnosed opioid use disorder (OUD). The latter should always result in an urgent referral to addiction medicine at the time of discontinuation. Members recommended that DHS add information about "imminent risk of overdose" into the taper discussion, including information about how to make such an assessment and provide an appropriate referral. Members also commented that there needs to be a distinction between the conditions that warrant an abrupt discontinuation of opioid therapy (proven diversion), and the conditions that warrant a dramatic dose reduction.

Routinely discuss the benefits and risks of continuing opioid therapy with all COAT patients. These should be routine discussions conducted in a supportive tone. Refer to patient goals established when COAT was initiated or established with a new patient. Discuss whether goals are being met, the patient's current functionality on opioid therapy, and any opioid-related adverse reactions. When discussing opioid-related risks with the patient, focus on the patient's medical risks related to opioid therapy, rather than societal risks associated with the opioid public health crisis.

Document the patient's risk-benefit profile based on routine discussion of the patient's ability to meet treatment goals and experience of any opioid-related adverse events. A brief discussion ensued about the frequency with which providers should document a patient's risk benefit profile in their health record. A member commented that these discussions demand more time than is allotted to a routine clinical visit. Another member commented that he has these conversations with his patients on long-term opioid therapy, even if it is very brief. Garrett commented that there are other places where the state can recommend providing clinicians with enough time to have these difficult conversations.

The discussion briefly turned to accidental overdoses in the elderly or among people who cannot take their medication appropriately. Is an accidental overdose a reason for dose reductions or tapers? At least one member indicated his support for adding that to the list of red flags.

A member suggested changing the first sentence of the recommendation to state "Routinely discuss the benefits and risks of continuing the current dose of opioid therapy with all COAT patients."

Use motivational interviewing techniques to discuss reducing dosage when the benefit of continuing opioid therapy no longer outweighs the risk, and the patient identifies a willingness to change their opioid treatment regimen. Patient voluntariness should be the goal for each patient (but not an absolute requirement) prior to initiating a taper. A member commented that providers should use motivational interviewing (MI) strategies even when a patient isn't willing to try to taper yet. Using MI techniques will help develop the patient's readiness, making them more willing to taper. Members also commented that voluntariness is a goal, and it is not often accomplished in one visit. Patients may need several visits to think about their readiness, repeated conversations are often needed, and they should not be rushed. Voluntariness does not always mean understanding, but they should be goals for the conversations.

The discussion briefly turned to the external factors that impact a patient's willingness to taper their opioid therapy. A patient's support network, their current experience with their pain and their mental health status are all dynamic, and affect their willingness to taper. A member commented that the taper should be viewed as progress, and not perfection. Some patients are alone and may not have a support network while they taper. Providers should consider these elements during the taper, and assess whether their clinic has the resources to help the patient. Another member commented on the increased ability of providers and clinics to engage an interdisciplinary team through virtual care.

Evaluate patients for opioid use disorder and depression or suicidal thoughts prior to initiating a taper, and throughout the tapering process. Treat or refer patients to treatment for substance use disorders or any active mental health crisis prior to initiating a taper. Members briefly discussed the importance of completing these universal precaution screenings in a non-threatening way. It needs to be clear that the screenings are not directed at a patient because they did something wrong. A member commented that the last sentence should be changed to state "Treat or refer patients to treatment for substance use disorders or any active mental health crisis at the beginning of the taper and any time throughout the taper process."

Use shared decision making to the extent possible to establish a taper plan individualized to the patient's circumstances. A plan that focuses on making incremental changes informed by reassessment of pain and function is more likely to be successful than a plan with a predetermined timeline and specific target dose. Consensus emerged among the work group members to add the word "safety" to the second sentence of the recommendation.

Consider consulting with a pharmacist to understand available medication formulations to optimize increments of dosage change. Changing the formulation of a given opioid (e.g., long-acting to short-acting formulations or strengths of the same formulation) may facilitate the dose reduction process, but also confuse the patient. Do not change or "rotate" types of opioids prior to the taper unless you have expertise doing so, e.g., oxycodone to methadone, or hydromorphone to tramadol. Members briefly discussed the two examples provided. A member commented that he works with pharmacists to give patients options when they begin a taper. The options include either different formulations or different types of tapers. The discussion turned to whether rotating opioid therapy is a still practiced. In general, members agreed it has generally faded from practice, and changing opioids during a taper carries risk. However, opioid types are sometimes changed due to limit options for dose reduction in a particular formulation, i.e. fentanyl patch. A member commented that rotating may occur when it is determined that an individual is unable to metabolize a given opioids efficiently.

Increase the frequency of clinic visits or remote visits during dose reductions. Invite the patient to contact the clinic if problems arise during dose reductions. Members did not proposed any changes.

Educate patient on the increased risks of overdose when tapering, supply a naloxone prescription, and encourage the patient to discuss rescue use with family and friends. A member suggested including conversations about the risks involved with mixing non-opioid substances with opioid therapy when tapering. Another member recommended that we change the word "educate" to "discuss", and include information about utilizing other clinicians to assist with naloxone education.

Cunningham called for a vote on the recommendations, as amended. Members unanimously approved the language.

Quality Improvement (QI) presentations

Prior to discussion the quality improvement program, Rinn asked the members to review revised versions of the OPIP goals. The revisions state:

1. Reduce initiating therapy for conditions not indicated for opioid analgesia, reduce initiating opioids at inappropriately high doses, and increase timely discontinuation of opioids once they are initiated.
2. Improve the consistency of decision making regarding opioid prescribing in the first months of a painful condition across medical settings and prescribers.
3. Manage patients on COAT carefully through multidisciplinary pain treatment, improved safety monitoring and interventions to optimize the benefit to harm ratio.

Members discussed the goals and proposed the following changes:

1. Reduce initiating opioid therapy for conditions not indicated for opioid analgesia. *When opioid therapy is indicated for the patient, prescribe the lowest effective dose for the shortest period of time. Reduce initiating opioids at doses which are inappropriately high for the indication.* Increase timely discontinuation of opioids once they are initiative in order to reduce the transition to long-term use.

2. Improve the consistency of decision making regarding opioid prescribing in the treatment of a painful condition.

3. Manage patients on COAT carefully through multidisciplinary pain treatment, improved safety monitoring and interventions to optimize the benefit to harm ratio.

Discussion then turned the quality improvement program. Rinn reviewed the proposed quality improvement program for providers over the QI threshold for measure two. A copy of the slides are available upon request. The discussion briefly turned to the use of 90 MME/day as the benchmark dose in measure five, and then returned to the quality improvement program proposal for measure two. A member asked for clarification about DHS' role and level of interaction with providers required to participate in the quality improvement program. Garrett explained that DHS' role is different from a health system in terms of engaging in the process. DHS will not insert our presence into a practice so that we are involved with the details with the change process. DHS will make a contractor with expertise in clinical quality improvement available for consultation. In general, DHS will flag the provider for QI, point them to resources and provide support for those who need it. A member commented that he appreciates DHS' modest expectations around change in year, but that it is important that DHS bring the health systems back to the table to understand the plan for the program. DHS staff commented that a health system meeting is part of the communications plan.

Members then discussed the proposal for reviewing providers' data and participation at the end of year one. DHS staff asked the OPWG whether it is sufficient for DHS to review the attestation form to make a decision, supported by the prescribing data for year one. In other words, DHS will review the information submitted in the attestation form and the data at the end of calendar year 2021. Members expressed that improvement on measure two is an achievable goal within the timeframe. Providers should be able to change prescribing or explain the DHS why their prescribing rate must stay high. A member commented that it is important that we do not make the journey too long, and that it is very important that DHS is able to identify providers whose prescriptions should be high, i.e., burn surgeons, orthopedic trauma surgeons, etc.

Rinn then reviewed the revised proposal for providers who are over the QI threshold on measure five and/or six. The proposal includes: 1) identifying providers who are over the QI threshold and requiring very limited engagement, with data monitoring throughout the year; 2) convening an ad hoc advisory committee on treating high-intensity chronic pain to develop emerging consensus on the conditions and circumstances that may warrant an exception to prescribing at rates below the QI threshold for either measure; 3) refinement of measures to monitor high quality chronic opioid analgesic therapy, i.e., dose stability and patient retention.

Members expressed concern with attempting to convene a group of experts to develop consensus around prescribing opioid therapy for high-intensity chronic pain. DHS staff commented that the group would be similar in nature to the work done on post-operative opioid prescribing in that peer to peer conversations about like-specialists would guide the work. A member suggested that instead of charging the group with consensus-building, a different approach may be more successful. The problem that this group is asked to address is that providers who are flagged for QI based on their COAT prescribing are likely to claim exception based on the unique nature of their patient population. DHS currently has no basis for how to engage with providers with that comment, which is why there is a need for this advisory body. Rather than charging the group with developing emerging consensus about how to treat this situation, the group should be charged with developing tools or a framework to help. A member commented that other terms that could be used to

describe the charge include “acceptable, clinical considerations” or “community standards”. A final comment was made that if opioid therapy is viewed as the option as last resort, it may be easier to find common ground.

Meeting adjourned.