



Opioid Prescribing Work Group

Minutes — January 25, 2015
12:30 – 3:30 p.m.
444 Lafayette Building, St. Paul

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

Members absent: Matthew Lewis

DHS employees: Lin Chen, Charity Densinger, Sara Drake, Dave Hoang, Ellie Garrett, Melanie LaBrie, Sarah Rinn

Guests: Cara Geffert (HealthPartners), Juliana Milhofer (Minnesota Medical Association), Anita Richardson (Minnesota Adult & Teen Challenge), Amber Soukkala (University of Minnesota), Trudy Ujdur (Sanford Health)

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. He introduced Dana Farley as the Minnesota Department of Health's non-voting member of the work group.

Schiff reported that Chris Johnson volunteered to serve as the OPWG's chair. No other members expressed interest in doing so. **A motion was made and seconded to name Johnson as chair, and the motion carried unanimously.** He will begin serving as chair during the OPWG's next meeting.

Schiff reported that Governor Dayton appointed Emily Johnson Piper as the new Commissioner of Human Services. The legislative session will be short this year, since it's a bonding and not a budget year. DHS staff members have begun planning for the 2017 session.

Garrett announced that starting with the next meeting, the OPWG will meet regularly on the third Thursdays of each month from noon to 3:00 p.m. in room 5139 at DHS' office at 444 Lafayette Road North, St. Paul. Live webcasts and archived recordings will continue to be available. She anticipates that monthly meetings will be held through 2016, moving to bi-monthly meetings in 2017.

II. Approval of Minutes

No corrections were offered to the November and December meeting minutes. **Upon motion made and seconded, both sets of minutes were approved unanimously.**

III. Recap of Meeting Two 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 December, the OPWG approved the domain grid, with the PMP criterion moved up into the gray ("before deciding to prescribe") section of the grid. Members agreed that prescribers should document the patient's presentation of pain and diminished physical function. Prescribers should use the pain scale as a relative tool, and document concordance (or lack of concordance) of the patient's self-assessment with prescriber's objective observations. Assessments should include a medication review and brief screening for substance abuse disorder and acute suicidality. There was consensus emerging at end of the December meeting regarding endorsing the ICSI's ABCDPQRS risk assessment mnemonic.

The agenda for today is first to confirm consensus on the ABCDPQRS risk assessment approach. Then the OPWG will (1) recommend dose and duration for initial prescription immediately following the index event; (2) address acute pain that is related or unrelated to a patient's chronic pain; (3) address diagnostic specificity and exclusions; (4) consider use of the PMP; and (5) consider alternatives to opioids.

IV. Public comment

Trudy Udjur introduced herself as a mid-level provider working in a methadone clinic. She had no conflicts of interest to disclose. She spoke in favor of checking and documenting the PMP as a routine step in assessing the patient before prescribing. She also commented on the difficulty and importance of changing clinical culture around opioid prescribing. She reported that two large health systems had successfully implemented policy on chronic prescribing that supported providers in weaning their patients off of opioids successfully. She recommended that the OPWG consider a similar policy and learning from those health systems' experiences with implementation.

V. Recommendations for Dose and Duration – Initial Outpatient Prescriptions following Acute Event

A member suggested endorsing ICSI's three-day/20 pill limit, reasoning that providers are already familiar with ICSI and that these limits are appropriately conservative. Another member asked if the pill restriction created an incentive to prescribe stronger medications. Discussion ensued, and other members noted that so long as the pills are limited to short-acting (but not ultra-short-acting) formulations, dosage variation is not concerning. Others suggested that creating a morphine-equivalence limit would be helpful. The limitation would be on the total prescription, not the daily dose since daily dose is difficult to calculate with acute prescriptions that are often issued with take "as-needed-but-not-to-exceed" instructions. Discussion also ensued regarding whether to discourage certain opioids in particular, such as codeine, methadone, oxycodone or hydrocodone. Several members stressed that any prescribing guidance must discourage unnecessary opioid prescribing with strong language; risks must be stated very clearly and compared to the benefits and risks of non-opioids.

A motions was made and seconded that acute prescribing guidance contain strong introductory language (stronger than the current ICSI guidance) about risks of opioids and the lack of efficacy for certain conditions; a small group of staff and members will wordsmith the language outside the meeting and bring it back to the work group for consideration. The motion carried by a show of hands.

Brief discussion ensued, and **a motion was made and seconded to adopt ICSI's guidance regarding dose and duration limit recommendations for acute prescribing. The motion carried by a show of hands.**

A member suggested that the acute prescribing limit also contain a 120 morphine equivalence limitation for the total amount in the bottle (not just the daily dose). This should be worded clearly and come with calculation instructions. Discussion ensued about the dangers of confusion with chronic opioid limits (expressed as daily limit) and also about whether the average ceiling should be 100 or 120 morphine equivalent dosage (MED) for a 3-day supply. **Schiff called for a show of hands, and the vote was 13 in favor of 100 MED; 1 in favor of 120 MED. The motion to recommend a 100 MED limitation carried.**

Discussion turned to exceptions for particular conditions (e.g., zoster), sites/specialties (e.g., surgery and dentistry), and for treating pregnant and lactating women. A member stressed that under-treating pain following major surgery in an inpatient setting is itself dangerous, but over-prescribing after outpatient surgery is concerning. Members agreed that they needed to spend more time discussing surgical prescribing at a future meeting. Schiff stated that staff would reach out to additional surgeons and/or anesthesiologists between meetings and either report back or invite them to come to a future meeting.

Another member asked about the impact of co-pays, because it will be more expensive to fill multiple small prescriptions than a single larger prescription. Schiff clarified that the co-pay issue is relevant for Medicare and commercial payers but effectively does not impact Minnesota Health Care Programs.

Members discussed how to treat acute illness or injury in a patient already receiving chronic opioids. A person on chronic opioids will have developed tolerance, but remains vulnerable to respiratory risks. Safety concerns about respiratory impact outweigh the need for increased dosage for efficacy in an opioid-tolerant person. The American College of Surgeons advises against increasing dosages for a patient who may be opioid tolerant. Also, a chronic pain patient complaining about an acute flare-up might really be suffering withdrawal symptoms, depending on timing and amount of last dose. A member suggested that asking the patient whether they have opioids at home currently can flag whether someone might be suffering withdrawal. Discussion ensued.

Schiff summarized discussions: **For patients already receiving chronic opioids and in the absence of a verifiable, new injury, opioid dosage will not be increased for acute pain; non-opioid treatments will be offered. For an identifiable, new injury in a patient receiving chronic opioids, dosage will be the same as for any patient not already on opioids. By a show of hands, the recommendation was endorsed.**

Discussion turned to treatment of acute pain suffered by patients in recovery from addiction. For stable patients not currently using opioids or medication assisted treatment, it is important to have a frank conversation about their state of recovery and about the high risk of addiction. It's also important to notify their substance abuse specialist or to refer them to a substance abuse professional. The patient should be engaged in the decision, with a clear understanding of the risks and benefits of opioid treatment for their injury.

Treatment of patients currently receiving medication-assisted treatment for opioid dependence is complex. A members stressed that risk of addiction is very high, and opioid analgesia should be avoided if at all possible. The patient should clearly understand risks, and should sign specific permission allowing release of substance abuse treatment information.

A member stated that buprenorphine and naltrexone will inhibit an opioid's effectiveness; patients can't be easily treated with opioid analgesia and with either of those substances simultaneously. Consultation with a prescriber or pharmacist specifically trained in the pharmacology of the drugs is required.

A member stated that treating acute pain in patients receiving methadone treatment is analogous to treating acute pain in a patient using chronic opioid analgesia except that the risk of addiction is particularly high. Acute analgesia dosage should not be adjusted upwards for tolerance, because of the respiratory risks.

The meeting was adjourned.