Opioid Prescribing Work Group

Minnesota Department of Human Services

Minutes — March 17, 2016
12:00 – 3:00 p.m.
444 Lafayette Building, St. Paul

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

Members absent: Chris Eaton, Alvaro Sanchez

DHS employees: Lin Chen, Sara Drake, Dave Hoang, Tara Holt, Ellie Garrett, Sarah Rinn, Steven Wesbar

Guests: Danny Ackert (UMN-Student), Cara Geffert (HealthPartners), Jacob Hutchins (UMMC), Trudy Ujdur (Sanford Health)

I. Welcome and Introductions

Chris Johnson called the meeting to order at 12:05 pm. Johnson welcomed members and guests, and introductions were made around the room and with members connecting to the meeting remotely.

Jeff Schiff reported that the DHS Health Services Advisory Council (HSAC) is discussing medication assisted recovery, with a specific focus on suboxone. The HSAC will develop criteria for a program to support suboxone treatment by primacy care providers.

II. Approval of Minutes

No corrections were offered to the February minutes. **Upon motion made and seconded, minutes were approved unanimously.**

III. Recap of Meeting Four Discussion and Today's Agenda

Rinn provided a brief update on federal and state legislation and initiatives related to opioid prescribing and treatment and recovery program expansion. She informed the group of a change in terminology from morphine equivalent dose (MED) to morphine milligram equivalent (MME), per the recent CDC Chronic Pain Guidance. She then introduced the draft Acute Pain Recommendations document and briefly recapped the acute pain prescribing recommendations made to date. A copy of her slides and the draft Acute Pain Recommendations are available upon request from OPWG staff. The draft contains both the recommendations previously voted upon by the group, and a limited number of recommendations to be discussed and voted upon today. Rinn also informed the group that the draft also serves as a model for future OPWG discussions. DHS staff will provide the members will a "straw

man" proposal for the post-acute and chronic pain phases. Members will use the proposal as a discussion starting point to develop the draft recommendations.

During the overview of acute pain prescribing recommendations made to date, two members requested more specific language related to complications for neck, back and musculoskeletal pain. DHS staff will revise the language related to neurological complications in Recommendation 8. A member also suggested a revision to the language in Recommendation 12 about one of the populations at high risk for overdose. The current recommendation describes the group as "recently incarcerated individuals with a history of substance abuse". The member suggested that we change the description to "individuals with chronic opioid exposure after a prolonged period of abstinence, such as incarceration". This definition also captures individuals recently discharged from an inpatient abstinence-based substance abuse program. The group agreed to revisit the description upon completion of all draft recommendations.

The Chair revised the meeting agenda in order to discuss the postsurgical recommendations immediately following the first public comment period. The OPWG agreed to first discuss and recommend acute pain prescribing in the postoperative setting. Then the OPWG agreed to (1) confirm consensus on the ABCDPQRS risk assessment approach; (2) confirm consensus on the dental recommendation; (3) address pregnant and lactating women; and (4) address prescribing opioids for acute pain in children.

IV. Public comment

Jacob Hutchins introduced himself as an anesthesiologist and the medical director of acute pain for the University of Minnesota and the Sports and Ambulatory Surgery Center. Hutchins commented that a 3-4 day duration of opioids is appropriate for most ambulatory surgery patients, especially opioid naïve patients. A patient with significant pain after 3 days should be assessed for surgical complications. Hutchins informed the group that combination opioid analgesics are discouraged at his practice sites in order to educate the patient about each specific medication, and its appropriate use. He commented on the importance of patient education and changing patient expectations of both pain and opioid use after surgery. Hutchins discussed his practice site's standard of care for opioid tolerant patients. Prescribers increase the opioid dose—using short acting opioids--by no more than 30 percent of the patient's preoperative opioid dose, and then adjust the dose downward if possible. Chronic opioid users with high daily doses may receive slightly less than a 30 percent increase. He commented that one purpose of this practice is to avoid dose adjustments made by providers outside of the care team, and to avoid pain readmissions due to insufficient, initial pain management.

V. Recommendation for Postoperative Acute Pain – Initial Outpatient Prescription Following a Procedure

Members continued discussion of managing postoperative acute pain for opioid tolerant patients. A member asked Hutchins about the typical timeframe for tapering chronic opioid users down to their preoperative dose. Hutchins stated that minor surgeries typically have a weeklong taper, and more invasive or complicated surgeries typically taper down within two to four weeks. A member opposed the notion that opioid tolerant patients should receive a longer duration of opioid therapy for postoperative pain management.

Discussion then turned to preoperative risk assessment in surgical centers. A member expressed concern about routinely increasing opioid doses for complicated, chronic opioid users without thorough risk assessment. Hutchins informed the group that all patients attend a pre-assessment clinic at this practice site, during which risk assessment occurs. High-risk patients meet with the anesthesiologist prior to surgery, and low risk patients may meet with a nurse practitioner. Next, the group discussed the importance of preoperative patient education. A member commented on the importance of educating the opioid tolerant patient that pain is expected, and that dosage will not be increased unless there are functional problems. Another member commented on the importance of setting expectations and timeframes for tapering when a chronic opioid user receives a dose increase after surgery avoiding letting the postsurgical dose become the new normal for that patient.

The group discussed preoperative education, discharge, and postoperative follow-up. The group agreed that all patients should receive preoperative education about expectation of pain, safe disposal, safe storage and driving. A member commented that disposal instructions are not often provided at discharge. Hutchins commented that opioid disposal education should be addressed preoperatively, and that patient should be counseled to bring unused opioids to his or her postsurgical follow-up appointment. This may create the expectation that not all opioids prescribed will be used, and may reinforce guidance to limit supply with surgeons. One member asked Hutchins about differences in postoperative follow-up for chronic opioid users. Hutchins answered that there is earlier postoperative follow-up with the surgeon, and patients are encouraged to schedule a follow-up appointment with the chronic pain provider.

Brief discussion ensued about patients in methadone management treatment undergoing surgery. A member commented that the methadone dose should be kept constant, and providers may allow up to double the normal acute pain medication dose. The chronic pain provider should be involved in preoperative and postoperative education. The member stressed that the number of days of healing does not differ between chronic opioid users and opioid naïve patients.

One member commented that the American College of Surgeons advises using the same dose and duration for all patients, and that dose or duration adjustments be made on a case-by-case basis. If a patient has significant pain past the typical healing time, it is important to understand why the pain is deviating from its typical pattern and not just increase the opioid dosage. The surgeon should assess the patient for surgical complications. Another member concurred, and commented that high-dose chronic opioid users often have significant comorbidities. These are high-risk patients who require close monitoring and absorb more services than opioid naïve patients.

Discussed then turned to the duration of the acute pain period following surgery or trauma. The group agreed to keep the 3-day range the recommendation for minor surgeries. A member suggested increasing the outside range for postoperative acute pain from 6 days to 7 days for convenience. There was consensus among the members that the acute prescribing period should be long enough to capture the period of acute pain experienced by the majority of patients undergoing surgery. One member expressed the need for latitude in this recommendation. He commented that the surgeon is liable for the postoperative management of the patient, and the period during which acute pain is experienced is often three days. However, the timeframe could be more or less for a complex, hospitalized patient depending on whether a hospitalist assumes management of the patient. Consensus emerged that length of surgery or diagnostic related groups (DRGs) are not an appropriate indicator for a minor or major surgery.

Schiff summarized the recommendation: **In most cases, pain from most surgical procedures (especially outpatient procedures) can be managed effectively without opioids or up to a three-day prescription of low-dose, short-acting opioids.**

Some surgical procedures and traumatic injury (especially procedures and injuries that are more extensive often requiring more than a 48-hour hospital stay) require greater pain management, because of an expectation of increased tissue damage and subsequent inflammatory response.

Prescribe no more opioids than will be needed for initial tissue recovery, usually no more than seven days or up to 200 MME. Patients undergoing surgery should receive opioid risk assessment and preoperative education. Preoperative education should address expected duration and intensity of pain, appropriate opioid use and expected results, safe storage and safe disposal of opioids. Upon motion and seconded, the recommendations was approved unanimously.

A brief discussion ensued about whether to increase the opioid dose for opioid-tolerant patients following surgery. Members agreed that the duration of opioid therapy should be the same for opioid naïve and opioid tolerant patients. One member vigorously objected to the possibility that chronic opioid users could receive less analgesia than opioid naïve patients. A member commented that increasing the opioid dose also increases the risk of accidental overdose and resetting the patient's tolerance level.

Consensus emerged around recommending additional resources for chronic opioid users, rather than recommending a specific dose increase. One member expressed preference for emphasizing the process that the physician has to follow, including documentation of the reason for the opioid prescription in the medical record, documentation of follow-up and treatment plan for opioids, and determination of whether patient requires a pain consultation. A member commented that not all hospitals and surgical centers will have the same level of resources, so the group should recommend a postsurgical opioid dose for opioid tolerant patients. Members agreed upon recommending that opioid-tolerant patients and opioid-naïve patients receive the same dose at discharge. A brief discussion ensued about the relative risks of opioid tolerant patients based on their daily opioid dose. A motion was made to recommend that **effective management of acute, postoperative pain in opioid tolerant patients may require additional education and resources. It is important to effectively manage acute post-operative pain, and opioid tolerant patients should receive no less treatment than opioid naïve patients. For opioid tolerant patients taking up to 100 MME/day, the standard postoperative dose and duration recommendations apply. Postoperative pain management for patients taking over 100 MME/day should include additional pain resources such as the chronic pain prescriber, pain specialists, anesthesiology, and psychologists.**

A member seconded the motion, and the motion passed unanimously.

VI. Remaining Acute Pain Protocols: ABCDPQRS Opioid Risk Assessment; Dental Recommendations, Pregnancy and lactating women and children

Members previously discussed the ABCDPQRS Opioid Risk Assessment approach during the January meeting, but did not vote to approve it. **Upon motion and second, the recommendation was approved unanimously.**

The group then followed-up on the discussion held at the last meeting regarding opioid prescribing for acute dental pain. One member questioned whether dental procedures should be considered under the post-surgical prescribing recommendation. The member questioned whether the 3 day/20 pills/100 MME dose and duration recommendation is too long for a dental procedure. Another member commented that the existing acute pain dose and duration recommendations are appropriate for pain

after a dental procedure. The group reached consensus that the surgical indications for less invasive procedures apply to dental extractions, i.e. 3 days/20 pills/100 MME.

A member read the proposed recommendation for patients presenting with acute oral/facial pain in a medical facility or hospital with no dentist available: **Prior to diagnosis and treatment plan for underlying source of pain, use appropriate non-opioid medications for pain management. Do not prescribe opioids without an examination and diagnosis of the underlying reason for the tooth pain by a dental provider as soon as possible. Opioids can mask pain and allow the patient to ignore a potential underlying serious dental problem, such as an abscess. Diagnosis should include appropriate tests and x-rays. Refer to a dental provider and assist with access to follow-up when possible.**

Surgical recommendations apply to patients undergoing dental extraction. Management of acute pain associated with dental extractions should adhere to the 3-day/20 pill/100 MME opioid prescription acute pain recommendation. Upon motion and second, the recommendation was approved unanimously.

Next the group discussed prescribing opioids for acute pain in pregnant and lactating women. A member commented on the high rate of opioid exposure in pregnancy and the increasing prevalence of Neonatal Abstinence Syndrome (NAS). The member questioned whether the group should consider expanding the recommendation to all women of childbearing age. Another member commented that expanding the recommendation to all women of childbearing age may be more appropriate in the post-acute and chronic prescribing protocols. The members clarified that we are not considering exposure to opioids during labor. Members agreed that opioids should be avoided in pregnancy, but if opioids cannot be avoided then it is critically important to discuss the risk of using the opioids for both the mother and the baby. A member suggested that pregnancy should be part of the assessment process when considering prescribing an opioid. The group agreed that all women of childbearing age should be assessed for pregnancy prior to receiving an opioid prescription. The group requested addition information about the risks of opioids for lactating women before voting upon a recommendation.

Members agreed to adopt the proposed recommendation for pregnant women, with additional recommendations about education and assessing pregnancy risk. **Avoid prescribing opioids to pregnant women. Assess pregnancy risk in all women of childbearing age prior to prescribing an opioid. If the benefit of using an opioid outweighs the risk to the woman, then prescribe the lowest dose and duration appropriate and educate pregnant women about the risks of taking opioids when pregnant for both the mother and the fetus. The motion was seconded, and passed unanimously.**

Finally the group discussed prescribing opioids for acute pain in children. A member requested that we add language to the recommendation about parental involvement, education, and safe storage. A motion was made to recommend that **acute dosing for children should be proportional by weight to the dosing guidance in Recommendation 3. All children over the age 10 should be screened as per the recommendations for adults (Recommendation 2). Prescribers and pharmacists should check the PMP for all children prior to prescribing an opioid, in order to identify parental diversion or concomitant use of sedative-hypnotic drugs. Avoid prescribing codeine to children in all circumstances.**

The motion was seconded and approved unanimously.

Meeting adjourned.