



Opioid Prescribing Work Group

Minutes — July 21, 2016
11:30 a.m. – 3:00 p.m.
444 Lafayette Building, St. Paul

Members present: Tiffany Elton, Dana Farley (non-voting), Chris Eaton, Chris Johnson, Matthew Lewis, Pete Marshall, Murray McAllister, Richard Nadeau, Mary Beth Reinke (non-voting), Charles Reznikoff, Alvaro Sanchez, Jeff Schiff (non-voting), Matthew St. George, Lindsey Thomas

Members absent: Julie Cunningham, Rebekah Forrest, Ifeyinwa Nneka Igwe, Ernest Lampe

DHS employees: Charity Densing, Ellie Garrett, Dave Hoang, Melanie LaBrie, Kulani Mori,

Guests: Jerod Downing (Purdue), James Eelkema (Heroin Project, LTD), Cassandra Johnson (Purdue), Juliana Milhofer (MMA), Daniel Okabue (DLI), Mark Rubino (Purdue), Ann Tart (DLI), Trudy Ujdur (Sanford Health), Lisa Wichterman (DLI)

I. Welcome and Introductions

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

Jeff Schiff provided updates on opioid-related efforts at the state level. The DHS Health Services Advisory Council recently completed their recommendations for Medication Assisted Recovery (MAR). The Department of Health (MDH) and the Board of Pharmacy are developing the naloxone prescribing protocol for pharmacists. Dana Farley reported that the protocol will be completed in August, with implementation planned for October. The Integrated Care for High Risk Pregnancies RFP will be released shortly. This is a grant to support collaborative services for pregnant women with opioid use disorder. Schiff shared that the Minnesota Hospital Association is preparing a standard, hospital-based Neonatal Abstinence Syndrome protocol.

Schiff also provided updates on federal-level efforts addressing the opioid crisis. The federal Comprehensive Addiction and Recovery Act (CARA) passed in July. CMS recently proposed a revision to the HCAPHS payment methodology, which would no longer tie payment to pain management scores. The National Governor's Association released a toolkit on state efforts to address the opioid crisis.

Sarah Rinn provided a brief overview of the agenda for the meeting.

II. Approval of Minutes

No corrections were offered to the May meeting minutes. **Sanchez motioned to approve the minutes, and Thomas seconded the motion. The minutes were approved unanimously.**

III. Opportunity for Public Comment

Lexi Reed Holtum of the Steve Rummeler Foundation (disclosed receipt of Naloxone donations) provided two comments on the Acute Pain Prescribing Recommendations. First, she suggested the group strengthen the language about harms related to opioid use. See the second sentence in the first paragraph of the introduction. Second, she suggested that the group strengthen the naloxone recommendation. Pharmacies are not stocking naloxone because providers are not co-prescribing it with opioid prescriptions. Holtum stated that more education is needed about co-prescribing naloxone with opioids.

IV. Acute Pain Prescribing Recommendations: Public Comments Received

Rinn summarized comments received during the June public comment period. DHS staff will address comments related to framing of the recommendations, and references to the literature. The group then discussed the comments received. Members agreed that no changes were needed in Recommendation 1 (assess pain and function). A brief discussion ensued about the perceived clinical burdens associated with the risk assessments in Recommendation 2. Members confirmed their intent to recommend checking the PMP for every opioid prescription in the acute pain phase. The group agreed to revise Recommendation 2 to state that the clinician should consider the factors included in the ICSI ABCDPQRS opioid risk assessment mnemonic, and document any relevant risk factors that were previously unknown to the provider.

Members agreed to strike the clause “unless circumstances clearly warrant additional opioid therapy, e.g. major surgical procedure or severe trauma” from Recommendation 3. Recommendation 12 (opioid prescribing following surgical procedures or major trauma) will become Recommendation 4 in order to reduce confusion about when additional opioid therapy is appropriate. Members then agreed to modify the language in Recommendation 5 to state that clinicians should avoid prescribing opioids to individuals “with a history of substance use disorder”, instead of individuals “in recovery from substance use disorder.”

The group then briefly discussed the comments received on Recommendations 6 and 7 (concurrent opioid and benzodiazepine use). DHS will internally address a comment received that the language in the recommendations is confusing. Reznikoff then addressed the comment received by ICSI to include a daily MME limit for individuals with concomitant opioid and benzodiazepine use. Work group members reached consensus to omit a daily MME limit from the recommendation, based on concerns that a daily limit may infer safe dosage. Discussion then turned to Recommendation 8, conditions not indicated for opioid therapy. The group addressed a comment received that suggested the inclusion of specific non-pharmacologic pain treatment. Members agreed that it is outside the scope of the work group to provide evidence-based recommendations on specific non-opioid and non-pharmacological therapies. The group addressed a second comment seeking clarification about what constitutes uncomplicated and complicated musculoskeletal pain. Members reached consensus to rephrase the recommendation. DHS staff will revise the language and present into the group.

Work group members confirmed their intent to recommend that clinicians consider co-prescribing naloxone with opioids prescribed for acute pain, especially to high-risk populations. Members considered the public comment received about including a recommendation to use tamper-proof formulations. Members agreed to revisit this recommendation during the chronic pain prescribing discussion, given that most tamper proof formulations are for extended-release prescription opioids.

V. Opportunity for Public Comment

Lisa Wichterman from the Department of Labor and Industry (DLI) provided comment on the Acute Pain Prescribing Recommendations proposal. She requested that the group consider excepting individuals in the worker's compensation program from the DHS recommendations. Wichterman provided an overview of the worker's compensation rules, and rule-making process. Her primary concern is that differences between the DHS recommendations and the worker's compensation program will cause confusion among clinicians that treat both populations. There is also concern about the differential treatment of patients based on their insurance status.

The group briefly discussed the relationship between the worker's compensation program rules, and the DHS Opioid Prescribing Improvement Project (including both the recommendations and quality improvement program). The group recognizes the statutory authority of the worker's compensation program rules, and acknowledges that the DHS recommendations serve as guidelines. DHS will consider how to address this in the preamble of the prescribing recommendations when they are all completed.

VI. Post-Acute Pain Prescribing Recommendations

Rinn introduced the draft post-acute pain prescribing recommendations, and the accompanying post-acute prescribing guide. Group members discussed Recommendation 1 (assess and document pain and function) Members recommended highlighting the last sentence in paragraph two, as well as the last sentence of the first paragraph under the Function heading. There was consensus among the members that the recommendations in general require providers to become more sophisticated about the source of pain. One member commented on the misconception that tissue healing should be complete prior to discontinuing opioids. Opioids are most beneficial when tissue damage and inflammation are acute.

No changes were made to Recommendation 2 (patient education and reassurance). The group reached consensus about approving the concept of pain education in Recommendation 3, and recommending varying levels of intensity based on the patient's needs. A variety of providers should provide basic pain education, and specialists and other formally trained professionals should provide intensive pain education. Several group members voiced concerns about access to trained providers of pain education. The group recommended adding pain psychologists to the example of clinicians able to provide intensive pain education. The group approved Recommendation 4, with one minor change. The word "all" should be deleted from the last sentence of the first paragraph. Group members recommended moving Recommendation 5 (reassess nature of pain) to Recommendation 2, so that it follows the pain and function assessment recommendation.

Discussion then turned to the risk assessment recommendations. Discussion focused primarily on the timing of the assessments, as captured in the Post-Acute Pain Prescribing guide. The group made a general recommendation to remove specific assessment tools from the body of the chart, and indicate whether screening is recommended with a "Yes" or a "No". Members reached consensus that the mental health screening is not recommended at the first refill (up to 14 days) when nociceptive pain is expected. A brief discussion followed about whether the clinician is assessing for past conditions that are risk factors, or emerging issues. The group agreed that the chemical dependency screenings are looking at past behavior, and that the chronicity screenings are meant to assess emerging conditions. Members recommended to add a note to consider additional risk factors for the third refill (up to 45 days) when nociceptive pain is not expected.

Members approved Recommendation 7 (check the PMP), but discussed potential pushback among primary care providers. Providers indicate that there is an increased burden when the PMP link is not embedded in the health record system. The group approved Recommendation 8 (dose and duration), pending the addition of an MME limit. Consensus was emerging around 200 MME per seven-day increment. Members recommended adding the phrase “if appropriate” to the second sentence in Recommendation 9 (provide safety information to patients, families and caregivers).

Meeting adjourned.