Opioid Prescribing Work Group

Minutes — January 28, 2021
12:00 pm – 3:00 pm
WebEx Video Event

Members present: Nathan Chomilo, Kurtis Couch, Julie Cunningham, Kurt DeVine, Tiffany Elton, Dana Farley, Rebekah Forrest, Chad Hope, Chris Johnson, Murray McAllister, Richard Nadeau, Adam Nelson, Charlie Reznikoff, Saudade SammuelSon, Charles Strack, Lindsey Thomas

Members absent: Sen. Chris Eaton, Matthew Lewis

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

Guest: Bret Haake, MD, MBA (HealthPartners)

Welcome and introductions

Julie Cunningham called the meeting to order and welcomed members. Opioid Prescribing Work Group (OPWG) members and DHS staff introduced themselves.

State agency updates

Ellie Garrett reviewed the changes to the OPIP statute that will be proposed during the 2021 legislative session. First, the policy proposal changes the nonvoting status of the OPWG chronic pain patient representative members to voting. Second, the policy proposal allows DHS to share all prescribing data—not limited to providers required to participate in QI—with prescribers' provider groups. This will shift responsibility for distributing the data to employers, instead of DHS mailing out individual reports. Garrett also informed the work group that DHS is currently reviewing proposals for the latest round of federal SAMHSA State Opioid Response funding.

Sarah Rinn reviewed the agenda and instructions on how to participate. A copy of the slide presentation is available upon request.

Opportunity for public comment

Sheila Grabosky—a chronic pain patient advocate—provided public comment. She had no financial conflicts of interest to disclose. Grabosky provided a brief overview of her painful condition and the changes in insurance coverage of non-opioid treatment modalities that occurred over the past year. Reductions in insurance coverage required her to increase her daily opioid dosage, and she is concerned that her provider will be penalized. She asked the work group how they plan to advocate for coverage of the treatment modalities recommended as alternatives to opioid therapy.

Cammie LaValle—a chronic pain patient advocate—provided public comment. She had not financial conflicts of interest to disclose. She expressed concern with the taper guidance introduction, specifically the language in the last paragraph, which is addresses risk factors for long-term opioid use.

Quality improvement program update

Jessica Hultgren provided an update on the quality improvement program timeline. Rinn provided a brief overview of the health system meeting held on January 27. This meeting was hosted by DHS and the Minnesota Hospital Association (MHA), with support from ICSI and MMA. The purpose of the meeting was to provide health system representatives and leadership with an overview of the 2021 QI project, and solicit feedback on the approach. In general, the information was well received and the attendees supported the QI approach for 2021.

Final review of taper guidance: public comments and proposed revisions

Introduction section

Rinn introduced the final review of the taper guidance section. She presented an algorithm published in an article by the National Academy of Medicine to frame the conversation. The algorithm emphasizes the risk-benefit analysis and then presents a process for both patients who agree to taper and those who are reluctant. Rinn presented the proposed language changes to the introduction.

Discussion ensued about the following sentences in the last paragraph of the discussion: "What most predicts long-term use of opioids among those with persistent pain is not severity of pain levels or severity of the conditions associated with the cause of pain. Rather, what most predicts use of long-term opioids among those with chronic pain are anxiety, depression, trauma, substance use disorders, and low health literacy." Members discussed a number of concerns related to this section. First, the language may be perceived as stigmatizing and inflammatory. Second, while the evidence supports that these conditions are risk factors, the magnitude of the risk is relative. Presence of these conditions does not mean that long-term use will develop. Third, a member shared concern that this message may have the unintended consequence of clinicians using the absence of mental health conditions as a reason to initiate or continue long term opioid therapy.

Members voted to revise the sentences in italics to: **"While anyone can develop long-term opioid use for chronic pain, those with anxiety, depression, or a history of trauma or substance use disorders are at higher risk."** The vote was approved unanimously.

Members then reviewed the first paragraph of the introduction. A brief discussion ensued about expanding the language to acknowledge that some patients request opioid tapers, and patient-led tapers are likely more common than people realize. A member commented that he has tapered hundreds of patients, and while it is difficult and evoke strong emotions, most people's pain and quality of life improves.

A motion was made to add the bolded phrases to the paragraph: "A taper is a reduction in daily opioid dosage done to improve a patient's safety profile **or quality of life.** A successful taper reflects shared decision making and can result in either a lower daily dose, or discontinuation of opioid therapy, dependent on the patient's goals and risk profile. A taper should only be undertaken when it improves the patient's risk benefit profile, **or when it is requested by the patient."** The vote was approved unanimously.

A brief discussion ensued about the next paragraph, and a member proposed to add the word "document" to the following sentence: "In order to determine whether a taper is indicated, providers must complete **and document** a thorough, thoughtful risk benefit analysis (RBA) of continuing opioid therapy at the current dose."

Members discussed the fourth paragraph of the introduction. A member commented that we should refer to sickle cell **disease.** The same sentence should indicate that long-term opioid therapy should be a component of the standard of care, rather than indicating opioid therapy may be the sole treatment modality.

Finally, members reviewed the fourth paragraph. Members discussed that the message needs to convey that successful tapers can be very challenging, but it does not mean that the patient will suffer intolerable pain and suffering. A member proposed the following alternative language: "**It is normal for patients to express apprehension, but over time, patients often experience a sense of empowerment as their opioids are tapered successfully and they become less reliant on the health care system."**

Clinical recommendations

Rinn presented the proposed changes alongside the previously voted upon language. A copy of the proposed changes are included as an attachment to the minutes. The proposed statement is provided in quotation, and changes are bolded.

Proposed recommendation: Recommendation 1

"Perform a thorough risk benefit analysis of initiating an opioid taper when the risk of ongoing opioid therapy at the current dose outweighs the benefit.

Reduce opioid dosage only when it improves the patient's risk profile, engaging the patient in shared decision making to the extent possible."

Members suggested three changes: 1) add patient request to the reasons why a taper is initiated; 2) include recommendation to document the risk benefit analysis; and 3) add "quality of life" at the end of the first clause of the second sentence. A discussion ensued about removing the statement "Providers should not taper a patient for their own convenience or solely to comply with pharmacy benefit manager, health insurance company, health system or state policy" from the recommendations. Members debated inclusion of the statement. Those who supported including stressed the importance of the message and that it is often the reason given as to why a taper occurs. Those who supported removing it agreed with the sentiment, but that including it in the clinical recommendation is pejorative. Member reached consensus about putting the statement back in.

Revised recommendation 1

"Perform **and document** a thorough risk benefit analysis of initiating an opioid taper when the risk of ongoing opioid therapy at the current dose outweighs the benefit.

Reduce opioid dosage only when it improves the patient's risk profile, engaging the patient in shared decision making to the extent possible. **Providers should not taper a patient for their own convenience or solely to comply with a pharmacy benefit manager, health insurance company, health system or state policy."**

Proposal: Recommendation 2

Use motivational interviewing (MI) techniques to discuss tapering opioids. This may help the patient identify a willingness to change their opioid treatment regimen.

No member discussion.

Proposal: Recommendation 3 (proposed addition)

"Providers should be aware of the behavioral health treatments available to patients (in-person, telehealth and digital options), and how to appropriately refer patients for treatment during a taper."

A member commented that the term "behavioral health" should be consistent with DHS terminology. No other discussion occurred.

Proposal: Recommendation 4

"Engage the patient in shared decision making to establish a taper plan that is individualized to the patient's circumstances. Develop a taper plan that focuses on making incremental changes informed by reassessment of pain, function and safety, rather than a plan with a predetermined timeline and specific target dose."

No member discussion.

Proposal: Recommendation 5

"Do not abruptly taper discontinue chronic opioid analgesic therapy, unless there is proven diversion. Clinical conditions that may warrant a dramatic dose reduction (~50%) include acute encephalopathy, acute respiratory failure, or a sudden change in medication clearance resulting in medication build-up."

No member discussion.

Proposal: Move Recommendation 6 to Part IV. Prescribing opioid therapy for chronic pain

Proposal: Recommendation 7

"Consider consulting with a pharmacist to understand available medication formulations to optimize increments of dosage change. Provide clear communication to the patient about any changes in the medication formulation."

No member discussion.

Proposal: Recommendation 8

"Increase the frequency of clinic visits, nurse visits, and/or remote visits during dose reductions. Encourage the patient to contact the clinic if problems arise during dose reductions."

No member discussion.

Proposal: Recommendation 9

"Support the patient throughout the taper, and especially during dose reductions. Patient support may include any or all of the following: withdrawal symptom education and management; non-opioid and non-pharmacological pain management; and behavioral health therapy. Patients will likely benefit from Cognitive Behavioral Therapy (CBT) during the taper process [assist the patient in locating these resources]."

No member discussion.

Proposal: Recommendation 10 (new recommendation)

"Determine if ongoing opioid use at the current dose could result in a life-threatening risk to the patient in the near future, i.e. before you will next evaluate the patient. If so, adjust the opioid dose to mitigate this danger and explain it to the patient. Schedule a follow-up visit in the near future."

Discussion ensued about the dilemma at the core of this recommendation – that non-voluntary tapers may be the appropriate clinical course of action in a very narrow set of circumstances. A member voiced concern that adding this recommendation will erode the trust and relationship between a patient and a provider. A physician may misjudge what a life-threatening risk includes. Another member acknowledged this concern, but argued that there has to be an acknowledgement of what occurs when attempts at shared-decision making, the patient is opposed to a dose change, but the health care provider thinks the patient's life is at risk. This document should define the instance when a provider can change the dose, even when the patient does not agree. A physician or other prescriber has a duty to act on their training and judgement when the patient's life is at risk.

Members reviewed the NAM algorithm that was presented at the beginning of the discussion. A member commented that the recommendation does point to a very narrowly defined situation: 1) shared-decision making as not successful; 2) risk of harm that is life-threatening and imminent; and 3) lower the dose enough only to mitigate the danger. This is about optimizing safety.

Proposal: Recommendation 11

"If there is no risk of imminent harm to the patient as described above, assess reasons for patient's reluctance to a taper, and periodically reengage the patient in tapering discussions."

A member commented on his clinic's approach to a very common clinical scenario: A provider broaches the topic with a patient is on a very high daily dose of short- and long-acting opioids. The patient and provider have a good relationship. The patient is ambivalent about the risk, and not willing to change his or her dosage. The provider then issues a challenge to the patient to just make a small reduction – reduce the prescription from 120 to 115 tablets – and carefully monitor how the change affects the patient. This is a common scenario, and the guidance should address it. Another member agreed, commenting that this expands the non-voluntary taper past just a life-threatening situation to also include a minimal dose change with intense follow up. The guidance should include an example of a very minimal dose reduction.

The guidance needs to address non-voluntary dose reductions, but it is critically important to address how to support the patient during this process. A member commented that when considering if the potential for harm is present, clinicians need to focus on the overall health of the patient, not just the impact of the prescribed opioids.

Proposal: Recommendation 12

"Evaluate patients for opioid use disorder (OUD) and depression or suicidal thoughts prior to a taper, and throughout the taper process. Patients with OUD or any active mental health crisis should be offered treatment or referral to treatment."

No member discussion.

Proposal: Recommendation 13

"Urgently refer patients to an Addiction Medicine specialist if they are at imminent risk for an opioid overdose, or experienced a non-fatal opioid overdose. This must be a warm hand-off from clinician to clinician. Both

ongoing treatment of pain with opioids and abrupt discontinuation of opioid analgesics in patients with such high risk of harm can pose a danger to the patient. Carefully consider if and at what dose opioids should be continued while addiction treatment is being arranged. Providers trained and certified to prescribe buprenorphine for OUD may choose to treat such high risk patients themselves without an Addiction Medicine referral."

Members reached consensus to revise the last statement to state "**Providers qualified to prescribe buprenorphine** may choose to treat such high risk patients themselves without an Addiction Medicine referral."

Proposal: Recommendation 14

"Ensure that nonopioid treatment of pain are optimized during the taper, during a referral to OUD treatment, and in any other instances when opioids are being modified."

No member discussion.

Proposal: Recommendation 15

"Educate patients on the increased risk of overdose when tapering, supply a naloxone prescription, and encourage the patient to ask family and friends to become educated about rescue use. Naloxone training is available in clinic settings, at pharmacies and through online education."

No discussion.

Meeting adjourned.

Attachment: Table of taper guidance recommendations

Previous Recommendation	**Proposed change at January OPWG meeting/New recommendation**
Recommendation 1: 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 pharmacy benefit manager, health insurance company, health system or state policy.] *Remove text in brackets*	Perform a thorough risk benefit analysis of initiating an opioid taper when the risk of ongoing opioid therapy at the current dose outweighs the benefit. Reduce opioid dosage only when it improves the patient's risk profile, engaging the patient in shared decision making to the extent possible.
Recommendation 2: Use motivational interviewing techniques to discuss reducing dosage when the benefit of continuing opioid therapy at the current dose no longer outweighs the risk. Using motivational interviewing techniques may help the patient identify a willingness to change their opioid treatment regimen. [Patient voluntariness and understanding should be the goal for each patient (but not an absolute requirement) prior to initiating a taper.] *Move copy in brackets into the discussion*	Use motivational interviewing (MI) techniques to discuss tapering opioids. This may help the patient identify a willingness to change their opioid treatment regimen.
	Recommendation 3: Providers should be aware of the behavioral health treatments available to patients (in-person, telehealth and digital options), and how to appropriately refer patients for treatment during a taper.
Recommendation 4: 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, function and safety is more likely to be successful than a plan with a predetermined timeline and specific target dose. [Patient care decisions must be tailored to the needs of each, individual patient.] *Remove copy in brackets*	Engage the patient in shared decision making to establish a taper plan that is individualized to the patient's circumstances. Develop a taper plan that focuses on making incremental changes informed by reassessment of pain, function and safety, rather than a plan with a predetermined timeline and specific target dose.
Recommendation 5: Chronic opioid analgesic therapy should not be abruptly discontinued unless there is proven opioid diversion. [Abrupt discontinuation can cause acute opioid withdrawal and poses a significant risk to the patient. Clinical	Do not abruptly taper discontinue chronic opioid analgesic therapy, unless there is proven diversion. Clinical conditions that may warrant a dramatic dose reduction (~50%) include acute encephalopathy, acute respiratory failure, or a sudden change in

situations that may warrant a dramatic (~50%) dose reduction include]: acute encephalopathy, acute respiratory failure, or a sudden change of medication clearance resulting in build-up of medication.	medication clearance resulting in medication build-up.
Recommendation 6: Routinely discuss the benefits and risks of continuing the current dose of 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.] *Move copy in brackets into discussion* 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.	Move to Part IV. Prescribing opioid therapy for chronic pain
Recommendation 7: 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.] *Move copy in brackets into discussion* Provide clear communication to the patient on any changes in the medication formulation.	Consider consulting with a pharmacist to understand available medication formulations to optimize increments of dosage change. Provide clear communication to the patient about any changes in the medication formulation.
Recommendation 8: 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. [Take extreme caution to ensure dose reductions are not accompanied by increased pain, reduction in activities of daily living or other adverse effects that	Increase the frequency of clinic visits, nurse visits, and/or remote visits during dose reductions. Encourage the patient to contact the clinic if problems arise during dose reductions.

might require halting the tapering strategy.] *Move copy in brackets into discussion* Invite the patient to contact the clinic if problems arise during dose reductions and strongly consider discontinuing the taper protocol until the patient can be evaluated.	
Recommendation 9: If available under the patient's insurance plan, and affordable and accessible due to social determinants of health and other factors, Offer non-opioid and non-pharmacological therapies to treat pain that may re-emerge during the taper and to treat any distressing withdrawal symptoms that occur during the taper. Withdrawal symptoms may indicate the need to slow a taper. Patients will likely benefit from Cognitive Behavioral Therapy (CBT) during the taper process.	Support the patient throughout the taper, and especially during dose reductions. Patient support may include any or all of the following: withdrawal symptom education and management; non-opioid and non-pharmacological pain management; and behavioral health therapy. Patients will likely benefit from Cognitive Behavioral Therapy (CBT) during the taper process [assist the patient in locating these resources]
	Recommendation 10: Determine if ongoing opioid use at the current dose could result in a life-threatening risk to the patient in the near future, i.e. before you will next evaluate the patient. If so, adjust the opioid dose to mitigate this danger and explain it to the patient. Schedule a follow-up visit in the near future.
	Recommendation 11: If there is no risk of imminent harm to the patient as described above, assess reasons for patient's reluctance to a taper, and periodically reengage the patient in tapering discussions.
Recommendation 12: 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 at the beginning of the taper and any time throughout the taper process.	Evaluate patients for opioid use disorder (OUD) and depression or suicidal thoughts prior to a taper, and throughout the taper process. Treat or refer patients to treatment of OUD or any active mental health crisis if present. Patients with OUD or any active mental health crisis should be offered treatment or a referral to treatment.
Recommendation 13: Patients at imminent risk of overdose due to a diagnosed opioid use disorder (OUD) should receive an urgent referral to addiction medicine. These referrals should be "warm hand-offs" including clinician to clinician communication about the case and rapid connection of the patient to the addiction medicine provider. [In instances	Urgently refer patients to an Addiction Medicine specialist if they are at imminent risk for an opioid overdose, or experienced a non-fatal opioid overdose. This must be a warm hand-off from clinician to clinician. Both ongoing treatment of pain with opioids and abrupt discontinuation of opioid analgesics in patients with such high risk of harm can pose a danger to the patient. Carefully consider if

where diversion may exist, careful attention must be paid to ensure the patient's pain remains controlled and coordination between providers is maintained.]	and at what dose opioids should be continued while addiction treatment is being arranged. Providers trained and certified to prescribe buprenorphine for OUD may choose to treat such high risk patients themselves without an Addiction Medicine referral.
Recommendation 14: Ensure that all patient's pain remains well-controlled during a taper, a referral for OUD treatment, and in cases of proven diversion. [Take extreme caution to ensure dose reductions are not accompanied by increased pain, reductions in activities of daily living, or other adverse effects.] *Remove text in brackets*	Ensure that nonopioid treatments of pain are optimized during the taper, a referral to OUD treatment, and in any other instances when opioids are being modified.
Recommendation 15: Educate patient on the increased risks of overdose when tapering, supply a naloxone prescription, and encourage the patient to ask family and friends to become educated about rescue use. A patient's friends and family can learn how to use naloxone in a clinic setting, at a pharmacy or through online education.	Educate patients on the increased risk of overdose when tapering, supply a naloxone prescription, and encourage the patient to ask family and friends to become educated about rescue use. Naloxone training is available in clinic settings, at pharmacies and through online education.