



Opioid Prescribing Work Group

Minutes — April 21, 2016
12:00 – 3:00 p.m.
444 Lafayette Building, St. Paul

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

Members absent: Chris Eaton, Ernest Lampe, Charles Reznikoff, Matthew St. George

DHS employees: Ellie Garrett, Dave Hoang, Melanie LaBrie, Sarah Rinn

Guests: Cara Geffert (HealthPartners), Juliana Milhofer (MMA), Trudy Ujdur (Sanford Health)

I. Welcome and Introductions

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

II. Approval of Minutes

McAllister offered two corrections to the March meeting minutes. First, change the dosing description from 3-day duration to 100 MME in the recommendation for postoperative acute pain. This change makes the postoperative acute pain dosing recommendation language consistent with the general acute pain dosing recommendation. Second, clarify what additional resources are recommended for postoperative pain management for patients taking over 100 MME/day. The term “chronic pain prescriber” is unclear in the last sentence of the recommendation.

Nadeau moved to approve the minutes with both corrections. Lewis seconded the motion, and the amended minutes were approved unanimously.

III. Recap of Meeting Five Discussion and Introduction to Today’s Topics

Rinn briefly recapped the previous meeting’s discussion and introduced today’s topics for discussion. A copy of her slides is available upon request from [OPWG staff](#). In March, the OPWG developed a postoperative opioid prescribing recommendation for patients with acute pain. Members endorsed the ABCDPQRS Opioid Risk Assessment approach for all individuals age 10 and older prescribed an opioid. Members endorsed the Minnesota Dental Association recommendations for patients presenting with acute oral/facial pain in a medical facility or hospital with no dentist available, and members agreed that the postoperative opioid prescribing recommendations apply to dental extractions. The OPWG developed an acute pain prescribing recommendation for pregnant women and for children.

The agenda for today is first to discuss and vote on an acute pain prescribing recommendation for lactating women. Then the OPWG will recommend acute pain sentinel measure domains to DHS for the initial analysis of acute pain prescribing practices among MHCP enrolled providers. Finally, members will discuss the post-acute pain prescribing period, and provide general feedback on the post-acute pain prescribing protocol domains.

IV. Public comment

No public comment was provided.

V. Recommendation for Acute Pain in Lactating Women

Members revisited the recommendation for prescribing for acute pain in pregnant women and discussed whether to include language in the recommendation advising prescribers to educate themselves about the dangers of opioids to the mother and fetus. A member expressed concern that prescribers may still ascribe to the belief that opioids are benign to the fetus. The group reached consensus about adding a cautionary statement in the acute pain prescribing recommendation for pregnant women.

Sanchez motioned to include the following statement in the recommendation: Prescribers must stay current on the known risks of opioids to both the mother and the fetus. Long-term risks may include adverse behavioral and developmental outcomes. Nadeau seconded the motion, and the recommendation was approved unanimously.

The discussion then turned to the prescribing recommendation for lactating women experiencing acute pain. This population includes lactating women experiencing post-partum pain, as well as women undergoing surgery. Members discussed the apparent inconsistency between the American Academy of Pediatrics' recommendation, and anecdotal evidence of clinical practice. Members also acknowledged that specific recommendations about breastfeeding techniques, specifically those intended to limit the infant's opioid exposure, are outside the scope of the work group. Johnson summarized the recommendation: **Provide proper pain control to lactating women experiencing acute pain following birth and surgical procedures. Non-pharmacologic therapies, including cold, heat and Sitz baths, are often sufficient relief for mild pain. If pain medication is indicated, use non-opioid pain relievers and avoid prescribing opioids when possible.**

If opioids are prescribed to lactating women for acute pain, prescribe the lowest dose and duration adequate to manage the pain. The American Academy of Pediatrics cautions against the use of codeine and oxycodone for lactating women, and recommends other opioids based on lower rates of excretion into breast milk, including hydromorphone, oral morphine and butorphanol. Consult [LactMed](#) for current and comprehensive information about the secretion of specific opioids into breastmilk.

Encourage breastfeeding for women using opioids to manage acute pain following delivery and surgical procedures, but provide education about how to minimize opioid exposure in the baby. Educate mother and other caregivers to monitor the baby for excess sedation, constipation and failure to achieve weight milestones.

Lewis motioned to approve the recommendation, Thomas seconded. Motion passed unanimously.

VI. Recommendation for Acute Pain Sentinel Measure Domains

Members discussed the overall purpose for the acute pain sentinel measures. The primary goal is to provide prescribers with useful data about their prescribing practices, and reduce variation among prescribers who may be unaware that they are practicing outside of the norm. In addition, the state will use the data to identify outliers and work with them to develop an opioid prescribing quality improvement plan. **Members reached consensus that the following domains should be used in the initial data analysis of acute pain opioid prescribing practices: total morphine milligram equivalent (MME); short-acting versus long-acting; and number of pills prescribed.**

VII. Discussion of Post-Acute Pain Prescribing Period

Members participated in a general discussion about the post-acute pain period. A brief discussion ensued about the decision to define the post-acute pain period as 4 to 45 days following an acute insult. Schiff informed the group that DHS chose this specific period for the following reasons. First, the evidence supports that physiologically withdrawal can begin within this period. Second, this period is likely to capture the second, third and possibly fourth prescription after the initial prescription for acute pain; and third, previous analysis of opioid utilization among MHCP enrollees suggests that an inflection point in the transition to chronic use may occur during this period. Members identified three important factors during this period: 1) the physiologic changes that occur because a patient is using opioids; 2) patient-specific risk factors for chronic pain and chronic opioid use; and 3) the development of chronic pain.

Discussion then turned to the nature of pain during the post-acute pain period. There are several phases of pain within the post-acute pain prescribing period including: continuation of acute pain; a phase during which the risk of continuing to treat nociceptive pain with opioids may outweigh the benefits; and finally when pain is maintained by the central nervous system. Members discussed whether it is within the group's scope of work to recommend non-opioid treatment options. As the patient progresses through the post-acute pain period, the treatment plan should change and include effective, non-opioid therapies. The group agreed that it is necessary to include non-opioid treatment in the recommendations, but that the recommendations about non-opioid pain management will have to remain general.

Finally, the group discussed possible recommendations to consider for the post-acute pain period. Potential recommendations include: a dosing duration limit of 7 days, or prescribing in multiples of 7 days; requiring a plan for how and when to discontinue opioids within this period; including a prompt to replace opioids with effective, non-opioid therapies during this period; specific considerations and assessments based on the number of refills requested; appropriate referrals to specialists; and more robust assessment of patient risk factors for opioid use disorder.

Meeting adjourned.