Opioid Prescribing Work Group

Minutes — December 15, 2016
noon – 3:00 p.m.
444 Lafayette Building, St. Paul

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

Members absent: Tiffany Elton, Ifeyinwa Nneka Igwe, Alvaro Sanchez, Lindsey Thomas

DHS employees: Charity Densinger, Sara Drake, Ellie Garrett, Tara Holt, Melanie LaBrie, Sarah Rinn

Guests: 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 briefly commented on the opioid report issued by the Minnesota Attorney General. Several recommendations within the report impact DHS programs, including expanding the Opioid Prescribing Improvement Program (OPIP) and removing prior authorization (PA) requirements for buprenorphine. Mary Beth Reinke informed members about specific concerns DHS has with the buprenorphine policy recommendations. In general, there is concern that removing the PA requirements would limit DHS' ability to monitor the quality of the treatment program, and negotiate prices with drug manufacturers. A lively discussion ensued about this topic, with several members voicing support for removing PA requirements for buprenorphine. DHS staff briefly discussed the possibility of lifting PA requirements for Medicaid-enrolled providers who are able to demonstrate that their MAT program includes the appropriate components.

Schiff updated the group about the Integrated Care for High Risk Pregnant Women grant. DHS issued three award letters to three of the northern tribes, and re-posted the RFP. He also informed the group that Minnesota had just received the Request for Application (RFA) for funding authorized under the 21st Century Cures Act. Minnesota is eligible for $5.3 million over two years to fund opioid use disorder prevention and treatment programs.

Approval of Minutes

No corrections were offered to the November meeting minutes. **The 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 at dhs.opioid@state.mn.us.

Rinn reviewed the changes made to the Introduction section, based on recommendations made by work group members during the November meeting. Members briefly discussed the description of recurrent acute pain provided at the bottom of page one. It was noted that there may be conflict between this description and the Workers Compensation program. Patients cared for under the workers compensation rule may perceive any new insult to be directly related to the initial injury, and request treatment under the workers compensation program. Members were reminded that a description of how these recommendations relate to the Workers Compensation program would be included in the preamble to the recommendations.

A member suggested clarifying language in the third paragraph of the Introduction to avoid unintentionally blessing the first 45 days of opioid use. Forty-five (45) days should be viewed as the outer limit of time at which continued opioid use needs to be addressed. Another member recommended removing the term pain sensation in the first paragraph under the heading *Chronic Pain*. A recommendation was made to remove the clause "that this is not evidence-based medicine" from the last full paragraph on page 2. Members were in consensus about removing the statement.

Chronic Pain Phase: Assessment Domains

Assess and document function, pain and quality of life

A member suggested using the word standardized instead of objective in the second paragraph of the recommendation.

Biopsychosocial evaluation and diagnosis

A brief discussion occurred about the concept of adverse selection, and the reinforcing nature of the risk factors that lead to chronic opioid use and abuse. High-risk patients (i.e., patients with mental health conditions) are more likely to end up on high doses of opioids over a long duration (adverse selection). However, it is also true that high-doses of opioids over a long duration creates risk among all patients. The relationship between risk factors and opioid use is cyclical, and providers must assess for risk factors on an ongoing basis.

Discussion turned to the pain typologies provided under the nociceptive or neuropathic pain recommendation. Members commented that these are accepted, traditional definitions of pain. However, this typology seems to contradict the IASP definition of pain, which highlights the sensory and emotional experience. Members expressed concern that using the traditional pain typology language may support the practice of continued

diagnostic testing until tissue damage is found. A member recommended revising the first sentence following the bolded section to state "Diagnose or confirm the diagnosis of the origin of pain **at this time**." Discussion continued about the practice and purpose of looking for a nociceptive pain generator when a patient presents with chronic pain. Members agreed that the purpose of this practice should be to identify definite (non-opioid) management for an injury. Discovery of a pain generator should allow clinicians to target the non-opioid treatment or define an end-point for opioid therapy. A brief discussion followed about whether any evidence exists to support the sense that the majority of chronic pain is neuropathic. There is a large body of literature to support this idea, but no one was aware of a single source of evidence.

Members briefly discussed the dental pain recommendation. A member recommended identifying dentists as the appropriate referral, and removing oral surgeons. Discussion then turned to opioid-induced pain. Work group members reviewed the ICSI recommendation for opioid-induced pain. The consensus of the group was to reference ICSI's description of opioid-induced pain in the recommendation. DHS staff will revise the recommendation and present to the group at the January meeting.

Psychological conditions

A brief discussion occurred about the appropriate heading for this section. Members discussed other options, including mental health or behavioral health conditions. Ultimately, members agreed that psychological conditions is an appropriate heading. Discussion then turned to the relationship between mental health conditions and chronic pain. Consensus emerged among the members to stress within these recommendations that psychological and social factors can cause, maintain and complicate pain. This represents a break from the traditional concept that psychosocial factors simply complicate pain. There is a deep relationship between an individual's pain, mental health conditions, culture, and social circumstances. Members made a number of recommendations for this section, including to revise language that maintains the sense that mental health is separate from the patient's pain. A member recommended adding a statement(s) about the patient's temperament and attitude, and how that influences his or her reaction to pain.

A brief discussion ensued about the data provided on the rates of mental health conditions among chronic pain patients. Members recommended removing the data cited, and inserting data from DHS's New Chronic User claims analysis. Discussion then turned to assessing suicidality. Members were in consensus that providers should assess suicidality prior to initiating COAT.

A member expressed concern about the recommendation to taper patients with post-traumatic stress disorder (PTSD). This is a vulnerable group of patients who require close monitoring, and a taper may not always be recommended. A brief discussion ensued about the taper recommendation, and consensus emerged to revise the recommendation to state **discuss whether to taper opioid dose**. This change will be made in each of the recommendations that address tapering under in the Psychological Conditions section. Members also recommended adding a statement after the PTSD recommendation to remind providers to consider other social risk factors that may cause, maintain or complicate pain.

A brief discussion ensued about whether to address the role of interpreters under the Cultural Context recommendation. Consensus emerged that this recommendation is intended to signal to providers to be aware of the cultural context of pain, however it is outside the scope of the OPWG to provide operational recommendations about culturally-appropriate clinical practices. Work group members recommended moving the Acute on Chronic pain recommendation to the prescribing section.

Chronic Pain Phase: Treatment Planning Domains

Patient barriers to treatment

Members suggested revising the recommendation to make it more applicable to the general public. Physical restrictions should be clearly communicated to all patients, not just those whose jobs have physical requirements. Members also recommended revising the last sentence to state: **Clinicians should help patients continue their work pattern and activities of daily living, when possible.**

Treatment goals

Members briefly discussed the treatment goals recommendation. Members agreed that elimination of pain should never be a treatment goal. A recommendation was made to remove the term objective from the statement. Members expressed concern that providers may default to relying on quantifiable measures if there is uncertainty about what constitutes an objective measure.

Treatment plan

Members addressed the list of treatment modalities included in the recommendation. Recommended changes included: removing dialectical treatment therapy; including medical cannabis; removing opioid therapy; removing traction; including self-management; and including interdisciplinary pain rehabilitation programs. An additional recommendation was made to identify one clinician or member of the care team to assume leadership over managing a multi-disciplinary treatment plan.

Meeting adjourned.