Opioid Prescribing Work Group

Minutes — January 19, 2017
Noon – 3:00 p.m.
444 Lafayette Rd., St. Paul

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

Members absent: Chris Eaton, Lindsey Thomas

DHS employees: Charity Densinger, Ellie Garrett, Dave Hoang, Tara Holt, Mike Kurz, Melanie LaBrie, Sarah Rinn, Brian Zirbes

Guests: Jocelyn Good (Pfizer), Cassaundra Johnson (Purdue), Juliana Milhofer (MMA), Lisa Wichterman (DLI)

Welcome and Introductions

Chris Johnson called the meeting to order. Johnson welcomed members and guests, and introductions were made around the room.

DHS Updates

Jeff Schiff provided updates to members about DHS opioid-related efforts. The agency recently received notice of a funding opportunity through SAMHSA—the State Targeted Response (STR) grants—for opioid addiction treatment and prevention. Minnesota is eligible to receive $5.3 million over two years. Brian Zirbes, Deputy Director of the DHS Alcohol and Drug Abuse Division, provided additional detail about Minnesota's substance use disorder reform efforts and a summary of the STR grant opportunities.

Schiff commented on the Attorney General's legislative proposal to expand the Opioid Prescribing Improvement Program beyond Medicaid. DHS supports implementing the OPIP as originally defined in the 2015 authorizing legislation. Schiff also commented that he presented DHS' opioid-related work, including OPIP, to the Minnesota Hospital Association's Board of Trustees in January. A presentation to the MMA Opioid Task Force is scheduled for February 8.

Approval of Minutes

Tiffany Elton provided a correction to the minutes. The attendance roster incorrectly listed her as present at the December meeting. **The corrected minutes were approved unanimously.**

Opportunity for Public Comment

No public comment was provided.

Chronic Pain Phase Recommendations

Sarah Rinn reviewed meeting logistics and confirmed the 2017 OPWG meeting schedule. A copy of her slide presentation is available by request at dhs.opioid@state.mn.us.

Chronic Pain Phase: Prescribing Domains

Dose and Duration

Members discussed the implications of using 50 MME and 100 MME daily dose limits. There was concern that there is little incentive to stay under 50 MME/day if 100 MME/day is accepted as the bright line in practice. A suggestion was made to address the continuum of risk between 50 MME/day and 100 MME/day, and define an expected standard of care along that continuum. Prescribers should not increase dose without a complete biopsychosocial evaluation and a face-to-face encounter. Members recommended adding a statement that tolerance at high doses is not a sufficient reason to prescribe over 100 MME/day.

Members commented that the recommendation does not address duration. Members recommended adding a statement that prescribers consider and discuss the duration of the opioid therapy with the patient at initiation, and continually offer dose reductions to the patient. Recommendation 18 (Taper or Discontinue Opioids) will be moved so that it directly follows the dose and duration recommendation, and reiterates the recommendation to continually offer dose reductions.

Formulation

A recommendation was made to add a statement that prescribers should not routinely change patients from short-acting to long-acting opioid formulations. Members expressed concern that the last statement in the recommendation—*Tamper proof formulations for opioids are preferred*—may needlessly skew prescribing towards newer, more expensive opioid formulations. Members recommended removing the last statement from the recommendation, and flagging the issue for future review. A member recommended including specific indications for the use of ER/LA opioids, e.g., daily dose greater than 60 MME/day, as well as contraindications, including sleep apnea and other comorbidities.

Opioid Rotation and Conversion

Members commented that opioid rotation is no longer a common practice. Members recommended changing the title of the recommendation to substitution, and possibly moving it further down the list of recommendations. Members recommended providing a range (30-50%) for dose reduction during substitution of opioids. A member recommended adding at statement that opioids should not be routinely rotated, however there specific indications when substitution may be appropriate, e.g., patients in renal failure, change of health insurance or drug formulary, or palliative pain management.

Methadone and Fentanyl

Members briefly discussed whether to include methadone and/or fentanyl in the recommendations, given that these drugs are more often used for palliative and cancer-related pain. These pain types are outside the scope of the OPIP. Members agreed it was important to address them for two reasons. First, methadone is prescribed for pain, and there is a subset of patients for whom its use may be appropriate. Second, it is worth commenting on fentanyl given its current high level of visibility. Members also discussed the conflicting recommendations from EPA and DEA regarding disposal of fentanyl patches. Members agreed to recommend disposing of fentanyl

patches via flushing them down the toilet, given the potential for diversion and significant harm to household members, including pets.

A brief discussion ensued about the use of methadone for pain versus addiction. Members commented that there is an appropriate role for methadone in pain treatment, however the prescriber has to be very experienced with methadone therapy. Members recommended adding indications for methadone therapy for pain management, and a referral to a pain specialist.

Members acknowledged that fentanyl is not commonly used outside palliative care and cancer-related pain. However, members recommended including several statements about fentanyl in the prescribing protocol, including:

- Fentanyl should never be prescribed in addition to another long-acting agent.
- Fentanyl should never be prescribed to patients with a history of substance use disorder

Acute on Chronic

Rinn commented that the acute on chronic pain prescribing domain was previously discussed.

Written Patient Provider Agreement

Purpose

A lengthy discussion of the patient provider agreements ensued. Members discussed the various purposes that a PPA serves, including harm prevention, patient education, setting patient and provider expectations, treatment planning and a diagnostic tool for opioid use disorder. Members also discussed the legal ramifications of a signed patient provider agreement. Members agreed that a PPA should embody the recommendations provided in the prescribing guidelines, and may be useful as a set of criteria for determining whether a patient is in control of his or her opioid use. Members commented on the lack of evidence that PPAs improve patient care or safety; however, they are common practice and required in certain health systems. The use of PPAs provides consistency and standardized practice across patients.

When a PPA is indicated

Members recommended revising the list of indications for PPAs to include: daily use of opioids > 45 days; episodic use for 90 or more days over the course of a year; and episodic use for 45 or more days over the course of 90 days.

Specific components of a PPA

Discussion ensued about the level of specificity to provide within the recommendation. Several members supported drafting a PPA template, while others supported providing an overview of the components that should be included. Consensus emerged to recommend the components of a PPA. The group did not reach consensus about whether there is an existing template that could be included as an appendix to the recommendations. Work group members recommended adding the following components of PPA:

- Statement about not sharing pills at any time for any reason.
- Tapering expectations
- Driving
- Use of other substances
- Screening

- Pill counts
- Revise consequences for failure to adhere to plan: Treatment or referral
- Plain language

Discussion then turned to the recommendation of obtaining informed consent from the patient. Consensus emerged to remove the informed consent language from the recommendation.

Meeting adjourned.