Opioid Prescribing Work Group

Minutes — December 14, 2015
12:30 – 3:30 p.m.
444 Lafayette Building, St. Paul

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

Members absent: None

State employees:

- Department of Human Services: Charity Densinger, Sara Drake, Ellie Garrett, Tara Holt, Sarah Rinn
- Department of Health: Dana Farley
- Department of Labor & Industry: Lisa Wichterman
- Board of Nursing: July Sabo

Guests: Shelly Elkington (Avenues for Care), Todd Gabrielson, Alexi-Reed Holtum (Steve Rummler Hope Foundation), Trudy Ujdur (Sanford Health)

I. Welcome and Introductions

Jeff Schiff called the meeting to order, and introductions were made around the room. Todd Gabrielson shared the compelling story of losing his daughter to an adverse reaction to codeine, which had been prescribed while she was hospitalized.

Ellie Garrett is working to schedule the January meeting and to set a standing meeting date and time. Schiff announced that Chris Johnson has offered to chair the group, and he expressed his appreciation to Johnson. Voting OPWG members will choose a chair at the next meeting, and members are encouraged to put forward their names if interested in serving.

A motion was made and seconded to create an ex-officio, non-voting seat for a representative of the Minnesota Department of Health. The motion passed unanimously.

II. Protocol Domains: Prescribing for acute pain

Garrett presented an overview of the goals for today's meeting, which included voting on the protocol domains for prescribing opioids to treat acute pain and discussing the content of the first four domains: assessing and documenting (1) function, (2) pain, (3) physical health and risks and (4) mental health and substance abuse. She suggested that the work group use ICSI's Acute Pain Assessment and Opioid Prescribing Protocol as a starting point for discussion and that members focus initially on primary care

prescribing. Modifications for other providers and sites of care (e.g., dental, surgical, emergency department) could be made later. A copy of Garrett's brief presentation is available upon request from OPWG staff.

Garrett asked whether there were other prescribing protocols that the work group should review. Richard Nadeau agreed to circulate a copy of the Minnesota Dental Association's protocol.

Schiff asked the committee to focus on the first four domains today. A member noted that nomenclature can create confusion. There is a difference between acute pain and treatment of pain in an acute care setting. Pain in an acute setting can be many things: mental health crisis, running out of medications, a flare-up of a chronic condition. This segued into a discussion about the importance and challenge of precisely diagnosing the patient. There are many instances in which pain may appear to be acute but may really be arising from a chronic problem. The committee agreed to focus initially on acute presentation of pain with no other confounding factors, such as chronic conditions.

Schiff asked the work group to consider the reorganized domains, as reflected in the version circulated for today's meeting. The first eight, shaded items are considerations that come first: issues influencing whether to prescribe opioids; the remaining domains concern how to prescribe opioids, having decided that opioids are appropriate in the instant case. (See Attachment A.)

A member suggested moving item #9 (checking the Minnesota Prescription Monitoring Program) up to the shaded area. The PMP results are part of patient assessment. Others noted that checking the PMP can inform whether the patient really is presenting for a new, acute problem. He observed that the only objection might be that it is a hassle for the provider. Other members countered that the only hassle is finding something that looks concerning that requires more time. Physicians are allowed to delegate checking the PMP to another member of the treating team (though pharmacists on the team need better access to the PMP), and checking the PMP only takes a couple of minutes once doing so is routinized into the provider's practice. Consensus emerged that discussions about checking the PMP should be moved up to the section on considerations prior to prescribing. A member stated that it is important to refer patients to counselling for addiction care if the patient assessment, including PMP findings, suggest that the patient might be suffering opioid use disorder. Another member agreed that there needs to be a follow-up in the protocol when there is a finding from the PMP.

A member stated that urine screening should also be considered, and identifies problems that do not always show up on the PMP. Another member countered that urine screens would be expensive and likely not needed for every patient. A member suggested that urine screening might be considered as a follow-up in the PMP.

A. Assessment of function

Garrett observed that there are many tools available for assessing function. Page 10 of Washington's guidance contains some combined pain and function scales in the context of chronic pain that might be useful to think about earlier during acute presentation.

A member questioned whether assessing function is really relevant for treating acute pain. Another member agreed, noting that the main reason to address function is to establish therapeutic goals: The opioid's purpose is to help the patient function better and not to eradicate pain completely. Well managed pain is part of the healing process.

A member suggested that assessing ability to perform activities of daily living (ADLs) is objectively verifiable information that can help assess healing post-surgery or trauma.

B. Assessment of pain

A member stressed that pain is not a vital sign. Vital signs require immediate, clinical response in order to address a symptom in the moment. Successful pain treatment should be measured in a month, not minutes or hours. There is enormous pressure on providers to lower their patients' pain scores. Another member agreed and stated that patient satisfaction measures on pain actually lead to inappropriate and ineffective pain management.

Schiff suggested that concerns regarding measuring pain as part of patient satisfaction should be something that the committee considers in a future meeting. He cautioned, though, about exacerbating racial and ethnic disparities in pain treatment.

A member stressed the importance of setting realistic goals for improvements in relative pain scores. A member stated that pain scores are useful clinically. Another member observed that pain scores are subjective, and one what one patient terms a five might be another patient's one or two or ten. Another member stated that the pain scale needs to be understood as reflecting not just pain but also emotional distress about pain. Schiff asked whether it would be reasonable to expect that the assessment and documentation include the patient's observed nature, e.g., distractibility or stoicism.

A member suggested that pain scales are fine, so long as they are not used to measure provider performance or dictate clinical responses in the abstract without considering the patient's full clinical presentation. Pain scales are only a guide, and should be used to help assess relative goals – like a 30 – 50% reduction in pain. Treat the patient, not the number. No numerical response to the pain scale alone warrants an opioid in and of itself.

A member suggested that the committee and/or DHS formally recommend to the Joint Commission that pain scores be removed from accreditation or other measurement standards. Several members agreed. Another member observed that corporate and system policies impede the appropriate prescribing of opioids. A member suggested that this topic is important enough for a separate agenda item, and he suggested tabling it for now.

Another member stated that cognitive threat and distress levels can be experimentally manipulated to help with diagnosis. Reporting the same sensation in the presence of different cognitive threats is instructive. Another member observed that the notion of "staying ahead of the pain," while appropriate in the treatment of terminally ill patients, is harmful in other contexts.

A member observed that Washington's guidance does a good job discussing the limits of opioids and their use. Opioids have limits, and there are more effective strategies for some patients and some conditions.

A member drew the group's attention to ICSI's guidance (page 9, section 3) on comprehensive pain assessment. Another member suggested that the risk/benefit grid page 19 of the ICSI guidance is also quite useful. Prescribers should document the physical findings that are consistent with pain and any prescription, including objective observation of discomfort, restlessness, tachycardia, crying, etc.

A member expressed concern about unintended consequences – that overemphasis on objective documentation could increase MRIs and other scans and tests inappropriately. Another member clarified

that objective assessment should document observations about the patient's discomfort. Members discussed the utility of SOAP documentation criteria (subjective, objective, assessment and plan). Some prescribers are not documenting even the barest of justifications for prescribing.

Schiff brought the discussion to a close and asked the group to either endorse ICSI's acute guidance vis-à-vis assessment and documentation or else propose concrete modifications. **A motion was made and seconded that the OPWG recommend both objective documentation of the patient's presentation of pain and diminished physical function. Documentation should include use of the pain scale as a relative tool, and concordance of the patient's assessment of his or her own pain with the prescriber's objective observations. The motion carried unanimously.**

1. Public Comment

Trudy Udjur of Sanford Health (no conflicts of interest to disclose) stated that prescribing opioids well is complex. The pain scale is not diagnostic. A person can exhibit significant pain on the pain scale simply because they have run out of opioids.

C. Assessment of mental health risks

A member suggested that ICSI's ABCDPQRS risk assessment approach (ICSI guidance, page 14) would be a useful place to start:

- Alcohol use
- Benzodiazepines and other drug use
- Clearance and metabolism of the drug
- Delirium, dementia and falls risk
- Psychiatric comorbidities
- Query the PMP
- Respiratory insufficiency and sleep apnea
- Safe driving, work, storage and disposal

Another member commented that safe driving will have to be addressed as part of the protocol at some point.

Schiff asked the group to focus on mental health and substance abuse risks for the moment. A member suggested that focus on anxiety disorders and depression would be a useful place to start. Another member stated that no screening tool is perfect, but revising past mental health history and medications is helpful. Even when a patient is presenting with a trauma, such as a femur fracture, knowing that the patient has a history of substance abuse or mental health disorders would be useful.

Members discussed the tension between adding to the prescriber's burden with extensive documentation and history requirements for the initial prescription in cases of objectively verifiable pain vs. shifting some of the burden to the sub-acute prescribing timeframe. Taking a complete family history might be too burdensome as a standard for all initial prescriptions. A member stated that a bare minimum should include current or past addiction history, depression, anxiety, PTSD and suicidality.

A member suggested that risk is also addressed when prescribing a smaller dose for a shorter duration for the initial prescription. Prescribing too many pills is a very big problem.

Returning to the question of mental health and substance abuse, members discussed how comprehensive a history should be required in connection with an initial prescription. A member observed that current medication history is instructive, both to avoid concomitant use of dangerous combinations of drugs (such as benzodiazepines and opioids) and to inform the prescriber about current mental health conditions. Another member stated that asking about substance abuse history should be required at a minimum. It's also important to ask patients if they feel like harming or killing themselves in order to assess suicidality.

Members discussed different sites of care, questioning whether the same standard should apply in primary care, dentists' offices, the emergency department and so forth.

Schiff surveyed members about whether suicidality should be assessed in every setting for every initial prescription. Eight voting members said yes; five said no.

One member said that mental health history will capture suicidality. Another member clarified that any member of the treating team could take a history, so that should help with managing burden to the provider.

A member stated that if any questions about mental health or substance abuse are positive, then that should prompt further inquiry, including questions about past history of overdose.

Schiff polled members, and they agreed by a show of hands that the assessment should include a medication review and brief screening for substance abuse disorder and acute suicidality. Members briefly discussed that any positive findings could prompt a more thorough history, including questions about prior overdose or a decision to prescribe Narcan.

D. Assessment of physical health risks

Schiff drew members' attention back to the ABCDPQRS assessment recommended by ICSI. Members discussed several risks, including advanced chronic obstructive pulmonary disease, renal failure, obesity and sleep apnea. Age cuts both ways, with youth being more associated with addiction risks and overdose more associated with middle and old age.

A member observed that using the ABCDPQRS assessment would support a culture change around prescribing. Another member added that opioids should never be prescribed, even to someone in obvious, traumatic pain, without informed consent about the risks, especially the risks of dependence and addiction. If prescribing to someone with a history of addiction because of severe injury or other objective, painful indication, then the prescriber should also refer the patient to an addiction specialist.

E. Next Steps

Members asked to discuss prescription dose and duration at the next meeting. They will also need to discuss prescribers and settings other than primary care, such as surgery, dentistry and emergency medicine.

In response to a question, Schiff stated that the Board of Pharmacy is likely to introduce legislation proposing mandatory enrollment in (as opposed to mandatory use of) the PMP.

Schiff adjourned the meeting at approximately 3:30 p.m.

Attachment A

Protocol Domains: Prescribing for Acute Pain			
Domain	**Washington**	**ICSI**	**ED**
1 Assess and document function	X	X	
2 Assess and document pain	X	X	
3 Assess physical health contraindications/risks	X	X	X
4 Assess mental health and substance use contraindications, including family history	X	X	X
5 Avoid concomitant use of benzodiazepines and other concerning drugs	X	X	
6 Considerations regarding acute pain related/unrelated to concomitant chronic pain		X	X
7 Diagnostic specificity and/or exclusions	X	X	
8 Consider multi-modal, non-opioid treatments as alternatives or adjuncts to opioids	X	X	
9 Use lowest dose and duration	X	X	X
9a Specific guidance regarding type of drug (short/long acting, IM, IV)	X	X	X
10 Provider and/or site-specific considerations			
10a Dental	X	X	
10b Emergency	refers to WA-ACEP	X	X
10c Surgical	X		
10d Other?			
11 Check PMP	X	X	X
12 Assess family and environmental risk of diversion			
13 Consider take-home naloxone	X		
14 Patient and family education about pain management, risks, benefits, reasonable expectations, safekeeping and disposal	X	X	X
15 Other?			

Key: Shaded: Considerations before prescribing opioids
Unshaded: Considerations after preliminarily deciding to prescribe opioids

Question for OPWG's discussion and decision: What prescribing domains belong in the OPWG's recommended opioid prescribing protocol for acute pain?