Opioid Prescribing Work Group

Minnesota Department of Human Services

Minutes — May 19, 2016
12:00 – 3:00 p.m.
444 Lafayette Building, St. Paul

Members present: Julie Cunningham, Tiffany Elton, Dana Farley (non-voting), Rebecca Forrest, Ifeyinwa Nneka Igwe, Chris Johnson, Ernest Lampe, Matthew Lewis, Pete Marshall, Murray McAllister, Richard Nadeau, Mary Beth Reinke (non-voting), Charles Reznikoff, Alvaro Sanchez, Jeff Schiff (non-voting)(remotely), Lindsey Thomas

Members absent: Chris Eaton, Matthew St. George

DHS employees: Charity Densinger, Dave Hoang, Melanie LaBrie, Sarah Rinn

Guests: Jon Collins (MPR), John Mertes (HealthPartners), Juliana Milhofer (MMA), Charles Sawyer (MCA), Trudy Ujdur (Sanford Health)

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 reported on three other opioid-related efforts underway in state government. First, the Alcohol and Drug Abuse Division (ADAD) at DHS is preparing three separate grant applications for funding to support primary prevention, medication-assisted recovery and a statewide, standard protocol for pharmacy dispensing of naloxone. Second, the enhanced PMP and opioid disposal bills continue to advance through the legislature. Finally, the Health Care Administration expects to publish the Integrated Care for High Risk Pregnant Women (ICHRP) RFP for the Native American population in June.

Johnson reported on his public testimony at the FDA Drug Safety and Risk Management Advisory Committee and the Anesthetic and Analgesic Drug Products Advisory Committee meeting on mandatory safety training for opioid prescribers.

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

II. Approval of Minutes

No corrections were offered to the April meeting minutes. **Sanchez motioned to approve the minutes, and McAllister seconded the motion. The minutes were approved unanimously.**

III. Acute Pain Prescribing Recommendations

Members reviewed the Acute Pain Prescribing Recommendations proposal. Rinn reported that the proposal will be posted to the OPWG Web site for public review, and comments will be accepted through June 30. Comments are welcome from all interested entities, including government agencies, professional organizations, individuals, etc. A member suggested revising Recommendation 8 to state that opioids are not indicated for headaches, including migraines. Members agreed upon adding the statement "including migraines" to the recommendation.

IV. Preliminary Data Analysis of Acute Pain Sentinel Measure Domains

Rinn reported on the preliminary analysis of the acute pain sentinel measure domains: quantity of tablets, short-acting versus long-acting formulation, and morphine milligram equivalence (MME). Rinn provided an overview of how the data analysis was completed, and a summary of the results. A copy of her slides is available upon request from OPWG staff.

Members discussed the high MME levels and variability in prescribing patterns of oxycodone, as compared to other opioids commonly prescribed during the analysis period. One member commented that the perceived strength of oxycodone is likely due to the fact that it has a higher MME than other opioids, and is prescribed more aggressively. Rinn presented a sample of distribution charts for oxycodone prescribing following obstetric surgery, dental extraction and injury. Discussion ensued about whether and how improved opioid prescribing behaviors should change the distribution curves. There was consensus among group members that in aggregate, the apex of the distribution curves are too high. Discussion turned to whether the domains selected for the acute pain sentinel measure are appropriate. The group recommended that measurement development continue using MME and quantity of tablets.

Members discussed the challenge presented by the lack of access to historical data on the population's exposure to all opioids. The only database containing statewide population exposure data is the Prescription Monitoring Program (PMP), but access to the PMP data is strictly limited. DHS will follow up with the Board of Pharmacy to determine what types of longitudinal analysis has been done with PMP data.

V. Opportunity for Public Comment

No public comment was offered.

VI. Post-Acute Pain Prescribing Recommendations

Rinn introduced the post-acute prescribing strawman proposal, and reviewed Recommendations 1 through 6 for the group's discussion. A brief discussion ensued about the importance of differentiating nociception from pain from suffering within the recommendations. In general, the group agreed upon the importance of assessing tissue healing following an acute insult (to the extent possible) when considering continued opioid therapy in the post-acute phase.

Discussion then turned to Recommendation 1: Assess and document pain and function. Members expressed reservations about highlighting functional assessments during this period for a number of

reasons. The primary concern was that prescribers would interpret improved patient perceptions of pain and function as a justification for continuing opioid therapy. However, the group also recognized the value of recommending functional assessments during this period, as a means to prompt assessments of psychosocial issues contributing to or exacerbating pain. The group agreed to recommend the use of functional assessments during the post-acute pain period, with cautionary language that improved physical function alone is not a justification for continued opioid therapy and reassessment of the etiology of the pain may be necessary.

The group discussed the importance of tapering during the post-acute period. A member recommended including a statement in the recommendations that in some circumstances no taper is required. A brief discussion ensued about whether to include specific tapering protocols in the recommendations. The tapering recommendation will be discussed at the next OPWG meeting, but there was initial agreement that it may be difficult to provide specific recommendations that address the broad range of patient circumstances that occur during the post-acute phase.

Discussion turned to Recommendation 3: Substance abuse assessment. Members discussed various mental health-screening tools that may be utilized during this phase. A member suggested recommending use of the NIDA Quick Screen – a single question substance abuse screening tool. Members discussed the timing and frequency of the various assessments recommended. The group agreed that while visit frequency alone is not associated with better health outcomes, frequent visits will allow providers to conduct the recommended assessments and prescribe smaller quantities of opioids, if needed.

Members discussed Recommendation 4: Assess risk factors for the development of chronic pain and disability and Recommendation 5: Set expectations about pain and avoiding chronic use. A member recommended using a tool such as the Keele's StarT Back assessment, because assessing fear avoidance during the phase should be sufficient to identify patients at risk for chronicity. The preferred assessment tool for the post-acute period must identify whether there are any major life stressors, but not be too lengthy or cumbersome. There was consensus emerging in the group that assessing pain catastrophizing and perceived injustice may be more appropriate for chronic pain. Discussion then turned to recommending patient neuroscience education for patients in the post-acute phase. Group members recognized the potential for neuroscience education to change patient's understanding and perception of pain, yet several expressed uncertainty about whether primary care providers have the resources to provide this type of patient education. One member shared that her health system uses brief, online videos to deliver patient neuroscience education. The group agreed to recommend neuroscience education for patients, and provide references to appropriate patient and provider education materials.

The group discussed the appropriate follow-up recommendations for individuals exhibiting fear avoidance or pain catastrophizing. A member stated that the recommended course of action is to refer the patient to a pain psychologist. The group discussed access issues related to pain psychologists and agreed that referring the patient to a pain psychologist, or a physical therapist, is likely the most practical recommendation for this phase.

Discussion turned to the patient's state of mind following a surgery or acute injury and elevated risk for chronicity or opioid use disorder. The population identified by the group include patient's whose state of mind is affected by the trauma or injury, but who do not have a clinical diagnosis or an axis-1 disorder. Group members were unfamiliar with any literature about elevated risk tied to discouragement or frustration, but identified Michael Hooten as someone who may serve as a resource. Julie Cunningham offered to follow up with him on this topic. A brief discussion followed about assessing post traumatic stress disorder (PTSD), and how it should be addressed during the post-acute period.

Consensus was beginning to emerge that PTSD should be included in the recommendations as a factor to consider, but routine assessment and screening during this period may not be appropriate.

Meeting adjourned.