Opioid Prescribing Work Group

Minutes — December 17, 2020
12:30 pm – 3:00 pm
WebEx Video Event

Members present: Nathan Chomilo, Kurtis Couch, Julie Cunningham, Kurt DeVine, Tiffany Elton, Dana Farley, Rebekah Forrest, Chad Hope, Chris Johnson, Murray McAllister, Richard Nadeau, Adam Nelson, Charlie Reznikoff, Saudade SammuelSon, Charles Strack, Lindsey Thomas

Members absent: Ralph Bovard, Sen. Chris Eaton, Brad Johnson, Matthew Lewis

DHS employees: Ellie Garrett, Jessica Hultgren, Sarah Rinn

Guest: Bret Haake, MD, MBA (HealthPartners)

Welcome and introductions

Julie Cunningham called the meeting to order and welcomed members. Opioid Prescribing Work Group (OPWG) members and DHS staff introduced themselves.

Approval of minutes

Cunningham called for a motion to approve the October minutes. Lindsey Thomas moved to approve the minutes, Chris Johnson seconded the motion. The minutes were approved unanimously.

State agency updates

Ellie Garrett provided a brief update on the latest round of federal State Opioid Response grant funding. The request for proposals (RFP) is open and it includes technical assistance support for the OPIP quality improvement program. If anyone has not seen the RFP and are interested in reviewing it, they should contact the OPIP staff at dhs.opioid@state.mn.us.

Dana Farley provided an overview of the recently published Minnesota Department of Health (MDH) preliminary, statewide overdose death data. The report provides preliminary data for all overdose deaths in the first half of 2020. The data indicates that the death rate in 2020 will exceed previous records; the increase is driven primarily by deaths which involved synthetic opioids and psychostimulants. There is also an increase in benzodiazepine and polydrug use. MDH is also tracking the cumulative overdose deaths during COVID-19 on a weekly basis. MDH issued another report that provides information about the increase in Neonatal Abstinence Syndrome (NAS) during COVID-19. In general, there will likely be a 30% increase in overdose deaths in 2020 compared to 2019. Farley notes that the 2019 data has not been finalized yet due to delays at CDC related to the COVID-19 response.

A brief discussion ensued about the report. A member asked for clarification about the mechanism for death in psychostimulant overdoses. Members commented that the primary cause is cardiac and central nervous system events, but that methamphetamine is commonly mixed with fentanyl and many of these overdoses involve polydrug use. Discussion then turned to the synergistic effect of the opioid use crisis and the pandemic. While recovery services, and behavioral and medical health services were very nimble in the transition to telemedicine and online support, there has been a significant interruption to services. A member commented hearing anecdotally that significant numbers of patient in recovery lapsed during the initial months of COVID-19. Other members commented on the interruptions to access to Medication Assisted Treatment (MAT) at the beginning.

Opportunity for public comment

No public comments were provided.

Quality improvement program update

Jessica Hultgren provided an update on the quality improvement (QI) program. A copy of her slides are available upon request. A member asked whether the 2016-2019 comparison data about the number of providers required to participate in QI—especially for the chronic measures—is indicative of forced tapers occurring in the community. Members briefly discussed the overall consolidation of prescribing opioid therapy for chronic pain. It is difficult to understand all of the reasons for consolidation based on reviewing this data alone, but DHS hopes to learn more about the consolidation as part of the QI work and additional data analysis.

Hultgren also presented a snapshot of the updated opioid prescriber reports. Discussion ensued about how to incorporate patient safety messaging into the reports. Members suggested adding a limited number of key take-home messages to the top of the report, and that the emphasis needs to be on safety. The reports should serve to prompt education and reflection when a providers' data is dramatically different from their peers. A member suggested that we add a sheet for providers with some extra description of the measure, and—importantly—guidance on what to do and what NOT to do when reviewing the report and their prescribing practice.

Taper guidance: Public comment review

Rinn introduced the public comments received and reviewed how the OPWG would discuss the comments. A copy of her slides is available upon request. The agenda for reviewing public comments started with general themes and questions that occurred throughout the public comments, and then reviewed specific comments within each section of the guidance.

1. What is the appropriate approach to patients who are stable and functional at their current opioid dose? Do all patients require a taper?

The discussion focused on the appropriate approach to determining whether a taper is indicated: completing a thoughtful, thorough risk benefit analysis, and then if the risk outweighs the benefit, seeking a voluntary taper. If a voluntary taper cannot be achieved or fails, then the provider has to consider what to do next based on the severity of the patient's risk profile. Members challenged using criteria such as stability and functionality to

determine whether a taper is appropriate. A patient can be stable, and still at high risk for opioid related harm. The same holds true for being functional. In addition, functionality can be challenging to gauge. A member recalled a 2016 Washington Post/Kaiser Family Foundation poll that found while many patients on long-term opioid therapy viewed themselves as functional, their families and friends had significant concerns about their well-being. A member pushed back and argued that functionality means being able to complete normal activities of daily living. Discussion turned to the use of pain scales, and the subjectivity involved in assessing patients' pain and function. Members agreed that assessments that incorporate the impact of pain on ability to work, serve in caregiver roles and perform daily activities are better than numerical pain scales. A member commented that not all patients require a taper, and the guidance should be explicit about this.

Discussion briefly turned the inherent risk faced by all patients on long-term opioid therapy. A member commented that he has patients with peripheral neuropathy, and some of his patients use opioid therapy for pain management and some do not. His patients on long-term opioid therapy are at higher risk than those who do not, even if they are stable and functional. Another member commented that he always approaches a taper by first asking why the patient was prescribed opioid therapy. There have been instances when the painful condition has resolved, which helps the patient understand why a taper should occur.

Members discussed the appropriate role for third party input when considering a taper. A member commented that parental and caregiver involvement in pediatric care is standard. He asked whether it occurs very often in adult medicine, and whether guidance about engaging social support would be useful. Members whose practice involves tapering opioid therapy commented that communication and support from family is often key to a successful taper, when the patient consents and family involvement is healthy and safe.

2. Should patients who are tapering their dose be able to change their mind and reverse the taper? Should clinicians who are managing the taper offer the possibility of a return to their original dose prior to starting?

This discussion also began with a return to the appropriate approach to a taper: a thoughtful risk benefit analysis, then seeking a voluntary taper using shared decision making. If a patient is tapering their opioid therapy and their clinical situation changes, a thoughtful risk benefit analysis may indicate that it is clinically appropriate to resume a prior dose. Members agreed that this is not a common occurrence, but it could occur. Members acknowledged that doing a risk benefit analysis is very difficult, and it takes time, experience and confidence to be able to do it well.

Members agreed that a patient-centered approach to tapering, with an emphasis on shared decision making and a shared understanding of why a taper is indicated, is critical for a successful taper for most patients. For patients who are not at severe risk and who are willing to try a taper, the taper can be as slow as it needs to be. If a patient is that scenario struggles with a dose decrease, then there is an opportunity to pause. Members were cautious about incorporating language into the guidance about reversing a taper, but there was discussion about patients returning to the last stable dose when the risk to the patient is not severe. While it is better to pause the taper than return to a previous dose, it does occur. Ultimately, clinical decisions about dose changes during the taper have to be made based on the patient's risk profile and their unique circumstance.

3. Should we refer to Chronic Pain Rehabilitation Programs (CPRP) in the taper guidance?

Members initially discussed limited access to CPRPs, but acknowledged that they are an important option for a portion of the chronic pain patient population. Cunningham addressed the changing landscape of patients enrolled in Mayo's rehabilitation program. A decade ago, patients were referred to the program for opioid tapering assistance, however now it appears more patients are able to undergo tapers with their primary health care provider. There remain patients who need extra support with completing a taper, but both patients who require assistance tapering and those who do not use long term opioid therapy have similar needs in terms of dealing with life stressors. Murray McAllister commented that CPRPs are an important option, and providers should be more aware of the programs available in MN. The HHS tapering guide recommends including behavioral health providers as part of the taper team. That can be achieved by a multi-disciplinary care team in the patient's primary care setting, or referral to a CPRP.

Discussion turned back to access to these programs. A member expressed concern about the cost of these programs, and another member commented that these programs are only found in metro settings. Providers should be sensitive to the cost associated with these programs for patients. A member cautioned that if the guidance includes a referral to these programs, then providers will believe they have to refer patients to these programs. Another member expressed that his experience is that the medical community is not very familiar with the existence of these programs, often to his surprise. This type of care is very beneficial to a portion of the chronic pain population. A brief discussion ensued about the need for providers who initiate opioid therapy to be able to taper opioid therapy. If a provider uses any kind of medical intervention, they have to know how to deal with the complications and understand how to develop an exit plan.

4. Clarify what is meant by "immediate risk" of harm for opioid therapy in the following statement:

Forced tapers are not recommended, and should only be undertaken when the patient is at immediate risk from the opioids and after careful education about those risks.

Discussion began around the use of the term 'immediate risk'. A clear example of immediate risk is a patient who presents with a life-threatening complication, e.g., hypoxic brain damage, or inadequate respiratory function. These patients typically present in an emergency setting, and if the patient is abruptly weaned, it is done in an inpatient setting. Members discussed that the 'immediate risk' presented in the guidance is likely at a threshold lower than this type of emergency. A member commented on patients who present in an ER or urgent care setting who experience a non-fatal overdose. The literature indicates that most of these patients resume their previous opioid therapy, despite the obvious risk of harm.

A member commented that elements of the statement above need to be treated separately. First, providers need to address both the presence of risk and whether the risk outweighs the benefit of continuing opioid use. Second, what is the willingness of the patient to try to taper? Third, the timing of the taper should correspond to the predictable onset of the risk. For a patient who is facing life-threatening harm in an emergency setting, the severity of the risk is extremely high and an abrupt taper in an in-patient setting is reasonable. However, for a patient in an outpatient setting whose risk of harm is low but there is no benefit to continued use, the timing of the taper can be extremely slow. Again, this come backs to the careful risk benefit analysis of the patient and their individual circumstances.

Members reached consensus to remove the term 'forced tapering' from the guidance. A more accurate description is clinician-led tapering.

5. Add a paragraph to the introduction about why tapering is important and why it is possible.

This comment came from McAllister, and he presented his reason for the request. The introduction should respond to the societal belief that tapering opioid therapy inevitably leads to intolerable pain and suffering. There is a common belief that because opioids are the most powerful pain relievers, those who take them the most must have the most severe pain. Viewed in this construct, it then logically follows that tapering opioid therapy in this patient population leads to intolerable pain, suffering, depression and even suicide. This is the underlying assumption in most of the public comments DHS received about the taper guidance. There are two issues that challenge this belief model. First, the chronic pain management model that focuses on behavioral health. This model of care has been empirically supported since the 1970s. Patients are routinely tapered off of opioid therapy, and typically have less pain and greater functioning. The second issue is the epidemiology of moderate to severe persistent pain and opioid use. Moderate to severe persistent pain in the general population is very common, and the majority of these people do not use long-term opioid therapy. So it must be possible to manage this type of pain without opioid therapy, and to manage it adequately. Surveys of pain patients who do not use opioid therapy find that they are satisfied with their pain management. These two issues indicate that it is possible to manage moderate the severe chronic pain without opioids—probably not for every single person—but it is possible.

The other important factor in this construct is that the most salient predictors of long-term opioid use for chronic pain is not the severity of pain or the severity of the injury that started the pain. There are two categories that predict long-term use: 1) dose and duration, especially of initial opioid analgesic therapy; and 2) the presence of certain underlying risk factors and vulnerabilities to becoming dependent on opioid therapy. This phenomenon is also known as 'adverse selection' and there is now a significant body of evidence that shows that people who receive opioid therapy are those who are most vulnerable to the risks of long-term use. The taper guidance needs to take account of this fact, and help providers understand it so that it is not a cause for stigma, negative judgement, etc. Rather, it is a reason for additional empathy, compassion and careful patient-centered care. Tapering opioid therapy is not just an opioid medication issue, it is also a pain, suffering and mental health issue.

McAllister clarified that this understanding does not make it easier, tapering can be a very difficult task for both the patient and the provider. People with persistent pain can manage their pain well without opioids, but it takes a lot of work, multi-modal treatments and self-management. It is very hard, but it is possible.

Discussion briefly turned to opioid hyperalgesia. In primary care, this is the most misunderstood and misdiagnosed problem in patients. A member estimated that 85% of the providers he interacts with have no idea what it is. In addition, if you talk with patients about hyperalgesia, it is often a good lead in to trying a taper.

Discussion ensued about the challenge of communicating this sensitive topic. A member agreed that the concept of adverse selection is important, but the description has to be very careful. Members agreed that this is a sensitive topic, and highly stigmatized. A member commented that when we shy away from it, it only maintains the stigma. We need to create space within the document to address that there are mental health risk factors involved in this conversation, both when using opioid therapy and tapering opioid therapy. These medications are centrally active opioids and work primarily in the limbic system. They are medicating other forms of distress, and we need to talk about it.

In conclusion, a member commented on the strength of this group and its wide variety of opinions, expertise, and experience. The final product may not be 100% satisfactory to everyone and that is expected. He is encouraged by the breadth of the clinical and patient expertise and experience to inform the discussion. It is important that we focus on the message and the final product, and that it is accessible and accurate.

Meeting adjourned.