Opioid Prescribing Work Group

Minutes: Feb. 22, 2018
noon-3 p.m.
444 Lafayette Building, St. Paul

Members present: Julie Cunningham, Chris Eaton, Tiffany Elton, Dana Farley (nonvoting), Rebekah Forrest, Ifeyinwa Nneka Igwe, Brad Johnson, Chris Johnson, Ernest Lampe (nonvoting), Matthew Lewis, Pete Marshall, Murray McAllister, Richard Nadeau, Charlie Reznikoff (remotely), Jeff Schiff (nonvoting), Charles Strack

Members absent: Mary Beth Reinke (nonvoting), Lindsey Thomas

DHS employees: Titi Adeniyi, Ellie Garrett, Dave Hoang, David Kelly, Sterling Kowalski, Sarah Rinn

Guests: Jim Cook (Mercer), Kate Erickson (MDH), Audrey Hansen (ICSI), Keegan Ilenda (NDSU pharmacy student), Kelly Rousseau (Weber Shandwick), Trudy Ujdur (Sanford), Kelly Waara-Wolleat (Purdue), Lisa Wichterman (DLI), Kaylan Wilson (Pfizer)

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 two updates on opioid-related activities in state government. First, Governor Dayton released an opioid legislative package during a joint press conference with Sen. Eaton and Rep. Baker Feb. 14, 2018. Sen. Eaton shared that she is optimistic that legislation will be passed this year. The opioid stewardship proposal — also known as “penny a pill” — has received a lot of attention, and will serve as a funding mechanism for prevention and treatment expansions if enacted.

Second, Schiff announced that the National Committee for Quality Assurance (NCQA) is including the Minnesota New Chronic User measure in the measures under consideration for the Medicaid Adult Core Set (national measure set used in Medicaid programs). The measure will be tested as part of the Health care Effectiveness Data and Information Set (HEDIS) 2019 measures.

Approval of Minutes and Opportunity for Public Comment

Members unanimously approved the December meeting minutes.

No public comments were offered.

Rinn reviewed the agenda and provided three updates on the Opioid Prescribing Improvement Program (OPIP). First, DHS and the University of Minnesota’s Office of Continuing Professional Development plan to develop an online training resource on the guidelines. The resource will be publicly available, and there will

also be the opportunity to obtain continuing education credits for participation. Second, the Weber Shandwick campaign development is moving forward. Focus groups will be held next week to test creative concepts and delivery mechanisms. Third, DHS is developing a website to host the prescribing guidelines, and to later serve as a resource for the quality improvement program. DHS asked the members to ask two to three colleagues to participate in a brief online survey about the website's organization. Rinn will send a link to the survey when it is ready.

Rinn reviewed the agenda for the meeting. A copy of her presentation is available upon request.

Opioid Prescribing Guidelines: Public Comments Review and Discussion

Rinn summarized the process for collecting and responding to public comments received about the draft guidelines. She proposed the following process for discussing the public comments: 1) review recommended revisions to the guidance that do not represent a major content change; 2) review and discuss major content revisions; and 3) review and discuss any additional topics.

Rinn reviewed recommended minor content changes to the introduction and the following sections: Patient Safety, Biopsychosocial Assessment and Acute Pain Prescribing recommendations. Members discussed including a clarifying statement about the regulatory nature of the guidelines. Members recommended that the sentence state: *The guidelines are for Minnesota prescribers, and are in support of the quality improvement program for Minnesota Health Care Programs-enrolled providers. They are based on best, current evidence, consideration of other guidance, and expert, clinical opinion and experience.*

Discussion then turned to a comment that suggested providers ask their patients about previous opioid exposure or whether the patient is currently in recovery. Schiff clarified that this is not related to a provider's access to a patient's substance use disorder history. The question is about whether the existing recommendation about screening for substance use disorders should explicitly address recovery status. Several work group members expressed concern that this recommendation is too prescriptive, and that questions about recovery should naturally come up when a person indicates past substance use concerns. There was a brief discussion about whether including this question could help destigmatize substance use disorders. The work group reached consensus that this question will not be added to the recommendations.

Members discussed the recommendation to add a new recommendation about nonopioid, first line drug therapy to the Acute Pain Prescribing recommendations. The suggested new recommendation one states:

Use multimodal analgesia (e.g., NSAIDS and acetaminophen) as the first line drug therapy for acute pain management. The evidence base demonstrates that optimal doses of NSAIDS are superior in efficacy to single entity opioids, and are at least as efficacious as optimal doses of opioid combination drugs. NSAIDS and acetaminophen also have a more favorable side-effect profile than agents containing opioids.

Work group members unanimously agreed to adopt the recommendation, with an amendment to omit the last sentence in the proposed language.

Members discussed consolidating acute pain prescribing measures 10 and 11 into one recommendation about acute on chronic pain prescribing. Members stressed the importance of preventing sequential dose escalation for chronic pain. Work group members reached consensus on condensing the recommendations, but recommended adding a statement about reassessing dosage after the acute event.

Medical Cannabis

Rinn reviewed the history of medical cannabis discussions at previous OPWG meetings. She presented two items for discussion: 1) move the reference to medical cannabis in the guidelines to the Patient Safety section (from the Non-opioid and non-pharmacological treatment modalities section); and 2) revised content for the reference. Discussion ensued about the appearance of endorsing medical cannabis, which the work group members oppose. A representative from the DHS Pharmacy Services unit addressed two specific concerns about including it in the guidelines. One, medical cannabis remains a Schedule I drug which prohibits coverage under Medicaid and other federally-regulated government programs. Two, there is insufficient evidence to support medical cannabis for pain management. A lively discussion ensued, and members discussed observational studies related to medical cannabis, patient access to medical cannabis in Minnesota, clinical experience with patients, and personal, conflicting opinions about the use of medical cannabis in the midst of the opioid epidemic. Ultimately, the work group reached consensus that the medical evidence is insufficient at this time to support medical cannabis, and that the use of medical cannabis is outside of the OPWG scope.

A motion was made to include any statement about medical cannabis. Three members voted in favor, and 10 were opposed. The motion failed, and the work group recommended to not include any statement about medical cannabis in the recommendations.

Postoperative Opioid Prescribing Recommendation

Rinn informed the work group that two organizations — Mayo Clinic and Allina Health System — submitted comments about the recommendations. Both organizations recommended aligning the OPIP postoperative opioid prescribing recommendation with the tiered dose recommendation developed by ICSI on behalf of the CEO Collaborative. Rinn presented revised language for the OPWG post-operative opioid dose recommendation that would maintain MME limits previously voted upon by the OPWG, and honor and align with the ICSI recommendation.

Work group members requested clarification about the second paragraph in the recommended revision. The paragraph addresses the expectation that when opioid prescriptions > 200 MME are prescribe postoperatively, the organization will conduct risk assessments for mental health, chemical dependency and risk of chronicity. Members questioned whether it was the organization's responsibility or the prescribing clinician. Members recommended revising the statement to indicate it is the prescriber's responsibility to conduct additional, appropriate assessments. Members also recommended revising the recommendation language for clarity, but approved the overall revision.

Introduction to Chronic Pain Prescribing and Tapering Opioid Therapy Sections

Rinn commented on a pervasive theme in the public comments received: What is the appropriate course of action for long-term, stable patients receiving chronic opioid analgesic therapy?

DHS staff proposed revising the introductory statement for both sections in order to provide more clarity about the intent of the recommendations. Members reviewed the proposed language for the Chronic Pain Prescribing section. A member requested that addiction be added to the list of potential opioid-related harms for patients receiving COAT. Discussion ensued about the need for the revision, especially the proposal to remove the statement that COAT is not indicated for chronic pain. Members agreed that this recommendation

is found throughout the guidelines. DHS clarified that the intent of the revision is to indicate that the recommendations in this section pertain to all patients receiving COAT, stable or otherwise. However, it is not the intent of the recommendations to indicate that COAT patients should be abruptly cut-off therapy or that prescribers should dismiss COAT patients from their care. Members reached consensus to revise the language to state:

While the safest possible course of treatment is to avoid COAT for chronic pain, patients already receiving COAT must be carefully managed to mitigate the potential for opioid-related harm, including Opioid Use Disorder, nonfatal and fatal overdoses. The following recommendations promote careful monitoring of patients receiving COAT.

Improving functional status and reducing pain intensity remain important goals and should be accomplished through multimodal, active pain management. Titration of opioids to pain or self-reported function status is not recommended. This often leads to accelerating doses based on a perception that higher doses will effectively ameliorate pain or improve function.

Discussion then turned to the recommended introductory statement for the tapering section. Members agreed to include the following statement:

The goal of opioid tapering is to improve the risk-benefit balance for patients on COAT. Changes in co-occurring conditions, diagnoses/medications, functional status, and the duration of opioid therapy affect the risk/benefit analysis for COAT patients.

Tapering COAT to a reduced dosage or to discontinuation is challenging for both the clinician and the patient. Preparing patients for a taper is challenging and can take multiple visits and time. This is why it is encouraged to discuss tapering early and often. Clear communication about the following topics is critical prior to initiating a taper and throughout the process: 1) reasons for taper; 2) taper process; 3) pain management during the taper; and 4) management of withdrawal symptoms.

Women of Childbearing Age

Members discussed a number of suggested revisions to the women of childbearing age section submitted by a Minneapolis-based obstetrician-gynecologist. The first revision reduces the recommended opioid dosage following a cesarean section or complicated vaginal birth from 200 MME to 100 MME. This aligns with emerging evidence about opioid prescribing and utilization patterns among women who undergo cesarean sections. Work group members accepted the revision. The second recommendation was to strengthen the recommendation to discuss effective contraception with women on COAT or Medication Assisted Treatment (MAT). Work group members did not raise any concern about the revision.

Discussion then turned to the recommendations regarding opioid prescribing to lactating women. The public comments received about this section indicated that the recommended opioid formulations were incorrect. Rinn presented the revised language, which reflects current recommendations from the American Academy of Pediatrics and LActMed about preferred opioid formulations for lactating women. Work group members recommended researching tramadol as an additional formulation not recommended for lactating women. Finally, Rinn reviewed a suggested revision that better reflects estimated incident rates of Neonatal Abstinence Syndrome among fetuses exposed to opioids in utero.

Chronic Opioid Analgesic Therapy Sentinel Measures: Review and Quality Improvement Threshold Discussion

Rinn presented changes to the definition of chronic opioid analgesic therapy used in the sentinel measures. Chronic opioid analgesic therapy is defined as a ≥ 60 consecutive days supply of opioids in the measurement period. A ≤ 3 day gap is permissible between prescriptions. The new definition results in approximately 3,000 fewer enrollees identified as receiving COAT. Members compared the data on the number and rate of prescribing COAT using the new (≥ 60 consecutive days) and old (> 90 days, not consecutive) definition of COAT. Rinn provided the data on primary care providers for comparison. The data presented was the number and rate of prescribing COAT by quartile. The average and median rate of prescribing COAT among the quartiles did not change significantly.

Members reviewed the prescribing rates of high-dose COAT — based on the old COAT definition — and the quality improvement (QI) threshold that was voted upon during the December OPWG meeting. Members then reviewed the new high-dose COAT prescribing analysis and discussed whether a new QI threshold was needed based on the data. Members agreed that the QI threshold voted upon and accepted during the December OPWG meeting was still appropriate. The QI threshold for high-dose COAT prescribing is no more than 10 percent of patients receive ≥ 90 MME/day.

Rinn previewed the discussion to be held at the March meeting. The OPWG members will review the new analysis of concomitant opioid and benzodiazepine prescribing and the multiple-prescriber measure, and determine QI thresholds for the remaining COAT measures.

Meeting adjourned.