Opioid Prescribing Work Group

Minnesota Department of Human Services

Minutes — November 17, 2016
noon – 3:00 p.m.
444 Lafayette Building, St. Paul

Members present: Julie Cunningham, Chris Eaton, Tiffany Elton, Dana Farley (non-voting), Rebekah Forrest, Ifeyinwa Nneka Igwe, Chris Johnson, Ernest Lampe (non-voting), Pete Marshall, Murray McAllister, Richard Nadeau, Mary Beth Reinke (non-voting), Charles Reznikoff, Jeff Schiff (non-voting), Matthew St. George, Lindsey Thomas

Members absent: Matthew Lewis, Alvaro Sanchez

DHS employees: Ryan Cotton (Student), Charity Densinger, Tara Holt, Pattie Macguire, Sarah Rinn

Guests: Nancy Keller (Purdue), Juliana Milhofer (MMA), William Steffen (Pfizer), Ann Tart (DLI), Trudy Ujdur (Sanford), 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. DHS Updates

Jeff Schiff provided an overview of recent opioid-related events at DHS. Minnesota was selected to participate in a National Governor's Association learning lab about telehealth and addiction services. Representatives from DHS, the Department of Public Safety, Essentia Health and Hennepin County Medical center recently attended a kick-off meeting for the project in New Mexico, where they learned about Project ECHO (Extension for Community Healthcare Outcomes). Schiff also informed the group that the NCQA recently expressed interest in the DHS New Chronic User measure.

III. Approval of Minutes

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

IV. 2017 OPWG Meeting Schedule

Sarah Rinn provided a brief overview of the agenda and meeting logistics.

Rinn proposed that the 2017 OPWG meeting schedule remain on the third Thursday of each month, from noon to 3 pm. She requested that group members email her with any concerns about the 2017 meeting schedule.

V. Opportunity for Public Comment

No public comment was provided.

VI. OPIP Educational Campaign

Rinn provided a brief update on the Opioid Prescribing Improvement Program's educational campaign. As a reminder, the purpose of the campaign is to develop educational resources for opioid prescribers about communicating with patients about pain management and the use of opioids to treat pain. DHS is currently developing an RFP in order to procure a vendor to assist with the campaign. Once a vendor is selected, the vendor will attend an OPWG meeting. Rinn commented on another successful social media campaign led by DHS' Alcohol and Drug Abuse Division. She will circulate a link to the website to the work group members.

A brief discussion about the campaign ensued. Schiff commented that the goal of the campaign is to create a common understanding across the state that addressing inappropriate opioid use is everyone's responsibility. Members commented on the importance of addressing clinicians' concerns about barriers to appropriate opioid prescribing. One key barrier identified was the potential lack of support by clinic leadership and health systems due to the importance placed on patient satisfaction by accreditation and payment entities. Members discussed educational resources used in their clinics and health systems.

Members highlighted two challenges related to clinician-patient discussions about appropriate opioid use. First, there are patient populations in which distrust of the clinician's intentions and/or the expectations of entitlement to treatment significantly influence prescribing considerations. Clinicians may be reluctant to address inappropriate opioid use based on concerns about jeopardizing their therapeutic relationship with the patient. Second, addressing addiction with patients is challenging. A member commented that developing resources for providers to address dependence may possible future discussions about addiction easier. Finally, a member commented that the educational campaign should address contacting law enforcement when criminal activity when appropriate.

VII. Chronic Pain Phase Introductory Statement

Rinn introduced the chronic pain phase introductory statement. A copy of the statement is available upon request to dhs.opioid@state.mn.us

A brief discussion ensued about broad system support for advancing changes in opioid prescribing behavior. A recommendation was made to revise the last sentence in the first paragraph to state: **Patient safety must be the paramount concern of the clinician and the health care system when continuing or initiating chronic opioid analgesic therapy.**

Another recommendation was made to revise a statement in the second paragraph to state: **This indicates that intervening earlier and addressing continued opioid use by 45 days following an acute event may prevent individuals from progressing to chronic opioid use.**

Members discussed the three general patient populations described in the introductory statement. A brief discussion ensued about the natural course of chronic pain; chronic pain is characterized by underlying discomfort with acute "flare-ups". Members discussed how to distinguish flare-ups that are caused by inflammation versus immunological response. A member commented that one way to differentiate them is by the degree of central sensitization that may occur. A recommendation was made to revise the description provided in number 3 to state: **Recurrent acute pain is caused by chronically-painful conditions correlated to recurring tissue injury, e.g. sickle cell anemia.**

A member recommended addressing the need for an exit strategy when initiating or continuing COAT. Providers and patients need to develop understanding that it is not realistic to take opioids over the course of a lifespan. In addition, a member commented on the importance of provider assertiveness when discussing opioid prescribing or discontinuation with patients. Patients often arrive with expectations around continued opioid use, and providers must be prepared to manage those expectations. A member commented that it may be useful to remind prescribers about compliance with their DEA licensure requirements.

Discussion then turned to the statement under number 5, Treatment Considerations. A member requested that more detail be provided about the specific types of multi-modal treatment that should be provided for patients with chronic pain. Members briefly discussed the phrase "inability to monitor adherence", clarifying that adherence meant adherence to the treatment plan. Members recommended revising the heading at number 5 to Treatment Considerations.

VIII. Chronic Pain Prescribing Domains

Rinn provided an overview of the chronic pain phase prescribing domains. For each domain, DHS provided two related prescribing recommendations. The first is the corresponding recommendation developed by the OPWG for the post-acute pain period. The second is the recommendation developed by ICSI for the appropriate domain.

Domain: Assess and document pain and function

Rinn presented both the OPWG post-acute pain and ICSI domain recommendations. A member recommended reviewing the PEG (Pain intensity, Enjoyment of life, and interference with General activity) tool. Discussion ensued about the appropriate use of clinical screening tools to measure pain and function. Members agreed that screening tools should be used as part of the clinical evaluation, however there was significant concern that screening tools create a sense of false security among providers. Clinicians should not become over-reliant on the screening tool results. Another member commented that the use of screening tools addresses provider bias. Using a validated tool across a health care system and within a clinician's patient panel reduces concerns about provider's prejudices and biases. Members recognized the utility and necessity of consistent screening tools, but recommended describing their intended use more explicitly in the recommendations.

Domain: Evaluation and Diagnosis

The group discussed considering opioid-induced pain as part of the differential diagnosis. Opioid induced pain is caused by adaptation of the opioid receptors to chronic exposure to opioids, physiologic

reaction to withdrawal of opioids or as a side effect of opioids.[1] A member clarified that the intent of including opioid-induced pain in the ICSI guidelines was to call attention to those patients who receive COAT and still experience pain. For some subset of that population, the pain generator may be related to their opioid exposure. The recommendation is intended to remind clinicians to consider the opioid exposure itself during evaluation and diagnosis. Clinicians may need to check the PMP specifically for this purpose; thereby using the PMP as a diagnostic tool rather a management tool. The recommendation should include the appropriate course of action when the PMP findings indicate opioid-induced pain.

A brief discussion ensued about the addressing the contextual information that influences the experience of pain. Consensus was beginning to emerge about expanding the assessment and diagnosis of pain to include physical and behavioral factors.

Domain: Dental Pain

Rinn reviewed the chronic dental pain draft recommendation. No changes were recommended.

Domain: Physical and Behavioral Health Comorbidities

Workgroup members discussed the presence of physical and behavioral comorbidities in chronic pain patients. The intent of this recommendation is to address comorbidities that complicate the pain treatment, and those comorbidities that cause or worsen the pain. Diabetic neuropathy was provided as an example of a physical condition for which clinicians must concurrently manage pain and treat the disease. Members expressed concern about the use of the word comorbidity, and consensus emerged among the members to reframe considerations of physical and behavioral health conditions in patients with chronic pain within the recommendations. Behavioral health conditions are more highly correlated with pain intensity than physical factors. The recommendations should emphasize the role of behavioral health conditions, and differentiate between co-existing conditions (e.g., PTSD, bipolar disorder, depression, anxiety) and co-occuring manifestations of chronic pain (e.g., fear avoidance, pain catastrophizing). Certain co-existing conditions may require separate treatment modalities from pain management.

A brief discussion ensued about nonverbal pain symptoms. A member commented that within her health system the emphasis is to decrease focus on pain behaviors. There is concern that focusing on pain behavior and paying attention to nonverbal symptoms will inadvertently reward the patient for displaying those behaviors. Group members briefly discussed how to address this issue, but no recommendation was provided.

Domain: Acute on Chronic

Rinn presented the prescription recommendation for patients on COAT with an acute injury developed by the OPWG workgroup. No changes were recommended. DHS will revise the recommendation for the chronic pain phase guideline.

Meeting adjourned.

[1] Hooten M, Thorson D, Bianco J, Bonte B, Clavel Jr A, Hora J, Johnson C, Kirksson E, Noonan MP, Reznikoff C, Schweim K, Wainio J, Walker N. Institute for Clinical Systems Improvement. Pain: Assessment, Non-Opioid Treatment Approaches and Opioid Management. Updated September 2016.