



Opioid Prescribing Work Group

Minutes — February 18, 2016
12:30 – 3:30 p.m.
444 Lafayette Building, St. Paul

Members present: Julie Cunningham, Chris Eaton, Tiffany Elton, Dana Farley (non-voting), Rebekah Forrest, Ifeyinwa Nneka Igwe, Chris Johnson, Matthew Lewis, Pete Marshall, Murray McAllister, Richard Nadeau, Charles Reznikoff, Jeff Schiff (non-voting), Matthew St. George

Members absent: Ernest Lampe (non-voting), Mary Beth Reinke (non-voting), Alvaro Sanchez, Lindsey Thomas

DHS employees: Lin Chen, Charity Donsinger, Sara Drake, Dave Hoang, Tara Holt, Ellie Garrett, Melanie LaBrie, Sarah Linville, Sarah Rinn

Guests: Irene Dang (UMN – Pharmacy), Cara Geffert (HealthPartners), Juliana Milhofer (Minnesota Medical Association), Trudy Ujdur (Sanford Health), Lisa Wichterman (DLI)

I. Welcome and Introductions

Jeff Schiff welcomed members and guests, and introductions were made around the room and with members connecting to the meeting remotely.

Schiff reported that DHS Commissioner Emily Johnson Piper has assumed leadership of the State Substance Abuse Strategy. The Strategy supports the work of the Opioid Prescribing Work Group and the State Opioid Oversight Project.

Schiff announced that Sarah Rinn accepted the Opioid Prescribing Improvement Program Coordinator position. Sarah will assume Ellie's responsibilities, and will staff the OPWG going forward.

II. Approval of Minutes

A guest, Trudy Udjur, offered a correction to the January minutes. Udjur currently works at Sanford Health, and no longer at a methadone clinic as stated in the minutes. **Upon motion made and seconded, the corrected minutes were approved unanimously.**

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

Garrett briefly recapped the previous meeting's discussions. A copy of her slides is available upon request from [OPWG staff](#). In January, members agreed that acute prescribing guidance contain strong introductory language about risks of opioids and lack of efficacy for certain conditions, stronger than the current ICSI guidance. The group adopted ICSI's guidance regarding dose and duration limit recommendations for acute prescribing, and will include a 100 morphine equivalent dose (MED) limit

for the total dose. For patients already on opioids for acute pain who present with a new, verifiable, acute injury, the acute dosage should be the same as for an opioid naïve patient.

The agenda for today is first to confirm guidance for treating acute pain in patients in recovery from opioid use disorder. Then the OPWG will (1) consider use of the PMP for acute pain; (2) address concomitant use of benzodiazepines and other sedating medications; (3) address diagnostic specificity and exclusions; (4) consider co-prescribing Naloxone for acute pain; and (4) consider patient and family education.

Garrett informed the group that at the next meeting an outpatient surgical anesthesiologist will present in conjunction with a conversation on site/specialty. The OPWG will begin discussing sentinel measures for acute pain, and post-acute prescribing will be introduced.

IV. Public comment

No public comment was made.

V. Follow-Up on Recovery Discussion

Members continued discussion of treatment of acute pain suffered by patients in recovery from addiction. A member questioned whether we want to specify the type of addiction, or whether the person is in recovery versus active addiction. Discussion ensued about treatment of acute pain for persons with a history of addiction, those in active recovery, and differences between and similarities among people addicted to different substances. Members agreed that it may be difficult to include this level of specificity in the recommendation, and that a frank conversation and close follow-up is important for patients in recovery. Schiff summarized discussions from previous meetings and the current meeting: **For patients in recovery from substance use disorder and for those with an active addiction, avoid new opioid prescriptions and explore alternative treatments for pain. If a new opioid is prescribed, prescribers must have a frank discussion with the patient about the risks associated with the new opioid, and plan for close follow-up. Prescribers should obtain a specific patient release to consult with a substance abuse provider. For patients on buprenorphine or naltrexone, consult with prescriber or pharmacist specifically trained in the drugs' pharmacology. For patients on methadone, dosage will be the same as for any patient not already on opioids. A motion was made and seconded to approve the recommendation. Motion carried unanimously.**

VI. Prescription Monitoring Program (PMP)

Discussion turned to checking the PMP when a patient presents with acute pain. Discussion ensued about whether checking the PMP should be mandatory in general, whether it should be mandatory for certain populations, and the context for which it should be checked. A member stressed that the PMP can influence prescribing practices when you learn that a patient with an acute injury has several prescriptions for narcotics. Another member offered that checking the PMP is cheaper and quicker than a urine drug screen. Members discussed generally the resistance to checking the PMP due to time constraints, and limitations on who receives access. A member expressed preference for checking the PMP over other certain assessment procedures. The member also offered that the evidence for mortality benefit is strong for the routine checking of the PMP.

A member stressed that mandatory checking of the PMP for pediatric patient populations may not be necessary, and is likely to meet resistance from pediatric providers. Discussion ensued about whether checking the PMP should be mandatory for children, and in particular, how to address drug-seeking parents of children with acute injuries. One of the challenges in these situations is that the provider is unable to query the parent, and therefore unable to learn about the parent's prescribing history. A member stated that nuanced discussions in these situations may be beneficial, given that this may be the child's first opioid exposure. A member cautioned against the slippery slope of excluding certain populations, and indicated support for a general recommendation to check the PMP. Garrett reminded the group that current ICSI guidance states to query the PMP, with no exceptions. Brief discussion ensued about when children typically begin having PMP findings, and what other drug interactions may come to light by checking the PMP.

A motion was made and seconded to require providers to check the PMP when prescribing an opioid for acute pain, and to include language in the recommendation that checking the PMP is becoming the accepted standard of care. An amendment was suggested to limit mandatory checking of the PMP to patients age 12 and above. The amendment was not adopted. The motion carried unanimously.

Members briefly discussed tracking whether providers check the PMP. Garrett reminded group that in a previous vote language was added to document action. Members agreed checking the PMP should be documented, and language about documentation will be included as part of the threshold discussion. Members also agreed to include language in the recommendation about what is not included in the PMP, e.g. methadone maintenance therapy, for educational purposes.

Discussion turned to legal issues related to the PMP. A member clarified that law enforcement requires a search warrant to look at the PMP, and Minnesota laws provide for very limited access.

VII. Concomitant use of Benzodiazepines

Discussion turned to concomitant use of opioids and benzodiazepines and other sedating medications. A member highlighted the challenges associated with release of information between psychiatrists treating a patient and providers treating the patient's pain. Another member stressed that there are not consensus-based treatment guidelines for using benzodiazepines and other hypnotics for anxiety and insomnia disorders. The group identified two patient populations to address: 1) Patients initiating opioid and benzodiazepine use at the same time; and 2) Patients with intermittent or ongoing use of benzodiazepines who are newly prescribed opioids. **A motion was made and seconded to recommend no concurrent, new prescriptions of opioids and benzodiazepines or other sedating or hypnotic medications for acute pain episodes. Motion carried unanimously.**

A motion was made and seconded to recommend that patients intermittently using benzodiazepines should be advised to limit or cease use during opioid use. For patients using benzodiazepines on ongoing basis, prescribers must advise patients to use benzodiazepines with caution, have a frank discussion with the patient the high risks associated with concomitant use, and conduct close follow-up. Motion carried unanimously.

Members agreed that providers prescribing opioids to intermittent or ongoing benzodiazepine users should use the opportunity to educate the patient about alternative therapies and risk of concomitant use.

VIII. Public Comment

Udjur (Sanford Health) spoke against prescribing benzodiazepines for anxiety and insomnia. She stated that benzodiazepines should only be used for catatonia and those presenting in the emergency department. She shared with the group that she is hopeful that the cautions about overprescribing benzodiazepines and their now more limited use will take place for opioids as well.

IX. Diagnostic Specificity and Exclusions

A member reminded the group that all guidance emphasizes the need for diagnostic precision, and that the ICSI guidelines include fibromyalgia, headache, self-limited illness, uncomplicated back and neck pain, and uncomplicated musculoskeletal pain as common pain conditions that are almost never indicated for opioids. A member clarified that these common pain conditions include both acute new presentations and acute exacerbations of a chronic condition. Members agreed that these recommendations, if followed, would constitute a significant change in current practice. Brief discussion ensued about whether recommendations can affect health systems' approaches to measuring pain.

Discussion narrowed in on specific recommendations for acute low back pain. One member suggested that the group should define what constitutes uncomplicated low back pain, and provide recommendations around specific indications of complications. One member suggested that uncomplicated back pain is present when patient has never had a back surgery. Another member suggested that uncomplicated pain is present at the first episode of back, neck, and uncomplicated musculoskeletal pain. Discussion ensued about whether to provide providers with more information about what constitutes complicated and uncomplicated pain, and the possible use of red flags associated with back pain. Members ultimately agreed that evidence of complications should be objectively verifiable. **A motion was made and seconded to adopt ICSI's guidance on common pain conditions that are almost never indicated for opioids. The non-exclusive list of conditions include: 1) fibromyalgia; 2) headache; 3) self-limited illness that usually has a low expected pain intensity; 4) uncomplicated back and neck pain; and 5) uncomplicated musculoskeletal pain. If opioids are prescribed for back, neck or musculoskeletal pain, evidence of complications must be objectively verifiable. Motion carried unanimously.**

Discussion turned to opioid treatment of acute dental pain. A member stated that the ICSI guidelines recommend treating the cause of pain before considering opioid medications. The member shared that previous practice was to provide patient with a prescription for an opioid while the patient is awaiting treatment, but it is moving towards treatment and referral first. There was a suggestion to recommend that dental pain be treated by a dentist, when available. Another member indicated that is very difficult for emergency departments to treat dental pain, and that tooth fracture from normal use typically occurs with significant underlying health concerns. **A motion was made and seconded to support and accept the ICSI non-traumatic, acute dental pain guidelines. Motion carried unanimously.**

X. Protocol Domains

The group discussed take-home naloxone when opioids are prescribed for acute pain. Garrett reminded the group that the recommendation was made to limit the duration of an opioid prescription for acute pain to 3 days with a 100 MED limit for the entire dose. She also asked the group to consider those in recovery and those who are actively using opioids. A member reminded the group that there are risks associated with naloxone, including flash pulmonary edema. A member updated the group about

forthcoming legislation around naloxone. One bill will allow pharmacists to prescribe any opioid agonist directly, and another bill will fund more access to naloxone.

A member stressed the importance of educating patients and their family members about the use of naloxone. It is better to coach family members and care givers about naloxone, given that the overdosing individual is unable to treat him or herself. Member also suggested five populations for which naloxone could be recommended: 1) individuals with substance use disorder; 2) individuals concomitantly using benzodiazepines; 3) individuals on chronic opioids with an acute injury; 4) individuals with a past overdose; and 5) individuals with respiratory insufficiency. A member suggested adding individuals coming out of incarceration who present in acute pain to the list. Schiff summarized the recommendation: **Naloxone is not contraindicated for someone receiving a prescription for opioids. Consider prescribing naloxone for all opioid prescriptions, and especially for the following populations who are at high-risk for overdose: 1) individuals with substance use disorder; 2) individuals concomitantly using benzodiazepines; 3) individuals on chronic opioids with an acute injury; 4) individuals with a past overdose; 5) individuals with respiratory insufficiency, especially sleep apnea; and 6) individuals who were recently incarcerated with a history of substance abuse. Provide education to family members and caregivers about the use of naloxone. A motion was made and seconded to approve the recommendation. Motion carried unanimously.**

Discussion turned to patient and family education. Members discussed current regulations regarding safe disposal of opioids. Minnesota state law prohibits pharmacies from taking back unused opioids. A member stressed that the proper disposal location is at a law enforcement center, given concerns about diversion at health facility locations. One member offered that patients may be disinclined to bring unused opioids to a law enforcement center, but that prescribers could suggest having a family member take it back. A member stated that the FDA and DEA approve of flushing schedule II drugs down the toilet, but the EPA does not endorse this. A member shared with the group that the health system where she works uses charcoal packs for disposal.

Members then discussed specific recommendations for patient and family education. A member stressed that the risk of overdose must be addressed. Another member strongly recommends using an agreement form to encourage discussion. Members agreed that patient and family education must address both safe use and the safe storage of opioids in a locked drawer or box. **A motion was made and seconded to adopt the ICSI patient and family education guidelines, and to add that prescribers must provide information about safe storage and safe disposal to both patients and family members with every acute opioid prescription. Advise patients prescribed opioids for acute pain to dispose of any opioids that they have not used in two weeks. The motion carried unanimously.**

Meeting adjourned.