

Opioid Prescribing Work Group

Minutes — June 15, 2017

noon – 3:00 p.m.

444 Lafayette Building, St. Paul

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

Members absent: Charlie Reznikoff

DHS employees: Titi Adeniyi, Charity Densinger, Ellie Garrett, Dave Hoang, Tara Holt, Chad Hope, David Kelly, Brian Zirbes (remotely)

Guests: Kira Bork (Weber Shandwick), Kate Erickson (MDH), Juliana Milhofer (MMA), Kelly Rousseau (Weber Shandwick), Kristen Thistle (Weber Shandwick), Kelley Waara-Wolleat (Purdue), Lisa Wichterman (DLI)

Welcome and Introductions

Chris Johnson called the meeting to order. Johnson welcomed members and guests, and introductions were made around the room. Members welcomed the two new OPWG members: Charlie Strack and Brad Johnson.

DHS Updates

Jeff Schiff provided a brief update on three state opioid-related activities. First, DHS is meeting with federal congressional staff in order to provide an update on opioid-related efforts. Second, the award letters were sent out to the State Targeted Response (STR) grant awardees. Schiff commented that the state is working hard to coordinate the multiple state and federally-funded projects in order to create a comprehensive response to the opioid crisis, rather than numerous independent efforts. Finally, the state has recently identified addiction treatment among the justice-involved population as a missing element among statewide coordination efforts.

Approval of Minutes

Members unanimously approved the May meeting minutes.

Opportunity for Public Comment

Sarah Rinn read a comment submitted by Laura Topor related to integrating the opioid prescribing recommendations into broader health IT efforts. A copy of her comment is available by request.

Rinn reviewed meeting logistics. A copy of the presentation is available by request to dhs.opioid@state.mn.us.

Chronic Pain Prescribing Recommendations Review

Recommendation 18. Dose and Duration

Members discussed aligning the OPWG and CDC Chronic Pain Prescribing Guideline dosage recommendation. There was unanimous agreement to change the upper limit in the OPWG recommendation to 90 MME/day from 100 MME/day. Discussion then turned to duration of the prescription and office visit frequency. Members recommended limiting prescriptions to one-month in duration, and scheduling face-to-face visits with the prescribing provider or a designee of the provider at least every 3 months. Members briefly discussed the practice of prescribing three individual month-long prescriptions at one time. No changes to the recommendation were suggested to address this practice.

Recommendation 20. Concomitant Prescribing of COAT and Benzodiazepines

Members discussed the strength of the recommendation to avoid concomitant COAT and sedative hypnotic prescriptions. Consensus emerged to revise the language to state that concomitant prescribing or establishing concomitant use should be avoided. Providers should check the Prescription Monitoring Program (PMP) to determine whether a patient is prescribed other medications, and address any concomitant use with other prescribers. Identification of concomitant prescribing should prompt providers to address medication management concerns. A member commented that coordination between providers requires the patient's consent and release of information. Discussion briefly turned to developing a special care category within health systems for patients with concomitant opioid and benzodiazepine use. Schiff commented that this would be a good topic for the CEO (ICSI) group to consider.

Recommendation 21. Tapering and Discontinuing Opioid Use

Members expressed concern about the recommendation stating "Do not taper opioids in patients with Opioid Use Disorder". The statement is too strong, and fails to capture the appropriate clinical course of action. A member recommended the following revision: "In patients with Opioid Use Disorder, offer substance use treatment, including Medication Assisted Treatment." The intent of the recommendation is to get the patient to the next level of care needed, and not to abandon the patient. Members briefly discussed whether the recommendation should include referral or provision of substance use treatment in general, or specifically MAT. MAT is the most evidence-based treatment, but the group agreed that not all patients who misuse opioids require MAT.

A brief discussion ensued about initiating COAT when there is evidence of other substance use disorders. Members expressed concern about patients with a history of misuse or abuse, especially benzodiazepine misuse, who are initiated on COAT. Although the patient may not have an active addiction, there is still considerable risk associated with previous use. Members reached consensus to add very cautionary language to the recommendations about patients with a history of substance use disorder. DHS staff will determine the appropriate place to insert this language.

Members reviewed the recommendation to discuss tapering opioids with the patient at least every 6 months. A member proposed revising the recommendation to every 3 months, in order to align with the visit frequency recommendation. Members reached consensus to change the recommendation about discussing a taper to at

least every 3 months, and to address the need for more frequent visits once a patient has begun tapering his or her dosage. Providers should ensure that the patient is not using all of his or her medication in the first week.

Recommendation 22. Substance Use Disorder

Rinn commented that DHS will review this recommendation internally to ensure consistency with other recommendations related to patients with a substance use disorder.

Recommendation 28. Reproductive Health

A member suggested adding a recommendation to monitor reproductive health in all women of childbearing age on COAT. Members agreed with adding the recommendation, but requested that additional information be provided about the known risks of opioid use in pregnancy.

Recommendation 30. Monitor for Medication Misuse, Aberrant Drug-related Behaviors, or Diversion

Members discussed a number of changes to the recommendation:

- Separate monitoring for misuse and aberrant drug-related behavior from diversion. Diversion is a criminal activity, and should be addressed separately.
- De-emphasize any punitive action against the patient, and remove any language that may be interpreted as a recommendation to abandon the patient or cease their care.
- Revise recommendation to state “If misuse is confirmed, consider treating patient for OUD or appropriate oversight of treatment”. There are a number of actions a provider can take when misuse is suspected: reducing the duration of the prescription to one week; more frequency face-to-face visits; more case management; referrals to specialists or other support; more frequent UDS, prescribing naloxone, etc. When misuse is suspected or confirmed, providers should engage all risk mitigation and monitoring strategies available to them.

Recommendation 31. Specialist Referral

Members recommended removing the statement about patients at lower risk of adverse opioid related events, and revising the recommendation to state:

Consult specialists trained in pain, addiction and mental health conditions when initiating COAT. Refer patients receiving COAT to pain, addiction, and/or mental health specialists when there is a significant risk for opioid-related harm, as appropriate for the patient’s needs. When referring a patient to another provider, the referring clinician should continue to treat the patient until a successful transfer of care has occurred.

Members briefly discussed the redundancy between Recommendations 14 and 31. DHS staff will review internally and streamline the two recommendations.

Recommendation 32. Opioid Use Disorder

Members discussed the recommendation for screening individuals for opioid use disorder. A recommendation was made to strike the first full paragraph on page 21 from the document. Members expressed concern that the statement suggested increasing opioid dosage. Members recommended the following changes:

- Highlight that pain care should not be equated with opioid management;
- Review Recommendations 10 and 32 together and address any inconsistencies or redundant language.

Recommendation: Naloxone

Members discussed a recommendation for prescribing naloxone to patients on COAT. A brief discussion ensued about the safety implications, the cost implications, and the feasibility of prescribing naloxone to every patient on COAT. **A motion was made to recommend that all patients on COAT should receive a naloxone prescription. The motion was seconded, and passed by a majority of members. Three members voted against the motion.**

Acute and Post-Acute Pain Prescribing Data Analysis Review

Acute Pain: Morphine Milligram Equivalence Review

Rinn presented the morphine milligram equivalence conversion data from the analysis of acute and post-acute prescribing data presented at the May OPWG meeting. A copy of the presentation is available by request to dhs.opioid@state.mn.us. Rinn clarified that the MME was calculated correctly initially, but the calculation was for daily MME rather than total MME. Members discussed the fact that the median daily MME is fairly consistent across the quartiles defined by prescribing rate. The total MME analysis will be completed for the July OPWG meeting.

Acute and Post-Acute Pain Prescribing Sentinel Measures

DHS staff introduced evaluating prescribing behavior in the acute pain and post-acute pain period through cumulative morphine exposure. In order to illustrate the approach, DHS staff reviewed revisions to the Acute and Post-Acute Pain Prescribing and Assessment Guide. Changes included adding a row for the acute pain phase; adding a column for Total MME Prescribed; and modifying the narrow timeframes provided within the post-acute pain period. Discussion ensued about the Total MME Prescribed column. DHS staff explained that the ranges provided within the column are consistent with the dosage and duration recommendations in the post-acute prescribing guidance. Members recommended changing the title of the column to Total MME Exposure.

Discussion turned to applying the concept of total MME exposure to the opioid prescribing sentinel measures for acute and post-acute pain. DHS staff presented the measurement concept, and reviewed the option of using benchmarks or ranges to measure and report on cumulative morphine exposure. DHS staff are preparing a data analysis of cumulative opioid exposure for the July OPWG meeting. Members reviewed benchmarks of cumulative opioid exposure selected for the analysis. The benchmarks correspond to the total MME limits provided in the OPWG recommendations, and to higher total limits documented in the medical literature. Members generally were in favor of the cumulative morphine exposure approach. A member commented that

while the approach seems promising, existing prescribing tools do not calculate cumulative morphine. Providers will likely need assistance with calculating cumulative morphine exposure when prescribing opioid therapy.

A brief discussion ensued about the utility of other columns within the Assessment and Prescribing guide. No additional changes to the prescribing guide were recommended. Discussion turned to the 2016 Deyo article in the Journal of General Internal Medicine. The study examined the association between initial opioid prescribing patterns and subsequent long-term use. Members briefly discussed the MME ranges used in the study and the benchmarks selected for future OPWG data analysis.

Meeting adjourned.