



Opioid Prescribing Work Group

Minutes — October 20, 2016
noon – 3:00 p.m.
444 Lafayette Building, St. Paul

Members present: Julie Cunningham, Chris Eaton, Tiffany Elton, Rebekah Forrest, Ifeyinwa Nneka Igwe (remotely), Chris Johnson, Pete Marshall, Murray McAllister, Richard Nadeau, Mary Beth Reinke (non-voting), Charles Reznikoff, Jeff Schiff (non-voting)

Members absent: Dana Farley, Ernest Lampe, Matthew Lewis, Alvaro Sanchez, Matthew St. George, Lindsey Thomas

DHS employees: Charity Densinger, Ellie Garrett, Tara Holt, Sarah Rinn (remotely)

Guests: Juliana Milhofer (MMA), 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.

II. Approval of Minutes

No corrections were offered to the September meeting minutes. **The minutes were approved unanimously.**

III. DHS Updates

Jeff Schiff updated the group on current opioid-related activities at the state government level. DHS leadership and staff attended the Tribal-State Opioid Summit on Tuesday, October 18. The summit addressed a number of opioid-related topics, including prescribing and prescription monitoring. Tribal members recommended that the state send the DHS prescribing protocols to the tribal leadership for review prior to approval by the DHS Commissioner. Schiff announced that DHS is participating in a National Governor's Association learning lab on Medication Assisted Therapy and telemedicine. DHS received several responses from tribes for the grant to expand integrated perinatal care for addicted pregnant women and new mothers. Finally, the St. Gabriel's/Morrison County team received the DHS Commissioner's Circle of Excellence Award. Chris Eaton provided an update on efforts to require opioid manufacturers to pay a penny per MME on all opioids sent to MN. Funds collected could be used for addiction treatment and prevention programs.

Ellie Garrett provided an overview of the meeting agenda.

IV. Opportunity for Public Comment

Trudy Ujdur (Sanford Health) provided public comment. She commented on the limitations of using telemedicine for Medication Assisted Treatment. Physicians at Sanford are required to have at least one face-to-face visit with patients receiving Suboxone. She also commented on the St. Gabriel's physicians who presented during September's OPWG, and their use of Suboxone for heroin addiction. Ujdur requested guidance or more information about the degrees of withdrawal among heroin addicts, and their experience with Suboxone.

Schiff responded to Ujdur's comments, and referred to the work of the DHS Alcohol and Drug Abuse Division. Treatment for addiction is outside the scope of the OPWG. A brief discussion ensued about challenges associated with prior authorization for Suboxone, and variation among insurance plans on prior authorization requirements.

V. Post-Acute Pain Prescribing Recommendations

Work group members reviewed revisions made to the Post-Acute Pain Prescribing Recommendations based on the previous' meetings discussion. No additional changes were made to Recommendation 6 (Risk Assessment).

Discussion turned to Recommendation 10 (Taper). A member advised changing the phrase "tissue healing resolves" to "tissue healing progresses" throughout the recommendation. Discussion ensued about the best way to communicate differences between patient-led dose reductions and the need for a formal taper regimen. Members agreed that a taper during this pain phase should take two weeks. The group recommended revising the last sentence in the bolded portion of the recommendation to state: **If a formal taper regimen is required, tapering is generally accomplished over two weeks to wean the patient off opioids completely or down to a pre-surgical dose.** Members recommended revising similar language through the recommendation for consistency.

A member commented that it should not be the expectation that patients experience no withdrawal symptoms while tapering. Mild withdrawal symptoms are common and acceptable. Group members recommended adding the following sentence to the recommendation: **Explain to the patient that mild withdrawal symptoms are expected, and do not represent a need to adjust the taper.**

Members recommended deleting the statement about the taper timeframe in the recommendation for patients receiving long-term opioid therapy.

Discussion moved on to Recommendation 12 (Naloxone). A member recommended adding patients on high daily morphine milligram equivalence (MME) to the list of populations who are at high risk for overdose. The group concurred, and the description of the third population listed was revised to state: **individuals on chronic opioids with an acute injury or major surgery taking over 100 MME/day.**

Schiff requested a motion to approve the post-acute pain recommendations with the revisions discussed. **A motion was made and seconded. The motion was passed unanimously.**

VI. Introduction to Chronic Pain/Chronic Opioid Use

Schiff presented briefly on the rationale for including chronic pain and chronic opioid use in the Opioid Prescribing Improvement Project prescribing protocols given the existence of other chronic pain guidelines. Garrett and Schiff then provided an overview of the New Chronic User (NCU) measure developed by DHS. The NCU measure identifies the population that was naïve to opioid use during a specific look-back period, and then progresses to chronic use over a specific look-forward period. A copy of the presentation is available upon request to dhs.opioid@state.mn.us.

A member commented on the difference between a person who becomes a chronic opioid user and a person who suffers from chronic pain. The group then discussed three distinct patient populations: 1) individuals for whom pain and opioid use lasts longer than 45 days; 2) chronic pain patients who are not on opioid analgesic therapy (opioid naïve or previous, intermittent use); and 3) individuals with recurrent acute pain. Group members agreed upon the significance of understanding and communicating those differences.

A member questioned whether the look-back period used for the NCU measure was able to capture complete opioid naïveté. Garrett explained that several look back periods were tested. The intent was not to be able to declare complete naïveté, but that the patient had been opioid naïve for a certain amount of time. Another member asked whether any risk factors were examined in development of the measure. Schiff reported that the data analysis found that 80% of new chronic opioid users had a mental health or substance abuse diagnosis. A member asked whether there was a sense of how often the first prescription written was large enough to encompass the measurement criteria. Schiff explained that the Minnesota Health Care Programs do not cover prescriptions greater than 30 days, so anyone meeting the measurement criteria would have had to fill at least two prescriptions.

Work group members indicated approval of using 45 days as the time period after which providers should consider patients to be progressing to chronic opioid use. A member requested that the group carefully consider the language used to advise providers to avoid prescribing opioids, especially to patients with a history of substance abuse or mental health diagnosis. The group should would like to identify new, strong language to convey the risks and lack of evidence associated with prescribing opioids for chronic pain.

VII. Chronic Pain Prescribing Domains

Garrett introduced the chronic pain prescribing domain discussion by briefly reviewing the 2016 CDC Prescribing for Chronic Pain Guidelines. The first domain addressed was nonpharmacologic therapy and nonopioid medications. A member expressed reservation about adopting any recommendation that appears to be promoting the use of a nonopioid pharmacologic therapy, because of the lack of evidence for specific nonopioid pharmacologic treatments for chronic pain. Another member echoed reservations about relying on nonopioid pharmacologic therapy. Any medication is a passive modality, and the literature consistently states that engaged patients who have more agency over the health care have better outcomes.

Discussion then turned to a more general conversation about the nature of chronic pain and the use of opioids. Members discussed the challenges that exist between understanding pain and the context in which an individual experiences pain, and identifying conditions under which it is appropriate to prescribe opioids. A member cautioned against placing too much emphasis on identifying the pain generator, and thinking about chronic pain purely from the biomedical perspective. Members discussed

how to acknowledge the nature of pain as a product of the peripheral and the central nerve system, while staying within the scope of the OPWG to address opioid prescribing. A member commented that in his previous experience developing protocols for opioid prescribing, the goal was to identify realistic boundaries in which opioid is a tool. The best reasonable boundaries are tissue damage that are a traditional indicator for opioids.

A brief discussion about chronic dental pain occurred. A member commented that chronic tooth pain is rare, and that chronic pain is usually caused by temporomandibular joint disorders or orofacial pain. Patients experiencing chronic dental pain should be referred to specialists.

Discussion returned to the importance of correctly defining the patient's experience in relation to chronic pain and opioid use. A member identified three patient populations that are often condensed under chronic pain prescribing guidelines: 1) a chronic pain patient who is currently opioid naïve; 2) an acute pain patient who is progressing to chronic opioid use; and 3) patients exposed to opioids for sustained periods and for whom pain may or may not be correlated to a diagnosis. The group agreed that the largest patient population are those defined in number 3. A member clarified that patients described in number 1 typically have had opioid exposure in the past.

A member commented that patients described in number one are often those with chronic pain caused by systemic disease. There may be justifiable use of opioids for patients in this category, but it is also a group who may be easier to wean off or avoid opioids altogether because they have biological markers associated with their pain condition that can be assessed. A brief discussion ensued about whether it would be appropriate to identify the diseases for which opioids should not be prescribed. Some members expressed concern that that would imply that conditions exist for which opioids are appropriate.

A member recommended that the group review the PEG Functional Assessment for chronic pain.

Discussion then turned to the concept of using Clinically Meaningful Improvement in Function (CMIF) as an indicator for continued opioid prescribing. Members spoke strongly against using function as a measure of improvement to justify continued opioid prescribing. Function and engagement in daily activities should be discussed and monitored in the clinical setting, but it should not be tied to opioid prescribing. Members discussed the importance of having an objective measure to gauge the patient's well-being and pain management. Patient goals are a good alternative, but goals must be measurable, e.g., returning to work or continued working. A member commented that the goals have to be patient-driven, because the provider cannot tell their patient what constitutes a good quality of life.

Consensus emerged among the work group members to use the 2016 ICSI Pain Health Care Guideline as the basis for the chronic pain discussion. Members requested that the CDC Chronic Pain recommendations and Washington State guidelines continue to be presented during development of the OPWG recommendations.

Meeting adjourned.